

107TH CONGRESS  
2D SESSION

# H. R. 5451

To amend title XVIII of the Social Security Act to modernize and reform payments and the regulatory structure of the Medicare Program to assure access to health care for senior citizens, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 24, 2002

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

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## A BILL

To amend title XVIII of the Social Security Act to modernize and reform payments and the regulatory structure of the Medicare Program to assure access to health care for senior citizens, and for other purposes.

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

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

6 (a) SHORT TITLE.—This Act may be cited as the  
7 “Seniors’ Access to Health Care Act of 2002”.

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

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

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

#### TITLE I—REFERENCES IN ACT

Sec. 101. References in Act.

#### TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

##### Subtitle A—Medicare+Choice Revitalization

- Sec. 201. Medicare+Choice improvements.
- Sec. 202. Making permanent change in Medicare+Choice reporting deadlines  
and annual, coordinated election period.
- Sec. 203. Avoiding duplicative State regulation.
- Sec. 204. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 205. Medicare MSAs.
- Sec. 206. Extension of reasonable cost and SHMO contracts.

##### Subtitle B—Medicare+Choice Competition Program

- Sec. 211. Medicare+Choice competition program.
- Sec. 212. Demonstration program for competitive-demonstration areas.
- Sec. 213. Conforming amendments.

#### TITLE III—RURAL HEALTH CARE IMPROVEMENTS

- Sec. 301. Reference to full market basket increase for sole community hos-  
pitals.
- Sec. 302. Enhanced disproportionate share hospital (DSH) treatment for rural  
hospitals and urban hospitals with fewer than 100 beds.
- Sec. 303. 2-year phased-in increase in the standardized amount in rural and  
small urban areas to achieve a single, uniform standardized  
amount.
- Sec. 304. More frequent update in weights used in hospital market basket.
- Sec. 305. Improvements to critical access hospital program.
- Sec. 306. Extension of temporary increase for home health services furnished  
in a rural area.

- Sec. 307. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.
- Sec. 308. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.
- Sec. 309. GAO study of geographic differences in payments for physicians' services.
- Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 311. Relief for certain non-teaching hospitals.

#### TITLE IV—PROVISIONS RELATING TO PART A

##### Subtitle A—Inpatient Hospital Services

- Sec. 401. Revision of acute care hospital payment updates.
- Sec. 402. 2-year increase in level of adjustment for indirect costs of medical education (IME).
- Sec. 403. Recognition of new medical technologies under inpatient hospital PPS.
- Sec. 404. Phase-in of Federal rate for hospitals in Puerto Rico.
- Sec. 405. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 406. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 407. Reference to provision for more frequent updates in the weights used in hospital market basket.
- Sec. 408. Reference to provision making improvements to critical access hospital program.
- Sec. 409. GAO study on improving the hospital wage index.

##### Subtitle B—Skilled Nursing Facility Services

- Sec. 411. Payment for covered skilled nursing facility services.

##### Subtitle C—Hospice

- Sec. 421. Coverage of hospice consultation services.
- Sec. 422. 10 percent increase in payment for hospice care furnished in a frontier area.
- Sec. 423. Rural hospice demonstration project.

##### Subtitle D—Other Provisions

- Sec. 431. Demonstration project for use of recovery audit contractors for part A services.

#### TITLE V—PROVISIONS RELATING TO PART B

##### Subtitle A—Physicians' Services

- Sec. 501. Revision of updates for physicians' services.
- Sec. 502. Studies on access to physicians' services.
- Sec. 503. MedPAC report on payment for physicians' services.

- Sec. 504. 1-year extension of treatment of certain physician pathology services under medicare.
- Sec. 505. Physician fee schedule wage index revision.

#### Subtitle B—Other Services

- Sec. 511. Payment for ambulance services.
- Sec. 512. 2-year extension of moratorium on therapy caps; provisions relating to reports.
- Sec. 513. Coverage of an initial preventive physical examination.
- Sec. 514. Renal dialysis services.
- Sec. 515. Improved payment for certain mammography services.
- Sec. 516. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 517. Coverage of cholesterol and blood lipid screening.

### TITLE VI—PROVISIONS RELATING TO PARTS A AND B

#### Subtitle A—Home Health Services

- Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.
- Sec. 602. Update in home health services.
- Sec. 603. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
- Sec. 604. MedPAC study on medicare margins of home health agencies.
- Sec. 605. Clarification of treatment of occasional absences in determining whether an individual is confined to the home.

#### Subtitle B—Direct Graduate Medical Education

- Sec. 611. Extension of update limitation on high cost programs.
- Sec. 612. Redistribution of unused resident positions.

#### Subtitle C—Other Provisions

- Sec. 621. Modifications to Medicare Payment Advisory Commission (MedPAC).
- Sec. 622. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
- Sec. 623. Demonstration project for medical adult day care services.
- Sec. 624. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

### TITLE VII—MEDICARE BENEFITS ADMINISTRATION

- Sec. 701. Establishment of Medicare Benefits Administration.

### TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

#### Subtitle A—Regulatory Reform

- Sec. 801. Construction; definition of supplier.
- Sec. 802. Issuance of regulations.
- Sec. 803. Compliance with changes in regulations and policies.
- Sec. 804. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

- Sec. 811. Increased flexibility in medicare administration.
- Sec. 812. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

- Sec. 821. Provider education and technical assistance.
- Sec. 822. Small provider technical assistance demonstration program.
- Sec. 823. Medicare provider ombudsman; medicare beneficiary ombudsman.
- Sec. 824. Beneficiary outreach demonstration program.

Subtitle D—Appeals and Recovery

- Sec. 831. Transfer of responsibility for medicare appeals.
- Sec. 832. Process for expedited access to review.
- Sec. 833. Revisions to medicare appeals process.
- Sec. 834. Prepayment review.
- Sec. 835. Recovery of overpayments.
- Sec. 836. Provider enrollment process; right of appeal.
- Sec. 837. Process for correction of minor errors and omissions on claims without pursuing appeals process.
- Sec. 838. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle E—Miscellaneous Provisions

- Sec. 841. Policy development regarding evaluation and management (E & M) documentation guidelines.
- Sec. 842. Improvement in oversight of technology and coverage.
- Sec. 843. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 844. EMTALA improvements.
- Sec. 845. Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group.
- Sec. 846. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.
- Sec. 847. Application of OSHA bloodborne pathogens standard to certain hospitals.
- Sec. 848. BIPA-related technical amendments and corrections.
- Sec. 849. Conforming authority to waive a program exclusion.
- Sec. 850. Treatment of certain dental claims.
- Sec. 851. Annual publication of list of national coverage determinations.

TITLE IX—MEDICAID PROVISIONS

- Sec. 901. National Bipartisan Commission on the Future of Medicaid.
- Sec. 902. Disproportionate share hospital (DSH) payments.

1 **TITLE I—REFERENCES IN ACT**

2 **SEC. 101. REFERENCES IN ACT.**

3 In this Act:

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

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

7 **TITLE        II—MEDICARE+CHOICE**  
 8 **REVITALIZATION                    AND**  
 9 **MEDICARE+CHOICE                COM-**  
 10 **PETITION PROGRAM**  
 11 **Subtitle A—Medicare+Choice**  
 12 **Revitalization**

13 **SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.**

14           (a) EQUALIZING PAYMENTS BETWEEN FEE-FOR-  
 15 SERVICE AND MEDICARE+CHOICE.—

16           (1) IN GENERAL.—Section 1853(c)(1) (42  
 17 U.S.C. 1395w–23(c)(1)) is amended by adding at  
 18 the end the following:

19                   “(D) BASED ON 100 PERCENT OF FEE-  
 20 FOR-SERVICE COSTS.—

21                   “(i) IN GENERAL.—For 2003 and  
 22 2004, the adjusted average per capita cost  
 23 for the year involved, determined under  
 24 section 1876(a)(4) for the  
 25 Medicare+Choice payment area for serv-

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

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

22          (2) CONFORMING AMENDMENT.—Such section  
23          is further amended, in the matter before subpara-  
24          graph (A), by striking “or (C)” and inserting “(C),  
25          or (D)”.

1 (b) REVISION OF BLEND.—

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

10 (2) CHANGE IN BUDGET NEUTRALITY.—Section  
 11 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

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

14 (B) in paragraph (5), by inserting “(before  
 15 2003)” after “for each year”.

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

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

24 “(v) For 2003 and 2004, 103 percent  
 25 of the annual Medicare+Choice capitation

1 rate under this paragraph for the area for  
2 the previous year.

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

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

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

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

18 “(E) INCLUSION OF COSTS OF DOD AND  
19 VA MILITARY FACILITY SERVICES TO MEDICARE-  
20 ELIGIBLE BENEFICIARIES.—In determining the  
21 area-specific Medicare+Choice capitation rate  
22 under subparagraph (A) for a year (beginning  
23 with 2003), the annual per capita rate of pay-  
24 ment for 1997 determined under section  
25 1876(a)(1)(C) shall be adjusted to include in

1 the rate the Secretary's estimate, on a per cap-  
2 ita basis, of the amount of additional payments  
3 that would have been made in the area involved  
4 under this title if individuals entitled to benefits  
5 under this title had not received services from  
6 facilities of the Department of Defense or the  
7 Department of Veterans Affairs.”.

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

16 (f) MEDPAC STUDY OF AAPCC.—

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

23 (A) the bases for variation in such costs  
24 between different areas, including differences in  
25 input prices, utilization, and practice patterns;

1 (B) the appropriate geographic area for  
2 payment under the Medicare+Choice program  
3 under part C of title XVIII of such Act; and

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

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

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

1 **SEC. 202. MAKING PERMANENT CHANGE IN**  
2 **MEDICARE+CHOICE REPORTING DEADLINES**  
3 **AND ANNUAL, COORDINATED ELECTION PE-**  
4 **RIOD.**

5 (a) **CHANGE IN REPORTING DEADLINE.**—Section  
6 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by  
7 section 532(b)(1) of the Public Health Security and Bio-  
8 terrorism Preparedness and Response Act of 2002, is  
9 amended by striking “2002, 2003, and 2004 (or July 1  
10 of each other year)” and inserting “2002 and each subse-  
11 quent year (or July 1 of each year before 2002)”.

12 (b) **DELAY IN ANNUAL, COORDINATED ELECTION**  
13 **PERIOD.**—Section 1851(e)(3)(B) (42 U.S.C. 1395w–  
14 21(e)(3)(B)), as amended by section 532(e)(1)(A) of the  
15 Public Health Security and Bioterrorism Preparedness  
16 and Response Act of 2002, is amended by striking “and  
17 after 2005, the month of November before such year and  
18 with respect to 2003, 2004, and 2005” and inserting “,  
19 the month of November before such year and with respect  
20 to 2003 and any subsequent year”.

21 (c) **ANNUAL ANNOUNCEMENT OF PAYMENT**  
22 **RATES.**—Section 1853(b)(1) (42 U.S.C. 1395w–  
23 23(b)(1)), as amended by section 532(d)(1) of the Public  
24 Health Security and Bioterrorism Preparedness and Re-  
25 sponse Act of 2002, is amended by striking “and after  
26 2005 not later than March 1 before the calendar year con-

1 cerned and for 2004 and 2005” and inserting “not later  
2 than March 1 before the calendar year concerned and for  
3 2004 and each subsequent year”.

4 (d) **REQUIRING PROVISION OF AVAILABLE INFORMA-**  
5 **TION COMPARING PLAN OPTIONS.**—The first sentence of  
6 section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w-  
7 21(d)(2)(A)(ii)) is amended by inserting before the period  
8 the following: “to the extent such information is available  
9 at the time of preparation of materials for the mailing”.

10 **SEC. 203. AVOIDING DUPLICATIVE STATE REGULATION.**

11 (a) **IN GENERAL.**—Section 1856(b)(3) (42 U.S.C.  
12 1395w-26(b)(3)) is amended to read as follows:

13 “(3) **RELATION TO STATE LAWS.**—The stand-  
14 ards established under this subsection shall super-  
15 sede any State law or regulation (other than State  
16 licensing laws or State laws relating to plan sol-  
17 vency) with respect to Medicare+Choice plans which  
18 are offered by Medicare+Choice organizations under  
19 this part.”.

20 (b) **EFFECTIVE DATE.**—The amendment made by  
21 subsection (a) shall take effect on the date of the enact-  
22 ment of this Act.

1 **SEC. 204. SPECIALIZED MEDICARE+CHOICE PLANS FOR**  
2 **SPECIAL NEEDS BENEFICIARIES.**

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

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

13 “(4) SPECIALIZED MEDICARE+CHOICE PLANS  
14 FOR SPECIAL NEEDS BENEFICIARIES.—

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

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

23 “(i) is institutionalized (as defined by  
24 the Secretary);

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

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

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

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

20           (d) REPORT TO CONGRESS.—Not later than Decem-  
21   ber 31, 2005, the Medicare Benefits Administrator shall  
22   submit to Congress a report that assesses the impact of  
23   specialized Medicare+Choice plans for special needs bene-  
24   ficiaries on the cost and quality of services provided to  
25   enrollees. Such report shall include an assessment of the

1 costs and savings to the medicare program as a result of  
2 amendments made by subsections (a), (b), and (c).

3 (e) EFFECTIVE DATES.—

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

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

15 **SEC. 205. MEDICARE MSAS.**

16 (a) EXEMPTION FROM REPORTING ENROLLEE EN-  
17 COUNTER DATA.—

18 (1) IN GENERAL.—Section 1852(e)(1) (42  
19 U.S.C. 1395w–22(e)(1)) is amended by inserting  
20 “(other than MSA plans)” after “Medicare+Choice  
21 plans”.

22 (2) CONFORMING AMENDMENTS.—Section 1852  
23 (42 U.S.C. 1395w–22) is amended—

1 (A) in subsection (c)(1)(I), by inserting be-  
2 fore the period at the end the following: “if re-  
3 quired under such section”; and

4 (B) in subparagraphs (A) and (B) of sub-  
5 section (e)(2), by striking “, a non-network  
6 MSA plan,” and “, NON-NETWORK MSA  
7 PLANS,” each place it appears.

8 (b) MAKING PROGRAM PERMANENT AND ELIMI-  
9 NATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w-  
10 21(b)(4)) is amended—

11 (1) in the heading, by striking “ON A DEM-  
12 ONSTRATION BASIS”;

13 (2) by striking the first sentence of subpara-  
14 graph (A); and

15 (3) by striking the second sentence of subpara-  
16 graph (C).

17 (c) APPLYING LIMITATIONS ON BALANCE BILL-  
18 ING.—Section 1852(k)(1) (42 U.S.C. 1395w-22(k)(1)) is  
19 amended by inserting “or with an organization offering  
20 a MSA plan” after “section 1851(a)(2)(A)”.

21 (d) ADDITIONAL AMENDMENT.—Section  
22 1851(e)(5)(A) (42 U.S.C. 1395w-21(e)(5)(A)) is amend-  
23 ed—

24 (1) by adding “or” at the end of clause (i);

- 1           (2) by striking “, or” at the end of clause (ii)  
2           and inserting a semicolon; and  
3           (3) by striking clause (iii).

4 **SEC. 206. EXTENSION OF REASONABLE COST AND SHMO**  
5 **CONTRACTS.**

6           (a) REASONABLE COST CONTRACTS.—

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

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

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

16                   (C) by adding at the end the following new  
17                   clause:

18           “(ii) In the case in which—

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

22                   “(II) such area is no longer included in such  
23                   service area after such date by reason of the oper-  
24                   ation of clause (i) because of the inclusion of such

1 area within the service area of a Medicare+Choice  
2 plan; and

3 “(III) all Medicare+Choice plans subsequently  
4 terminate coverage in such area;  
5 such reasonable cost reimbursement contract may be ex-  
6 tended and renewed to cover such area (so long as it is  
7 not included in the service area of any Medicare+Choice  
8 plan).”.

9 (2) STUDY.—The Medicare Benefits Adminis-  
10 trator shall conduct a study of an appropriate tran-  
11 sition for plans offered under reasonable cost con-  
12 tracts under section 1876 of the Social Security Act  
13 on and after January 1, 2005. Such a transition  
14 may take into account whether there are one or  
15 more coordinated care Medicare+Choice plans being  
16 offered in the areas involved. Not later than Feb-  
17 ruary 1, 2004, the Administrator shall submit to  
18 Congress a report on such study and shall include  
19 recommendations regarding any changes in the  
20 amendment made by paragraph (1) as the Adminis-  
21 trator determines to be appropriate.

22 (b) EXTENSION OF SOCIAL HEALTH MAINTENANCE  
23 ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

24 (1) IN GENERAL.—Section 4018(b)(1) of the  
25 Omnibus Budget Reconciliation Act of 1987 is

1 amended by striking “the date that is 30 months  
 2 after the date that the Secretary submits to Con-  
 3 gress the report described in section 4014(c) of the  
 4 Balanced Budget Act of 1997” and inserting “De-  
 5 cember 31, 2004”.

6 (2) SHMOS OFFERING MEDICARE+CHOICE  
 7 PLANS.—Nothing in such section 4018 shall be con-  
 8 strued as preventing a social health maintenance or-  
 9 ganization from offering a Medicare+Choice plan  
 10 under part C of title XVIII of the Social Security  
 11 Act.

## 12 **Subtitle B—Medicare+Choice** 13 **Competition Program**

### 14 **SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.**

15 (a) SUBMISSION OF BID AMOUNTS.—Section 1854  
 16 (42 U.S.C. 1395w–24) is amended—

17 (1) in the heading by inserting “AND BID  
 18 AMOUNTS” after “PREMIUMS”;

19 (2) in subsection (a)(1)(A)—

20 (A) by striking “(A)” and inserting “(A)(i)  
 21 if the following year is before 2005,”; and

22 (B) by inserting before the semicolon at  
 23 the end the following: “or (ii) if the following  
 24 year is 2005 or later, the information described  
 25 in paragraph (6)(A)”;

1           (3) by adding at the end of subsection (a) the  
2 following:

3           “(6) SUBMISSION OF BID AMOUNTS BY  
4 MEDICARE+CHOICE ORGANIZATIONS.—

5           “(A) INFORMATION TO BE SUBMITTED.—

6           The information described in this subparagraph  
7 is as follows:

8           “(i) The monthly aggregate bid  
9 amount for provision of all items and serv-  
10 ices under this part and the actuarial basis  
11 for determining such amount.

12           “(ii) The proportions of such bid  
13 amount that are attributable to—

14           “(I) the provision of statutory  
15 benefits (such portion referred to in  
16 this part as the ‘unadjusted monthly  
17 bid amount’); and

18           “(II) the provision of non-statu-  
19 tory benefits;  
20 and the actuarial basis for determining  
21 such proportions.

22           “(iii) Such additional information as  
23 the Administrator may require to verify  
24 the actuarial bases described in clauses (i)  
25 and (ii).

1           “(B) STATUTORY BENEFITS DEFINED.—

2           For purposes of this part, the term ‘statutory  
3           benefits’ means benefits under parts A and B.

4           “(C) ACCEPTANCE AND NEGOTIATION OF

5           BID AMOUNTS.—The Administrator has the au-

6           thority to negotiate regarding monthly bid

7           amounts submitted under subparagraph (A)

8           (and the proportion described in subparagraph

9           (A)(ii)). The Administrator may reject such a

10          bid amount or proportion if the Administrator

11          determines that such amount or proportion is

12          not supported by the actuarial bases provided

13          under subparagraph (A).”.

14          (b) PROVIDING FOR BENEFICIARY SAVINGS FOR

15          CERTAIN PLANS.—

16                 (1) IN GENERAL.—Section 1854(b) (42 U.S.C.

17                 1395w-24(b)) is amended—

18                         (A) by adding at the end of paragraph (1)

19                         the following new subparagraph:

20                                 “(C) BENEFICIARY REBATE RULE.—

21   “(i)                         REQUIREMENT.—The

22   Medicare+Choice plan shall provide to the

23   enrollee a monthly rebate equal to 75 per-

24   cent of the average per capita savings (if

1 any) described in paragraph (3) applicable  
2 to the plan and year involved.

3 “(iii) FORM OF REBATE.—A rebate  
4 required under this subparagraph shall be  
5 provided—

6 “(I) through the crediting of the  
7 amount of the rebate towards the  
8 Medicare+Choice monthly supple-  
9 mentary beneficiary premium;

10 “(II) through a direct monthly  
11 payment (through electronic funds  
12 transfer or otherwise); or

13 “(III) through other means ap-  
14 proved by the Medicare Benefits Ad-  
15 ministrator,

16 or any combination thereof.”; and

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

19 “(3) COMPUTATION OF AVERAGE PER CAPITA  
20 MONTHLY SAVINGS.—For purposes of paragraph  
21 (1)(C)(i), the average per capita monthly savings re-  
22 ferred to in such paragraph for a Medicare+Choice  
23 plan and year is computed as follows:

24 “(A) DETERMINATION OF STATE-WIDE AV-  
25 ERAGE RISK ADJUSTMENT.—

1           “(i) IN GENERAL.—The Medicare  
2           Benefits Administrator shall determine, at  
3           the same time rates are promulgated under  
4           section 1853(b)(1) (beginning with 2005),  
5           for each State the average of the risk ad-  
6           justment factors to be applied to enrollees  
7           under section 1853(a)(1)(A) in that State.  
8           In the case of a State in which a  
9           Medicare+Choice plan was offered in the  
10          previous year, the Administrator may com-  
11          pute such average based upon risk adjust-  
12          ment factors applied in that State in a pre-  
13          vious year.

14          “(ii) TREATMENT OF NEW STATES.—  
15          In the case of a State in which no  
16          Medicare+Choice plan was offered in the  
17          previous year, the Administrator shall esti-  
18          mate such average. In making such esti-  
19          mate, the Administrator may use average  
20          risk adjustment factors applied to com-  
21          parable States or applied on a national  
22          basis.

23          “(B) DETERMINATION OF RISK ADJUSTED  
24          BENCHMARK AND RISK-ADJUSTED BID.—For

1 each Medicare+Choice plan offered in a State,  
2 the Administrator shall—

3 “(i) adjust the fee-for-service area-  
4 specific benchmark amount by the applica-  
5 ble average risk adjustment factor com-  
6 puted under subparagraph (A); and

7 “(ii) adjust the unadjusted monthly  
8 bid amount by such applicable average risk  
9 adjustment factor.

10 “(C) DETERMINATION OF AVERAGE PER  
11 CAPITA MONTHLY SAVINGS.—The average per  
12 capita monthly savings described in this sub-  
13 paragraph is equal to the amount (if any) by  
14 which—

15 “(i) the risk-adjusted benchmark  
16 amount computed under subparagraph  
17 (B)(i), exceeds

18 “(ii) the risk-adjusted bid computed  
19 under subparagraph (B)(ii).

20 “(D) AUTHORITY TO DETERMINE RISK AD-  
21 JUSTMENT FOR AREAS OTHER THAN STATES.—  
22 The Administrator may provide for the deter-  
23 mination and application of risk adjustment  
24 factors under this paragraph on the basis of  
25 areas other than States.”.

1           (2) COMPUTATION OF FEE-FOR-SERVICE AREA-  
2 SPECIFIC BENCHMARK.—Section 1853 (42 U.S.C.  
3 1395w–23) is amended by adding at the end the fol-  
4 lowing new subsection:

5           “(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPE-  
6 CIFIC BENCHMARK AMOUNT.—For purposes of this part,  
7 the term ‘fee-for-service area-specific benchmark amount’  
8 means, with respect to a Medicare+Choice payment area  
9 for a month in a year, an amount equal to the greater  
10 of the following (but in no case less than  $\frac{1}{12}$  of the rate  
11 computed under subsection (c)(1), without regard to sub-  
12 paragraph (A), for the year):

13           “(1) BASED ON 100 PERCENT OF FEE-FOR-  
14 SERVICE COSTS IN THE AREA.—An amount equal to  
15  $\frac{1}{12}$  of 100 percent (for 2005 through 2007, or 95  
16 percent for 2008 and years thereafter) of the ad-  
17 justed average per capita cost for the year involved,  
18 determined under section 1876(a)(4) for the  
19 Medicare+Choice payment area, for the area and  
20 the year involved, for services covered under parts A  
21 and B for individuals entitled to benefits under part  
22 A and enrolled under part B who are not enrolled  
23 in a Medicare+Choice plan under this part for the  
24 year, and adjusted to exclude from such cost the  
25 amount the Medicare Benefits Administrator esti-

1 mates is payable for costs described in subclauses (I)  
2 and (II) of subsection (c)(3)(C)(i) for the year in-  
3 volved and also adjusted in the manner described in  
4 subsection (c)(1)(D)(ii) (relating to inclusion of  
5 costs of VA and DOD military facility services to  
6 medicare-eligible beneficiaries).

7 “(2) MINIMUM MONTHLY AMOUNT.—The min-  
8 imum amount specified in this paragraph is the  
9 amount specified in subsection (c)(1)(B)(iv) for the  
10 year involved.”.

11 (c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

12 (1) IN GENERAL.—Section 1853(a)(1)(A) (42  
13 U.S.C. 1395w–23) is amended by striking “in an  
14 amount” and all that follows and inserting the fol-  
15 lowing: “in an amount determined as follows:

16 “(i) PAYMENT BEFORE 2005.—For  
17 years before 2005, the payment amount  
18 shall be equal to  $\frac{1}{12}$  of the annual  
19 Medicare+Choice capitation rate (as cal-  
20 culated under subsection (e)) with respect  
21 to that individual for that area, reduced by  
22 the amount of any reduction elected under  
23 section 1854(f)(1)(E) and adjusted under  
24 clause (iii).

1           “(ii) PAYMENT FOR STATUTORY BEN-  
2 EFITS BEGINNING WITH 2005.—For years  
3 beginning with 2005—

4           “(I) PLANS WITH BIDS BELOW  
5 BENCHMARK.—In the case of a plan  
6 for which there are average per capita  
7 monthly savings described in section  
8 1854(b)(3)(C), the payment under  
9 this subsection is equal to the  
10 unadjusted monthly bid amount, ad-  
11 justed under clause (iii), plus the  
12 amount of the monthly rebate com-  
13 puted under section 1854(b)(1)(C)(i)  
14 for that plan and year.

15           “(II) PLANS WITH BIDS AT OR  
16 ABOVE BENCHMARK.—In the case of a  
17 plan for which there are no average  
18 per capita monthly savings described  
19 in section 1854(b)(3)(C), the payment  
20 amount under this subsection is equal  
21 to the fee-for-service area-specific  
22 benchmark amount, adjusted under  
23 clause (iii).

24           “(iii) DEMOGRAPHIC ADJUSTMENT,  
25 INCLUDING ADJUSTMENT FOR HEALTH

1 STATUS.—The Administrator shall adjust  
2 the payment amount under clause (i), the  
3 unadjusted monthly bid amount under  
4 clause (ii)(I), and the fee-for-service area-  
5 specific benchmark amount under clause  
6 (ii)(II) for such risk factors as age, dis-  
7 ability status, gender, institutional status,  
8 and such other factors as the Adminis-  
9 trator determines to be appropriate, in-  
10 cluding adjustment for health status under  
11 paragraph (3), so as to ensure actuarial  
12 equivalence. The Administrator may add  
13 to, modify, or substitute for such adjust-  
14 ment factors if such changes will improve  
15 the determination of actuarial equiva-  
16 lence.”.

17 (d) CONFORMING AMENDMENTS.—

18 (1) PROTECTION AGAINST BENEFICIARY SELEC-  
19 TION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w-  
20 22(b)(1)(A)) is amended by adding at the end the  
21 following: “The Administrator shall not approve a  
22 plan of an organization if the Administrator deter-  
23 mines that the benefits are designed to substantially  
24 discourage enrollment by certain Medicare+Choice  
25 eligible individuals with the organization.”.

1           (2) CONFORMING AMENDMENT TO PREMIUM  
2           TERMINOLOGY.—Subparagraphs (A) and (B) of sec-  
3           tion 1854(b)(2) (42 U.S.C. 1395w-24(b)(2)) are  
4           amended to read as follows:

5                   “(A) MEDICARE+CHOICE MONTHLY BASIC  
6           BENEFICIARY PREMIUM.—The term  
7           ‘Medicare+Choice monthly basic beneficiary  
8           premium’ means, with respect to a  
9           Medicare+Choice plan—

10                   “(i) described in section  
11           1853(a)(1)(A)(ii)(I) (relating to plans pro-  
12           viding rebates), zero; or

13                   “(ii) described in section  
14           1853(a)(1)(A)(ii)(II), the amount (if any)  
15           by which the unadjusted monthly bid  
16           amount exceeds the fee-for-service area-  
17           specific benchmark amount.

18                   “(B) MEDICARE+CHOICE MONTHLY SUP-  
19           PLEMENTAL BENEFICIARY PREMIUM.—The  
20           term ‘Medicare+Choice monthly supplemental  
21           beneficiary premium’ means, with respect to a  
22           Medicare+Choice plan, the portion of the ag-  
23           gregate monthly bid amount submitted under  
24           clause (i) of subsection (a)(6)(A) for the year

1           that is attributable under such section to the  
2           provision of nonstatutory benefits.”.

3           (3) REQUIREMENT FOR UNIFORM BID  
4           AMOUNTS.—Section 1854(e) (42 U.S.C. 1395w–  
5           24(c)) is amended to read as follows:

6           “(c) UNIFORM BID AMOUNTS.—The  
7           Medicare+Choice monthly bid amount submitted under  
8           subsection (a)(6) of a Medicare+Choice organization  
9           under this part may not vary among individuals enrolled  
10          in the plan.”.

11          (4) PERMITTING BENEFICIARY REBATES.—

12                 (A) Section 1851(h)(4)(A) (42 U.S.C.  
13                 1395w–21(h)(4)(A)) is amended by inserting  
14                 “except as provided under section  
15                 1854(b)(1)(C)” after “or otherwise”.

16                 (B) Section 1854(d) (42 U.S.C. 1395w–  
17                 24(d)) is amended by inserting “, except as pro-  
18                 vided under subsection (b)(1)(C),” after “and  
19                 may not provide”.

20          (e) EFFECTIVE DATE.—The amendments made by  
21          this section shall apply to payments and premiums for  
22          months beginning with January 2005.

1 **SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-**  
 2 **DEMONSTRATION AREAS.**

3 (a) IDENTIFICATION OF COMPETITIVE-DEMONSTRA-  
 4 TION AREAS FOR DEMONSTRATION PROGRAM; COMPUTA-  
 5 TION OF CHOICE BENCHMARKS.—Section 1853, as  
 6 amended by section 211(b)(2), is amended by adding at  
 7 the end the following new subsection:

8 “(k) ESTABLISHMENT OF COMPETITIVE DEM-  
 9 ONSTRATION PROGRAM.—

10 “(1) DESIGNATION OF COMPETITIVE-DEM-  
 11 ONSTRATION AREAS AS PART OF PROGRAM.—

12 “(A) IN GENERAL.—For purposes of this  
 13 part, the Administrator shall establish a dem-  
 14 onstration program under which the Adminis-  
 15 trator designates Medicare+Choice areas as  
 16 competitive-demonstration areas consistent with  
 17 the following limitations:

18 “(i) LIMITATION ON NUMBER OF  
 19 AREAS THAT MAY BE DESIGNATED.—The  
 20 Administrator may not designate more  
 21 than 4 areas as competitive-demonstration  
 22 areas.

23 “(ii) LIMITATION ON PERIOD OF DES-  
 24 IGNATION OF ANY AREA.—The Adminis-  
 25 trator may not designate any area as a

1 competitive-demonstration area for a pe-  
2 riod of more than 2 years.

3 The Administrator has the discretion to decide  
4 whether or not to designate as a competitive-  
5 demonstration area an area that qualifies for  
6 such designation.

7 “(B) QUALIFICATIONS FOR DESIGNA-  
8 TION.—For purposes of this title, a  
9 Medicare+Choice area (which is a metropolitan  
10 statistical area or other area with a substantial  
11 number of Medicare+Choice enrollees) may not  
12 be designated as a ‘competitive-demonstration  
13 area’ for a 2-year period beginning with a year  
14 unless the Administrator determines, by such  
15 date before the beginning of the year as the Ad-  
16 ministrator determines appropriate, that—

17 “(i) there will be offered during the  
18 open enrollment period under this part be-  
19 fore the beginning of the year at least 2  
20 Medicare+Choice plans (in addition to the  
21 fee-for-service program under parts A and  
22 B), each offered by a different  
23 Medicare+Choice organization; and

24 “(ii) during March of the previous  
25 year at least 50 percent of the number of

1 Medicare+Choice eligible individuals who  
2 reside in the area were enrolled in a  
3 Medicare+Choice plan.

4 “(2) CHOICE BENCHMARK AMOUNT.—For pur-  
5 poses of this part, the term ‘choice benchmark  
6 amount’ means, with respect to a Medicare+Choice  
7 payment area for a month in a year, the sum of the  
8 2 components described in paragraph (3) for the  
9 area and year. The Administrator shall compute  
10 such benchmark amount for each competitive-dem-  
11 onstration area before the beginning of each annual,  
12 coordinated election period under section  
13 1851(e)(3)(B) for each year (beginning with 2005)  
14 in which it is designated as such an area.

15 “(3) TWO COMPONENTS.—For purposes of  
16 paragraph (2), the two components described in this  
17 paragraph for an area and a year are the following:

18 “(A) FEE-FOR-SERVICE COMPONENT  
19 WEIGHTED BY NATIONAL FEE-FOR-SERVICE  
20 MARKET SHARE.—The product of the following:

21 “(i) NATIONAL FEE-FOR-SERVICE  
22 MARKET SHARE.—The national fee-for-  
23 service market share percentage (deter-  
24 mined under paragraph (5)) for the year.

1                   “(ii) FEE-FOR-SERVICE AREA-SPE-  
 2                   CIFIC BID.—The fee-for-service area-spe-  
 3                   cific bid (as defined in paragraph (6)) for  
 4                   the area and year.

5                   “(B) M+C COMPONENT WEIGHTED BY NA-  
 6                   TIONAL MEDICARE+CHOICE MARKET SHARE.—  
 7                   The product of the following:

8                   “(i) NATIONAL MEDICARE+CHOICE  
 9                   MARKET SHARE.—1 minus the national  
 10                  fee-for-service market share percentage for  
 11                  the year.

12                  “(ii) WEIGHTED AVERAGE OF PLAN  
 13                  BIDS IN AREA.—The weighted average of  
 14                  the plan bids for the area and year (as de-  
 15                  termined under paragraph (4)(A)).

16                  “(4) DETERMINATION OF WEIGHTED AVERAGE  
 17                  BIDS FOR AN AREA.—

18                  “(A) IN GENERAL.—For purposes of para-  
 19                  graph (3)(B)(ii), the weighted average of plan  
 20                  bids for an area and a year is the sum of the  
 21                  following products for Medicare+Choice plans  
 22                  described in subparagraph (C) in the area and  
 23                  year:

24                  “(i) PROPORTION OF EACH PLAN’S  
 25                  ENROLLEES IN THE AREA.—The number

1 of individuals described in subparagraph  
2 (B), divided by the total number of such  
3 individuals for all Medicare+Choice plans  
4 described in subparagraph (C) for that  
5 area and year.

6 “(ii) MONTHLY BID AMOUNT.—The  
7 unadjusted monthly bid amount.

8 “(B) COUNTING OF INDIVIDUALS.—The  
9 Administrator shall count, for each  
10 Medicare+Choice plan described in subpara-  
11 graph (C) for an area and year, the number of  
12 individuals who reside in the area and who were  
13 enrolled under such plan under this part during  
14 March of the previous year.

15 “(C) EXCLUSION OF PLANS NOT OFFERED  
16 IN PREVIOUS YEAR.—For an area and year, the  
17 Medicare+Choice plans described in this sub-  
18 paragraph are plans that are offered in the area  
19 and year and were offered in the area in March  
20 of the previous year.

21 “(5) COMPUTATION OF NATIONAL FEE-FOR-  
22 SERVICE MARKET SHARE PERCENTAGE.—The Ad-  
23 ministrator shall determine, for a year, the propor-  
24 tion (in this subsection referred to as the ‘national  
25 fee-for-service market share percentage’) of

1 Medicare+Choice eligible individuals who during  
2 March of the previous year were not enrolled in a  
3 Medicare+Choice plan.

4 “(6) FEE-FOR-SERVICE AREA-SPECIFIC BID.—  
5 For purposes of this part, the term ‘fee-for-service  
6 area-specific bid’ means, for an area and year, the  
7 amount described in section 1853(j)(1) for the area  
8 and year, except that any reference to a percent of  
9 less than 100 percent shall be deemed a reference to  
10 100 percent.”.

11 (b) APPLICATION OF CHOICE BENCHMARK IN COM-  
12 PETITIVE-DEMONSTRATION AREAS.—

13 (1) IN GENERAL.—Section 1854 is amended—

14 (A) in subsection (b)(1)(C)(i), as added by  
15 section 211(b)(1)(A), by striking “(i) REQUIRE-  
16 MENT.—The” and inserting “(i) REQUIREMENT  
17 FOR NON-COMPETITIVE-DEMONSTRATION  
18 AREAS.—In the case of a Medicare+Choice  
19 payment area that is not a competitive-dem-  
20 onstration area designated under section  
21 1853(k)(1), the”;

22 (B) in subsection (b)(1)(C), as so added,  
23 by inserting after clause (i) the following new  
24 clause:

1                   “(ii) REQUIREMENT FOR COMPETITIVE-DEMONSTRATION AREAS.—In the  
2                   case of a Medicare+Choice payment area  
3                   that is designated as a competitive-demonstration area under section 1853(k)(1),  
4                   if there are average per capita monthly savings described in paragraph (4) for a  
5                   Medicare+Choice plan and year, the Medicare+Choice plan shall provide to the  
6                   enrollee a monthly rebate equal to 75 percent of such savings.”;

7                   (C) by adding at the end of subsection (b),  
8                   as amended by section 211(b)(1), the following  
9                   new paragraph:

10                   “(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—For purposes of paragraph (1)(C)(ii),  
11                   the average per capita monthly savings referred to  
12                   in such paragraph for a Medicare+Choice plan and  
13                   year shall be computed in the same manner as the  
14                   average per capita monthly savings is computed  
15                   under paragraph (3) except that the reference to the  
16                   fee-for-service area-specific benchmark amount in  
17                   paragraph (3)(B)(i) (or to the benchmark amount as  
18                   adjusted under paragraph (3)(C)(i)) is deemed to be  
19

1 a reference to the choice benchmark amount (or  
2 such amount as adjusted in the manner described in  
3 paragraph (3)(B)(i)).”; and

4 (D) in subsection (d), as amended by sec-  
5 tion 211(d)(4), by inserting “and subsection  
6 (b)(1)(D)” after “subsection (b)(1)(C)”.

7 (2) CONFORMING AMENDMENTS.—

8 (A) PAYMENT OF PLANS.—Section  
9 1853(a)(1)(A)(ii), as amended by section  
10 211(c)(1), is amended—

11 (i) in subclause (I), by inserting “(or,  
12 in the case of a competitive-demonstration  
13 area, the choice benchmark amount)” after  
14 “unadjusted monthly bid amount”; and

15 (ii) in subclauses (I) and (II), by in-  
16 sserting “(or, in the case of a competitive-  
17 demonstration area, described in section  
18 1854(b)(4))” after “section  
19 1854(b)(3)(C)”.

20 (B) DEFINITION OF MONTHLY BASIC PRE-  
21 MIUM.—Section 1854(b)(2)(A)(ii), as amended  
22 by section 211(d)(2), is amended by inserting  
23 “(or, in the case of a competitive-demonstration  
24 area, the choice benchmark amount)” after  
25 “benchmark amount”.

1 (c) PREMIUM ADJUSTMENT.—Section 1839 (42  
2 U.S.C. 1395r) is amended by adding at the end the fol-  
3 lowing new subsection:

4 “(h)(1) In the case of an individual who resides in  
5 a competitive-demonstration area designated under section  
6 1851(k)(1) and who is not enrolled in a Medicare+Choice  
7 plan under part C, the monthly premium otherwise applied  
8 under this part (determined without regard to subsections  
9 (b) and (f) or any adjustment under this subsection) shall  
10 be adjusted as follows: If the fee-for-service area-specific  
11 bid (as defined in section 1853(k)(6)) for the  
12 Medicare+Choice area in which the individual resides for  
13 a month—

14 “(A) does not exceed the choice benchmark (as  
15 determined under section 1853(k)(2)) for such area,  
16 the amount of the premium for the individual for the  
17 month shall be reduced by an amount equal to 75  
18 percent of the amount by which such benchmark ex-  
19 ceeds such fee-for-service bid; or

20 “(B) exceeds such choice benchmark, the  
21 amount of the premium for the individual for the  
22 month shall be adjusted to ensure that—

23 “(i) the sum of the amount of the adjusted  
24 premium and the choice benchmark for the  
25 area, is equal to

1           “(ii) the sum of the unadjusted premium  
2           plus amount of the fee-for-service area-specific  
3           bid for the area.

4           “(2) Nothing in this subsection shall be construed as  
5           preventing a reduction under paragraph (1)(A) in the pre-  
6           mium otherwise applicable under this part to zero or from  
7           requiring the provision of a rebate to the extent such pre-  
8           mium would otherwise be required to be less than zero.

9           “(3) The adjustment in the premium under this sub-  
10          section shall be effected in such manner as the Medicare  
11          Benefits Administrator determines appropriate.

12          “(4) In order to carry out this subsection (insofar as  
13          it is effected through the manner of collection of premiums  
14          under 1840(a)), the Medicare Benefits Administrator shall  
15          transmit to the Commissioner of Social Security—

16                 “(A) at the beginning of each year, the name,  
17                 social security account number, and the amount of  
18                 the adjustment (if any) under this subsection for  
19                 each individual enrolled under this part for each  
20                 month during the year; and

21                 “(B) periodically throughout the year, informa-  
22                 tion to update the information previously trans-  
23                 mitted under this paragraph for the year.”.

24          (d) CONFORMING AMENDMENT.—Section 1844(c)  
25          (42 U.S.C. 1395w(c)) is amended by inserting “and with-

1 out regard to any premium adjustment effected under sec-  
2 tion 1839(h)” before the period at the end.

3 (e) REPORT ON DEMONSTRATION PROGRAM.—Not  
4 later than 6 months after the date on which the designa-  
5 tion of the 4th competitive-demonstration area under sec-  
6 tion 1851(k)(1) of the Social Security Act ends, the Medi-  
7 care Payment Advisory Commission shall submit to Con-  
8 gress a report on the impact of the demonstration pro-  
9 gram under the amendments made by this section, includ-  
10 ing such impact on premiums of medicare beneficiaries,  
11 savings to the medicare program, and on adverse selection.

12 (f) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to payments and premiums for pe-  
14 riods beginning on or after January 1, 2005.

15 **SEC. 213. CONFORMING AMENDMENTS.**

16 (a) CONFORMING AMENDMENTS RELATING TO  
17 BIDS.—

18 (1) Section 1854 (42 U.S.C. 1395w–24) is  
19 amended—

20 (A) in the heading of subsection (a), by in-  
21 serting “AND BID AMOUNTS” after “PRE-  
22 MIUMS”; and

23 (B) in subsection (a)(5)(A), by inserting  
24 “paragraphs (2), (3), and (4) of” after “filed  
25 under”.

1 (b) ADDITIONAL CONFORMING AMENDMENTS.—

2 (1) ANNUAL DETERMINATION AND ANNOUNCE-  
3 MENT OF CERTAIN FACTORS.—Section 1853(b) (42  
4 U.S.C. 1395w–23(b)) is amended—

5 (A) in paragraph (1), by striking “the re-  
6 spective calendar year” and all that follows and  
7 inserting the following: “the calendar year con-  
8 cerned with respect to each Medicare+Choice  
9 payment area, the following:

10 “(A) PRE-COMPETITION INFORMATION.—  
11 For years before 2005, the following:

12 “(i) MEDICARE+CHOICE CAPITATION  
13 RATES.—The annual Medicare+Choice  
14 capitation rate for each Medicare+Choice  
15 payment area for the year.

16 “(ii) ADJUSTMENT FACTORS.—The  
17 risk and other factors to be used in adjust-  
18 ing such rates under subsection (a)(1)(A)  
19 for payments for months in that year.

20 “(B) COMPETITION INFORMATION.—For  
21 years beginning with 2005, the following:

22 “(i) BENCHMARKS.—The fee-for-serv-  
23 ice area-specific benchmark under section  
24 1853(j) and, if applicable, the choice  
25 benchmark under section 1853(k)(2), for

1 the year involved and, if applicable, the na-  
2 tional fee-for-service market share percent-  
3 age.

4 “(ii) ADJUSTMENT FACTORS.—The  
5 adjustment factors applied under section  
6 1853(a)(1)(A)(iii) (relating to demographic  
7 adjustment), section 1853(a)(1)(B) (relat-  
8 ing to adjustment for end-stage renal dis-  
9 ease), and section 1853(a)(3) (relating to  
10 health status adjustment).

11 “(iii) PROJECTED FEE-FOR-SERVICE  
12 BID.—In the case of a competitive area,  
13 the projected fee-for-service area-specific  
14 bid (as determined under subsection  
15 (k)(6)) for the area.

16 “(iv) INDIVIDUALS.—The number of  
17 individuals counted under subsection  
18 (k)(4)(B) and enrolled in each  
19 Medicare+Choice plan in the area.”; and

20 (B) in paragraph (3), by striking “in suffi-  
21 cient detail” and all that follows up to the pe-  
22 riod at the end.

23 (2) REPEAL OF PROVISIONS RELATING TO AD-  
24 JUSTED COMMUNITY RATE (ACR).—

1 (A) IN GENERAL.—Subsections (e) and (f)  
2 of section 1854 (42 U.S.C. 1395w–24) are re-  
3 pealed.

4 (B) CONFORMING AMENDMENT.—Section  
5 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended  
6 by striking “, and to reflect” and all that fol-  
7 lows and inserting a period.

8 (3) PROSPECTIVE IMPLEMENTATION OF NA-  
9 TIONAL COVERAGE DETERMINATIONS.—Section  
10 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)) is amended  
11 to read as follows:

12 “(5) PROSPECTIVE IMPLEMENTATION OF NA-  
13 TIONAL COVERAGE DETERMINATIONS.—The Sec-  
14 retary shall only implement a national coverage de-  
15 termination that will result in a significant change  
16 in the costs to a Medicare+Choice organization in a  
17 prospective manner that applies to announcements  
18 made under section 1853(b) after the date of the  
19 implementation of the determination.”.

20 (4) PERMITTING GEOGRAPHIC ADJUSTMENT TO  
21 CONSOLIDATE MULTIPLE MEDICARE+CHOICE PAY-  
22 MENT AREAS IN A STATE INTO A SINGLE STATEWIDE  
23 MEDICARE+CHOICE PAYMENT AREA.—Section  
24 1853(d)(3) (42 U.S.C. 1395w–23(e)(3)) is amend-  
25 ed—

1 (A) by amending clause (i) of subpara-  
2 graph (A) to read as follows:

3 “(i) to a single statewide  
4 Medicare+Choice payment area,”; and

5 (B) by amending subparagraph (B) to read  
6 as follows:

7 “(B) BUDGET NEUTRALITY ADJUST-  
8 MENT.—In the case of a State requesting an  
9 adjustment under this paragraph, the Medicare  
10 Benefits Administrator shall initially (and an-  
11 nually thereafter) adjust the payment rates oth-  
12 erwise established under this section for  
13 Medicare+Choice payment areas in the State in  
14 a manner so that the aggregate of the pay-  
15 ments under this section in the State shall not  
16 exceed the aggregate payments that would have  
17 been made under this section for  
18 Medicare+Choice payment areas in the State in  
19 the absence of the adjustment under this para-  
20 graph.”.

21 (c) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to payments and premiums for pe-  
23 riods beginning on or after January 1, 2005.

1 **TITLE III—RURAL HEALTH CARE**  
2 **IMPROVEMENTS**

3 **SEC. 301. REFERENCE TO FULL MARKET BASKET INCREASE**  
4 **FOR SOLE COMMUNITY HOSPITALS.**

5 For provision eliminating any reduction from full  
6 market basket in the update for inpatient hospital services  
7 for sole community hospitals, see section 401.

8 **SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOS-**  
9 **PITAL (DSH) TREATMENT FOR RURAL HOS-**  
10 **PITALS AND URBAN HOSPITALS WITH FEWER**  
11 **THAN 100 BEDS.**

12 (a) BLENDING OF PAYMENT AMOUNTS.—

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

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

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

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

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

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

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

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

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

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

4 **SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARD-**  
5 **IZED AMOUNT IN RURAL AND SMALL URBAN**  
6 **AREAS TO ACHIEVE A SINGLE, UNIFORM**  
7 **STANDARDIZED AMOUNT.**

8 Section 1886(d)(3)(A)(iv) (42 U.S.C.  
9 1395ww(d)(3)(A)(iv)) is amended—

10 (1) by striking “(iv) For discharges” and in-  
11 sserting “(iv)(I) Subject to the succeeding provisions  
12 of this clause, for discharges”; and

13 (2) by adding at the end the following new sub-  
14 clauses:

15 “(II) For discharges occurring during fiscal  
16 year 2003, the average standardized amount for hos-  
17 pitals located other than in a large urban area shall  
18 be increased by  $\frac{1}{2}$  of the difference between the av-  
19 erage standardized amount determined under sub-  
20 clause (I) for hospitals located in large urban areas  
21 for such fiscal year and such amount determined  
22 (without regard to this subclause) for other hospitals  
23 for such fiscal year.

24 “(III) For discharges occurring in a fiscal year  
25 beginning with fiscal year 2004, the Secretary shall

1 compute an average standardized amount for hos-  
2 pitals located in any area within the United States  
3 and within each region equal to the average stand-  
4 arized amount computed for the previous fiscal  
5 year under this subparagraph for hospitals located  
6 in a large urban area (or, beginning with fiscal year  
7 2005, for hospitals located in any area) increased  
8 by the applicable percentage increase under sub-  
9 section (b)(3)(B)(i).”.

10 **SEC. 304. MORE FREQUENT UPDATE IN WEIGHTS USED IN**  
11 **HOSPITAL MARKET BASKET.**

12 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After  
13 revising the weights used in the hospital market basket  
14 under section 1886(b)(3)(B)(iii) of the Social Security Act  
15 (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most cur-  
16 rent data available, the Secretary shall establish a fre-  
17 quency for revising such weights in such market basket  
18 to reflect the most current data available more frequently  
19 than once every 5 years.

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

1 **SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**  
2 **PROGRAM.**

3 (a) REINSTATEMENT OF PERIODIC INTERIM PAY-  
4 MENT (PIP).—Section 1815(e)(2) (42 U.S.C.  
5 1395g(e)(2)) is amended—

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

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

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

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

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

17 “The Secretary may not require, as a condition for  
18 applying subparagraph (B) with respect to a critical  
19 access hospital, that each physician providing profes-  
20 sional services in the hospital must assign billing  
21 rights with respect to such services, except that such  
22 subparagraph shall not apply to those physicians  
23 who have not assigned such billing rights.”.

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

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

3           (2) by adding at the end of subsection (c) the  
4           following new paragraph:

5           “(3) INCREASE IN MAXIMUM NUMBER OF BEDS  
6           FOR HOSPITALS WITH STRONG SEASONAL CENSUS  
7           FLUCTUATIONS.—

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

16          “(B) STANDARDS.—The Secretary shall  
17          specify standards for determining whether a  
18          critical access hospital has sufficiently strong  
19          seasonal variations in patient admissions to jus-  
20          tify the increase in bed limitation provided  
21          under subparagraph (A).”; and

22          (3) in subsection (f)—

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

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

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

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

10           (d) 5-YEAR EXTENSION OF THE AUTHORIZATION  
11 FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section  
12 1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking  
13 “through 2002” and inserting “through 2007”.

14           (e) PROHIBITION OF RETROACTIVE RECOUPMENT.—  
15 The Secretary shall not recoup (or otherwise seek to re-  
16 cover) overpayments made for outpatient critical access  
17 hospital services under part B of title XVIII of the Social  
18 Security Act, for services furnished in cost reporting peri-  
19 ods that began before October 1, 2002, insofar as such  
20 overpayments are attributable to payment being based on  
21 80 percent of reasonable costs (instead of 100 percent of  
22 reasonable costs minus 20 percent of charges).

23           (f) EFFECTIVE DATES.—

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

4           (2) PHYSICIAN PAYMENT ADJUSTMENT CONDI-  
5           TION.—The amendment made by subsection (b)  
6           shall be effective as if included in the enactment of  
7           section 403(d) of the Medicare, Medicaid, and  
8           SCHIP Balanced Budget Refinement Act of 1999  
9           (113 Stat. 1501A–371).

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

15 **SEC. 306. EXTENSION OF TEMPORARY INCREASE FOR**  
16                   **HOME HEALTH SERVICES FURNISHED IN A**  
17                   **RURAL AREA.**

18          (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.  
19 2763A–533) is amended—

20           (1) by striking “24-MONTH INCREASE BEGIN-  
21           NING APRIL 1, 2001” and inserting “IN GENERAL”;  
22           and

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

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

6 **SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAY-**  
7 **MENT FOR HOSPICE CARE FURNISHED IN A**  
8 **FRONTIER AREA AND RURAL HOSPICE DEM-**  
9 **ONSTRATION PROJECT.**

10 For—

11 (1) provision of 10 percent increase in payment  
12 for hospice care furnished in a frontier area, see sec-  
13 tion 422; and

14 (2) provision of a rural hospice demonstration  
15 project, see section 423.

16 **SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LO-**  
17 **CATED IN RURAL OR SMALL URBAN AREAS IN**  
18 **REDISTRIBUTION OF UNUSED GRADUATE**  
19 **MEDICAL EDUCATION RESIDENCIES.**

20 For provision providing priority for hospitals located  
21 in rural or small urban areas in redistribution of unused  
22 graduate medical education residencies, see section 612.

1 **SEC. 309. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN**  
2 **PAYMENTS FOR PHYSICIANS' SERVICES.**

3 (a) STUDY.—The Comptroller General of the United  
4 States shall conduct a study of differences in payment  
5 amounts under the physician fee schedule under section  
6 1848 of the Social Security Act (42 U.S.C. 1395w–4) for  
7 physicians' services in different geographic areas. Such  
8 study shall include—

9 (1) an assessment of the validity of the geo-  
10 graphic adjustment factors used for each component  
11 of the fee schedule;

12 (2) an evaluation of the measures used for such  
13 adjustment, including the frequency of revisions; and

14 (3) an evaluation of the methods used to deter-  
15 mine professional liability insurance costs used in  
16 computing the malpractice component, including a  
17 review of increases in professional liability insurance  
18 premiums and variation in such increases by State  
19 and physician specialty and methods used to update  
20 the geographic cost of practice index and relative  
21 weights for the malpractice component.

22 (b) REPORT.—Not later than 1 year after the date  
23 of the enactment of this Act, the Comptroller General shall  
24 submit to Congress a report on the study conducted under  
25 subsection (a). The report shall include recommendations  
26 regarding the use of more current data in computing geo-

1 graphic cost of practice indices as well as the use of data  
2 directly representative of physicians' costs (rather than  
3 proxy measures of such costs).

4 **SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COL-**  
5 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**  
6 **CALLY UNDERSERVED POPULATIONS.**

7 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
8 1320a–7(b)(3)) is amended—

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

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

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

15 “(G) any remuneration between a public or  
16 nonprofit private health center entity described  
17 under clause (i) or (ii) of section 1905(l)(2)(B)  
18 and any individual or entity providing goods,  
19 items, services, donations or loans, or a com-  
20 bination thereof, to such health center entity  
21 pursuant to a contract, lease, grant, loan, or  
22 other agreement, if such agreement contributes  
23 to the ability of the health center entity to  
24 maintain or increase the availability, or enhance  
25 the quality, of services provided to a medically

1 underserved population served by the health  
2 center entity.”.

3 (b) RULEMAKING FOR EXCEPTION FOR HEALTH  
4 CENTER ENTITY ARRANGEMENTS.—

5 (1) ESTABLISHMENT.—

6 (A) IN GENERAL.—The Secretary of  
7 Health and Human Services (in this subsection  
8 referred to as the “Secretary”) shall establish,  
9 on an expedited basis, standards relating to the  
10 exception described in section 1128B(b)(3)(H)  
11 of the Social Security Act, as added by sub-  
12 section (a), for health center entity arrange-  
13 ments to the antikickback penalties.

14 (B) FACTORS TO CONSIDER.—The Sec-  
15 retary shall consider the following factors,  
16 among others, in establishing standards relating  
17 to the exception for health center entity ar-  
18 rangements under subparagraph (A):

19 (i) Whether the arrangement between  
20 the health center entity and the other  
21 party results in savings of Federal grant  
22 funds or increased revenues to the health  
23 center entity.

24 (ii) Whether the arrangement between  
25 the health center entity and the other

1 party restricts or limits a patient's freedom  
2 of choice.

3 (iii) Whether the arrangement be-  
4 tween the health center entity and the  
5 other party protects a health care profes-  
6 sional's independent medical judgment re-  
7 garding medically appropriate treatment.

8 The Secretary may also include other standards  
9 and criteria that are consistent with the intent  
10 of Congress in enacting the exception estab-  
11 lished under this section.

12 (2) INTERIM FINAL EFFECT.—No later than  
13 180 days after the date of enactment of this Act, the  
14 Secretary shall publish a rule in the Federal Reg-  
15 ister consistent with the factors under paragraph  
16 (1)(B). Such rule shall be effective and final imme-  
17 diately on an interim basis, subject to such change  
18 and revision, after public notice and opportunity (for  
19 a period of not more than 60 days) for public com-  
20 ment, as is consistent with this subsection.

21 **SEC. 311. RELIEF FOR CERTAIN NON-TEACHING HOS-**  
22 **PITALS.**

23 (a) IN GENERAL.—In the case of a non-teaching hos-  
24 pital that meets the condition of subsection (b), in each  
25 of fiscal years 2003, 2004, and 2005 the amount of pay-

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

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

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

1           (2) it is located in an urban area and the  
2 amount of the aggregate payments under subsection  
3 (d) of such section for hospitals located in urban  
4 areas in the State for their cost reporting periods  
5 beginning during fiscal year 1999 is less than 103  
6 percent of the aggregate allowable operating costs of  
7 inpatient hospital services (as defined in subsection  
8 (a)(4) of such section) for all subsection (d) hos-  
9 pitals in such areas in such State with respect to  
10 such cost reporting periods.

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

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

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

1 such section shall, for purposes of this section, also  
2 be treated as a non-teaching hospital unless a chair-  
3 man of a department in the medical school with  
4 which the hospital is affiliated is serving or has been  
5 appointed as a clinical chief of service in the hos-  
6 pital.

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

11 **TITLE IV—PROVISIONS**  
12 **RELATING TO PART A**  
13 **Subtitle A—Inpatient Hospital**  
14 **Services**

15 **SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT**  
16 **UPDATES.**

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

20 “(XVIII) for fiscal year 2003, the market bas-  
21 ket percentage increase for sole community hospitals  
22 and such increase minus 0.25 percentage points for  
23 other hospitals, and”.

1 **SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR**  
 2 **INDIRECT COSTS OF MEDICAL EDUCATION**  
 3 **(IME).**

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

6 (1) in subclause (VI) by striking “and” at the  
 7 end;

8 (2) by redesignating subclause (VII) as sub-  
 9 clause (IX);

10 (3) in subclause (IX) as so redesignated, by  
 11 striking “2002” and inserting “2004”; and

12 (4) by inserting after subclause (VI) the fol-  
 13 lowing new subclause:

14 “(VII) during fiscal year 2003, ‘e’ is equal  
 15 to 1.47;

16 “(VIII) during fiscal year 2004, ‘e’ is  
 17 equal to 1.45; and”.

18 **SEC. 403. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**  
 19 **UNDER INPATIENT HOSPITAL PPS.**

20 (a) IMPROVING TIMELINESS OF DATA COLLEC-  
 21 TION.—Section 1886(d)(5)(K) (42 U.S.C.  
 22 1395ww(d)(5)(K)) is amended by adding at the end the  
 23 following new clause:

24 “(vii) Under the mechanism under this subpara-  
 25 graph, the Secretary shall provide for the addition of new  
 26 diagnosis and procedure codes in April 1 of each year, but

1 the addition of such codes shall not require the Secretary  
2 to adjust the payment (or diagnosis-related group classi-  
3 fication) under this subsection until the fiscal year that  
4 begins after such date.”.

5 (b) ELIGIBILITY STANDARD.—

6 (1) MINIMUM PERIOD FOR RECOGNITION OF  
7 NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi)  
8 (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

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

10 (B) by adding at the end the following new  
11 subclause:

12 “(II) Under such criteria, a service or technology  
13 shall not be denied treatment as a new service or tech-  
14 nology on the basis of the period of time in which the serv-  
15 ice or technology has been in use if such period ends before  
16 the end of the 2 to 3-year period that begins on the effec-  
17 tive date of implementation of a code under ICD–9–CM  
18 (or a successor coding methodology) that enables the iden-  
19 tification of a significant sample of specific discharges in  
20 which the service or technology has been used.”.

21 (2) ADJUSTMENT OF THRESHOLD.—Section  
22 1886(d)(5)(K)(ii)(I) (42 U.S.C.  
23 1395ww(d)(5)(K)(ii)(I)) is amended by inserting  
24 “(applying a threshold specified by the Secretary  
25 that is the lesser of 50 percent of the national aver-

1       age standardized amount for operating costs of inpa-  
2       tient hospital services for all hospitals and all diag-  
3       nosis-related groups or one standard deviation for  
4       the diagnosis-related group involved)” after “is inad-  
5       equate”.

6               (3) CRITERION FOR SUBSTANTIAL IMPROVE-  
7       MENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C.  
8       1395ww(d)(5)(K)(vi)), as amended by paragraph  
9       (1), is further amended by adding at the end the fol-  
10      lowing subclause:

11      “(III) The Secretary shall by regulation provide for  
12      further clarification of the criteria applied to determine  
13      whether a new service or technology represents an advance  
14      in medical technology that substantially improves the diag-  
15      nosis or treatment of beneficiaries. Under such criteria,  
16      in determining whether a new service or technology rep-  
17      resents an advance in medical technology that substan-  
18      tially improves the diagnosis or treatment of beneficiaries,  
19      the Secretary shall deem a service or technology as meet-  
20      ing such requirement if the service or technology is a drug  
21      or biological that is designated under section 506 or 526  
22      of the Federal Food, Drug, and Cosmetic Act, approved  
23      under section 314.510 or 601.41 of title 21, Code of Fed-  
24      eral Regulations, or designated for priority review when  
25      the marketing application for such drug or biological was

1 filed or is a medical device for which an exemption has  
2 been granted under section 520(m) of such Act, or for  
3 which priority review has been provided under section  
4 515(d)(5) of such Act.”.

5 (4) PROCESS FOR PUBLIC INPUT.—Section  
6 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as  
7 amended by paragraph (1), is amended—

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

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

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

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

24 “(II) The Secretary shall accept comments, rec-  
25 ommendations, and data from the public regarding

1       whether the service or technology represents a sub-  
2       stantial improvement.

3               “(III) The Secretary shall provide for a meeting  
4       at which organizations representing hospitals, physi-  
5       cians, medicare beneficiaries, manufacturers, and  
6       any other interested party may present comments,  
7       recommendations, and data to the clinical staff of  
8       the Centers for Medicare & Medicaid Services before  
9       publication of a notice of proposed rulemaking re-  
10      garding whether service or technology represents a  
11      substantial improvement.”.

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

16           “(ix) Before establishing any add-on payment under  
17      this subparagraph with respect to a new technology, the  
18      Secretary shall seek to identify one or more diagnosis-re-  
19      lated groups associated with such technology, based on  
20      similar clinical or anatomical characteristics and the cost  
21      of the technology. Within such groups the Secretary shall  
22      assign an eligible new technology into a diagnosis-related  
23      group where the average costs of care most closely approx-  
24      imate the costs of care of using the new technology. In  
25      such case, no add-on payment under this subparagraph

1 shall be made with respect to such new technology and  
2 this clause shall not affect the application of paragraph  
3 (4)(C)(iii).”.

4 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-  
5 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.  
6 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after  
7 “the estimated average cost of such service or technology”  
8 the following: “(based on the marginal rate applied to  
9 costs under subparagraph (A))”.

10 (e) EFFECTIVE DATE.—

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

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

22 (A) the Secretary shall automatically re-  
23 consider the application as an application for  
24 fiscal year 2004 under the amendments made  
25 by this section; and

1 (B) the maximum time period otherwise  
2 permitted for such classification of the service  
3 or technology shall be extended by 12 months.

4 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN**  
5 **PUERTO RICO.**

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

8 (1) in subparagraph (A)—

9 (A) in clause (i), by striking “for dis-  
10 charges beginning on or after October 1, 1997,  
11 50 percent (and for discharges between October  
12 1, 1987, and September 30, 1997, 75 percent)”  
13 and inserting “the applicable Puerto Rico per-  
14 centage (specified in subparagraph (E))”; and

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

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

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

1           “(i) between October 1, 1987, and September  
2           30, 1997, the applicable Puerto Rico percentage is  
3           75 percent and the applicable Federal percentage is  
4           25 percent;

5           “(ii) on or after October 1, 1997, and before  
6           October 1, 2003, the applicable Puerto Rico percent-  
7           age is 50 percent and the applicable Federal per-  
8           centage is 50 percent;

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

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

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

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

21          “(vii) on or after October 1, 2007, the applica-  
22          ble Puerto Rico percentage is 25 percent and the appli-  
23          cable Federal percentage is 75 percent.”.

1 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**  
2 **HANCED DISPROPORTIONATE SHARE HOS-**  
3 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**  
4 **PITALS AND URBAN HOSPITALS WITH FEWER**  
5 **THAN 100 BEDS.**

6 For provision enhancing disproportionate share hos-  
7 pital (DSH) treatment for rural hospitals and urban hos-  
8 pitals with fewer than 100 beds, see section 302.

9 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR**  
10 **PHASED-IN INCREASE IN THE STANDARDIZED**  
11 **AMOUNT IN RURAL AND SMALL URBAN**  
12 **AREAS TO ACHIEVE A SINGLE, UNIFORM**  
13 **STANDARDIZED AMOUNT.**

14 For provision phasing in over a 2-year period an in-  
15 crease in the standardized amount for rural and small  
16 urban areas to achieve a single, uniform, standardized  
17 amount, see section 303.

18 **SEC. 407. REFERENCE TO PROVISION FOR MORE FRE-**  
19 **QUENT UPDATES IN THE WEIGHTS USED IN**  
20 **HOSPITAL MARKET BASKET.**

21 For provision providing for more frequent updates in  
22 the weights used in hospital market basket, see section  
23 304.

1 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**  
2 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**  
3 **GRAM.**

4 For provision providing making improvements to crit-  
5 ical access hospital program, see section 305.

6 **SEC. 409. GAO STUDY ON IMPROVING THE HOSPITAL WAGE**  
7 **INDEX.**

8 (a) STUDY.—

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

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

25 (3) WAGE DATA.—The study shall specifically  
26 examine the portions of the hospital cost reports re-

1       lating to wages, and methods for improving the ac-  
 2       curacy of the wage data and for reducing inequities  
 3       resulting from differences among hospitals in the re-  
 4       porting of wage data.

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

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

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

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

## 19                   **Subtitle B—Skilled Nursing** 20                   **Facility Services**

### 21       **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FA-** 22                   **CILITY SERVICES.**

23       (a) TEMPORARY INCREASE IN NURSING COMPONENT  
 24       OF PPS FEDERAL RATE.—Section 312(a) of BIPA is  
 25       amended by adding at the end the following new sentence:

1 “The Secretary of Health and Human Services shall in-  
2 crease by 12, 10, and 8 percent the nursing component  
3 of the case-mix adjusted Federal prospective payment rate  
4 specified in Tables 3 and 4 of the final rule published in  
5 the Federal Register by the Health Care Financing Ad-  
6 ministration on July 31, 2000 (65 Fed. Reg. 46770) and  
7 as subsequently updated under section 1888(e)(4)(E)(ii)  
8 of the Social Security Act (42 U.S.C.  
9 1395yy(e)(4)(E)(ii)), effective for services furnished dur-  
10 ing fiscal years 2003, 2004, and 2005, respectively.”.

11 (b) ADJUSTMENT TO RUGS FOR AIDS RESI-  
12 DENTS.—

13 (1) IN GENERAL.—Paragraph (12) of section  
14 1888(e) (42 U.S.C. 1395yy(e)) is amended to read  
15 as follows:

16 “(12) ADJUSTMENT FOR RESIDENTS WITH  
17 AIDS.—

18 “(A) IN GENERAL.—Subject to subpara-  
19 graph (B), in the case of a resident of a skilled  
20 nursing facility who is afflicted with acquired  
21 immune deficiency syndrome (AIDS), the per  
22 diem amount of payment otherwise applicable  
23 shall be increased by 128 percent to reflect in-  
24 creased costs associated with such residents.

1           “(B) SUNSET.—Subparagraph (A) shall  
2           not apply on and after such date as the Sec-  
3           retary certifies that there is an appropriate ad-  
4           justment in the case mix under paragraph  
5           (4)(G)(i) to compensate for the increased costs  
6           associated with residents described in such sub-  
7           paragraph.”.

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

## 11                                   **Subtitle C—Hospice**

### 12   **SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERV-** 13                                   **ICES.**

14          (a) COVERAGE OF HOSPICE CONSULTATION SERV-  
15   ICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amend-  
16   ed—

17           (1) by striking “and” at the end of paragraph  
18           (3);

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

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

23           “(5) for individuals who are terminally ill, have  
24           not made an election under subsection (d)(1), and  
25           have not previously received services under this

1 paragraph, services that are furnished by a physi-  
2 cian who is either the medical director or an em-  
3 ployee of a hospice program and that consist of—

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

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

8 “(C) advising the individual regarding ad-  
9 vanced care planning.”.

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

13 “(4) The amount paid to a hospice program with re-  
14 spect to the services under section 1812(a)(5) for which  
15 payment may be made under this part shall be equal to  
16 an amount equivalent to the amount established for an  
17 office or other outpatient visit for evaluation and manage-  
18 ment associated with presenting problems of moderate se-  
19 verity under the fee schedule established under section  
20 1848(b), other than the portion of such amount attrib-  
21 utable to the practice expense component.”.

22 (c) CONFORMING AMENDMENT.—Section  
23 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is  
24 amended by inserting before the comma at the end the  
25 following: “and services described in section 1812(a)(5)”.

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

4 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**  
5 **PICE CARE FURNISHED IN A FRONTIER AREA.**

6 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.  
7 1395f(i)(1)) is amended by adding at the end the following  
8 new subparagraph:

9 “(D) With respect to hospice care furnished in a fron-  
10 tier area on or after January 1, 2003, and before January  
11 1, 2008, the payment rates otherwise established for such  
12 care shall be increased by 10 percent. For purposes of this  
13 subparagraph, the term ‘frontier area’ means a county in  
14 which the population density is less than 7 persons per  
15 square mile.”.

16 (b) REPORT ON COSTS.—Not later than January 1,  
17 2007, the Comptroller General of the United States shall  
18 submit to Congress a report on the costs of furnishing  
19 hospice care in frontier areas. Such report shall include  
20 recommendations regarding the appropriateness of extend-  
21 ing, and modifying, the payment increase provided under  
22 the amendment made by subsection (a).

23 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

24 (a) IN GENERAL.—The Secretary shall conduct a  
25 demonstration project for the delivery of hospice care to

1 medicare beneficiaries in rural areas. Under the project  
2 medicare beneficiaries who are unable to receive hospice  
3 care in the home for lack of an appropriate caregiver are  
4 provided such care in a facility of 20 or fewer beds which  
5 offers, within its walls, the full range of services provided  
6 by hospice programs under section 1861(dd) of the Social  
7 Security Act (42 U.S.C. 1395x(dd)).

8 (b) SCOPE OF PROJECT.—The Secretary shall con-  
9 duct the project under this section with respect to no more  
10 than 3 hospice programs over a period of not longer than  
11 5 years each.

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

14 (1) the hospice program shall comply with oth-  
15 erwise applicable requirements, except that it shall  
16 not be required to offer services outside of the home  
17 or to meet the requirements of section  
18 1861(dd)(2)(A)(iii) of the Social Security Act; and

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

22 The Secretary may require the program to comply with  
23 such additional quality assurance standards for its provi-  
24 sion of services in its facility as the Secretary deems ap-  
25 propriate.

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

## 6 **Subtitle D—Other Provisions**

### 7 **SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOV-** 8 **ERY AUDIT CONTRACTORS.**

9 (a) IN GENERAL.—The Secretary of Health and  
10 Human Services shall conduct a demonstration project  
11 under this section (in this section referred to as the  
12 “project”) to demonstrate the use of recovery audit con-  
13 tractors under the Medicare Integrity Program in identi-  
14 fying underpayments and overpayments and recouping  
15 overpayments under the medicare program for services for  
16 which payment is made under part A of title XVIII of  
17 the Social Security Act. Under the project—

18 (1) payment may be made to such a contractor  
19 on a contingent basis;

20 (2) a percentage of the amount recovered may  
21 be retained by the Secretary and shall be available  
22 to the program management account of the Centers  
23 for Medicare & Medicaid Services; and

24 (3) the Secretary shall examine the efficacy of  
25 such use with respect to duplicative payments, accu-

1 racy of coding, and other payment policies in which  
2 inaccurate payments arise.

3 (b) SCOPE AND DURATION.—The project shall cover  
4 at least 2 States and at least 3 contractors and shall last  
5 for not longer than 3 years.

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

11 (d) QUALIFICATIONS OF CONTRACTORS.—

12 (1) IN GENERAL.—The Secretary shall enter  
13 into a recovery audit contract under this section  
14 with an entity only if the entity has staff that has  
15 knowledge of and experience with the payment rules  
16 and regulations under the medicare program or the  
17 entity has or will contract with another entity that  
18 has such knowledgeable and experienced staff.

19 (2) INELIGIBILITY OF CERTAIN CONTRAC-  
20 TORS.—The Secretary may not enter into a recovery  
21 audit contract under this section with an entity to  
22 the extent that the entity is a fiscal intermediary  
23 under section 1816 of the Social Security Act (42  
24 U.S.C. 1395h), a carrier under section 1842 of such

1 Act (42 U.S.C. 1395u), or a Medicare Administra-  
2 tive Contractor under section 1874A of such Act.

3 (3) PREFERENCE FOR ENTITIES WITH DEM-  
4 ONSTRATED PROFICIENCY WITH PRIVATE INSUR-  
5 ERS.—In awarding contracts to recovery audit con-  
6 tractors under this section, the Secretary shall give  
7 preference to those entities that the Secretary deter-  
8 mines have demonstrated proficiency in recovery au-  
9 dits with private insurers or under the medicaid pro-  
10 gram under title XIX of such Act.

11 (e) REPORT.—The Secretary of Health and Human  
12 Services shall submit to Congress a report on the project  
13 not later than 6 months after the date of its completion.  
14 Such reports shall include information on the impact of  
15 the project on savings to the medicare program and rec-  
16 ommendations on the cost-effectiveness of extending or ex-  
17 panding the project.

18 **TITLE V—PROVISIONS**  
19 **RELATING TO PART B**  
20 **Subtitle A—Physicians’ Services**

21 **SEC. 501. REVISION OF UPDATES FOR PHYSICIANS’ SERV-**  
22 **ICES.**

23 (a) UPDATE FOR 2003 THROUGH 2005.—

1           (1) IN GENERAL.—Section 1848(d) (42 U.S.C.  
2           1395w-4(d)) is amended by adding at the end the  
3           following new paragraphs:

4           “(5) UPDATE FOR 2003.—The update to the  
5           single conversion factor established in paragraph  
6           (1)(C) for 2003 is 3 percent.

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

11                   “(A) USE OF 2002 DATA IN DETERMINING  
12                   ALLOWABLE COSTS.—

13                           “(i) The reference in clause (ii)(I) of  
14                           such paragraph to April 1, 1996, is  
15                           deemed to be a reference to January 1,  
16                           2002.

17                           “(ii) The allowed expenditures for  
18                           2002 is deemed to be equal to the actual  
19                           expenditures for physicians’ services fur-  
20                           nished during 2002, as estimated by the  
21                           Secretary.

22                   “(B) 1 PERCENTAGE POINT INCREASE IN  
23                   GDP UNDER SGR.—The annual average percent-  
24                   age growth in real gross domestic product per  
25                   capita under subsection (f)(2)(C) for each of

1           2003, 2004, and 2005 is deemed to be in-  
2           creased by 1 percentage point.”.

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

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

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

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

17                   (A) by striking “projected” and inserting  
18                   “annual average”; and

19                   (B) by striking “from the previous applica-  
20                   ble period to the applicable period involved”  
21                   and inserting “during the 10-year period ending  
22                   with the applicable period involved”.

23           (2) EFFECTIVE DATE.—The amendment made  
24          by paragraph (1) shall apply to computations of the

1 sustainable growth rate for years beginning with  
2 2002.

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

8 (d) GAO STUDY OF MEDICARE PAYMENT FOR INHA-  
9 LATION THERAPY.—

10 (1) STUDY.—The Comptroller General of the  
11 United States shall conduct a study to examine the  
12 adequacy of current reimbursements for inhalation  
13 therapy under the medicare program.

14 (2) REPORT.—Not later than May 1, 2003, the  
15 Comptroller General shall submit to Congress a re-  
16 port on the study conducted under paragraph (1).

17 **SEC. 502. STUDIES ON ACCESS TO PHYSICIANS’ SERVICES.**

18 (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-  
19 CIANS’ SERVICES.—

20 (1) STUDY.—The Comptroller General of the  
21 United States shall conduct a study on access of  
22 medicare beneficiaries to physicians’ services under  
23 the medicare program. The study shall include—

24 (A) an assessment of the use by bene-  
25 ficiaries of such services through an analysis of

1 claims submitted by physicians for such services  
2 under part B of the medicare program;

3 (B) an examination of changes in the use  
4 by beneficiaries of physicians' services over  
5 time;

6 (C) an examination of the extent to which  
7 physicians are not accepting new medicare  
8 beneficiaries as patients.

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

14 (A) data from claims submitted by physi-  
15 cians under part B of the medicare program in-  
16 dicate potential access problems for medicare  
17 beneficiaries in certain geographic areas; and

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

21 (b) STUDY AND REPORT ON SUPPLY OF PHYSI-  
22 CIANS.—

23 (1) STUDY.—The Secretary shall request the  
24 Institute of Medicine of the National Academy of  
25 Sciences to conduct a study on the adequacy of the

1 supply of physicians (including specialists) in the  
2 United States and the factors that affect such sup-  
3 ply.

4 (2) REPORT TO CONGRESS.—Not later than 2  
5 years after the date of enactment of this section, the  
6 Secretary shall submit to Congress a report on the  
7 results of the study described in paragraph (1), in-  
8 cluding any recommendations for legislation.

9 **SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS’**  
10 **SERVICES.**

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

19 (1) The effect of such refinements on payment  
20 for physicians’ services.

21 (2) The interaction of the practice expense com-  
22 ponent with other components of and adjustments to  
23 payment for physicians’ services under such section.

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

1           (4) The effect of such refinements on access to  
2           care by medicare beneficiaries to physicians' serv-  
3           ices.

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

6 **SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN**  
7                   **PHYSICIAN PATHOLOGY SERVICES UNDER**  
8                   **MEDICARE.**

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

11 **SEC. 505. PHYSICIAN FEE SCHEDULE WAGE INDEX REVI-**  
12                   **SION.**

13           (a) INDEX REVISION.—

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

22           (2) SECRETARIAL DISCRETION.—Paragraph (1)  
23           shall not take effect or be in force if the Secretary  
24           determines, taking into account the report of the  
25           Comptroller General under subsection (b)(2), that

1 there is no sound economic rationale for the imple-  
2 mentation of such paragraph.

3 (3) EXEMPTION FROM LIMITATION ON ANNUAL  
4 ADJUSTMENTS.—Any increase in expenditures at-  
5 tributable to paragraph (1) during 2004 shall not be  
6 taken into account in applying section  
7 1848(e)(2)(B)(ii)(II) of the Social Security Act (42  
8 U.S.C. 1395w-4(e)(2)(B)(ii)(II)) for that year.

9 (b) GAO REPORT.—

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

14 (A) Whether there is a sound economic  
15 basis for the implementation of the adjustment  
16 under subsection (a)(1) in those areas in which  
17 the adjustment applies.

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

21 (i) differences in recruitment costs  
22 and retention rates for physicians, includ-  
23 ing specialists, between large urban areas  
24 and other areas; and

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

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

5 (2) REPORT.—By not later than September 1,  
6 2003, the Comptroller General shall submit to Con-  
7 gress and to the Secretary a report on the evaluation  
8 conducted under paragraph (1).

## 9 **Subtitle B—Other Services**

### 10 **SEC. 511. PAYMENT FOR AMBULANCE SERVICES.**

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

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

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

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

21 “(10) PHASE-IN PROVIDING FLOOR USING  
22 BLEND OF FEE SCHEDULE AND REGIONAL FEE  
23 SCHEDULES.—In carrying out the phase-in under  
24 paragraph (2)(E) for each level of service furnished  
25 in a year before January 1, 2007, the portion of the

1 payment amount that is based on the fee schedule  
2 shall not be less than the following blended rate of  
3 the fee schedule under paragraph (1) and of a re-  
4 gional fee schedule for the region involved:

5 “(A) For 2003, the blended rate shall be  
6 based 20 percent on the fee schedule under  
7 paragraph (1) and 80 percent on the regional  
8 fee schedule.

9 “(B) For 2004, the blended rate shall be  
10 based 40 percent on the fee schedule under  
11 paragraph (1) and 60 percent on the regional  
12 fee schedule.

13 “(C) For 2005, the blended rate shall be  
14 based 60 percent on the fee schedule under  
15 paragraph (1) and 40 percent on the regional  
16 fee schedule.

17 “(D) For 2006, the blended rate shall be  
18 based 80 percent on the fee schedule under  
19 paragraph (1) and 20 percent on the regional  
20 fee schedule.

21 For purposes of this paragraph, the Secretary shall  
22 establish a regional fee schedule for each of the 9  
23 Census divisions using the methodology (used in es-  
24 tablishing the fee schedule under paragraph (1)) to  
25 calculate a regional conversion factor and a regional

1 mileage payment rate and using the same payment  
2 adjustments and the same relative value units as  
3 used in the fee schedule under such paragraph.”.

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

8 “(11) ADJUSTMENT IN PAYMENT FOR CERTAIN  
9 LONG TRIPS.—In the case of ground ambulance  
10 services furnished on or after January 1, 2003, and  
11 before January 1, 2008, regardless of where the  
12 transportation originates, the fee schedule estab-  
13 lished under this subsection shall provide that, with  
14 respect to the payment rate for mileage for a trip  
15 above 50 miles the per mile rate otherwise estab-  
16 lished shall be increased by  $\frac{1}{4}$  of the payment per  
17 mile otherwise applicable to such miles.”.

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

21 **SEC. 512. 2-YEAR EXTENSION OF MORATORIUM ON THER-**  
22 **APY CAPS; PROVISIONS RELATING TO RE-**  
23 **PORTS.**

24 (a) 2-YEAR EXTENSION OF MORATORIUM ON THER-  
25 APY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4))

1 is amended by striking “and 2002” and inserting “2002,  
2 2003, and 2004”.

3 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON  
4 PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY  
5 SERVICES.—Not later than December 31, 2002, the Sec-  
6 retary shall submit to Congress the reports required under  
7 section 4541(d)(2) of the Balanced Budget Act of 1997  
8 (relating to alternatives to a single annual dollar cap on  
9 outpatient therapy) and under section 221(d) of the Medi-  
10 care, Medicaid, and SCHIP Balanced Budget Refinement  
11 Act of 1999 (relating to utilization patterns for outpatient  
12 therapy).

13 (c) IDENTIFICATION OF CONDITIONS AND DISEASES  
14 JUSTIFYING WAIVER OF THERAPY CAP.—

15 (1) STUDY.—The Secretary shall request the  
16 Institute of Medicine of the National Academy of  
17 Sciences to identify conditions or diseases that  
18 should justify conducting an assessment of the need  
19 to waive the therapy caps under section 1833(g)(4)  
20 of the Social Security Act (42 U.S.C. 1395l(g)(4)).

21 (2) REPORTS TO CONGRESS.—Not later than  
22 September 1, 2003, the Secretary shall submit to  
23 Congress a preliminary report on the conditions and  
24 diseases identified under paragraph (1) and not later

1 than December 31, 2003, a final report on the con-  
2 ditions and diseases so identified.

3 (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL  
4 THERAPIST SERVICES.—

5 (1) STUDY.—The Comptroller General of the  
6 United States shall conduct a study on access to  
7 physical therapist services in States authorizing such  
8 services without a physician referral and in States  
9 that require such a physician referral. The study  
10 shall—

11 (A) examine the use of and referral pat-  
12 terns for physical therapist services for patients  
13 age 50 and older in States that authorize such  
14 services without a physician referral and in  
15 States that require such a physician referral;

16 (B) examine the use of and referral pat-  
17 terns for physical therapist services for patients  
18 who are medicare beneficiaries;

19 (C) examine the potential effect of prohib-  
20 iting a physician from referring patients to  
21 physical therapy services owned by the physi-  
22 cian and provided in the physician's office;

23 (D) examine the delivery of physical thera-  
24 pists' services within the facilities of Depart-  
25 ment of Defense; and

1           (E) analyze the potential impact on medi-  
2           care beneficiaries and on expenditures under  
3           the medicare program of eliminating the need  
4           for a physician referral and physician certifi-  
5           cation for physical therapist services under the  
6           medicare program.

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

11 **SEC. 513. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**  
12 **ICAL EXAMINATION.**

13          (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
14 1395x(s)(2)) is amended—

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

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

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

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

23          (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
24 1395x) is amended by adding at the end the following new  
25          subsection:

1 “Initial Preventive Physical Examination

2 “(ww) The term ‘initial preventive physical examina-  
3 tion’ means physicians’ services consisting of a physical  
4 examination with the goal of health promotion and disease  
5 detection and includes items and services (excluding clin-  
6 ical laboratory tests), as determined by the Secretary, con-  
7 sistent with the recommendations of the United States  
8 Preventive Services Task Force.”.

9 (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

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

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

13 (B) by inserting before the period at the  
14 end the following: “, and (7) such deductible  
15 shall not apply with respect to an initial preven-  
16 tive physical examination (as defined in section  
17 1861(ww))”.

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

20 (A) in clause (N), by inserting “(or 100  
21 percent in the case of an initial preventive phys-  
22 ical examination, as defined in section  
23 1861(ww))” after “80 percent”; and

24 (B) in clause (O), by inserting “(or 100  
25 percent in the case of an initial preventive phys-

1 ical examination, as defined in section  
2 1861(wv))” after “80 percent”.

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

6 (e) OTHER CONFORMING AMENDMENTS.—Section  
7 1862(a) (42 U.S.C. 1395y(a)) is amended—

8 (1) in paragraph (1)—

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

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

13 (C) by adding at the end the following new  
14 subparagraph:

15 “(J) in the case of an initial preventive physical  
16 examination, which is performed not later than 6  
17 months after the date the individual’s first coverage  
18 period begins under part B;”; and

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

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

1 **SEC. 514. RENAL DIALYSIS SERVICES.**

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

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

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

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

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

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

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

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

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

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

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

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

1 **SEC. 515. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**  
2 **RAPHY SERVICES.**

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

9 (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For  
10 diagnostic mammography performed on or after January  
11 1, 2004, for which payment is made under the physician  
12 fee schedule under section 1848 of the Social Security Act  
13 (42 U.S.C. 1395w–4), the Secretary, based on the most  
14 recent cost data available, shall provide for an appropriate  
15 adjustment in the payment amount for the technical com-  
16 ponent of the diagnostic mammography.

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

20 **SEC. 516. WAIVER OF PART B LATE ENROLLMENT PENALTY**  
21 **FOR CERTAIN MILITARY RETIREES; SPECIAL**  
22 **ENROLLMENT PERIOD.**

23 (a) WAIVER OF PENALTY.—

24 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.  
25 1395r(b)) is amended by adding at the end the fol-  
26 lowing new sentence: “No increase in the premium

1 shall be effected for a month in the case of an indi-  
2 vidual who is 65 years of age or older, who enrolls  
3 under this part during 2001, 2002, or 2003, and  
4 who demonstrates to the Secretary before December  
5 31, 2003, that the individual is a covered beneficiary  
6 (as defined in section 1072(5) of title 10, United  
7 States Code). The Secretary of Health and Human  
8 Services shall consult with the Secretary of Defense  
9 in identifying individuals described in the previous  
10 sentence.”.

11 (2) EFFECTIVE DATE.—The amendment made  
12 by paragraph (1) shall apply to premiums for  
13 months beginning with January 2003. The Secretary  
14 of Health and Human Services shall establish a  
15 method for providing rebates of premium penalties  
16 paid for months on or after January 2003 for which  
17 a penalty does not apply under such amendment but  
18 for which a penalty was previously collected.

19 (b) MEDICARE PART B SPECIAL ENROLLMENT PE-  
20 RIOD.—

21 (1) IN GENERAL.—In the case of any individual  
22 who, as of the date of the enactment of this Act, is  
23 65 years of age or older, is eligible to enroll but is  
24 not enrolled under part B of title XVIII of the So-  
25 cial Security Act, and is a covered beneficiary (as

1 defined in section 1072(5) of title 10, United States  
2 Code), the Secretary of Health and Human Services  
3 shall provide for a special enrollment period during  
4 which the individual may enroll under such part.  
5 Such period shall begin as soon as possible after the  
6 date of the enactment of this Act and shall end on  
7 December 31, 2003.

8 (2) COVERAGE PERIOD.—In the case of an indi-  
9 vidual who enrolls during the special enrollment pe-  
10 riod provided under paragraph (1), the coverage pe-  
11 riod under part B of title XVIII of the Social Secu-  
12 rity Act shall begin on the first day of the month  
13 following the month in which the individual enrolls.

14 **SEC. 517. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**  
15 **SCREENING.**

16 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
17 1395x(s)(2)), as amended by section 513(a), is amended—

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

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

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

1                   “(X) cholesterol and other blood lipid  
2                   screening tests (as defined in subsection  
3                   (XX));”.

4           (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
5 1395x), as amended by section 513(b), is amended by add-  
6 ing at the end the following new subsection:

7           “Cholesterol and Other Blood Lipid Screening Test

8           “(xx)(1) The term ‘cholesterol and other blood lipid  
9 screening test’ means diagnostic testing of cholesterol and  
10 other lipid levels of the blood for the purpose of early de-  
11 tection of abnormal cholesterol and other lipid levels.

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

17           (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.  
18 1395y(a)(1)), as amended by section 513(e), is amend-  
19 ed—

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

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

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

1           “(K) in the case of a cholesterol and other  
2 blood lipid screening test (as defined in section  
3 1861(xx)(1)), which is performed more frequently  
4 than is covered under section 1861(xx)(2).”.

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

8                           **TITLE VI—PROVISIONS**  
9                           **RELATING TO PARTS A AND B**  
10                          **Subtitle A—Home Health Services**

11           **SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN**  
12                           **PAYMENT RATES UNDER THE PROSPECTIVE**  
13                           **PAYMENT SYSTEM.**

14           (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.  
15 1395fff(b)(3)(A)) is amended to read as follows:

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

20   “(i) Such amount (or amounts) shall  
21 initially be based on the most current au-  
22 dited cost report data available to the Sec-  
23 retary and shall be computed in a manner  
24 so that the total amounts payable under  
25 the system for fiscal year 2001 shall be

1 equal to the total amount that would have  
2 been made if the system had not been in  
3 effect and if section 1861(v)(1)(L)(ix) had  
4 not been enacted.

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

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

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

22 Each such amount shall be standardized in a  
23 manner that eliminates the effect of variations  
24 in relative case mix and area wage adjustments  
25 among different home health agencies in a

1 budget neutral manner consistent with the case  
2 mix and wage level adjustments provided under  
3 paragraph (4)(A). Under the system, the Sec-  
4 retary may recognize regional differences or dif-  
5 ferences based upon whether or not the services  
6 or agency are in an urbanized area.”.

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

13 **SEC. 602. UPDATE IN HOME HEALTH SERVICES.**

14 (a) CHANGE TO CALENDAR YEAR UPDATE.—

15 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.  
16 1395fff(b)(3)) is amended—

17 (A) in paragraph (3)(B)(i)—

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

22 (ii) by inserting “or year” after “the  
23 fiscal year”;

24 (B) in paragraph (3)(B)(ii)—

1 (i) in subclause (II), by striking “fis-  
2 cal year” and inserting “year” and by re-  
3 designating such subclause as subclause  
4 (III); and

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

11 “(II) 2003”;

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

15 (D) in paragraph (3)(B)(iv)—

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

18 (ii) by inserting “or years” after “fis-  
19 cal years”; and

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

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

1 be such amount (or amounts) for the previous cal-  
2 endar quarter.

3 (b) CHANGES IN UPDATES FOR 2003, 2004, AND  
4 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C.  
5 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B),  
6 is amended—

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

11 (2) by striking “or” at the end of subclause  
12 (II);

13 (3) by redesignating subclause (III) as sub-  
14 clause (V); and

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

17 “(III) 2004, 1.1 percentage  
18 points;

19 “(IV) 2005, 2.7 percentage  
20 points; or”.

21 (c) PAYMENT ADJUSTMENT.—

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

1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) shall apply to years beginning with  
3           2003.

4 **SEC. 603. OASIS TASK FORCE; SUSPENSION OF CERTAIN**  
5                   **OASIS DATA COLLECTION REQUIREMENTS**  
6                   **PENDING TASK FORCE SUBMITTAL OF RE-**  
7                   **PORT.**

8           (a) ESTABLISHMENT.—The Secretary of Health and  
9           Human Services shall establish and appoint a task force  
10           (to be known as the “OASIS Task Force”) to examine  
11           the data collection and reporting requirements under  
12           OASIS. For purposes of this section, the term “OASIS”  
13           means the Outcome and Assessment Information Set re-  
14           quired by reason of section 4602(e) of Balanced Budget  
15           Act of 1997 (42 U.S.C. 1395fff note).

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

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

20                   (2) Representatives of home health agencies.

21                   (3) Health care professionals and research and  
22                   health care quality experts outside the Federal Gov-  
23                   ernment with expertise in post-acute care.

24                   (4) Advocates for individuals requiring home  
25                   health services.

1 (c) DUTIES.—

2 (1) REVIEW AND RECOMMENDATIONS.—The  
3 OASIS Task Force shall review and make rec-  
4 ommendations to the Secretary regarding changes in  
5 OASIS to improve and simplify data collection for  
6 purposes of—

7 (A) assessing the quality of home health  
8 services; and

9 (B) providing consistency in classification  
10 of patients into home health resource groups  
11 (HHRGs) for payment under section 1895 of  
12 the Social Security Act (42 U.S.C. 1395fff).

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

16 (A) the 41 outcome measures currently in  
17 use;

18 (B) the timing and frequency of data col-  
19 lection; and

20 (C) the collection of information on  
21 comorbidities and clinical indicators.

22 (3) REPORT.—The OASIS Task Force shall  
23 submit a report to the Secretary containing its find-  
24 ings and recommendations for changes in OASIS by

1 not later than 18 months after the date of the enact-  
2 ment of this Act.

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

6 (e) NONAPPLICATION OF FACCA.—The provisions of  
7 the Federal Advisory Committee Act shall not apply to  
8 the OASIS Task Force.

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

12 (1) IN GENERAL.—During the period described  
13 in paragraph (2), the Secretary of Health and  
14 Human Services may not require, under section  
15 4602(e) of the Balanced Budget Act of 1997 or oth-  
16 erwise under OASIS, a home health agency to gath-  
17 er or submit information that relates to an indi-  
18 vidual who is not eligible for benefits under either  
19 title XVIII or title XIX of the Social Security Act.

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

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

23 (B) ends on the last day of the 2nd month  
24 beginning after the date the report is submitted  
25 under subsection (c)(2).

1 **SEC. 604. MEDPAC STUDY ON MEDICARE MARGINS OF**  
2 **HOME HEALTH AGENCIES.**

3 (a) **STUDY.**—The Medicare Payment Advisory Com-  
4 mission shall conduct a study of payment margins of home  
5 health agencies under the home health prospective pay-  
6 ment system under section 1895 of the Social Security Act  
7 (42 U.S.C. 1395fff). Such study shall examine whether  
8 systematic differences in payment margins are related to  
9 differences in case mix (as measured by home health re-  
10 source groups (HHRGs)) among such agencies. The study  
11 shall use the partial or full-year cost reports filed by home  
12 health agencies.

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

16 **SEC. 605. CLARIFICATION OF TREATMENT OF OCCASIONAL**  
17 **ABSENCES IN DETERMINING WHETHER AN**  
18 **INDIVIDUAL IS CONFINED TO THE HOME.**

19 (a) **IN GENERAL.**—The penultimate sentence of sec-  
20 tion 1814(a) (42 U.S.C. 1395f(a) and the penultimate  
21 sentence of section 1835(a) (42 U.S.C. 1395n(a)) are each  
22 amended to read as follows: “Any other absence of an indi-  
23 vidual from the home shall not so disqualify the individual  
24 if the absence is infrequent or of relatively short duration,  
25 such as an occasional trip to the barber or a walk around  
26 the block, and is not inconsistent with the assessment un-

1 derlying the individual’s plan of care for home health serv-  
 2 ices.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
 4 subsection (a) shall take effect on the date of the enact-  
 5 ment of this Act.

## 6 **Subtitle B—Direct Graduate** 7 **Medical Education**

### 8 **SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH** 9 **COST PROGRAMS.**

10 Section 1886(h)(2)(D)(iv) (42 U.S.C.

11 1395ww(h)(2)(D)(iv)) is amended—

12 (1) in subclause (I)—

13 (A) by striking “AND 2002” and inserting  
 14 “THROUGH 2012”;

15 (B) by striking “during fiscal year 2001 or  
 16 fiscal year 2002” and inserting “during the pe-  
 17 riod beginning with fiscal year 2001 and ending  
 18 with fiscal year 2012”; and

19 (C) by striking “subject to subclause  
 20 (III),”;

21 (2) by striking subclause (II); and

22 (3) in subclause (III)—

23 (A) by redesignating such subclause as  
 24 subclause (II); and

25 (B) by striking “or (II)”.

1 **SEC. 612. REDISTRIBUTION OF UNUSED RESIDENT POSI-**  
2 **TIONS.**

3 (a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C.  
4 1395ww(h)(4)) is amended—

5 (1) in subparagraph (F)(i), by inserting “sub-  
6 ject to subparagraph (I),” after “October 1, 1997,”;

7 (2) in subparagraph (H)(i), by inserting “sub-  
8 ject to subparagraph (I),” after “subparagraphs (F)  
9 and (G),”; and

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

12 “(I) REDISTRIBUTION OF UNUSED RESI-  
13 DENT POSITIONS.—

14 “(i) REDUCTION IN LIMIT BASED ON  
15 UNUSED POSITIONS.—

16 “(I) IN GENERAL.—If a hos-  
17 pital’s resident level (as defined in  
18 clause (iii)(I)) is less than the other-  
19 wise applicable resident limit (as de-  
20 fined in clause (iii)(II)) for each of  
21 the reference periods (as defined in  
22 subclause (II)), effective for cost re-  
23 porting periods beginning on or after  
24 January 1, 2003, the otherwise appli-  
25 cable resident limit shall be reduced  
26 by 75 percent of the difference be-

1           tween such limit and the reference  
2           resident level specified in subclause  
3           (III) (or subclause (IV) if applicable).

4           “(II) REFERENCE PERIODS DE-  
5           FINED.—In this clause, the term ‘ref-  
6           erence periods’ means, for a hospital,  
7           the 3 most recent consecutive cost re-  
8           porting periods of the hospital for  
9           which cost reports have been settled  
10          (or, if not, submitted) on or before  
11          September 30, 2001.

12          “(III) REFERENCE RESIDENT  
13          LEVEL.—Subject to subclause (IV),  
14          the reference resident level specified in  
15          this subclause for a hospital is the  
16          highest resident level for the hospital  
17          during any of the reference periods.

18          “(IV) ADJUSTMENT PROCESS.—  
19          Upon the timely request of a hospital,  
20          the Secretary may adjust the ref-  
21          erence resident level for a hospital to  
22          be the resident level for the hospital  
23          for the cost reporting period that in-  
24          cludes July 1, 2002.

25          “(ii) REDISTRIBUTION.—

1           “(I) IN GENERAL.—The Sec-  
2           retary is authorized to increase the  
3           otherwise applicable resident limits for  
4           hospitals by an aggregate number es-  
5           timated by the Secretary that does  
6           not exceed the aggregate reduction in  
7           such limits attributable to clause (i)  
8           (without taking into account any ad-  
9           justment under subclause (IV) of such  
10          clause).

11          “(II) EFFECTIVE DATE.—No in-  
12          crease under subclause (I) shall be  
13          permitted or taken into account for a  
14          hospital for any portion of a cost re-  
15          porting period that occurs before July  
16          1, 2003, or before the date of the hos-  
17          pital’s application for an increase  
18          under this clause. No such increase  
19          shall be permitted for a hospital un-  
20          less the hospital has applied to the  
21          Secretary for such increase by Decem-  
22          ber 31, 2004.

23          “(III) CONSIDERATIONS IN RE-  
24          DISTRIBUTION.—In determining for  
25          which hospitals the increase in the

1 otherwise applicable resident limit is  
2 provided under subclause (I), the Sec-  
3 retary shall take into account the  
4 need for such an increase by specialty  
5 and location involved, consistent with  
6 subclause (IV).

7 “(IV) PRIORITY FOR RURAL AND  
8 SMALL URBAN AREAS.—In deter-  
9 mining for which hospitals and resi-  
10 dency training programs an increase  
11 in the otherwise applicable resident  
12 limit is provided under subclause (I),  
13 the Secretary shall first distribute the  
14 increase to programs of hospitals lo-  
15 cated in rural areas or in urban areas  
16 that are not large urban areas (as de-  
17 fined for purposes of subsection (d))  
18 on a first-come-first-served basis (as  
19 determined by the Secretary) based on  
20 a demonstration that the hospital will  
21 fill the positions made available under  
22 this clause and not to exceed an in-  
23 crease of 25 full-time equivalent posi-  
24 tions with respect to any hospital.

1                   “(V) APPLICATION OF LOCALITY  
2                   ADJUSTED NATIONAL AVERAGE PER  
3                   RESIDENT AMOUNT.—With respect to  
4                   additional residency positions in a  
5                   hospital attributable to the increase  
6                   provided under this clause, notwith-  
7                   standing any other provision of this  
8                   subsection, the approved FTE resi-  
9                   dent amount is deemed to be equal to  
10                  the locality adjusted national average  
11                  per resident amount computed under  
12                  subparagraph (E) for that hospital.

13                  “(VI) CONSTRUCTION.—Nothing  
14                  in this clause shall be construed as  
15                  permitting the redistribution of reduc-  
16                  tions in residency positions attrib-  
17                  utable to voluntary reduction pro-  
18                  grams under paragraph (6) or as af-  
19                  fecting the ability of a hospital to es-  
20                  tablish new medical residency training  
21                  programs under subparagraph (H).

22                  “(iii) RESIDENT LEVEL AND LIMIT  
23                  DEFINED.—In this subparagraph:

24                         “(I) RESIDENT LEVEL.—The  
25                         term ‘resident level’ means, with re-

1           spect to a hospital, the total number  
2           of full-time equivalent residents, be-  
3           fore the application of weighting fac-  
4           tors (as determined under this para-  
5           graph), in the fields of allopathic and  
6           osteopathic medicine for the hospital.

7                   “(II) OTHERWISE APPLICABLE  
8           RESIDENT LIMIT.—The term ‘other-  
9           wise applicable resident limit’ means,  
10          with respect to a hospital, the limit  
11          otherwise applicable under subpara-  
12          graphs (F)(i) and (H) on the resident  
13          level for the hospital determined with-  
14          out regard to this subparagraph.”.

15          (b) NO APPLICATION OF INCREASE TO IME.—Sec-  
16          tion 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is  
17          amended by adding at the end the following: “The provi-  
18          sions of clause (i) of subparagraph (I) of subsection (h)(4)  
19          shall apply with respect to the first sentence of this clause  
20          in the same manner as it applies with respect to subpara-  
21          graph (F) of such subsection, but the provisions of clause  
22          (ii) of such subparagraph shall not apply.”.

23          (c) REPORT ON EXTENSION OF APPLICATIONS  
24          UNDER REDISTRIBUTION PROGRAM.—Not later than July  
25          1, 2004, the Secretary shall submit to Congress a report

1 containing recommendations regarding whether to extend  
2 the deadline for applications for an increase in resident  
3 limits under section 1886(h)(4)(I)(ii)(II) of the Social Se-  
4 curity Act (as added by subsection (a)).

## 5 **Subtitle C—Other Provisions**

### 6 **SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVI-** 7 **SORY COMMISSION (MEDPAC).**

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

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

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

21 (c) ADDITIONAL REPORTS.—

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

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

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

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

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

18 **SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MAN-**  
19 **AGEMENT FOR CERTAIN MEDICARE BENE-**  
20 **FICIARIES WITH DIABETES.**

21 (a) IN GENERAL.—The Secretary of Health and  
22 Human Services shall conduct a demonstration project  
23 under this section (in this section referred to as the  
24 “project”) to demonstrate the impact on costs and health  
25 outcomes of applying disease management to certain medi-

1 care beneficiaries with diagnosed diabetes. In no case may  
2 the number of participants in the project exceed 30,000  
3 at any time.

4 (b) VOLUNTARY PARTICIPATION.—

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

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

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

14 (C) their physicians approve of partici-  
15 pation in the project; and

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

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

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

22 (B) for payment for all costs for prescrip-  
23 tion drugs without regard to whether or not  
24 they relate to the diabetes, except that the

1 project may provide for modest cost-sharing  
2 with respect to prescription drug coverage.

3 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-  
4 NIZATIONS.—

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

13 (2) CONTRACT PROVISIONS.—Under such con-  
14 tracts—

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

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

1 medicare program as a result of the project;  
2 and

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

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

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

22 (2) In applying paragraph (1)—

23 (A) any reference in clause (v) or (vi) of section  
24 1882(s)(3)(B) of such Act to 12 months is deemed

1 a reference to the period of the demonstration  
2 project; and

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

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

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

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

22 (h) WORKING GROUP ON MEDICARE DISEASE MAN-  
23 AGEMENT PROGRAMS.—The Secretary shall establish  
24 within the Department of Health and Human Services a

1 working group consisting of employees of the Department  
2 to carry out the following:

3 (1) To oversee the project.

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

8 (3) To identify targeted medical conditions and  
9 targeted individuals.

10 (4) To select areas in which such programs are  
11 carried out.

12 (5) To monitor health outcomes under such  
13 programs.

14 (6) To measure the effectiveness of such pro-  
15 grams in meeting any budget neutrality require-  
16 ments.

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

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

1 management. The study shall identify the cost-effective-  
2 ness of such programs and any savings achieved by such  
3 programs. The Comptroller General shall submit a report  
4 on such study to Congress by not later than 18 months  
5 after the date of the enactment of this Act.

6 **SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT**  
7 **DAY CARE SERVICES.**

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

19 (b) PAYMENT.—

20 (1) IN GENERAL.—The amount of payment for  
21 an episode of care for home health services, a por-  
22 tion of which consists of substitute medical adult  
23 day care services, under the demonstration project  
24 shall be made at a rate equal to 95 percent of the  
25 amount that would otherwise apply for such home

1 health services under section 1895 of the Social Se-  
2 curity Act (42 U.S.C. 1395fff). In no case may a  
3 home health agency, or a medical adult day care fa-  
4 cility under arrangements with a home health agen-  
5 cy, separately charge a beneficiary for medical adult  
6 day care services furnished under the plan of care.

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

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

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

23 (e) VOLUNTARY PARTICIPATION.—Participation of  
24 medicare beneficiaries in the demonstration project shall  
25 be voluntary. The total number of such beneficiaries that

1 may participate in the project at any given time may not  
2 exceed 15,000.

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

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

15 (h) EVALUATION AND REPORT.—The Secretary shall  
16 conduct an evaluation of the clinical and cost effectiveness  
17 of the demonstration project. Not later 30 months after  
18 the commencement of the project, the Secretary shall sub-  
19 mit to Congress a report on the evaluation, and shall in-  
20 clude in the report the following:

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

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

4           (i) DEFINITIONS.—In this section:

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

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

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

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

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

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

3 (3) MEDICAL ADULT DAY CARE SERVICES.—

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

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

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

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

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

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

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

1 **SEC. 624. PUBLICATION ON FINAL WRITTEN GUIDANCE**  
 2 **CONCERNING PROHIBITIONS AGAINST DIS-**  
 3 **CRIMINATION BY NATIONAL ORIGIN WITH**  
 4 **RESPECT TO HEALTH CARE SERVICES.**

5 Not later than January 1, 2003, the Secretary shall  
 6 issue final written guidance concerning the application of  
 7 the prohibition in title VI of the Civil Rights Act of 1964  
 8 against national origin discrimination as it affects persons  
 9 with limited English proficiency with respect to access to  
 10 health care services under the medicare program.

11 **TITLE VII—MEDICARE BENEFITS**  
 12 **ADMINISTRATION**

13 **SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS AD-**  
 14 **MINISTRATION.**

15 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
 16 seq.) is amended by inserting after 1806 the following new  
 17 section:

18 “MEDICARE BENEFITS ADMINISTRATION

19 “SEC. 1807. (a) ESTABLISHMENT.—There is estab-  
 20 lished within the Department of Health and Human Serv-  
 21 ices an agency to be known as the Medicare Benefits Ad-  
 22 ministration.

23 “(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR;  
 24 CHIEF ACTUARY.—

25 “(1) ADMINISTRATOR.—

1           “(A) IN GENERAL.—The Medicare Bene-  
2           fits Administration shall be headed by an ad-  
3           ministrators to be known as the ‘Medicare Bene-  
4           fits Administrator’ (in this section referred to  
5           as the ‘Administrator’) who shall be appointed  
6           by the President, by and with the advice and  
7           consent of the Senate. The Administrator shall  
8           be in direct line of authority to the Secretary.

9           “(B) COMPENSATION.—The Administrator  
10          shall be paid at the rate of basic pay payable  
11          for level III of the Executive Schedule under  
12          section 5314 of title 5, United States Code.

13          “(C) TERM OF OFFICE.—The Adminis-  
14          trator shall be appointed for a term of 5 years.  
15          In any case in which a successor does not take  
16          office at the end of an Administrator’s term of  
17          office, that Administrator may continue in of-  
18          fice until the entry upon office of such a suc-  
19          cessor. An Administrator appointed to a term of  
20          office after the commencement of such term  
21          may serve under such appointment only for the  
22          remainder of such term.

23          “(D) GENERAL AUTHORITY.—The Admin-  
24          istrator shall be responsible for the exercise of  
25          all powers and the discharge of all duties of the

1 Administration, and shall have authority and  
2 control over all personnel and activities thereof.

3 “(E) RULEMAKING AUTHORITY.—The Ad-  
4 ministrator may prescribe such rules and regu-  
5 lations as the Administrator determines nec-  
6 essary or appropriate to carry out the functions  
7 of the Administration. The regulations pre-  
8 scribed by the Administrator shall be subject to  
9 the rulemaking procedures established under  
10 section 553 of title 5, United States Code.

11 “(F) AUTHORITY TO ESTABLISH ORGANI-  
12 ZATIONAL UNITS.—The Administrator may es-  
13 tablish, alter, consolidate, or discontinue such  
14 organizational units or components within the  
15 Administration as the Administrator considers  
16 necessary or appropriate, except as specified in  
17 this section.

18 “(G) AUTHORITY TO DELEGATE.—The Ad-  
19 ministrator may assign duties, and delegate, or  
20 authorize successive redelegations of, authority  
21 to act and to render decisions, to such officers  
22 and employees of the Administration as the Ad-  
23 ministrator may find necessary. Within the lim-  
24 itations of such delegations, redelegations, or  
25 assignments, all official acts and decisions of

1 such officers and employees shall have the same  
2 force and effect as though performed or ren-  
3 dered by the Administrator.

4 “(2) DEPUTY ADMINISTRATOR.—

5 “(A) IN GENERAL.—There shall be a Dep-  
6 uty Administrator of the Medicare Benefits Ad-  
7 ministration who shall be appointed by the  
8 President, by and with the advice and consent  
9 of the Senate.

10 “(B) COMPENSATION.—The Deputy Ad-  
11 ministrator shall be paid at the rate of basic  
12 pay payable for level IV of the Executive Sched-  
13 ule under section 5315 of title 5, United States  
14 Code.

15 “(C) TERM OF OFFICE.—The Deputy Ad-  
16 ministrator shall be appointed for a term of 5  
17 years. In any case in which a successor does not  
18 take office at the end of a Deputy Administra-  
19 tor’s term of office, such Deputy Administrator  
20 may continue in office until the entry upon of-  
21 fice of such a successor. A Deputy Adminis-  
22 trator appointed to a term of office after the  
23 commencement of such term may serve under  
24 such appointment only for the remainder of  
25 such term.

1           “(D) DUTIES.—The Deputy Administrator  
2 shall perform such duties and exercise such  
3 powers as the Administrator shall from time to  
4 time assign or delegate. The Deputy Adminis-  
5 trator shall be Acting Administrator of the Ad-  
6 ministration during the absence or disability of  
7 the Administrator and, unless the President  
8 designates another officer of the Government as  
9 Acting Administrator, in the event of a vacancy  
10 in the office of the Administrator.

11           “(3) CHIEF ACTUARY.—

12           “(A) IN GENERAL.—There is established in  
13 the Administration the position of Chief Actu-  
14 ary. The Chief Actuary shall be appointed by,  
15 and in direct line of authority to, the Adminis-  
16 trator of such Administration. The Chief Actu-  
17 ary shall be appointed from among individuals  
18 who have demonstrated, by their education and  
19 experience, superior expertise in the actuarial  
20 sciences. The Chief Actuary may be removed  
21 only for cause.

22           “(B) COMPENSATION.—The Chief Actuary  
23 shall be compensated at the highest rate of  
24 basic pay for the Senior Executive Service

1 under section 5382(b) of title 5, United States  
2 Code.

3 “(C) DUTIES.—The Chief Actuary shall  
4 exercise such duties as are appropriate for the  
5 office of the Chief Actuary and in accordance  
6 with professional standards of actuarial inde-  
7 pendence.

8 “(4) SECRETARIAL COORDINATION OF PROGRAM  
9 ADMINISTRATION.—The Secretary shall ensure ap-  
10 propriate coordination between the Administrator  
11 and the Administrator of the Centers for Medicare  
12 & Medicaid Services in carrying out the programs  
13 under this title.

14 “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

15 “(1) DUTIES.—

16 “(A) GENERAL DUTIES.—The Adminis-  
17 trator shall carry out part C, including negoti-  
18 ating, entering into, and enforcing, contracts  
19 with plans for the offering of Medicare+Choice  
20 plans under part C.

21 “(B) OTHER DUTIES.—The Administrator  
22 shall carry out any duty provided for under  
23 part C, including demonstration projects carried  
24 out in part or in whole under such parts, the  
25 programs of all-inclusive care for the elderly

1 (PACE program) under section 1894, the social  
2 health maintenance organization (SHMO) dem-  
3 onstration projects (referred to in section  
4 4104(c) of the Balanced Budget Act of 1997),  
5 and through a Medicare+Choice project that  
6 demonstrates the application of capitation pay-  
7 ment rates for frail elderly medicare bene-  
8 ficiaries through the use of a interdisciplinary  
9 team and through the provision of primary care  
10 services to such beneficiaries by means of such  
11 a team at the nursing facility involved).

12 “(C) ANNUAL REPORTS.—Not later March  
13 31 of each year, the Administrator shall submit  
14 to Congress and the President a report on the  
15 administration of part C during the previous  
16 fiscal year.

17 “(2) STAFF.—

18 “(A) IN GENERAL.—The Administrator,  
19 with the approval of the Secretary, may employ,  
20 without regard to chapter 31 of title 5, United  
21 States Code, other than sections 3110 and  
22 3112, such officers and employees as are nec-  
23 essary to administer the activities to be carried  
24 out through the Medicare Benefits Administra-  
25 tion. The Administrator shall employ staff with

1 appropriate and necessary expertise in negoti-  
2 ating contracts in the private sector.

3 “(B) FLEXIBILITY WITH RESPECT TO COM-  
4 PENSATION.—

5 “(i) IN GENERAL.—The staff of the  
6 Medicare Benefits Administration shall,  
7 subject to clause (ii), be paid without re-  
8 gard to the provisions of chapter 51 (other  
9 than section 5101) and chapter 53 (other  
10 than section 5301) of such title (relating to  
11 classification and schedule pay rates).

12 “(ii) MAXIMUM RATE.—In no case  
13 may the rate of compensation determined  
14 under clause (i) exceed the rate of basic  
15 pay payable for level IV of the Executive  
16 Schedule under section 5315 of title 5,  
17 United States Code.

18 “(C) LIMITATION ON FULL-TIME EQUIVA-  
19 LENT STAFFING FOR CURRENT CMS FUNCTIONS  
20 BEING TRANSFERRED.—The Administrator may  
21 not employ under this paragraph a number of  
22 full-time equivalent employees, to carry out  
23 functions that were previously conducted by the  
24 Centers for Medicare & Medicaid Services and  
25 that are conducted by the Administrator by rea-

1 son of this section, that exceeds the number of  
2 such full-time equivalent employees authorized  
3 to be employed by the Centers for Medicare &  
4 Medicaid Services to conduct such functions as  
5 of the date of the enactment of this Act.

6 “(3) REDELEGATION OF CERTAIN FUNCTIONS  
7 OF THE CENTERS FOR MEDICARE & MEDICAID SERV-  
8 ICES.—

9 “(A) IN GENERAL.—The Secretary, the  
10 Administrator, and the Administrator of the  
11 Centers for Medicare & Medicaid Services shall  
12 establish an appropriate transition of responsi-  
13 bility in order to redelegate the administration  
14 of part C from the Secretary and the Adminis-  
15 trator of the Centers for Medicare & Medicaid  
16 Services to the Administrator as is appropriate  
17 to carry out the purposes of this section.

18 “(B) TRANSFER OF DATA AND INFORMA-  
19 TION.—The Secretary shall ensure that the Ad-  
20 ministrator of the Centers for Medicare & Med-  
21 icaid Services transfers to the Administrator of  
22 the Medicare Benefits Administration such in-  
23 formation and data in the possession of the Ad-  
24 ministrator of the Centers for Medicare & Med-  
25 icaid Services as the Administrator of the Medi-

1 care Benefits Administration requires to carry  
2 out the duties described in paragraph (1).

3 “(C) CONSTRUCTION.—Insofar as a re-  
4 sponsibility of the Secretary or the Adminis-  
5 trator of the Centers for Medicare & Medicaid  
6 Services is redelegated to the Administrator  
7 under this section, any reference to the Sec-  
8 retary or the Administrator of the Centers for  
9 Medicare & Medicaid Services in this title or  
10 title XI with respect to such responsibility is  
11 deemed to be a reference to the Administrator.

12 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

13 “(1) ESTABLISHMENT.—The Secretary shall es-  
14 tablish within the Medicare Benefits Administration  
15 an Office of Beneficiary Assistance to coordinate  
16 functions relating to outreach and education of  
17 medicare beneficiaries under this title, including the  
18 functions described in paragraph (2). The Office  
19 shall be separate operating division within the Ad-  
20 ministration.

21 “(2) DISSEMINATION OF INFORMATION ON  
22 BENEFITS AND APPEALS RIGHTS.—

23 “(A) DISSEMINATION OF BENEFITS INFOR-  
24 MATION.—The Office of Beneficiary Assistance  
25 shall disseminate, directly or through contract,

1 to medicare beneficiaries, by mail, by posting on  
2 the Internet site of the Medicare Benefits Ad-  
3 ministration and through a toll-free telephone  
4 number, information with respect to the fol-  
5 lowing:

6 “(i) Benefits, and limitations on pay-  
7 ment (including cost-sharing, stop-loss pro-  
8 visions, and formulary restrictions) under  
9 parts C and D.

10 “(ii) Benefits, and limitations on pay-  
11 ment under parts A and B, including in-  
12 formation on medicare supplemental poli-  
13 cies under section 1882.

14 Such information shall be presented in a man-  
15 ner so that medicare beneficiaries may compare  
16 benefits under parts A, B, D, and medicare  
17 supplemental policies with benefits under  
18 Medicare+Choice plans under part C.

19 “(B) DISSEMINATION OF APPEALS RIGHTS  
20 INFORMATION.—The Office of Beneficiary As-  
21 sistance shall disseminate to medicare bene-  
22 ficiaries in the manner provided under subpara-  
23 graph (A) a description of procedural rights (in-  
24 cluding grievance and appeals procedures) of  
25 beneficiaries under the original medicare fee-

1 for-service program under parts A and B, the  
2 Medicare+Choice program under part C.

3 “(e) MEDICARE POLICY ADVISORY BOARD.—

4 “(1) ESTABLISHMENT.—There is established  
5 within the Medicare Benefits Administration the  
6 Medicare Policy Advisory Board (in this section re-  
7 ferred to the ‘Board’). The Board shall advise, con-  
8 sult with, and make recommendations to the Admin-  
9 istrator of the Medicare Benefits Administration  
10 with respect to the administration of parts C and D,  
11 including the review of payment policies under such  
12 parts.

13 “(2) REPORTS.—

14 “(A) IN GENERAL.—With respect to mat-  
15 ters of the administration of parts C and D, the  
16 Board shall submit to Congress and to the Ad-  
17 ministrator of the Medicare Benefits Adminis-  
18 tration such reports as the Board determines  
19 appropriate. Each such report may contain such  
20 recommendations as the Board determines ap-  
21 propriate for legislative or administrative  
22 changes to improve the administration of such  
23 parts, including the topics described in subpara-  
24 graph (B). Each such report shall be published  
25 in the Federal Register.

1           “(B) TOPICS DESCRIBED.—Reports re-  
2           quired under subparagraph (A) may include the  
3           following topics:

4                   “(i) FOSTERING COMPETITION.—Rec-  
5                   ommendations or proposals to increase  
6                   competition under parts C and D for serv-  
7                   ices furnished to medicare beneficiaries.

8                   “(ii) EDUCATION AND ENROLL-  
9                   MENT.—Recommendations for the im-  
10                  provement to efforts to provide medicare  
11                  beneficiaries information and education on  
12                  the program under this title, and specifi-  
13                  cally parts C and D, and the program for  
14                  enrollment under the title.

15                  “(iii) IMPLEMENTATION OF RISK-AD-  
16                  JUSTMENT.—Evaluation of the implemen-  
17                  tation under section 1853(a)(3)(C) of the  
18                  risk adjustment methodology to payment  
19                  rates under that section to  
20                  Medicare+Choice organizations offering  
21                  Medicare+Choice plans that accounts for  
22                  variations in per capita costs based on  
23                  health status and other demographic fac-  
24                  tors.

1           “(iv) DISEASE MANAGEMENT PRO-  
2           GRAMS.—Recommendations on the incor-  
3           poration of disease management programs  
4           under parts C and D.

5           “(v) RURAL ACCESS.—Recommendations to improve competition and access to  
6           plans under parts C and D in rural areas.

8           “(C) MAINTAINING INDEPENDENCE OF  
9           BOARD.—The Board shall directly submit to  
10          Congress reports required under subparagraph  
11          (A). No officer or agency of the United States  
12          may require the Board to submit to any officer  
13          or agency of the United States for approval,  
14          comments, or review, prior to the submission to  
15          Congress of such reports.

16          “(3) DUTY OF ADMINISTRATOR OF MEDICARE  
17          BENEFITS ADMINISTRATION.—With respect to any  
18          report submitted by the Board under paragraph  
19          (2)(A), not later than 90 days after the report is  
20          submitted, the Administrator of the Medicare Bene-  
21          fits Administration shall submit to Congress and the  
22          President an analysis of recommendations made by  
23          the Board in such report. Each such analysis shall  
24          be published in the Federal Register.

25          “(4) MEMBERSHIP.—

1           “(A) APPOINTMENT.—Subject to the suc-  
2 ceeding provisions of this paragraph, the Board  
3 shall consist of seven members to be appointed  
4 as follows:

5                   “(i) Three members shall be ap-  
6 pointed by the President.

7                   “(ii) Two members shall be appointed  
8 by the Speaker of the House of Represent-  
9 atives, with the advice of the chairmen and  
10 the ranking minority members of the Com-  
11 mittees on Ways and Means and on En-  
12 ergy and Commerce of the House of Rep-  
13 resentatives.

14                   “(iii) Two members shall be appointed  
15 by the President pro tempore of the Senate  
16 with the advice of the chairman and the  
17 ranking minority member of the Senate  
18 Committee on Finance.

19           “(B) QUALIFICATIONS.—The members  
20 shall be chosen on the basis of their integrity,  
21 impartiality, and good judgment, and shall be  
22 individuals who are, by reason of their edu-  
23 cation and experience in health care benefits  
24 management, exceptionally qualified to perform  
25 the duties of members of the Board.

1           “(C) PROHIBITION ON INCLUSION OF FED-  
2           ERAL EMPLOYEES.—No officer or employee of  
3           the United States may serve as a member of  
4           the Board.

5           “(5) COMPENSATION.—Members of the Board  
6           shall receive, for each day (including travel time)  
7           they are engaged in the performance of the functions  
8           of the board, compensation at rates not to exceed  
9           the daily equivalent to the annual rate in effect for  
10          level IV of the Executive Schedule under section  
11          5315 of title 5, United States Code.

12          “(6) TERMS OF OFFICE.—

13                 “(A) IN GENERAL.—The term of office of  
14                 members of the Board shall be 3 years.

15                 “(B) TERMS OF INITIAL APPOINTEES.—As  
16                 designated by the President at the time of ap-  
17                 pointment, of the members first appointed—

18                         “(i) one shall be appointed for a term  
19                         of 1 year;

20                         “(ii) three shall be appointed for  
21                         terms of 2 years; and

22                         “(iii) three shall be appointed for  
23                         terms of 3 years.

1           “(C) REAPPOINTMENTS.—Any person ap-  
2           pointed as a member of the Board may not  
3           serve for more than 8 years.

4           “(D) VACANCY.—Any member appointed  
5           to fill a vacancy occurring before the expiration  
6           of the term for which the member’s predecessor  
7           was appointed shall be appointed only for the  
8           remainder of that term. A member may serve  
9           after the expiration of that member’s term until  
10          a successor has taken office. A vacancy in the  
11          Board shall be filled in the manner in which the  
12          original appointment was made.

13          “(7) CHAIR.—The Chair of the Board shall be  
14          elected by the members. The term of office of the  
15          Chair shall be 3 years.

16          “(8) MEETINGS.—The Board shall meet at the  
17          call of the Chair, but in no event less than three  
18          times during each fiscal year.

19          “(9) DIRECTOR AND STAFF.—

20                 “(A) APPOINTMENT OF DIRECTOR.—The  
21                 Board shall have a Director who shall be ap-  
22                 pointed by the Chair.

23                 “(B) IN GENERAL.—With the approval of  
24                 the Board, the Director may appoint, without  
25                 regard to chapter 31 of title 5, United States

1 Code, such additional personnel as the Director  
2 considers appropriate.

3 “(C) FLEXIBILITY WITH RESPECT TO COM-  
4 PENSATION.—

5 “(i) IN GENERAL.—The Director and  
6 staff of the Board shall, subject to clause  
7 (ii), be paid without regard to the provi-  
8 sions of chapter 51 and chapter 53 of such  
9 title (relating to classification and schedule  
10 pay rates).

11 “(ii) MAXIMUM RATE.—In no case  
12 may the rate of compensation determined  
13 under clause (i) exceed the rate of basic  
14 pay payable for level IV of the Executive  
15 Schedule under section 5315 of title 5,  
16 United States Code.

17 “(D) ASSISTANCE FROM THE ADMINIS-  
18 TRATOR OF THE MEDICARE BENEFITS ADMINIS-  
19 TRATION.—The Administrator of the Medicare  
20 Benefits Administration shall make available to  
21 the Board such information and other assist-  
22 ance as it may require to carry out its func-  
23 tions.

24 “(10) CONTRACT AUTHORITY.—The Board may  
25 contract with and compensate government and pri-

1 vate agencies or persons to carry out its duties  
2 under this subsection, without regard to section  
3 3709 of the Revised Statutes (41 U.S.C. 5).

4 “(f) FUNDING.—There is authorized to be appro-  
5 priated, in appropriate part from the Federal Hospital In-  
6 surance Trust Fund and from the Federal Supplementary  
7 Medical Insurance Trust Fund, such sums as are nec-  
8 essary to carry out this section.”.

9 (b) EFFECTIVE DATE.—

10 (1) IN GENERAL.—The amendment made by  
11 subsection (a) shall take effect on the date of the en-  
12 actment of this Act.

13 (2) TIMING OF INITIAL APPOINTMENTS.—The  
14 Administrator and Deputy Administrator of the  
15 Medicare Benefits Administration may not be ap-  
16 pointed before March 1, 2003.

17 (3) DUTIES WITH RESPECT TO ELIGIBILITY DE-  
18 TERMINATIONS AND ENROLLMENT.—The Adminis-  
19 trator of the Medicare Benefits Administration shall  
20 carry out enrollment under title XVIII of the Social  
21 Security Act, make eligibility determinations under  
22 such title, and carry out part C of such title for  
23 years beginning or after January 1, 2005.

24 (4) TRANSITION.—Before the date the Adminis-  
25 trator of the Medicare Benefits Administration is

1 appointed and assumes responsibilities under this  
2 section and section 1807 of the Social Security Act,  
3 the Secretary of Health and Human Services shall  
4 provide for the conduct of any responsibilities of  
5 such Administrator that are otherwise provided  
6 under law.

7 (c) MISCELLANEOUS ADMINISTRATIVE PROVI-  
8 SIONS.—

9 (1) ADMINISTRATOR AS MEMBER OF THE  
10 BOARD OF TRUSTEES OF THE MEDICARE TRUST  
11 FUNDS.—Section 1817(b) and section 1841(b) (42  
12 U.S.C. 1395i(b), 1395t(b)) are each amended by  
13 striking “and the Secretary of Health and Human  
14 Services, all ex officio,” and inserting “the Secretary  
15 of Health and Human Services, and the Adminis-  
16 trator of the Medicare Benefits Administration, all  
17 ex officio,”.

18 (2) INCREASE IN GRADE TO EXECUTIVE LEVEL  
19 III FOR THE ADMINISTRATOR OF THE CENTERS FOR  
20 MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDI-  
21 CARE BENEFITS ADMINISTRATOR.—

22 (A) IN GENERAL.—Section 5314 of title 5,  
23 United States Code, by adding at the end the  
24 following:

1 “Administrator of the Centers for Medicare &  
2 Medicaid Services.

3 “Administrator of the Medicare Benefits Ad-  
4 ministration.”.

5 (B) CONFORMING AMENDMENT.—Section  
6 5315 of such title is amended by striking “Ad-  
7 ministrator of the Health Care Financing Ad-  
8 ministration.”.

9 (C) EFFECTIVE DATE.—The amendments  
10 made by this paragraph take effect on January  
11 1, 2003.

12 **TITLE VIII—REGULATORY RE-**  
13 **DUCTION AND CONTRACTING**  
14 **REFORM**

15 **Subtitle A—Regulatory Reform**

16 **SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.**

17 (a) CONSTRUCTION.—Nothing in this title shall be  
18 construed—

19 (1) to compromise or affect existing legal rem-  
20 edies for addressing fraud or abuse, whether it be  
21 criminal prosecution, civil enforcement, or adminis-  
22 trative remedies, including under sections 3729  
23 through 3733 of title 31, United States Code  
24 (known as the False Claims Act); or



1 tions to carry out this title only on one business day of  
2 every month.

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

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

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

12 If the Secretary makes a finding under this paragraph,  
13 the Secretary shall include such finding, and brief state-  
14 ment of the reasons for such finding, in the issuance of  
15 such regulation.

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

21 (2) GAO REPORT ON PUBLICATION OF REGULA-  
22 TIONS ON A QUARTERLY BASIS.—Not later than 3  
23 years after the date of the enactment of this Act, the  
24 Comptroller General of the United States shall sub-  
25 mit to Congress a report on the feasibility of requir-

1       ing that regulations described in section 1871(d) of  
2       the Social Security Act be promulgated on a quar-  
3       terly basis rather than on a monthly basis.

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

8       (b) REGULAR TIMELINE FOR PUBLICATION OF  
9       FINAL RULES.—

10           (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
11       1395hh(a)) is amended by adding at the end the fol-  
12       lowing new paragraph:

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

18       “(B) Such timeline may vary among different regula-  
19       tions based on differences in the complexity of the regula-  
20       tion, the number and scope of comments received, and  
21       other relevant factors, but shall not be longer than 3 years  
22       except under exceptional circumstances. If the Secretary  
23       intends to vary such timeline with respect to the publica-  
24       tion of a final regulation, the Secretary shall cause to have  
25       published in the Federal Register notice of the different

1 timeline by not later than the timeline previously estab-  
2 lished with respect to such regulation. Such notice shall  
3 include a brief explanation of the justification for such  
4 variation.

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

19       “(D) The Secretary shall annually submit to Con-  
20 gress a report that describes the instances in which the  
21 Secretary failed to publish a final regulation within the  
22 applicable regular timeline under this paragraph and that  
23 provides an explanation for such failures.”.

24               (2) EFFECTIVE DATE.—The amendment made  
25       by paragraph (1) shall take effect on the date of the

1 enactment of this Act. The Secretary shall provide  
2 for an appropriate transition to take into account  
3 the backlog of previously published interim final reg-  
4 ulations.

5 (c) LIMITATIONS ON NEW MATTER IN FINAL REGU-  
6 LATIONS.—

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

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

19 (2) EFFECTIVE DATE.—The amendment made  
20 by paragraph (1) shall apply to final regulations  
21 published on or after the date of the enactment of  
22 this Act.

1 **SEC. 803. COMPLIANCE WITH CHANGES IN REGULATIONS**  
2 **AND POLICIES.**

3 (a) NO RETROACTIVE APPLICATION OF SUB-  
4 STANTIVE CHANGES.—

5 (1) IN GENERAL.—Section 1871 (42 U.S.C.  
6 1395hh), as amended by section 802(a), is amended  
7 by adding at the end the following new subsection:

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

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

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

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

22 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE  
23 CHANGES AFTER NOTICE.—

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

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

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

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

21           (2) EFFECTIVE DATE.—The amendment made  
22    by paragraph (1) shall apply to compliance actions  
23    undertaken on or after the date of the enactment of  
24    this Act.

25           (c) RELIANCE ON GUIDANCE.—

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

4           “(2)(A) If—

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

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

18               “(iii) the guidance was in error;  
19            the provider of services or supplier shall not be subject  
20            to any sanction (including any penalty or requirement for  
21            repayment of any amount) if the provider of services or  
22            supplier reasonably relied on such guidance.

23           “(B) Subparagraph (A) shall not be construed as pre-  
24            venting the recoupment or repayment (without any addi-  
25            tional penalty) relating to an overpayment insofar as the

1 overpayment was solely the result of a clerical or technical  
2 operational error.”.

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

8 **SEC. 804. REPORTS AND STUDIES RELATING TO REGU-**  
9 **LATORY REFORM.**

10           (a) GAO STUDY ON ADVISORY OPINION AUTHOR-  
11 ITY.—

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

23           (2) REPORT.—The Comptroller General shall  
24 submit to Congress a report on the study conducted

1 under paragraph (1) by not later than January 1,  
2 2004.

3 (b) REPORT ON LEGAL AND REGULATORY INCON-  
4 SISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as  
5 amended by section 803(a), is amended by adding at the  
6 end the following new subsection:

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

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

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

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

24 “(3) A report under paragraph (1) shall include a de-  
25 scription of efforts by the Secretary to reduce such incon-

1 sistency or conflicts, and recommendations for legislation  
 2 or administrative action that the Secretary determines ap-  
 3 propriate to further reduce such inconsistency or con-  
 4 flicts.”.

## 5 **Subtitle B—Contracting Reform**

### 6 **SEC. 811. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-** 7 **TRATION.**

8 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE  
 9 ADMINISTRATION.—

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

13 “CONTRACTS WITH MEDICARE ADMINISTRATIVE  
 14 CONTRACTORS

15 “SEC. 1874A. (a) AUTHORITY.—

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

24 “(2) ELIGIBILITY OF ENTITIES.—An entity is  
 25 eligible to enter into a contract with respect to the

1 performance of a particular function described in  
2 paragraph (4) only if—

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

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

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

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

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

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

19 “(B) APPROPRIATE MEDICARE ADMINIS-  
20 TRATIVE CONTRACTOR.—With respect to the  
21 performance of a particular function in relation  
22 to an individual entitled to benefits under part  
23 A or enrolled under part B, or both, a specific  
24 provider of services or supplier (or class of such  
25 providers of services or suppliers), the ‘appro-

1           appropriate' medicare administrative contractor is the  
2           medicare administrative contractor that has a  
3           contract under this section with respect to the  
4           performance of that function in relation to that  
5           individual, provider of services or supplier or  
6           class of provider of services or supplier.

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

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

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

24                 “(C) BENEFICIARY EDUCATION AND AS-  
25                 SISTANCE.—Providing education and outreach

1 to individuals entitled to benefits under part A  
2 or enrolled under part B, or both, and pro-  
3 viding assistance to those individuals with spe-  
4 cific issues, concerns or problems.

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

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

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

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

1 “(5) RELATIONSHIP TO MIP CONTRACTS.—

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

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

19 “(6) APPLICATION OF FEDERAL ACQUISITION  
20 REGULATION.—Except to the extent inconsistent  
21 with a specific requirement of this title, the Federal  
22 Acquisition Regulation applies to contracts under  
23 this title.

24 “(b) CONTRACTING REQUIREMENTS.—

25 “(1) USE OF COMPETITIVE PROCEDURES.—

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

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

22           “(C) TRANSFER OF FUNCTIONS.—The  
23 Secretary may transfer functions among medi-  
24 care administrative contractors consistent with  
25 the provisions of this paragraph. The Secretary

1 shall ensure that performance quality is consid-  
2 ered in such transfers. The Secretary shall pro-  
3 vide public notice (whether in the Federal Reg-  
4 ister or otherwise) of any such transfer (includ-  
5 ing a description of the functions so trans-  
6 ferred, a description of the providers of services  
7 and suppliers affected by such transfer, and  
8 contact information for the contractors in-  
9 volved).

10 “(D) INCENTIVES FOR QUALITY.—The  
11 Secretary shall provide incentives for medicare  
12 administrative contractors to provide quality  
13 service and to promote efficiency.

14 “(2) COMPLIANCE WITH REQUIREMENTS.—No  
15 contract under this section shall be entered into with  
16 any medicare administrative contractor unless the  
17 Secretary finds that such medicare administrative  
18 contractor will perform its obligations under the con-  
19 tract efficiently and effectively and will meet such  
20 requirements as to financial responsibility, legal au-  
21 thority, quality of services provided, and other mat-  
22 ters as the Secretary finds pertinent.

23 “(3) PERFORMANCE REQUIREMENTS.—

24 “(A) DEVELOPMENT OF SPECIFIC PER-  
25 FORMANCE REQUIREMENTS.—In developing

1 contract performance requirements, the Sec-  
2 retary shall develop performance requirements  
3 applicable to functions described in subsection  
4 (a)(4).

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

14 “(C) INCLUSION IN CONTRACTS.—All con-  
15 tractor performance requirements shall be set  
16 forth in the contract between the Secretary and  
17 the appropriate medicare administrative con-  
18 tractor. Such performance requirements—

19 “(i) shall reflect the performance re-  
20 quirements developed under subparagraph  
21 (A), but may include additional perform-  
22 ance requirements;

23 “(ii) shall be used for evaluating con-  
24 tractor performance under the contract;  
25 and

1                   “(iii) shall be consistent with the writ-  
2                   ten statement of work provided under the  
3                   contract.

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

8                   “(A) to furnish to the Secretary such time-  
9                   ly information and reports as the Secretary may  
10                  find necessary in performing his functions  
11                  under this title; and

12                  “(B) to maintain such records and afford  
13                  such access thereto as the Secretary finds nec-  
14                  essary to assure the correctness and verification  
15                  of the information and reports under subpara-  
16                  graph (A) and otherwise to carry out the pur-  
17                  poses of this title.

18                  “(5) SURETY BOND.—A contract with a medi-  
19                  care administrative contractor under this section  
20                  may require the medicare administrative contractor,  
21                  and any of its officers or employees certifying pay-  
22                  ments or disbursing funds pursuant to the contract,  
23                  or otherwise participating in carrying out the con-  
24                  tract, to give surety bond to the United States in

1 such amount as the Secretary may deem appro-  
2 priate.

3 “(c) TERMS AND CONDITIONS.—

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

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

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

22 “(1) CERTIFYING OFFICER.—No individual des-  
23 igned pursuant to a contract under this section as  
24 a certifying officer shall, in the absence of gross neg-  
25 ligence or intent to defraud the United States, be

1       liable with respect to any payments certified by the  
2       individual under this section.

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

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

19          “(4) INDEMNIFICATION BY SECRETARY.—

20           “(A) IN GENERAL.—Subject to subpara-  
21      graphs (B) and (D), in the case of a medicare  
22      administrative contractor (or a person who is a  
23      director, officer, or employee of such a con-  
24      tractor or who is engaged by the contractor to  
25      participate directly in the claims administration

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

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

20 “(C) SCOPE OF INDEMNIFICATION.—In-  
21 demnification by the Secretary under subpara-  
22 graph (A) may include payment of judgments,  
23 settlements (subject to subparagraph (D)),  
24 awards, and costs (including reasonable legal  
25 expenses).

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

14          “(E) CONSTRUCTION.—Nothing in this  
15          paragraph shall be construed—

16                 “(i) to change any common law immu-  
17                 nity that may be available to a medicare  
18                 administrative contractor or person de-  
19                 scribed in subparagraph (A); or

20                 “(ii) to permit the payment of costs  
21                 not otherwise allowable, reasonable, or allo-  
22                 cable under the Federal Acquisition Regu-  
23                 lations.”.

24          (2) CONSIDERATION OF INCORPORATION OF  
25          CURRENT LAW STANDARDS.—In developing contract

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

11 (b) CONFORMING AMENDMENTS TO SECTION 1816  
12 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816  
13 (42 U.S.C. 1395h) is amended as follows:

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

15 “PROVISIONS RELATING TO THE ADMINISTRATION OF  
16 PART A”.

17 (2) Subsection (a) is amended to read as fol-  
18 lows:

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

22 (3) Subsection (b) is repealed.

23 (4) Subsection (c) is amended—

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

25 (B) in each of paragraphs (2)(A) and

26 (3)(A), by striking “agreement under this sec-



- 1 (A) by striking paragraph (1);
- 2 (B) in paragraph (2)—
- 3 (i) by striking subparagraphs (A) and
- 4 (B);
- 5 (ii) in subparagraph (C), by striking
- 6 “carriers” and inserting “medicare admin-
- 7 istrative contractors”; and
- 8 (iii) by striking subparagraphs (D)
- 9 and (E);
- 10 (C) in paragraph (3)—
- 11 (i) in the matter before subparagraph
- 12 (A), by striking “Each such contract shall
- 13 provide that the carrier” and inserting
- 14 “The Secretary”;
- 15 (ii) by striking “will” the first place it
- 16 appears in each of subparagraphs (A), (B),
- 17 (F), (G), (H), and (L) and inserting
- 18 “shall”;
- 19 (iii) in subparagraph (B), in the mat-
- 20 ter before clause (i), by striking “to the
- 21 policyholders and subscribers of the car-
- 22 rier” and inserting “to the policyholders
- 23 and subscribers of the medicare adminis-
- 24 trative contractor”;

1 (iv) by striking subparagraphs (C),  
2 (D), and (E);

3 (v) in subparagraph (H)—

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

8 (II) by striking “carrier” and in-  
9 serting “medicare administrative con-  
10 tractor” in clause (i);

11 (vi) by striking subparagraph (I);

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

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

18 (ix) in the seventh sentence, by insert-  
19 ing “medicare administrative contractor,”  
20 after “carrier,”; and

21 (D) by striking paragraph (5);

22 (E) in paragraph (6)(D)(iv), by striking  
23 “carrier” and inserting “medicare administra-  
24 tive contractor”; and

1 (F) in paragraph (7), by striking “the car-  
2 rier” and inserting “the Secretary” each place  
3 it appears.

4 (4) Subsection (c) is amended—

5 (A) by striking paragraph (1);

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

12 (C) in paragraph (3)(A), by striking “sub-  
13 section (a)(1)(B)” and inserting “section  
14 1874A(a)(3)(B)”;

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

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

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

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

24 (7) Subsection (h) is amended—

25 (A) in paragraph (2)—

1 (i) by striking “Each carrier having  
2 an agreement with the Secretary under  
3 subsection (a)” and inserting “The Sec-  
4 retary”; and

5 (ii) by striking “Each such carrier”  
6 and inserting “The Secretary”;

7 (B) in paragraph (3)(A)—

8 (i) by striking “a carrier having an  
9 agreement with the Secretary under sub-  
10 section (a)” and inserting “medicare ad-  
11 ministrative contractor having a contract  
12 under section 1874A that provides for  
13 making payments under this part”; and

14 (ii) by striking “such carrier” and in-  
15 serting “such contractor”;

16 (C) in paragraph (3)(B)—

17 (i) by striking “a carrier” and insert-  
18 ing “a medicare administrative contractor”  
19 each place it appears; and

20 (ii) by striking “the carrier” and in-  
21 serting “the contractor” each place it ap-  
22 pears; and

23 (D) in paragraphs (5)(A) and (5)(B)(iii),  
24 by striking “carriers” and inserting “medicare

1 administrative contractors” each place it ap-  
2 pears.

3 (8) Subsection (l) is amended—

4 (A) in paragraph (1)(A)(iii), by striking  
5 “carrier” and inserting “medicare administra-  
6 tive contractor”; and

7 (B) in paragraph (2), by striking “carrier”  
8 and inserting “medicare administrative con-  
9 tractor”.

10 (9) Subsection (p)(3)(A) is amended by striking  
11 “carrier” and inserting “medicare administrative  
12 contractor”.

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

15 (d) EFFECTIVE DATE; TRANSITION RULE.—

16 (1) EFFECTIVE DATE.—

17 (A) IN GENERAL.—Except as otherwise  
18 provided in this subsection, the amendments  
19 made by this section shall take effect on Octo-  
20 ber 1, 2004, and the Secretary is authorized to  
21 take such steps before such date as may be nec-  
22 essary to implement such amendments on a  
23 timely basis.

24 (B) CONSTRUCTION FOR CURRENT CON-  
25 TRACTS.—Such amendments shall not apply to

1 contracts in effect before the date specified  
2 under subparagraph (A) that continue to retain  
3 the terms and conditions in effect on such date  
4 (except as otherwise provided under this Act,  
5 other than under this section) until such date  
6 as the contract is let out for competitive bid-  
7 ding under such amendments.

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

14 (D) WAIVER OF PROVIDER NOMINATION  
15 PROVISIONS DURING TRANSITION.—During the  
16 period beginning on the date of the enactment  
17 of this Act and before the date specified under  
18 subparagraph (A), the Secretary may enter into  
19 new agreements under section 1816 of the So-  
20 cial Security Act (42 U.S.C. 1395h) without re-  
21 gard to any of the provider nomination provi-  
22 sions of such section.

23 (2) GENERAL TRANSITION RULES.—The Sec-  
24 retary shall take such steps, consistent with para-  
25 graph (1)(B) and (1)(C), as are necessary to provide

1 for an appropriate transition from contracts under  
2 section 1816 and section 1842 of the Social Security  
3 Act (42 U.S.C. 1395h, 1395u) to contracts under  
4 section 1874A, as added by subsection (a)(1).

5 (3) AUTHORIZING CONTINUATION OF MIP  
6 FUNCTIONS UNDER CURRENT CONTRACTS AND  
7 AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—  
8 The provisions contained in the exception in section  
9 1893(d)(2) of the Social Security Act (42 U.S.C.  
10 1395ddd(d)(2)) shall continue to apply notwith-  
11 standing the amendments made by this section, and  
12 any reference in such provisions to an agreement or  
13 contract shall be deemed to include a contract under  
14 section 1874A of such Act, as inserted by subsection  
15 (a)(1), that continues the activities referred to in  
16 such provisions.

17 (e) REFERENCES.—On and after the effective date  
18 provided under subsection (d)(1), any reference to a fiscal  
19 intermediary or carrier under title XI or XVIII of the So-  
20 cial Security Act (or any regulation, manual instruction,  
21 interpretative rule, statement of policy, or guideline issued  
22 to carry out such titles) shall be deemed a reference to  
23 an appropriate medicare administrative contractor (as  
24 provided under section 1874A of the Social Security Act).

25 (f) REPORTS ON IMPLEMENTATION.—

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

12           (2) STATUS OF IMPLEMENTATION.—The Sec-  
13 retary shall submit a report to Congress not later  
14 than October 1, 2007, that describes the status of  
15 implementation of such amendments and that in-  
16 cludes a description of the following:

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

19                   (B) The distribution of functions among  
20                   contracts and contractors.

21                   (C) A timeline for complete transition to  
22                   full competition.

23                   (D) A detailed description of how the Sec-  
24                   retary has modified oversight and management

1 of medicare contractors to adapt to full com-  
2 petition.

3 **SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY**  
4 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**  
5 **TORS.**

6 (a) IN GENERAL.—Section 1874A, as added by sec-  
7 tion 811(a)(1), is amended by adding at the end the fol-  
8 lowing new subsection:

9 “(e) REQUIREMENTS FOR INFORMATION SECU-  
10 RITY.—

11 “(1) DEVELOPMENT OF INFORMATION SECU-  
12 RITY PROGRAM.—A medicare administrative con-  
13 tractor that performs the functions referred to in  
14 subparagraphs (A) and (B) of subsection (a)(4) (re-  
15 lating to determining and making payments) shall  
16 implement a contractor-wide information security  
17 program to provide information security for the op-  
18 eration and assets of the contractor with respect to  
19 such functions under this title. An information secu-  
20 rity program under this paragraph shall meet the re-  
21 quirements for information security programs im-  
22 posed on Federal agencies under section 3534(b)(2)  
23 of title 44, United States Code (other than require-  
24 ments under subparagraphs (B)(ii), (F)(iii), and  
25 (F)(iv) of such section).

1 “(2) INDEPENDENT AUDITS.—

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

11 “(i) be performed by an entity that  
12 meets such requirements for independence  
13 as the Inspector General of the Depart-  
14 ment of Health and Human Services may  
15 establish; and

16 “(ii) test the effectiveness of informa-  
17 tion security control techniques for an ap-  
18 propriate subset of the contractor’s infor-  
19 mation systems (as defined in section  
20 3502(8) of title 44, United States Code)  
21 relating to such functions under this title  
22 and an assessment of compliance with the  
23 requirements of this subsection and related  
24 information security policies, procedures,  
25 standards and guidelines.

1           “(B) DEADLINE FOR INITIAL EVALUA-  
2           TION.—

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

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

23          “(C) REPORTS ON EVALUATIONS.—

24          “(i) TO THE INSPECTOR GENERAL.—  
25          The results of independent evaluations

1 under subparagraph (A) shall be submitted  
2 promptly to the Inspector General of the  
3 Department of Health and Human Serv-  
4 ices.

5 “(ii) TO CONGRESS.—The Inspector  
6 General of Department of Health and  
7 Human Services shall submit to Congress  
8 annual reports on the results of such eval-  
9 uations.”.

10 (b) APPLICATION OF REQUIREMENTS TO FISCAL  
11 INTERMEDIARIES AND CARRIERS.—

12 (1) IN GENERAL.—The provisions of section  
13 1874A(e)(2) of the Social Security Act (other than  
14 subparagraph (B)), as added by subsection (a), shall  
15 apply to each fiscal intermediary under section 1816  
16 of the Social Security Act (42 U.S.C. 1395h) and  
17 each carrier under section 1842 of such Act (42  
18 U.S.C. 1395u) in the same manner as they apply to  
19 medicare administrative contractors under such pro-  
20 visions.

21 (2) DEADLINE FOR INITIAL EVALUATION.—In  
22 the case of such a fiscal intermediary or carrier with  
23 an agreement or contract under such respective sec-  
24 tion in effect as of the date of the enactment of this  
25 Act, the first evaluation under section

1 1874A(e)(2)(A) of the Social Security Act (as added  
2 by subsection (a)), pursuant to paragraph (1), shall  
3 be completed (and a report on the evaluation sub-  
4 mitted to the Secretary) by not later than 1 year  
5 after such date.

## 6 **Subtitle C—Education and** 7 **Outreach**

### 8 **SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSIST-** 9 **ANCE.**

10 (a) COORDINATION OF EDUCATION FUNDING.—

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

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

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

24 (3) REPORT.—Not later than October 1, 2003,  
25 the Secretary shall submit to Congress a report that  
26 includes a description and evaluation of the steps

1 taken to coordinate the funding of provider edu-  
2 cation under section 1889(a) of the Social Security  
3 Act, as added by paragraph (1).

4 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-  
5 FORMANCE.—

6 (1) IN GENERAL.—Section 1874A, as added by  
7 section 811(a)(1) and as amended by section 812(a),  
8 is amended by adding at the end the following new  
9 subsection:

10 “(f) INCENTIVES TO IMPROVE CONTRACTOR PER-  
11 FORMANCE IN PROVIDER EDUCATION AND OUTREACH.—  
12 In order to give medicare administrative contractors an  
13 incentive to implement effective education and outreach  
14 programs for providers of services and suppliers, the Sec-  
15 retary shall develop and implement a methodology to  
16 measure the specific claims payment error rates of such  
17 contractors in the processing or reviewing of medicare  
18 claims.”.

19 (2) APPLICATION TO FISCAL INTERMEDIARIES  
20 AND CARRIERS.—The provisions of section 1874A(f)  
21 of the Social Security Act, as added by paragraph  
22 (1), shall apply to each fiscal intermediary under  
23 section 1816 of the Social Security Act (42 U.S.C.  
24 1395h) and each carrier under section 1842 of such  
25 Act (42 U.S.C. 1395u) in the same manner as they

1 apply to medicare administrative contractors under  
2 such provisions.

3 (3) GAO REPORT ON ADEQUACY OF METHOD-  
4 OLOGY.—Not later than October 1, 2003, the Comp-  
5 troller General of the United States shall submit to  
6 Congress and to the Secretary a report on the ade-  
7 quacy of the methodology under section 1874A(f) of  
8 the Social Security Act, as added by paragraph (1),  
9 and shall include in the report such recommenda-  
10 tions as the Comptroller General determines appro-  
11 priate with respect to the methodology.

12 (4) REPORT ON USE OF METHODOLOGY IN AS-  
13 SESSING CONTRACTOR PERFORMANCE.—Not later  
14 than October 1, 2003, the Secretary shall submit to  
15 Congress a report that describes how the Secretary  
16 intends to use such methodology in assessing medi-  
17 care contractor performance in implementing effec-  
18 tive education and outreach programs, including  
19 whether to use such methodology as a basis for per-  
20 formance bonuses. The report shall include an anal-  
21 ysis of the sources of identified errors and potential  
22 changes in systems of contractors and rules of the  
23 Secretary that could reduce claims error rates.

1 (c) PROVISION OF ACCESS TO AND PROMPT RE-  
2 SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-  
3 TORS.—

4 (1) IN GENERAL.—Section 1874A, as added by  
5 section 811(a)(1) and as amended by section 812(a)  
6 and subsection (b), is further amended by adding at  
7 the end the following new subsection:

8 “(g) COMMUNICATIONS WITH BENEFICIARIES, PRO-  
9 VIDERS OF SERVICES AND SUPPLIERS.—

10 “(1) COMMUNICATION STRATEGY.—The Sec-  
11 retary shall develop a strategy for communications  
12 with individuals entitled to benefits under part A or  
13 enrolled under part B, or both, and with providers  
14 of services and suppliers under this title.

15 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each  
16 medicare administrative contractor shall, for those  
17 providers of services and suppliers which submit  
18 claims to the contractor for claims processing and  
19 for those individuals entitled to benefits under part  
20 A or enrolled under part B, or both, with respect to  
21 whom claims are submitted for claims processing,  
22 provide general written responses (which may be  
23 through electronic transmission) in a clear, concise,  
24 and accurate manner to inquiries of providers of  
25 services, suppliers and individuals entitled to bene-

1 fits under part A or enrolled under part B, or both,  
2 concerning the programs under this title within 45  
3 business days of the date of receipt of such inquiries.

4 “(3) RESPONSE TO TOLL-FREE LINES.—The  
5 Secretary shall ensure that each medicare adminis-  
6 trative contractor shall provide, for those providers  
7 of services and suppliers which submit claims to the  
8 contractor for claims processing and for those indi-  
9 viduals entitled to benefits under part A or enrolled  
10 under part B, or both, with respect to whom claims  
11 are submitted for claims processing, a toll-free tele-  
12 phone number at which such individuals, providers  
13 of services and suppliers may obtain information re-  
14 garding billing, coding, claims, coverage, and other  
15 appropriate information under this title.

16 “(4) MONITORING OF CONTRACTOR RE-  
17 SPONSES.—

18 “(A) IN GENERAL.—Each medicare admin-  
19 istrative contractor shall, consistent with stand-  
20 ards developed by the Secretary under subpara-  
21 graph (B)—

22 “(i) maintain a system for identifying  
23 who provides the information referred to in  
24 paragraphs (2) and (3); and

1           “(ii) monitor the accuracy, consist-  
2           ency, and timeliness of the information so  
3           provided.

4           “(B) DEVELOPMENT OF STANDARDS.—

5           “(i) IN GENERAL.—The Secretary  
6           shall establish and make public standards  
7           to monitor the accuracy, consistency, and  
8           timeliness of the information provided in  
9           response to written and telephone inquiries  
10          under this subsection. Such standards shall  
11          be consistent with the performance require-  
12          ments established under subsection (b)(3).

13          “(ii) EVALUATION.—In conducting  
14          evaluations of individual medicare adminis-  
15          trative contractors, the Secretary shall  
16          take into account the results of the moni-  
17          toring conducted under subparagraph (A)  
18          taking into account as performance re-  
19          quirements the standards established  
20          under clause (i). The Secretary shall, in  
21          consultation with organizations rep-  
22          resenting providers of services, suppliers,  
23          and individuals entitled to benefits under  
24          part A or enrolled under part B, or both,  
25          establish standards relating to the accu-

1           racy, consistency, and timeliness of the in-  
2           formation so provided.

3           “(C) DIRECT MONITORING.—Nothing in  
4           this paragraph shall be construed as preventing  
5           the Secretary from directly monitoring the ac-  
6           curacy, consistency, and timeliness of the infor-  
7           mation so provided.”.

8           (2) EFFECTIVE DATE.—The amendment made  
9           by paragraph (1) shall take effect October 1, 2003.

10          (3) APPLICATION TO FISCAL INTERMEDIARIES  
11          AND CARRIERS.—The provisions of section 1874A(g)  
12          of the Social Security Act, as added by paragraph  
13          (1), shall apply to each fiscal intermediary under  
14          section 1816 of the Social Security Act (42 U.S.C.  
15          1395h) and each carrier under section 1842 of such  
16          Act (42 U.S.C. 1395u) in the same manner as they  
17          apply to medicare administrative contractors under  
18          such provisions.

19          (d) IMPROVED PROVIDER EDUCATION AND TRAIN-  
20          ING.—

21                 (1) IN GENERAL.—Section 1889, as added by  
22                 subsection (a), is amended by adding at the end the  
23                 following new subsections:

24                 “(b) ENHANCED EDUCATION AND TRAINING.—

1           “(1) ADDITIONAL RESOURCES.—There are au-  
2           thorized to be appropriated to the Secretary (in ap-  
3           propriate part from the Federal Hospital Insurance  
4           Trust Fund and the Federal Supplementary Medical  
5           Insurance Trust Fund) \$25,000,000 for each of fis-  
6           cal years 2004 and 2005 and such sums as may be  
7           necessary for succeeding fiscal years.

8           “(2) USE.—The funds made available under  
9           paragraph (1) shall be used to increase the conduct  
10          by medicare contractors of education and training of  
11          providers of services and suppliers regarding billing,  
12          coding, and other appropriate items and may also be  
13          used to improve the accuracy, consistency, and time-  
14          liness of contractor responses.

15          “(c) TAILORING EDUCATION AND TRAINING ACTIVI-  
16          TIES FOR SMALL PROVIDERS OR SUPPLIERS.—

17                 “(1) IN GENERAL.—Insofar as a medicare con-  
18                 tractor conducts education and training activities, it  
19                 shall tailor such activities to meet the special needs  
20                 of small providers of services or suppliers (as defined  
21                 in paragraph (2)).

22                 “(2) SMALL PROVIDER OF SERVICES OR SUP-  
23                 PLIER.—In this subsection, the term ‘small provider  
24                 of services or supplier’ means—

1           “(A) a provider of services with fewer than  
2           25 full-time-equivalent employees; or

3           “(B) a supplier with fewer than 10 full-  
4           time-equivalent employees.”.

5           (2) EFFECTIVE DATE.—The amendment made  
6           by paragraph (1) shall take effect on October 1,  
7           2003.

8           (e) REQUIREMENT TO MAINTAIN INTERNET  
9           SITES.—

10           (1) IN GENERAL.—Section 1889, as added by  
11           subsection (a) and as amended by subsection (d), is  
12           further amended by adding at the end the following  
13           new subsection:

14           “(d) INTERNET SITES; FAQs.—The Secretary, and  
15           each medicare contractor insofar as it provides services  
16           (including claims processing) for providers of services or  
17           suppliers, shall maintain an Internet site which—

18           “(1) provides answers in an easily accessible  
19           format to frequently asked questions, and

20           “(2) includes other published materials of the  
21           contractor,

22           that relate to providers of services and suppliers under the  
23           programs under this title (and title XI insofar as it relates  
24           to such programs).”.

1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) shall take effect on October 1,  
3           2003.

4           (f) ADDITIONAL PROVIDER EDUCATION PROVI-  
5           SIONS.—

6           (1) IN GENERAL.—Section 1889, as added by  
7           subsection (a) and as amended by subsections (d)  
8           and (e), is further amended by adding at the end  
9           the following new subsections:

10          “(e) ENCOURAGEMENT OF PARTICIPATION IN EDU-  
11          CATION PROGRAM ACTIVITIES.—A medicare contractor  
12          may not use a record of attendance at (or failure to at-  
13          tend) educational activities or other information gathered  
14          during an educational program conducted under this sec-  
15          tion or otherwise by the Secretary to select or track pro-  
16          viders of services or suppliers for the purpose of con-  
17          ducting any type of audit or prepayment review.

18          “(f) CONSTRUCTION.—Nothing in this section or sec-  
19          tion 1893(g) shall be construed as providing for disclosure  
20          by a medicare contractor of information that would com-  
21          promise pending law enforcement activities or reveal find-  
22          ings of law enforcement-related audits.

23          “(g) DEFINITIONS.—For purposes of this section, the  
24          term ‘medicare contractor’ includes the following:

1           “(1) A medicare administrative contractor with  
2           a contract under section 1874A, including a fiscal  
3           intermediary with a contract under section 1816 and  
4           a carrier with a contract under section 1842.

5           “(2) An eligible entity with a contract under  
6           section 1893.

7 Such term does not include, with respect to activities of  
8 a specific provider of services or supplier an entity that  
9 has no authority under this title or title IX with respect  
10 to such activities and such provider of services or sup-  
11 plier.”.

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

15 **SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**  
16 **ONSTRATION PROGRAM.**

17           (a) ESTABLISHMENT.—

18           (1) IN GENERAL.—The Secretary shall establish  
19           a demonstration program (in this section referred to  
20           as the “demonstration program”) under which tech-  
21           nical assistance described in paragraph (2) is made  
22           available, upon request and on a voluntary basis, to  
23           small providers of services or suppliers in order to  
24           improve compliance with the applicable requirements  
25           of the programs under medicare program under title

1 XVIII of the Social Security Act (including provi-  
2 sions of title XI of such Act insofar as they relate  
3 to such title and are not administered by the Office  
4 of the Inspector General of the Department of  
5 Health and Human Services).

6 (2) FORMS OF TECHNICAL ASSISTANCE.—The  
7 technical assistance described in this paragraph is—

8 (A) evaluation and recommendations re-  
9 garding billing and related systems; and

10 (B) information and assistance regarding  
11 policies and procedures under the medicare pro-  
12 gram, including coding and reimbursement.

13 (3) SMALL PROVIDERS OF SERVICES OR SUP-  
14 PLIERS.—In this section, the term “small providers  
15 of services or suppliers” means—

16 (A) a provider of services with fewer than  
17 25 full-time-equivalent employees; or

18 (B) a supplier with fewer than 10 full-  
19 time-equivalent employees.

20 (b) QUALIFICATION OF CONTRACTORS.—In con-  
21 ducting the demonstration program, the Secretary shall  
22 enter into contracts with qualified organizations (such as  
23 peer review organizations or entities described in section  
24 1889(g)(2) of the Social Security Act, as inserted by sec-  
25 tion 5(f)(1)) with appropriate expertise with billing sys-

1 tems of the full range of providers of services and sup-  
2 pliers to provide the technical assistance. In awarding such  
3 contracts, the Secretary shall consider any prior investiga-  
4 tions of the entity's work by the Inspector General of De-  
5 partment of Health and Human Services or the Comp-  
6 troller General of the United States.

7 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The  
8 technical assistance provided under the demonstration  
9 program shall include a direct and in-person examination  
10 of billing systems and internal controls of small providers  
11 of services or suppliers to determine program compliance  
12 and to suggest more efficient or effective means of achiev-  
13 ing such compliance.

14 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROB-  
15 LEMS IDENTIFIED AS CORRECTED.—The Secretary shall  
16 provide that, absent evidence of fraud and notwith-  
17 standing any other provision of law, any errors found in  
18 a compliance review for a small provider of services or sup-  
19 plier that participates in the demonstration program shall  
20 not be subject to recovery action if the technical assistance  
21 personnel under the program determine that—

22 (1) the problem that is the subject of the com-  
23 pliance review has been corrected to their satisfac-  
24 tion within 30 days of the date of the visit by such

1 personnel to the small provider of services or sup-  
2 plier; and

3 (2) such problem remains corrected for such pe-  
4 riod as is appropriate.

5 The previous sentence applies only to claims filed as part  
6 of the demonstration program and lasts only for the dura-  
7 tion of such program and only as long as the small pro-  
8 vider of services or supplier is a participant in such pro-  
9 gram.

10 (e) GAO EVALUATION.—Not later than 2 years after  
11 the date of the date the demonstration program is first  
12 implemented, the Comptroller General, in consultation  
13 with the Inspector General of the Department of Health  
14 and Human Services, shall conduct an evaluation of the  
15 demonstration program. The evaluation shall include a de-  
16 termination of whether claims error rates are reduced for  
17 small providers of services or suppliers who participated  
18 in the program and the extent of improper payments made  
19 as a result of the demonstration program. The Comp-  
20 troller General shall submit a report to the Secretary and  
21 the Congress on such evaluation and shall include in such  
22 report recommendations regarding the continuation or ex-  
23 tension of the demonstration program.

24 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The  
25 provision of technical assistance to a small provider of

1 services or supplier under the demonstration program is  
2 conditioned upon the small provider of services or supplier  
3 paying an amount estimated (and disclosed in advance of  
4 a provider's or supplier's participation in the program) to  
5 be equal to 25 percent of the cost of the technical assist-  
6 ance.

7 (g) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated to the Secretary (in ap-  
9 propriate part from the Federal Hospital Insurance Trust  
10 Fund and the Federal Supplementary Medical Insurance  
11 Trust Fund) to carry out the demonstration program—

12 (1) for fiscal year 2004, \$1,000,000, and

13 (2) for fiscal year 2005, \$6,000,000.

14 **SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**  
15 **BENEFICIARY OMBUDSMAN.**

16 (a) MEDICARE PROVIDER OMBUDSMAN.—Section  
17 1868 (42 U.S.C. 1395ee) is amended—

18 (1) by adding at the end of the heading the fol-  
19 lowing: “; MEDICARE PROVIDER OMBUDSMAN”;

20 (2) by inserting “PRACTICING PHYSICIANS AD-  
21 VISORY COUNCIL.—(1)” after “(a)”;

22 (3) in paragraph (1), as so redesignated under  
23 paragraph (2), by striking “in this section” and in-  
24 serting “in this subsection”;

1           (4) by redesignating subsections (b) and (c) as  
2 paragraphs (2) and (3), respectively; and

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

5           “(b) MEDICARE PROVIDER OMBUDSMAN.—The Sec-  
6 retary shall appoint within the Department of Health and  
7 Human Services a Medicare Provider Ombudsman. The  
8 Ombudsman shall—

9           “(1) provide assistance, on a confidential basis,  
10 to providers of services and suppliers with respect to  
11 complaints, grievances, and requests for information  
12 concerning the programs under this title (including  
13 provisions of title XI insofar as they relate to this  
14 title and are not administered by the Office of the  
15 Inspector General of the Department of Health and  
16 Human Services) and in the resolution of unclear or  
17 conflicting guidance given by the Secretary and  
18 medicare contractors to such providers of services  
19 and suppliers regarding such programs and provi-  
20 sions and requirements under this title and such  
21 provisions; and

22           “(2) submit recommendations to the Secretary  
23 for improvement in the administration of this title  
24 and such provisions, including—

1           “(A) recommendations to respond to recur-  
2           ring patterns of confusion in this title and such  
3           provisions (including recommendations regard-  
4           ing suspending imposition of sanctions where  
5           there is widespread confusion in program ad-  
6           ministration), and

7           “(B) recommendations to provide for an  
8           appropriate and consistent response (including  
9           not providing for audits) in cases of self-identi-  
10          fied overpayments by providers of services and  
11          suppliers.

12 The Ombudsman shall not serve as an advocate for any  
13 increases in payments or new coverage of services, but  
14 may identify issues and problems in payment or coverage  
15 policies.”.

16          (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title  
17 XVIII, as amended by section 701, is amended by insert-  
18 ing after section 1807 the following new section:

19           “MEDICARE BENEFICIARY OMBUDSMAN

20          “SEC. 1808. (a) IN GENERAL.—The Secretary shall  
21 appoint within the Department of Health and Human  
22 Services a Medicare Beneficiary Ombudsman who shall  
23 have expertise and experience in the fields of health care  
24 and education of (and assistance to) individuals entitled  
25 to benefits under this title.

1       “(b) DUTIES.—The Medicare Beneficiary Ombuds-  
2 man shall—

3           “(1) receive complaints, grievances, and re-  
4 quests for information submitted by individuals enti-  
5 tled to benefits under part A or enrolled under part  
6 B, or both, with respect to any aspect of the medi-  
7 care program;

8           “(2) provide assistance with respect to com-  
9 plaints, grievances, and requests referred to in para-  
10 graph (1), including—

11           “(A) assistance in collecting relevant infor-  
12 mation for such individuals, to seek an appeal  
13 of a decision or determination made by a fiscal  
14 intermediary, carrier, Medicare+Choice organi-  
15 zation, or the Secretary; and

16           “(B) assistance to such individuals with  
17 any problems arising from disenrollment from a  
18 Medicare+Choice plan under part C; and

19           “(3) submit annual reports to Congress and the  
20 Secretary that describe the activities of the Office  
21 and that include such recommendations for improve-  
22 ment in the administration of this title as the Om-  
23 budsman determines appropriate.

24 The Ombudsman shall not serve as an advocate for any  
25 increases in payments or new coverage of services, but

1 may identify issues and problems in payment or coverage  
2 policies.

3       “(c) WORKING WITH HEALTH INSURANCE COUN-  
4 SELING PROGRAMS.—To the extent possible, the Ombuds-  
5 man shall work with health insurance counseling programs  
6 (receiving funding under section 4360 of Omnibus Budget  
7 Reconciliation Act of 1990) to facilitate the provision of  
8 information to individuals entitled to benefits under part  
9 A or enrolled under part B, or both regarding  
10 Medicare+Choice plans and changes to those plans. Noth-  
11 ing in this subsection shall preclude further collaboration  
12 between the Ombudsman and such programs.”.

13       (c) DEADLINE FOR APPOINTMENT.—The Secretary  
14 shall appoint the Medicare Provider Ombudsman and the  
15 Medicare Beneficiary Ombudsman, under the amendments  
16 made by subsections (a) and (b), respectively, by not later  
17 than 1 year after the date of the enactment of this Act.

18       (d) FUNDING.—There are authorized to be appro-  
19 priated to the Secretary (in appropriate part from the  
20 Federal Hospital Insurance Trust Fund and the Federal  
21 Supplementary Medical Insurance Trust Fund) to carry  
22 out the provisions of subsection (b) of section 1868 of the  
23 Social Security Act (relating to the Medicare Provider  
24 Ombudsman), as added by subsection (a)(5) and section  
25 1808 of such Act (relating to the Medicare Beneficiary

1 Ombudsman), as added by subsection (b), such sums as  
2 are necessary for fiscal year 2003 and each succeeding fis-  
3 cal year.

4 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-  
5 MEDICARE).—

6 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDI-  
7 CARE HANDBOOK INSTEAD OF OTHER TOLL-FREE  
8 NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-  
9 2(b)) is amended by adding at the end the following:  
10 “The Secretary shall provide, through the toll-free  
11 number 1-800-MEDICARE, for a means by which  
12 individuals seeking information about, or assistance  
13 with, such programs who phone such toll-free num-  
14 ber are transferred (without charge) to appropriate  
15 entities for the provision of such information or as-  
16 sistance. Such toll-free number shall be the toll-free  
17 number listed for general information and assistance  
18 in the annual notice under subsection (a) instead of  
19 the listing of numbers of individual contractors.”.

20 (2) MONITORING ACCURACY.—

21 (A) STUDY.—The Comptroller General of  
22 the United States shall conduct a study to mon-  
23 itor the accuracy and consistency of information  
24 provided to individuals entitled to benefits  
25 under part A or enrolled under part B, or both,

1 through the toll-free number 1-800-MEDI-  
2 CARE, including an assessment of whether the  
3 information provided is sufficient to answer  
4 questions of such individuals. In conducting the  
5 study, the Comptroller General shall examine  
6 the education and training of the individuals  
7 providing information through such number.

8 (B) REPORT.—Not later than 1 year after  
9 the date of the enactment of this Act, the  
10 Comptroller General shall submit to Congress a  
11 report on the study conducted under subpara-  
12 graph (A).

13 **SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION PRO-**  
14 **GRAM.**

15 (a) IN GENERAL.—The Secretary shall establish a  
16 demonstration program (in this section referred to as the  
17 “demonstration program”) under which medicare special-  
18 ists employed by the Department of Health and Human  
19 Services provide advice and assistance to individuals enti-  
20 tled to benefits under part A of title XVIII of the Social  
21 Security Act, or enrolled under part B of such title, or  
22 both, regarding the medicare program at the location of  
23 existing local offices of the Social Security Administration.

24 (b) LOCATIONS.—

1           (1) IN GENERAL.—The demonstration program  
2 shall be conducted in at least 6 offices or areas.  
3 Subject to paragraph (2), in selecting such offices  
4 and areas, the Secretary shall provide preference for  
5 offices with a high volume of visits by individuals re-  
6 ferred to in subsection (a).

7           (2) ASSISTANCE FOR RURAL BENEFICIARIES.—  
8 The Secretary shall provide for the selection of at  
9 least 2 rural areas to participate in the demonstra-  
10 tion program. In conducting the demonstration pro-  
11 gram in such rural areas, the Secretary shall provide  
12 for medicare specialists to travel among local offices  
13 in a rural area on a scheduled basis.

14          (c) DURATION.—The demonstration program shall be  
15 conducted over a 3-year period.

16          (d) EVALUATION AND REPORT.—

17           (1) EVALUATION.—The Secretary shall provide  
18 for an evaluation of the demonstration program.  
19 Such evaluation shall include an analysis of—

20                   (A) utilization of, and satisfaction of those  
21 individuals referred to in subsection (a) with,  
22 the assistance provided under the program; and

23                   (B) the cost-effectiveness of providing ben-  
24 eficiary assistance through out-stationing medi-

1 care specialists at local offices of the Social Se-  
2 curity Administration.

3 (2) REPORT.—The Secretary shall submit to  
4 Congress a report on such evaluation and shall in-  
5 clude in such report recommendations regarding the  
6 feasibility of permanently out-stationing medicare  
7 specialists at local offices of the Social Security Ad-  
8 ministration.

## 9 **Subtitle D—Appeals and Recovery**

### 10 **SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDICARE**

#### 11 **APPEALS.**

12 (a) TRANSITION PLAN.—

13 (1) IN GENERAL.—Not later than October 1,  
14 2003, the Commissioner of Social Security and the  
15 Secretary shall develop and transmit to Congress  
16 and the Comptroller General of the United States a  
17 plan under which the functions of administrative law  
18 judges responsible for hearing cases under title  
19 XVIII of the Social Security Act (and related provi-  
20 sions in title XI of such Act) are transferred from  
21 the responsibility of the Commissioner and the So-  
22 cial Security Administration to the Secretary and  
23 the Department of Health and Human Services.

24 (2) GAO EVALUATION.—The Comptroller Gen-  
25 eral of the United States shall evaluate the plan

1 and, not later than the date that is 6 months after  
2 the date on which the plan is received by the Comp-  
3 troller General, shall submit to Congress a report on  
4 such evaluation.

5 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

6 (1) IN GENERAL.—Not earlier than July 1,  
7 2004, and not later than October 1, 2004, the Com-  
8 missioner of Social Security and the Secretary shall  
9 implement the transition plan under subsection (a)  
10 and transfer the administrative law judge functions  
11 described in such subsection from the Social Secu-  
12 rity Administration to the Secretary.

13 (2) ASSURING INDEPENDENCE OF JUDGES.—  
14 The Secretary shall assure the independence of ad-  
15 ministrative law judges performing the administra-  
16 tive law judge functions transferred under para-  
17 graph (1) from the Centers for Medicare & Medicaid  
18 Services and its contractors.

19 (3) GEOGRAPHIC DISTRIBUTION.—The Sec-  
20 retary shall provide for an appropriate geographic  
21 distribution of administrative law judges performing  
22 the administrative law judge functions transferred  
23 under paragraph (1) throughout the United States  
24 to ensure timely access to such judges.

1           (4) HIRING AUTHORITY.—Subject to the  
2 amounts provided in advance in appropriations Act,  
3 the Secretary shall have authority to hire adminis-  
4 trative law judges to hear such cases, giving priority  
5 to those judges with prior experience in handling  
6 medicare appeals and in a manner consistent with  
7 paragraph (3), and to hire support staff for such  
8 judges.

9           (5) FINANCING.—Amounts payable under law  
10 to the Commissioner for administrative law judges  
11 performing the administrative law judge functions  
12 transferred under paragraph (1) from the Federal  
13 Hospital Insurance Trust Fund and the Federal  
14 Supplementary Medical Insurance Trust Fund shall  
15 become payable to the Secretary for the functions so  
16 transferred.

17           (6) SHARED RESOURCES.—The Secretary shall  
18 enter into such arrangements with the Commissioner  
19 as may be appropriate with respect to transferred  
20 functions of administrative law judges to share office  
21 space, support staff, and other resources, with ap-  
22 propriate reimbursement from the Trust Funds de-  
23 scribed in paragraph (5).

24           (c) INCREASED FINANCIAL SUPPORT.—In addition to  
25 any amounts otherwise appropriated, to ensure timely ac-

1 tion on appeals before administrative law judges and the  
2 Departmental Appeals Board consistent with section 1869  
3 of the Social Security Act (as amended by section 521 of  
4 BIPA, 114 Stat. 2763A–534), there are authorized to be  
5 appropriated (in appropriate part from the Federal Hos-  
6 pital Insurance Trust Fund and the Federal Supple-  
7 mentary Medical Insurance Trust Fund) to the Secretary  
8 such sums as are necessary for fiscal year 2004 and each  
9 subsequent fiscal year to—

10 (1) increase the number of administrative law  
11 judges (and their staffs) under subsection (b)(4);

12 (2) improve education and training opportuni-  
13 ties for administrative law judges (and their staffs);  
14 and

15 (3) increase the staff of the Departmental Ap-  
16 peals Board.

17 (d) CONFORMING AMENDMENT.—Section  
18 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added  
19 by section 522(a) of BIPA (114 Stat. 2763A–543), is  
20 amended by striking “of the Social Security Administra-  
21 tion”.

22 **SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

23 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Sec-  
24 tion 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA,  
25 is amended—

1           (1) in paragraph (1)(A), by inserting “, subject  
2           to paragraph (2),” before “to judicial review of the  
3           Secretary’s final decision”;

4           (2) in paragraph (1)(F)—

5                 (A) by striking clause (ii);

6                 (B) by striking “PROCEEDING” and all  
7           that follows through “DETERMINATION” and in-  
8           serting “DETERMINATIONS AND RECONSIDER-  
9           ATIONS”; and

10                (C) by redesignating subclauses (I) and  
11           (II) as clauses (i) and (ii) and by moving the  
12           indentation of such subclauses (and the matter  
13           that follows) 2 ems to the left; and

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

16                “(2) EXPEDITED ACCESS TO JUDICIAL RE-  
17           VIEW.—

18                “(A) IN GENERAL.—The Secretary shall  
19           establish a process under which a provider of  
20           services or supplier that furnishes an item or  
21           service or an individual entitled to benefits  
22           under part A or enrolled under part B, or both,  
23           who has filed an appeal under paragraph (1)  
24           may obtain access to judicial review when a re-  
25           view panel (described in subparagraph (D)), on

1 its own motion or at the request of the appel-  
2 lant, determines that no entity in the adminis-  
3 trative appeals process has the authority to de-  
4 cide the question of law or regulation relevant  
5 to the matters in controversy and that there is  
6 no material issue of fact in dispute. The appel-  
7 lant may make such request only once with re-  
8 spect to a question of law or regulation in a  
9 case of an appeal.

10 “(B) PROMPT DETERMINATIONS.—If, after  
11 or coincident with appropriately filing a request  
12 for an administrative hearing, the appellant re-  
13 quests a determination by the appropriate re-  
14 view panel that no review panel has the author-  
15 ity to decide the question of law or regulations  
16 relevant to the matters in controversy and that  
17 there is no material issue of fact in dispute and  
18 if such request is accompanied by the docu-  
19 ments and materials as the appropriate review  
20 panel shall require for purposes of making such  
21 determination, such review panel shall make a  
22 determination on the request in writing within  
23 60 days after the date such review panel re-  
24 ceives the request and such accompanying docu-  
25 ments and materials. Such a determination by

1 such review panel shall be considered a final de-  
2 cision and not subject to review by the Sec-  
3 retary.

4 “(C) ACCESS TO JUDICIAL REVIEW.—

5 “(i) IN GENERAL.—If the appropriate  
6 review panel—

7 “(I) determines that there are no  
8 material issues of fact in dispute and  
9 that the only issue is one of law or  
10 regulation that no review panel has  
11 the authority to decide; or

12 “(II) fails to make such deter-  
13 mination within the period provided  
14 under subparagraph (B);

15 then the appellant may bring a civil action  
16 as described in this subparagraph.

17 “(ii) DEADLINE FOR FILING.—Such  
18 action shall be filed, in the case described  
19 in—

20 “(I) clause (i)(I), within 60 days  
21 of date of the determination described  
22 in such subparagraph; or

23 “(II) clause (i)(II), within 60  
24 days of the end of the period provided

1 under subparagraph (B) for the deter-  
2 mination.

3 “(iii) VENUE.—Such action shall be  
4 brought in the district court of the United  
5 States for the judicial district in which the  
6 appellant is located (or, in the case of an  
7 action brought jointly by more than one  
8 applicant, the judicial district in which the  
9 greatest number of applicants are located)  
10 or in the district court for the District of  
11 Columbia.

12 “(iv) INTEREST ON AMOUNTS IN CON-  
13 TROVERSY.—Where a provider of services  
14 or supplier seeks judicial review pursuant  
15 to this paragraph, the amount in con-  
16 troversy shall be subject to annual interest  
17 beginning on the first day of the first  
18 month beginning after the 60-day period  
19 as determined pursuant to clause (ii) and  
20 equal to the rate of interest on obligations  
21 issued for purchase by the Federal Hos-  
22 pital Insurance Trust Fund and by the  
23 Federal Supplementary Medical Insurance  
24 Trust Fund for the month in which the  
25 civil action authorized under this para-

1 graph is commenced, to be awarded by the  
2 reviewing court in favor of the prevailing  
3 party. No interest awarded pursuant to the  
4 preceding sentence shall be deemed income  
5 or cost for the purposes of determining re-  
6 imbursement due providers of services or  
7 suppliers under this Act.

8 “(D) REVIEW PANELS.—For purposes of  
9 this subsection, a ‘review panel’ is a panel con-  
10 sisting of 3 members (who shall be administra-  
11 tive law judges, members of the Departmental  
12 Appeals Board, or qualified individuals associ-  
13 ated with a qualified independent contractor (as  
14 defined in subsection (c)(2)) or with another  
15 independent entity) designated by the Secretary  
16 for purposes of making determinations under  
17 this paragraph.”.

18 (b) APPLICATION TO PROVIDER AGREEMENT DETER-  
19 MINATIONS.—Section 1866(h)(1) (42 U.S.C.  
20 1395cc(h)(1)) is amended—

21 (1) by inserting “(A)” after “(h)(1)”; and

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

24 “(B) An institution or agency described in subpara-  
25 graph (A) that has filed for a hearing under subparagraph

1 (A) shall have expedited access to judicial review under  
2 this subparagraph in the same manner as providers of  
3 services, suppliers, and individuals entitled to benefits  
4 under part A or enrolled under part B, or both, may ob-  
5 tain expedited access to judicial review under the process  
6 established under section 1869(b)(2). Nothing in this sub-  
7 paragraph shall be construed to affect the application of  
8 any remedy imposed under section 1819 during the pend-  
9 ency of an appeal under this subparagraph.”.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 this section shall apply to appeals filed on or after October  
12 1, 2003.

13 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER  
14 AGREEMENT DETERMINATIONS.—

15 (1) TERMINATION AND CERTAIN OTHER IMME-  
16 DIATE REMEDIES.—The Secretary shall develop and  
17 implement a process to expedite proceedings under  
18 sections 1866(h) of the Social Security Act (42  
19 U.S.C. 1395cc(h)) in which the remedy of termi-  
20 nation of participation, or a remedy described in  
21 clause (i) or (iii) of section 1819(h)(2)(B) of such  
22 Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied  
23 on an immediate basis, has been imposed. Under  
24 such process priority shall be provided in cases of  
25 termination.

1           (2) INCREASED FINANCIAL SUPPORT.—In addi-  
2           tion to any amounts otherwise appropriated, to re-  
3           duce by 50 percent the average time for administra-  
4           tive determinations on appeals under section  
5           1866(h) of the Social Security Act (42 U.S.C.  
6           1395cc(h)), there are authorized to be appropriated  
7           (in appropriate part from the Federal Hospital In-  
8           surance Trust Fund and the Federal Supplementary  
9           Medical Insurance Trust Fund) to the Secretary  
10          such additional sums for fiscal year 2004 and each  
11          subsequent fiscal year as may be necessary. The  
12          purposes for which such amounts are available in-  
13          clude increasing the number of administrative law  
14          judges (and their staffs) and the appellate level staff  
15          at the Departmental Appeals Board of the Depart-  
16          ment of Health and Human Services and educating  
17          such judges and staffs on long-term care issues.

18 **SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.**

19          (a) REQUIRING FULL AND EARLY PRESENTATION OF  
20 EVIDENCE.—

21           (1) IN GENERAL.—Section 1869(b) (42 U.S.C.  
22           1395ff(b)), as amended by BIPA and as amended by  
23           section 832(a), is further amended by adding at the  
24           end the following new paragraph:

1           “(3) REQUIRING FULL AND EARLY PRESEN-  
2           TATION OF EVIDENCE BY PROVIDERS.—A provider  
3           of services or supplier may not introduce evidence in  
4           any appeal under this section that was not presented  
5           at the reconsideration conducted by the qualified  
6           independent contractor under subsection (c), unless  
7           there is good cause which precluded the introduction  
8           of such evidence at or before that reconsideration.”.

9           (2) EFFECTIVE DATE.—The amendment made  
10          by paragraph (1) shall take effect on October 1,  
11          2003.

12          (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section  
13          1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as  
14          amended by BIPA, is amended by inserting “(including  
15          the medical records of the individual involved)” after  
16          “clinical experience”.

17          (c) NOTICE REQUIREMENTS FOR MEDICARE AP-  
18          PEALS.—

19                 (1) INITIAL DETERMINATIONS AND REDETER-  
20                 MINATIONS.—Section 1869(a) (42 U.S.C.  
21                 1395ff(a)), as amended by BIPA, is amended by  
22                 adding at the end the following new paragraph:

23                 “(4) REQUIREMENTS OF NOTICE OF DETER-  
24                 MINATIONS AND REDETERMINATIONS.—A written  
25                 notice of a determination on an initial determination

1 or on a redetermination, insofar as such determina-  
2 tion or redetermination results in a denial of a claim  
3 for benefits, shall include—

4 “(A) the specific reasons for the deter-  
5 mination, including—

6 “(i) upon request, the provision of the  
7 policy, manual, or regulation used in mak-  
8 ing the determination; and

9 “(ii) as appropriate in the case of a  
10 redetermination, a summary of the clinical  
11 or scientific evidence used in making the  
12 determination;

13 “(B) the procedures for obtaining addi-  
14 tional information concerning the determination  
15 or redetermination; and

16 “(C) notification of the right to seek a re-  
17 determination or otherwise appeal the deter-  
18 mination and instructions on how to initiate  
19 such a redetermination or appeal under this  
20 section.

21 The written notice on a redetermination shall be  
22 provided in printed form and written in a manner  
23 calculated to be understood by the individual entitled  
24 to benefits under part A or enrolled under part B,  
25 or both.”.

1           (2)                   RECONSIDERATIONS.—Section  
2   1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as  
3   amended by BIPA, is amended—

4           (A) by inserting “be written in a manner  
5           calculated to be understood by the individual  
6           entitled to benefits under part A or enrolled  
7           under part B, or both, and shall include (to the  
8           extent appropriate)” after “in writing, ”; and

9           (B) by inserting “and a notification of the  
10          right to appeal such determination and instruc-  
11          tions on how to initiate such appeal under this  
12          section” after “such decision,”.

13          (3) APPEALS.—Section 1869(d) (42 U.S.C.  
14   1395ff(d)), as amended by BIPA, is amended—

15          (A) in the heading, by inserting “; NO-  
16          TICE” after “SECRETARY”; and

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

19          “(4) NOTICE.—Notice of the decision of an ad-  
20          ministrative law judge shall be in writing in a man-  
21          ner calculated to be understood by the individual en-  
22          titled to benefits under part A or enrolled under part  
23          B, or both, and shall include—

24                  “(A) the specific reasons for the deter-  
25                  mination (including, to the extent appropriate,

1 a summary of the clinical or scientific evidence  
2 used in making the determination);

3 “(B) the procedures for obtaining addi-  
4 tional information concerning the decision; and

5 “(C) notification of the right to appeal the  
6 decision and instructions on how to initiate  
7 such an appeal under this section.”.

8 (4) SUBMISSION OF RECORD FOR APPEAL.—

9 Section 1869(c)(3)(J)(i) (42 U.S.C.  
10 1395ff(c)(3)(J)(i)) by striking “prepare” and insert-  
11 ing “submit” and by striking “with respect to” and  
12 all that follows through “and relevant policies”.

13 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

14 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED  
15 INDEPENDENT CONTRACTORS.—Section 1869(c)(3)  
16 (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is  
17 amended—

18 (A) in subparagraph (A), by striking “suf-  
19 ficient training and expertise in medical science  
20 and legal matters” and inserting “sufficient  
21 medical, legal, and other expertise (including  
22 knowledge of the program under this title) and  
23 sufficient staffing”; and

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

1 “(K) INDEPENDENCE REQUIREMENTS.—

2 “(i) IN GENERAL.—Subject to clause  
3 (ii), a qualified independent contractor  
4 shall not conduct any activities in a case  
5 unless the entity—

6 “(I) is not a related party (as de-  
7 fined in subsection (g)(5));

8 “(II) does not have a material fa-  
9 miliary, financial, or professional rela-  
10 tionship with such a party in relation  
11 to such case; and

12 “(III) does not otherwise have a  
13 conflict of interest with such a party.

14 “(ii) EXCEPTION FOR REASONABLE  
15 COMPENSATION.—Nothing in clause (i)  
16 shall be construed to prohibit receipt by a  
17 qualified independent contractor of com-  
18 pensation from the Secretary for the con-  
19 duct of activities under this section if the  
20 compensation is provided consistent with  
21 clause (iii).

22 “(iii) LIMITATIONS ON ENTITY COM-  
23 PENSATION.—Compensation provided by  
24 the Secretary to a qualified independent  
25 contractor in connection with reviews

1 under this section shall not be contingent  
2 on any decision rendered by the contractor  
3 or by any reviewing professional.”.

4 (2) ELIGIBILITY REQUIREMENTS FOR REVIEW-  
5 ERS.—Section 1869 (42 U.S.C. 1395ff), as amended  
6 by BIPA, is amended—

7 (A) by amending subsection (c)(3)(D) to  
8 read as follows:

9 “(D) QUALIFICATIONS FOR REVIEWERS.—  
10 The requirements of subsection (g) shall be met  
11 (relating to qualifications of reviewing profes-  
12 sionals).”; and

13 (B) by adding at the end the following new  
14 subsection:

15 “(g) QUALIFICATIONS OF REVIEWERS.—

16 “(1) IN GENERAL.—In reviewing determina-  
17 tions under this section, a qualified independent con-  
18 tractor shall assure that—

19 “(A) each individual conducting a review  
20 shall meet the qualifications of paragraph (2);

21 “(B) compensation provided by the con-  
22 tractor to each such reviewer is consistent with  
23 paragraph (3); and

24 “(C) in the case of a review by a panel de-  
25 scribed in subsection (c)(3)(B) composed of

1 physicians or other health care professionals  
2 (each in this subsection referred to as a ‘review-  
3 ing professional’), each reviewing professional  
4 meets the qualifications described in paragraph  
5 (4) and, where a claim is regarding the fur-  
6 nishing of treatment by a physician (allopathic  
7 or osteopathic) or the provision of items or  
8 services by a physician (allopathic or osteo-  
9 pathic), each reviewing professional shall be a  
10 physician (allopathic or osteopathic).

11 “(2) INDEPENDENCE.—

12 “(A) IN GENERAL.—Subject to subpara-  
13 graph (B), each individual conducting a review  
14 in a case shall—

15 “(i) not be a related party (as defined  
16 in paragraph (5));

17 “(ii) not have a material familial, fi-  
18 nancial, or professional relationship with  
19 such a party in the case under review; and

20 “(iii) not otherwise have a conflict of  
21 interest with such a party.

22 “(B) EXCEPTION.—Nothing in subpara-  
23 graph (A) shall be construed to—

24 “(i) prohibit an individual, solely on  
25 the basis of a participation agreement with

1 a fiscal intermediary, carrier, or other con-  
2 tractor, from serving as a reviewing profes-  
3 sional if—

4 “(I) the individual is not involved  
5 in the provision of items or services in  
6 the case under review;

7 “(II) the fact of such an agree-  
8 ment is disclosed to the Secretary and  
9 the individual entitled to benefits  
10 under part A or enrolled under part  
11 B, or both, (or authorized representa-  
12 tive) and neither party objects; and

13 “(III) the individual is not an  
14 employee of the intermediary, carrier,  
15 or contractor and does not provide  
16 services exclusively or primarily to or  
17 on behalf of such intermediary, car-  
18 rier, or contractor;

19 “(ii) prohibit an individual who has  
20 staff privileges at the institution where the  
21 treatment involved takes place from serv-  
22 ing as a reviewer merely on the basis of  
23 having such staff privileges if the existence  
24 of such privileges is disclosed to the Sec-  
25 retary and such individual (or authorized

1 representative), and neither party objects;  
2 or

3 “(iii) prohibit receipt of compensation  
4 by a reviewing professional from a con-  
5 tractor if the compensation is provided  
6 consistent with paragraph (3).

7 For purposes of this paragraph, the term ‘par-  
8 ticipation agreement’ means an agreement re-  
9 lating to the provision of health care services by  
10 the individual and does not include the provi-  
11 sion of services as a reviewer under this sub-  
12 section.

13 “(3) LIMITATIONS ON REVIEWER COMPENSA-  
14 TION.—Compensation provided by a qualified inde-  
15 pendent contractor to a reviewer in connection with  
16 a review under this section shall not be contingent  
17 on the decision rendered by the reviewer.

18 “(4) LICENSURE AND EXPERTISE.—Each re-  
19 viewing professional shall be—

20 “(A) a physician (allopathic or osteopathic)  
21 who is appropriately credentialed or licensed in  
22 one or more States to deliver health care serv-  
23 ices and has medical expertise in the field of  
24 practice that is appropriate for the items or  
25 services at issue; or

1           “(B) a health care professional who is le-  
2 gally authorized in one or more States (in ac-  
3 cordance with State law or the State regulatory  
4 mechanism provided by State law) to furnish  
5 the health care items or services at issue and  
6 has medical expertise in the field of practice  
7 that is appropriate for such items or services.

8           “(5) RELATED PARTY DEFINED.—For purposes  
9 of this section, the term ‘related party’ means, with  
10 respect to a case under this title involving a specific  
11 individual entitled to benefits under part A or en-  
12 rolled under part B, or both, any of the following:

13           “(A) The Secretary, the medicare adminis-  
14 trative contractor involved, or any fiduciary, of-  
15 ficer, director, or employee of the Department  
16 of Health and Human Services, or of such con-  
17 tractor.

18           “(B) The individual (or authorized rep-  
19 resentative).

20           “(C) The health care professional that pro-  
21 vides the items or services involved in the case.

22           “(D) The institution at which the items or  
23 services (or treatment) involved in the case are  
24 provided.

1           “(E) The manufacturer of any drug or  
2           other item that is included in the items or serv-  
3           ices involved in the case.

4           “(F) Any other party determined under  
5           any regulations to have a substantial interest in  
6           the case involved.”.

7           (3) EFFECTIVE DATE.—The amendments made  
8           by paragraphs (1) and (2) shall be effective as if in-  
9           cluded in the enactment of the respective provisions  
10          of subtitle C of title V of BIPA, (114 Stat. 2763A–  
11          534).

12          (4) TRANSITION.—In applying section 1869(g)  
13          of the Social Security Act (as added by paragraph  
14          (2)), any reference to a medicare administrative con-  
15          tractor shall be deemed to include a reference to a  
16          fiscal intermediary under section 1816 of the Social  
17          Security Act (42 U.S.C. 1395h) and a carrier under  
18          section 1842 of such Act (42 U.S.C. 1395u).

19 **SEC. 834. PREPAYMENT REVIEW.**

20          (a) IN GENERAL.—Section 1874A, as added by sec-  
21          tion 811(a)(1) and as amended by sections 812(b),  
22          821(b)(1), and 821(c)(1), is further amended by adding  
23          at the end the following new subsection:

24          “(h) CONDUCT OF PREPAYMENT REVIEW.—

1           “(1) CONDUCT OF RANDOM PREPAYMENT RE-  
2           VIEW.—

3                   “(A) IN GENERAL.—A medicare adminis-  
4                   trative contractor may conduct random prepay-  
5                   ment review only to develop a contractor-wide  
6                   or program-wide claims payment error rates or  
7                   under such additional circumstances as may be  
8                   provided under regulations, developed in con-  
9                   sultation with providers of services and sup-  
10                  pliers.

11                  “(B) USE OF STANDARD PROTOCOLS  
12                  WHEN CONDUCTING PREPAYMENT REVIEWS.—  
13                  When a medicare administrative contractor con-  
14                  ducts a random prepayment review, the con-  
15                  tractor may conduct such review only in accord-  
16                  ance with a standard protocol for random pre-  
17                  payment audits developed by the Secretary.

18                  “(C) CONSTRUCTION.—Nothing in this  
19                  paragraph shall be construed as preventing the  
20                  denial of payments for claims actually reviewed  
21                  under a random prepayment review.

22                  “(D) RANDOM PREPAYMENT REVIEW.—  
23                  For purposes of this subsection, the term ‘ran-  
24                  dom prepayment review’ means a demand for

1 the production of records or documentation ab-  
2 sent cause with respect to a claim.

3 “(2) LIMITATIONS ON NON-RANDOM PREPAY-  
4 MENT REVIEW.—

5 “(A) LIMITATIONS ON INITIATION OF NON-  
6 RANDOM PREPAYMENT REVIEW.—A medicare  
7 administrative contractor may not initiate non-  
8 random prepayment review of a provider of  
9 services or supplier based on the initial identi-  
10 fication by that provider of services or supplier  
11 of an improper billing practice unless there is a  
12 likelihood of sustained or high level of payment  
13 error (as defined in subsection (i)(3)(A)).

14 “(B) TERMINATION OF NON-RANDOM PRE-  
15 PAYMENT REVIEW.—The Secretary shall issue  
16 regulations relating to the termination, includ-  
17 ing termination dates, of non-random prepay-  
18 ment review. Such regulations may vary such a  
19 termination date based upon the differences in  
20 the circumstances triggering prepayment re-  
21 view.”.

22 (b) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as provided in this  
24 subsection, the amendment made by subsection (a)

1 shall take effect 1 year after the date of the enact-  
2 ment of this Act.

3 (2) DEADLINE FOR PROMULGATION OF CER-  
4 TAIN REGULATIONS.—The Secretary shall first issue  
5 regulations under section 1874A(h) of the Social Se-  
6 curity Act, as added by subsection (a), by not later  
7 than 1 year after the date of the enactment of this  
8 Act.

9 (3) APPLICATION OF STANDARD PROTOCOLS  
10 FOR RANDOM PREPAYMENT REVIEW.—Section  
11 1874A(h)(1)(B) of the Social Security Act, as added  
12 by subsection (a), shall apply to random prepayment  
13 reviews conducted on or after such date (not later  
14 than 1 year after the date of the enactment of this  
15 Act) as the Secretary shall specify.

16 (c) APPLICATION TO FISCAL INTERMEDIARIES AND  
17 CARRIERS.—The provisions of section 1874A(h) of the So-  
18 cial Security Act, as added by subsection (a), shall apply  
19 to each fiscal intermediary under section 1816 of the So-  
20 cial Security Act (42 U.S.C. 1395h) and each carrier  
21 under section 1842 of such Act (42 U.S.C. 1395u) in the  
22 same manner as they apply to medicare administrative  
23 contractors under such provisions.

1 **SEC. 835. RECOVERY OF OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1893 (42 U.S.C.  
3 1395ddd) is amended by adding at the end the following  
4 new subsection:

5 “(f) RECOVERY OF OVERPAYMENTS.—

6 “(1) USE OF REPAYMENT PLANS.—

7 “(A) IN GENERAL.—If the repayment,  
8 within 30 days by a provider of services or sup-  
9 plier, of an overpayment under this title would  
10 constitute a hardship (as defined in subpara-  
11 graph (B)), subject to subparagraph (C), upon  
12 request of the provider of services or supplier  
13 the Secretary shall enter into a plan with the  
14 provider of services or supplier for the repay-  
15 ment (through offset or otherwise) of such over-  
16 payment over a period of at least 6 months but  
17 not longer than 3 years (or not longer than 5  
18 years in the case of extreme hardship, as deter-  
19 mined by the Secretary). Interest shall accrue  
20 on the balance through the period of repay-  
21 ment. Such plan shall meet terms and condi-  
22 tions determined to be appropriate by the Sec-  
23 retary.

24 “(B) HARDSHIP.—

25 “(i) IN GENERAL.—For purposes of  
26 subparagraph (A), the repayment of an

1 overpayment (or overpayments) within 30  
2 days is deemed to constitute a hardship  
3 if—

4 “(I) in the case of a provider of  
5 services that files cost reports, the ag-  
6 gregate amount of the overpayments  
7 exceeds 10 percent of the amount paid  
8 under this title to the provider of  
9 services for the cost reporting period  
10 covered by the most recently sub-  
11 mitted cost report; or

12 “(II) in the case of another pro-  
13 vider of services or supplier, the ag-  
14 gregate amount of the overpayments  
15 exceeds 10 percent of the amount paid  
16 under this title to the provider of  
17 services or supplier for the previous  
18 calendar year.

19 “(ii) RULE OF APPLICATION.—The  
20 Secretary shall establish rules for the ap-  
21 plication of this subparagraph in the case  
22 of a provider of services or supplier that  
23 was not paid under this title during the  
24 previous year or was paid under this title  
25 only during a portion of that year.

1                   “(iii) TREATMENT OF PREVIOUS  
2                   OVERPAYMENTS.—If a provider of services  
3                   or supplier has entered into a repayment  
4                   plan under subparagraph (A) with respect  
5                   to a specific overpayment amount, such  
6                   payment amount under the repayment plan  
7                   shall not be taken into account under  
8                   clause (i) with respect to subsequent over-  
9                   payment amounts.

10                   “(C) EXCEPTIONS.—Subparagraph (A)  
11                   shall not apply if—

12                   “(i) the Secretary has reason to sus-  
13                   pect that the provider of services or sup-  
14                   plier may file for bankruptcy or otherwise  
15                   cease to do business or discontinue partici-  
16                   pation in the program under this title; or

17                   “(ii) there is an indication of fraud or  
18                   abuse committed against the program.

19                   “(D) IMMEDIATE COLLECTION IF VIOLA-  
20                   TION OF REPAYMENT PLAN.—If a provider of  
21                   services or supplier fails to make a payment in  
22                   accordance with a repayment plan under this  
23                   paragraph, the Secretary may immediately seek  
24                   to offset or otherwise recover the total balance

1 outstanding (including applicable interest)  
2 under the repayment plan.

3 “(E) RELATION TO NO FAULT PROVI-  
4 SION.—Nothing in this paragraph shall be con-  
5 strued as affecting the application of section  
6 1870(c) (relating to no adjustment in the cases  
7 of certain overpayments).

8 “(2) LIMITATION ON RECOUPMENT.—

9 “(A) IN GENERAL.—In the case of a pro-  
10 vider of services or supplier that is determined  
11 to have received an overpayment under this title  
12 and that seeks a reconsideration by a qualified  
13 independent contractor on such determination  
14 under section 1869(b)(1), the Secretary may  
15 not take any action (or authorize any other per-  
16 son, including any medicare contractor, as de-  
17 fined in subparagraph (C)) to recoup the over-  
18 payment until the date the decision on the re-  
19 consideration has been rendered. If the provi-  
20 sions of section 1869(b)(1) (providing for such  
21 a reconsideration by a qualified independent  
22 contractor) are not in effect, in applying the  
23 previous sentence any reference to such a recon-  
24 sideration shall be treated as a reference to a

1 redetermination by the fiscal intermediary or  
2 carrier involved.

3 “(B) COLLECTION WITH INTEREST.—Inso-  
4 far as the determination on such appeal is  
5 against the provider of services or supplier, in-  
6 terest on the overpayment shall accrue on and  
7 after the date of the original notice of overpay-  
8 ment. Insofar as such determination against the  
9 provider of services or supplier is later reversed,  
10 the Secretary shall provide for repayment of the  
11 amount recouped plus interest at the same rate  
12 as would apply under the previous sentence for  
13 the period in which the amount was recouped.

14 “(C) MEDICARE CONTRACTOR DEFINED.—  
15 For purposes of this subsection, the term ‘medi-  
16 care contractor’ has the meaning given such  
17 term in section 1889(g).

18 “(3) LIMITATION ON USE OF EXTRAPO-  
19 LATION.—A medicare contractor may not use ex-  
20 trapolation to determine overpayment amounts to be  
21 recovered by recoupment, offset, or otherwise un-  
22 less—

23 “(A) there is a sustained or high level of  
24 payment error (as defined by the Secretary by  
25 regulation); or

1           “(B) documented educational intervention  
2           has failed to correct the payment error (as de-  
3           termined by the Secretary).

4           “(4) PROVISION OF SUPPORTING DOCUMENTA-  
5           TION.—In the case of a provider of services or sup-  
6           plier with respect to which amounts were previously  
7           overpaid, a medicare contractor may request the  
8           periodic production of records or supporting docu-  
9           mentation for a limited sample of submitted claims  
10          to ensure that the previous practice is not con-  
11          tinuing.

12          “(5) CONSENT SETTLEMENT REFORMS.—

13                 “(A) IN GENERAL.—The Secretary may  
14                 use a consent settlement (as defined in sub-  
15                 paragraph (D)) to settle a projected overpay-  
16                 ment.

17                 “(B) OPPORTUNITY TO SUBMIT ADDI-  
18                 TIONAL INFORMATION BEFORE CONSENT SET-  
19                 TLEMENT OFFER.—Before offering a provider  
20                 of services or supplier a consent settlement, the  
21                 Secretary shall—

22                         “(i) communicate to the provider of  
23                         services or supplier—

24                                 “(I) that, based on a review of  
25                                 the medical records requested by the

1 Secretary, a preliminary evaluation of  
2 those records indicates that there  
3 would be an overpayment;

4 “(II) the nature of the problems  
5 identified in such evaluation; and

6 “(III) the steps that the provider  
7 of services or supplier should take to  
8 address the problems; and

9 “(ii) provide for a 45-day period dur-  
10 ing which the provider of services or sup-  
11 plier may furnish additional information  
12 concerning the medical records for the  
13 claims that had been reviewed.

14 “(C) CONSENT SETTLEMENT OFFER.—The  
15 Secretary shall review any additional informa-  
16 tion furnished by the provider of services or  
17 supplier under subparagraph (B)(ii). Taking  
18 into consideration such information, the Sec-  
19 retary shall determine if there still appears to  
20 be an overpayment. If so, the Secretary—

21 “(i) shall provide notice of such deter-  
22 mination to the provider of services or sup-  
23 plier, including an explanation of the rea-  
24 son for such determination; and

1                   “(ii) in order to resolve the overpay-  
2                   ment, may offer the provider of services or  
3                   supplier—

4                                 “(I) the opportunity for a statis-  
5                                 tically valid random sample; or

6                                 “(II) a consent settlement.

7                   The opportunity provided under clause (ii)(I)  
8                   does not waive any appeal rights with respect to  
9                   the alleged overpayment involved.

10                               “(D) CONSENT SETTLEMENT DEFINED.—

11                   For purposes of this paragraph, the term ‘con-  
12                   sent settlement’ means an agreement between  
13                   the Secretary and a provider of services or sup-  
14                   plier whereby both parties agree to settle a pro-  
15                   jected overpayment based on less than a statis-  
16                   tically valid sample of claims and the provider  
17                   of services or supplier agrees not to appeal the  
18                   claims involved.

19                               “(6) NOTICE OF OVER-UTILIZATION OF  
20                   CODES.—The Secretary shall establish, in consulta-  
21                   tion with organizations representing the classes of  
22                   providers of services and suppliers, a process under  
23                   which the Secretary provides for notice to classes of  
24                   providers of services and suppliers served by the con-  
25                   tractor in cases in which the contractor has identi-

1       fied that particular billing codes may be overutilized  
2       by that class of providers of services or suppliers  
3       under the programs under this title (or provisions of  
4       title XI insofar as they relate to such programs).

5               “(7) PAYMENT AUDITS.—

6                       “(A) WRITTEN NOTICE FOR POST-PAY-  
7                       MENT AUDITS.—Subject to subparagraph (C), if  
8                       a medicare contractor decides to conduct a  
9                       post-payment audit of a provider of services or  
10                      supplier under this title, the contractor shall  
11                      provide the provider of services or supplier with  
12                      written notice (which may be in electronic form)  
13                      of the intent to conduct such an audit.

14                     “(B) EXPLANATION OF FINDINGS FOR ALL  
15                     AUDITS.—Subject to subparagraph (C), if a  
16                     medicare contractor audits a provider of serv-  
17                     ices or supplier under this title, the contractor  
18                     shall—

19                               “(i) give the provider of services or  
20                               supplier a full review and explanation of  
21                               the findings of the audit in a manner that  
22                               is understandable to the provider of serv-  
23                               ices or supplier and permits the develop-  
24                               ment of an appropriate corrective action  
25                               plan;

1           “(ii) inform the provider of services or  
2           supplier of the appeal rights under this  
3           title as well as consent settlement options  
4           (which are at the discretion of the Sec-  
5           retary);

6           “(iii) give the provider of services or  
7           supplier an opportunity to provide addi-  
8           tional information to the contractor; and

9           “(iv) take into account information  
10          provided, on a timely basis, by the provider  
11          of services or supplier under clause (iii).

12          “(C) EXCEPTION.—Subparagraphs (A)  
13          and (B) shall not apply if the provision of no-  
14          tice or findings would compromise pending law  
15          enforcement activities, whether civil or criminal,  
16          or reveal findings of law enforcement-related  
17          audits.

18          “(8) STANDARD METHODOLOGY FOR PROBE  
19          SAMPLING.—The Secretary shall establish a stand-  
20          ard methodology for medicare contractors to use in  
21          selecting a sample of claims for review in the case  
22          of an abnormal billing pattern.”.

23          (b) EFFECTIVE DATES AND DEADLINES.—

24                 (1) USE OF REPAYMENT PLANS.—Section  
25          1893(f)(1) of the Social Security Act, as added by

1 subsection (a), shall apply to requests for repayment  
2 plans made after the date of the enactment of this  
3 Act.

4 (2) LIMITATION ON RECOUPMENT.—Section  
5 1893(f)(2) of the Social Security Act, as added by  
6 subsection (a), shall apply to actions taken after the  
7 date of the enactment of this Act.

8 (3) USE OF EXTRAPOLATION.—Section  
9 1893(f)(3) of the Social Security Act, as added by  
10 subsection (a), shall apply to statistically valid ran-  
11 dom samples initiated after the date that is 1 year  
12 after the date of the enactment of this Act.

13 (4) PROVISION OF SUPPORTING DOCUMENTA-  
14 TION.—Section 1893(f)(4) of the Social Security  
15 Act, as added by subsection (a), shall take effect on  
16 the date of the enactment of this Act.

17 (5) CONSENT SETTLEMENT.—Section  
18 1893(f)(5) of the Social Security Act, as added by  
19 subsection (a), shall apply to consent settlements en-  
20 tered into after the date of the enactment of this  
21 Act.

22 (6) NOTICE OF OVERUTILIZATION.—Not later  
23 than 1 year after the date of the enactment of this  
24 Act, the Secretary shall first establish the process  
25 for notice of overutilization of billing codes under

1 section 1893A(f)(6) of the Social Security Act, as  
2 added by subsection (a).

3 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of  
4 the Social Security Act, as added by subsection (a),  
5 shall apply to audits initiated after the date of the  
6 enactment of this Act.

7 (8) STANDARD FOR ABNORMAL BILLING PAT-  
8 TERNS.—Not later than 1 year after the date of the  
9 enactment of this Act, the Secretary shall first es-  
10 tablish a standard methodology for selection of sam-  
11 ple claims for abnormal billing patterns under sec-  
12 tion 1893(f)(8) of the Social Security Act, as added  
13 by subsection (a).

14 **SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF AP-**  
15 **PEAL.**

16 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)  
17 is amended—

18 (1) by adding at the end of the heading the fol-  
19 lowing: “; ENROLLMENT PROCESSES”; and

20 (2) by adding at the end the following new sub-  
21 section:

22 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF  
23 SERVICES AND SUPPLIERS.—

24 “(1) ENROLLMENT PROCESS.—

1           “(A) IN GENERAL.—The Secretary shall  
2           establish by regulation a process for the enroll-  
3           ment of providers of services and suppliers  
4           under this title.

5           “(B) DEADLINES.—The Secretary shall es-  
6           tablish by regulation procedures under which  
7           there are deadlines for actions on applications  
8           for enrollment (and, if applicable, renewal of  
9           enrollment). The Secretary shall monitor the  
10          performance of medicare administrative con-  
11          tractors in meeting the deadlines established  
12          under this subparagraph.

13          “(C) CONSULTATION BEFORE CHANGING  
14          PROVIDER ENROLLMENT FORMS.—The Sec-  
15          retary shall consult with providers of services  
16          and suppliers before making changes in the pro-  
17          vider enrollment forms required of such pro-  
18          viders and suppliers to be eligible to submit  
19          claims for which payment may be made under  
20          this title.

21          “(2) HEARING RIGHTS IN CASES OF DENIAL OR  
22          NON-RENEWAL.—A provider of services or supplier  
23          whose application to enroll (or, if applicable, to  
24          renew enrollment) under this title is denied may  
25          have a hearing and judicial review of such denial

1 under the procedures that apply under subsection  
2 (h)(1)(A) to a provider of services that is dissatisfied  
3 with a determination by the Secretary.”.

4 (b) EFFECTIVE DATES.—

5 (1) ENROLLMENT PROCESS.—The Secretary  
6 shall provide for the establishment of the enrollment  
7 process under section 1866(j)(1) of the Social Secu-  
8 rity Act, as added by subsection (a)(2), within 6  
9 months after the date of the enactment of this Act.

10 (2) CONSULTATION.—Section 1866(j)(1)(C) of  
11 the Social Security Act, as added by subsection  
12 (a)(2), shall apply with respect to changes in pro-  
13 vider enrollment forms made on or after January 1,  
14 2003.

15 (3) HEARING RIGHTS.—Section 1866(j)(2) of  
16 the Social Security Act, as added by subsection  
17 (a)(2), shall apply to denials occurring on or after  
18 such date (not later than 1 year after the date of  
19 the enactment of this Act) as the Secretary specifies.

20 **SEC. 837. PROCESS FOR CORRECTION OF MINOR ERRORS**  
21 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**  
22 **SUING APPEALS PROCESS.**

23 The Secretary shall develop, in consultation with ap-  
24 propriate medicare contractors (as defined in section  
25 1889(g) of the Social Security Act, as inserted by section

1 821(a)(1)) and representatives of providers of services and  
2 suppliers, a process whereby, in the case of minor errors  
3 or omissions (as defined by the Secretary) that are de-  
4 tected in the submission of claims under the programs  
5 under title XVIII of such Act, a provider of services or  
6 supplier is given an opportunity to correct such an error  
7 or omission without the need to initiate an appeal. Such  
8 process shall include the ability to resubmit corrected  
9 claims.

10 **SEC. 838. PRIOR DETERMINATION PROCESS FOR CERTAIN**  
11 **ITEMS AND SERVICES; ADVANCE BENE-**  
12 **FICIARY NOTICES.**

13 (a) IN GENERAL.—Section 1869 (42 U.S.C.  
14 1395ff(b)), as amended by sections 521 and 522 of BIPA  
15 and section 833(d)(2)(B), is further amended by adding  
16 at the end the following new subsection:

17 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN  
18 ITEMS AND SERVICES.—

19 “(1) ESTABLISHMENT OF PROCESS.—

20 “(A) IN GENERAL.—With respect to a  
21 medicare administrative contractor that has a  
22 contract under section 1874A that provides for  
23 making payments under this title with respect  
24 to eligible items and services described in sub-  
25 paragraph (C), the Secretary shall establish a

1 prior determination process that meets the re-  
2 quirements of this subsection and that shall be  
3 applied by such contractor in the case of eligible  
4 requesters.

5 “(B) ELIGIBLE REQUESTER.—For pur-  
6 poses of this subsection, each of the following  
7 shall be an eligible requester:

8 “(i) A physician, but only with respect  
9 to eligible items and services for which the  
10 physician may be paid directly.

11 “(ii) An individual entitled to benefits  
12 under this title, but only with respect to an  
13 item or service for which the individual re-  
14 ceives, from the physician who may be paid  
15 directly for the item or service, an advance  
16 beneficiary notice under section 1879(a)  
17 that payment may not be made (or may no  
18 longer be made) for the item or service  
19 under this title.

20 “(C) ELIGIBLE ITEMS AND SERVICES.—  
21 For purposes of this subsection and subject to  
22 paragraph (2), eligible items and services are  
23 items and services which are physicians’ serv-  
24 ices (as defined in paragraph (4)(A) of section

1           1848(f) for purposes of calculating the sustain-  
2           able growth rate under such section).

3           “(2) SECRETARIAL FLEXIBILITY.—The Sec-  
4           retary shall establish by regulation reasonable limits  
5           on the categories of eligible items and services for  
6           which a prior determination of coverage may be re-  
7           quested under this subsection. In establishing such  
8           limits, the Secretary may consider the dollar amount  
9           involved with respect to the item or service, adminis-  
10          trative costs and burdens, and other relevant factors.

11          “(3) REQUEST FOR PRIOR DETERMINATION.—

12                 “(A) IN GENERAL.—Subject to paragraph  
13                 (2), under the process established under this  
14                 subsection an eligible requester may submit to  
15                 the contractor a request for a determination,  
16                 before the furnishing of an eligible item or serv-  
17                 ice involved as to whether the item or service is  
18                 covered under this title consistent with the ap-  
19                 plicable requirements of section 1862(a)(1)(A)  
20                 (relating to medical necessity).

21                 “(B) ACCOMPANYING DOCUMENTATION.—  
22                 The Secretary may require that the request be  
23                 accompanied by a description of the item or  
24                 service, supporting documentation relating to  
25                 the medical necessity for the item or service,

1 and any other appropriate documentation. In  
2 the case of a request submitted by an eligible  
3 requester who is described in paragraph  
4 (1)(B)(ii), the Secretary may require that the  
5 request also be accompanied by a copy of the  
6 advance beneficiary notice involved.

7 “(4) RESPONSE TO REQUEST.—

8 “(A) IN GENERAL.—Under such process,  
9 the contractor shall provide the eligible re-  
10 quester with written notice of a determination  
11 as to whether—

12 “(i) the item or service is so covered;

13 “(ii) the item or service is not so cov-  
14 ered; or

15 “(iii) the contractor lacks sufficient  
16 information to make a coverage determina-  
17 tion.

18 If the contractor makes the determination de-  
19 scribed in clause (iii), the contractor shall in-  
20 clude in the notice a description of the addi-  
21 tional information required to make the cov-  
22 erage determination.

23 “(B) DEADLINE TO RESPOND.—Such no-  
24 tice shall be provided within the same time pe-  
25 riod as the time period applicable to the con-

1 tractor providing notice of initial determinations  
2 on a claim for benefits under subsection  
3 (a)(2)(A).

4 “(C) INFORMING BENEFICIARY IN CASE OF  
5 PHYSICIAN REQUEST.—In the case of a request  
6 in which an eligible requester is not the indi-  
7 vidual described in paragraph (1)(B)(ii), the  
8 process shall provide that the individual to  
9 whom the item or service is proposed to be fur-  
10 nished shall be informed of any determination  
11 described in clause (ii) (relating to a determina-  
12 tion of non-coverage) and the right (referred to  
13 in paragraph (6)(B)) to obtain the item or serv-  
14 ice and have a claim submitted for the item or  
15 service.

16 “(5) EFFECT OF DETERMINATIONS.—

17 “(A) BINDING NATURE OF POSITIVE DE-  
18 TERMINATION.—If the contractor makes the de-  
19 termination described in paragraph (4)(A)(i),  
20 such determination shall be binding on the con-  
21 tractor in the absence of fraud or evidence of  
22 misrepresentation of facts presented to the con-  
23 tractor.

24 “(B) NOTICE AND RIGHT TO REDETER-  
25 MINATION IN CASE OF A DENIAL.—

1           “(i) IN GENERAL.—If the contractor  
2 makes the determination described in para-  
3 graph (4)(A)(ii)—

4           “(I) the eligible requester has the  
5 right to a redetermination by the con-  
6 tractor on the determination that the  
7 item or service is not so covered; and

8           “(II) the contractor shall include  
9 in notice under paragraph (4)(A) a  
10 brief explanation of the basis for the  
11 determination, including on what na-  
12 tional or local coverage or noncov-  
13 erage determination (if any) the de-  
14 termination is based, and the right to  
15 such a redetermination.

16           “(ii) DEADLINE FOR REDETERMINA-  
17 TIONS.—The contractor shall complete and  
18 provide notice of such redetermination  
19 within the same time period as the time  
20 period applicable to the contractor pro-  
21 viding notice of redeterminations relating  
22 to a claim for benefits under subsection  
23 (a)(3)(C)(ii).

24           “(6) LIMITATION ON FURTHER REVIEW.—

1           “(A) IN GENERAL.—Contractor determina-  
2           tions described in paragraph (4)(A)(ii) or  
3           (4)(A)(iii) (and redeterminations made under  
4           paragraph (5)(B)), relating to pre-service  
5           claims are not subject to further administrative  
6           appeal or judicial review under this section or  
7           otherwise.

8           “(B) DECISION NOT TO SEEK PRIOR DE-  
9           TERMINATION OR NEGATIVE DETERMINATION  
10           DOES NOT IMPACT RIGHT TO OBTAIN SERVICES,  
11           SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—  
12           Nothing in this subsection shall be construed as  
13           affecting the right of an individual who—

14                   “(i) decides not to seek a prior deter-  
15                   mination under this subsection with re-  
16                   spect to items or services; or

17                   “(ii) seeks such a determination and  
18                   has received a determination described in  
19                   paragraph (4)(A)(ii),  
20           from receiving (and submitting a claim for)  
21           such items services and from obtaining adminis-  
22           trative or judicial review respecting such claim  
23           under the other applicable provisions of this  
24           section. Failure to seek a prior determination  
25           under this subsection with respect to items and

1 services shall not be taken into account in such  
2 administrative or judicial review.

3 “(C) NO PRIOR DETERMINATION AFTER  
4 RECEIPT OF SERVICES.—Once an individual is  
5 provided items and services, there shall be no  
6 prior determination under this subsection with  
7 respect to such items or services.”.

8 (b) EFFECTIVE DATE; TRANSITION.—

9 (1) EFFECTIVE DATE.—The Secretary shall es-  
10 tablish the prior determination process under the  
11 amendment made by subsection (a) in such a man-  
12 ner as to provide for the acceptance of requests for  
13 determinations under such process filed not later  
14 than 18 months after the date of the enactment of  
15 this Act.

16 (2) TRANSITION.—During the period in which  
17 the amendment made by subsection (a) has become  
18 effective but contracts are not provided under sec-  
19 tion 1874A of the Social Security Act with medicare  
20 administrative contractors, any reference in section  
21 1869(g) of such Act (as added by such amendment)  
22 to such a contractor is deemed a reference to a fiscal  
23 intermediary or carrier with an agreement under  
24 section 1816, or contract under section 1842, re-  
25 spectively, of such Act.

1           (3) LIMITATION ON APPLICATION TO SGR.—For  
2 purposes of applying section 1848(f)(2)(D) of the  
3 Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)),  
4 the amendment made by subsection (a) shall not be  
5 considered to be a change in law or regulation.

6           (c) PROVISIONS RELATING TO ADVANCE BENE-  
7 FICIARY NOTICES; REPORT ON PRIOR DETERMINATION  
8 PROCESS.—

9           (1) DATA COLLECTION.—The Secretary shall  
10 establish a process for the collection of information  
11 on the instances in which an advance beneficiary no-  
12 tice (as defined in paragraph (4)) has been provided  
13 and on instances in which a beneficiary indicates on  
14 such a notice that the beneficiary does not intend to  
15 seek to have the item or service that is the subject  
16 of the notice furnished.

17           (2) OUTREACH AND EDUCATION.—The Sec-  
18 retary shall establish a program of outreach and  
19 education for beneficiaries and providers of services  
20 and other persons on the appropriate use of advance  
21 beneficiary notices and coverage policies under the  
22 medicare program.

23           (3) GAO REPORT ON USE OF ADVANCE BENE-  
24 FICIARY NOTICES.—Not later than 18 months after  
25 the date on which section 1869(g) of the Social Se-

1 security Act (as added by subsection (a)) takes effect,  
2 the Comptroller General of the United States shall  
3 submit to Congress a report on the use of advance  
4 beneficiary notices under title XVIII of such Act.  
5 Such report shall include information concerning the  
6 providers of services and other persons that have  
7 provided such notices and the response of bene-  
8 ficiaries to such notices.

9 (4) GAO REPORT ON USE OF PRIOR DETER-  
10 MINATION PROCESS.—Not later than 18 months  
11 after the date on which section 1869(g) of the Social  
12 Security Act (as added by subsection (a)) takes ef-  
13 fect, the Comptroller General of the United States  
14 shall submit to Congress a report on the use of the  
15 prior determination process under such section. Such  
16 report shall include—

17 (A) information concerning the types of  
18 procedures for which a prior determination has  
19 been sought, determinations made under the  
20 process, and changes in receipt of services re-  
21 sulting from the application of such process;  
22 and

23 (B) an evaluation of whether the process  
24 was useful for physicians (and other suppliers)  
25 and beneficiaries, whether it was timely, and

1           whether the amount of information required  
2           was burdensome to physicians and beneficiaries.

3           (5) ADVANCE BENEFICIARY NOTICE DE-  
4           FINED.—In this subsection, the term “advance bene-  
5           ficiary notice” means a written notice provided  
6           under section 1879(a) of the Social Security Act (42  
7           U.S.C. 1395pp(a)) to an individual entitled to bene-  
8           fits under part A or B of title XVIII of such Act  
9           before items or services are furnished under such  
10          part in cases where a provider of services or other  
11          person that would furnish the item or service be-  
12          lieves that payment will not be made for some or all  
13          of such items or services under such title.

14                   **Subtitle E—Miscellaneous**  
15                   **Provisions**

16   **SEC. 841. POLICY DEVELOPMENT REGARDING EVALUATION**  
17                   **AND MANAGEMENT (E & M) DOCUMENTATION**  
18                   **GUIDELINES.**

19          (a) IN GENERAL.—The Secretary may not implement  
20          any new documentation guidelines for evaluation and man-  
21          agement physician services under the title XVIII of the  
22          Social Security Act on or after the date of the enactment  
23          of this Act unless the Secretary—

24                  (1) has developed the guidelines in collaboration  
25          with practicing physicians (including both generalists

1 and specialists) and provided for an assessment of  
2 the proposed guidelines by the physician community;

3 (2) has established a plan that contains specific  
4 goals, including a schedule, for improving the use of  
5 such guidelines;

6 (3) has conducted appropriate and representa-  
7 tive pilot projects under subsection (b) to test modi-  
8 fications to the evaluation and management docu-  
9 mentation guidelines;

10 (4) finds that the objectives described in sub-  
11 section (c) will be met in the implementation of such  
12 guidelines; and

13 (5) has established, and is implementing, a pro-  
14 gram to educate physicians on the use of such guide-  
15 lines and that includes appropriate outreach.

16 The Secretary shall make changes to the manner in which  
17 existing evaluation and management documentation guide-  
18 lines are implemented to reduce paperwork burdens on  
19 physicians.

20 (b) PILOT PROJECTS TO TEST EVALUATION AND  
21 MANAGEMENT DOCUMENTATION GUIDELINES.—

22 (1) IN GENERAL.—The Secretary shall conduct  
23 under this subsection appropriate and representative  
24 pilot projects to test new evaluation and manage-

1       ment documentation guidelines referred to in sub-  
2       section (a).

3               (2) LENGTH AND CONSULTATION.—Each pilot  
4       project under this subsection shall—

5                       (A) be voluntary;

6                       (B) be of sufficient length as determined  
7       by the Secretary to allow for preparatory physi-  
8       cian and medicare contractor education, anal-  
9       ysis, and use and assessment of potential eval-  
10      uation and management guidelines; and

11                      (C) be conducted, in development and  
12      throughout the planning and operational stages  
13      of the project, in consultation with practicing  
14      physicians (including both generalists and spe-  
15      cialists).

16               (3) RANGE OF PILOT PROJECTS.—Of the pilot  
17      projects conducted under this subsection—

18                      (A) at least one shall focus on a peer re-  
19      view method by physicians (not employed by a  
20      medicare contractor) which evaluates medical  
21      record information for claims submitted by phy-  
22      sicians identified as statistical outliers relative  
23      to definitions published in the Current Proce-  
24      dures Terminology (CPT) code book of the  
25      American Medical Association;

1 (B) at least one shall focus on an alter-  
2 native method to detailed guidelines based on  
3 physician documentation of face to face encoun-  
4 ter time with a patient;

5 (C) at least one shall be conducted for  
6 services furnished in a rural area and at least  
7 one for services furnished outside such an area;  
8 and

9 (D) at least one shall be conducted in a  
10 setting where physicians bill under physicians'  
11 services in teaching settings and at least one  
12 shall be conducted in a setting other than a  
13 teaching setting.

14 (4) BANNING OF TARGETING OF PILOT  
15 PROJECT PARTICIPANTS.—Data collected under this  
16 subsection shall not be used as the basis for overpay-  
17 ment demands or post-payment audits. Such limita-  
18 tion applies only to claims filed as part of the pilot  
19 project and lasts only for the duration of the pilot  
20 project and only as long as the provider is a partici-  
21 pant in the pilot project.

22 (5) STUDY OF IMPACT.—Each pilot project  
23 shall examine the effect of the new evaluation and  
24 management documentation guidelines on—

1 (A) different types of physician practices,  
2 including those with fewer than 10 full-time-  
3 equivalent employees (including physicians);  
4 and

5 (B) the costs of physician compliance, in-  
6 cluding education, implementation, auditing,  
7 and monitoring.

8 (6) PERIODIC REPORTS.—The Secretary shall  
9 submit to Congress periodic reports on the pilot  
10 projects under this subsection.

11 (c) OBJECTIVES FOR EVALUATION AND MANAGE-  
12 MENT GUIDELINES.—The objectives for modified evalua-  
13 tion and management documentation guidelines developed  
14 by the Secretary shall be to—

15 (1) identify clinically relevant documentation  
16 needed to code accurately and assess coding levels  
17 accurately;

18 (2) decrease the level of non-clinically pertinent  
19 and burdensome documentation time and content in  
20 the physician's medical record;

21 (3) increase accuracy by reviewers; and

22 (4) educate both physicians and reviewers.

23 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF  
24 DOCUMENTATION FOR PHYSICIAN CLAIMS.—

1           (1) STUDY.—The Secretary shall carry out a  
2 study of the matters described in paragraph (2).

3           (2) MATTERS DESCRIBED.—The matters re-  
4 ferred to in paragraph (1) are—

5                   (A) the development of a simpler, alter-  
6 native system of requirements for documenta-  
7 tion accompanying claims for evaluation and  
8 management physician services for which pay-  
9 ment is made under title XVIII of the Social  
10 Security Act; and

11                   (B) consideration of systems other than  
12 current coding and documentation requirements  
13 for payment for such physician services.

14           (3) CONSULTATION WITH PRACTICING PHYSI-  
15 CIANS.—In designing and carrying out the study  
16 under paragraph (1), the Secretary shall consult  
17 with practicing physicians, including physicians who  
18 are part of group practices and including both gen-  
19 eralists and specialists.

20           (4) APPLICATION OF HIPAA UNIFORM CODING  
21 REQUIREMENTS.—In developing an alternative sys-  
22 tem under paragraph (2), the Secretary shall con-  
23 sider requirements of administrative simplification  
24 under part C of title XI of the Social Security Act.

1           (5) REPORT TO CONGRESS.—(A) Not later than  
2           October 1, 2004, the Secretary shall submit to Con-  
3           gress a report on the results of the study conducted  
4           under paragraph (1).

5           (B) The Medicare Payment Advisory Commis-  
6           sion shall conduct an analysis of the results of the  
7           study included in the report under subparagraph (A)  
8           and shall submit a report on such analysis to Con-  
9           gress.

10          (e) STUDY ON APPROPRIATE CODING OF CERTAIN  
11          EXTENDED OFFICE VISITS.—The Secretary shall conduct  
12          a study of the appropriateness of coding in cases of ex-  
13          tended office visits in which there is no diagnosis made.  
14          Not later than October 1, 2004, the Secretary shall submit  
15          a report to Congress on such study and shall include rec-  
16          ommendations on how to code appropriately for such visits  
17          in a manner that takes into account the amount of time  
18          the physician spent with the patient.

19          (f) DEFINITIONS.—In this section—

20                 (1) the term “rural area” has the meaning  
21                 given that term in section 1886(d)(2)(D) of the So-  
22                 cial Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

23                 (2) the term “teaching settings” are those set-  
24                 tings described in section 415.150 of title 42, Code  
25                 of Federal Regulations.

1 **SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**  
2 **AND COVERAGE.**

3 (a) IMPROVED COORDINATION BETWEEN FDA AND  
4 CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DE-  
5 VICES.—

6 (1) IN GENERAL.—Upon request by an appli-  
7 cant and to the extent feasible (as determined by the  
8 Secretary), the Secretary shall, in the case of a class  
9 III medical device that is subject to premarket ap-  
10 proval under section 515 of the Federal Food, Drug,  
11 and Cosmetic Act, ensure the sharing of appropriate  
12 information from the review for application for pre-  
13 market approval conducted by the Food and Drug  
14 Administration for coverage decisions under title  
15 XVIII of the Social Security Act.

16 (2) PUBLICATION OF PLAN.—Not later than 6  
17 months after the date of the enactment of this Act,  
18 the Secretary shall submit to appropriate Commit-  
19 tees of Congress a report that contains the plan for  
20 improving such coordination and for shortening the  
21 time lag between the premarket approval by the  
22 Food and Drug Administration and coding and cov-  
23 erage decisions by the Centers for Medicare & Med-  
24 icaid Services.

25 (3) CONSTRUCTION.—Nothing in this sub-  
26 section shall be construed as changing the criteria

1 for coverage of a medical device under title XVIII of  
2 the Social Security Act nor premarket approval by  
3 the Food and Drug Administration and nothing in  
4 this subsection shall be construed to increase pre-  
5 market approval application requirements under the  
6 Federal Food, Drug, and Cosmetic Act.

7 (b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—  
8 Section 1868 (42 U.S.C. 1395ee), as amended by section  
9 823(a), is amended by adding at the end the following new  
10 subsection:

11 “(c) COUNCIL FOR TECHNOLOGY AND INNOVA-  
12 TION.—

13 “(1) ESTABLISHMENT.—The Secretary shall es-  
14 tablish a Council for Technology and Innovation  
15 within the Centers for Medicare & Medicaid Services  
16 (in this section referred to as ‘CMS’).

17 “(2) COMPOSITION.—The Council shall be com-  
18 posed of senior CMS staff and clinicians and shall  
19 be chaired by the Executive Coordinator for Tech-  
20 nology and Innovation (appointed or designated  
21 under paragraph (4)).

22 “(3) DUTIES.—The Council shall coordinate the  
23 activities of coverage, coding, and payment processes  
24 under this title with respect to new technologies and  
25 procedures, including new drug therapies, and shall

1 coordinate the exchange of information on new tech-  
2 nologies between CMS and other entities that make  
3 similar decisions.

4 “(4) EXECUTIVE COORDINATOR FOR TECH-  
5 NOLOGY AND INNOVATION.—The Secretary shall ap-  
6 point (or designate) a noncareer appointee (as de-  
7 fined in section 3132(a)(7) of title 5, United States  
8 Code) who shall serve as the Executive Coordinator  
9 for Technology and Innovation. Such executive coor-  
10 dinator shall report to the Administrator of CMS,  
11 shall chair the Council, shall oversee the execution of  
12 its duties, and shall serve as a single point of con-  
13 tact for outside groups and entities regarding the  
14 coverage, coding, and payment processes under this  
15 title.”.

16 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL  
17 DATA COLLECTION FOR USE IN THE MEDICARE INPA-  
18 TIENT PAYMENT SYSTEM.—

19 (1) STUDY.—The Comptroller General of the  
20 United States shall conduct a study that analyzes  
21 which external data can be collected in a shorter  
22 time frame by the Centers for Medicare & Medicaid  
23 Services for use in computing payments for inpatient  
24 hospital services. The study may include an evalua-  
25 tion of the feasibility and appropriateness of using

1 of quarterly samples or special surveys or any other  
2 methods. The study shall include an analysis of  
3 whether other executive agencies, such as the Bu-  
4 reau of Labor Statistics in the Department of Com-  
5 merce, are best suited to collect this information.

6 (2) REPORT.—By not later than October 1,  
7 2003, the Comptroller General shall submit a report  
8 to Congress on the study under paragraph (1).

9 (d) IOM STUDY ON LOCAL COVERAGE DETERMINA-  
10 TIONS.—

11 (1) STUDY.—The Secretary shall enter into an  
12 arrangement with the Institute of Medicine of the  
13 National Academy of Sciences under which the Insti-  
14 tute shall conduct a study on local coverage deter-  
15 minations (including the application of local medical  
16 review policies) under the medicare program under  
17 title XVIII of the Social Security Act. Such study  
18 shall examine—

19 (A) the consistency of the definitions used  
20 in such determinations;

21 (B) the types of evidence on which such  
22 determinations are based, including medical and  
23 scientific evidence;

24 (C) the advantages and disadvantages of  
25 local coverage decisionmaking, including the

1 flexibility it offers for ensuring timely patient  
2 access to new medical technology for which data  
3 are still being collected;

4 (D) the manner in which the local coverage  
5 determination process is used to develop data  
6 needed for a national coverage determination,  
7 including the need for collection of such data  
8 within a protocol and informed consent by indi-  
9 viduals entitled to benefits under part A of title  
10 XVIII of the Social Security Act, or enrolled  
11 under part B of such title, or both; and

12 (E) the advantages and disadvantages of  
13 maintaining local medicare contractor advisory  
14 committees that can advise on local coverage  
15 decisions based on an open, collaborative public  
16 process.

17 (2) REPORT.—Such arrangement shall provide  
18 that the Institute shall submit to the Secretary a re-  
19 port on such study by not later than 3 years after  
20 the date of the enactment of this Act. The Secretary  
21 shall promptly transmit a copy of such report to  
22 Congress.

23 (e) METHODS FOR DETERMINING PAYMENT BASIS  
24 FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C.  
25 1395l(h)) is amended by adding at the end the following:

1       “(8)(A) The Secretary shall establish by regulation  
2 procedures for determining the basis for, and amount of,  
3 payment under this subsection for any clinical diagnostic  
4 laboratory test with respect to which a new or substan-  
5 tially revised HCPCS code is assigned on or after January  
6 1, 2004 (in this paragraph referred to as ‘new tests’).

7       “(B) Determinations under subparagraph (A) shall  
8 be made only after the Secretary—

9           “(i) makes available to the public (through an  
10 Internet site and other appropriate mechanisms) a  
11 list that includes any such test for which establish-  
12 ment of a payment amount under this subsection is  
13 being considered for a year;

14           “(ii) on the same day such list is made avail-  
15 able, causes to have published in the Federal Reg-  
16 ister notice of a meeting to receive comments and  
17 recommendations (and data on which recommenda-  
18 tions are based) from the public on the appropriate  
19 basis under this subsection for establishing payment  
20 amounts for the tests on such list;

21           “(iii) not less than 30 days after publication of  
22 such notice convenes a meeting, that includes rep-  
23 resentatives of officials of the Centers for Medicare  
24 & Medicaid Services involved in determining pay-  
25 ment amounts, to receive such comments and rec-

1       ommendations (and data on which the recommenda-  
2       tions are based);

3               “(iv) taking into account the comments and rec-  
4       ommendations (and accompanying data) received at  
5       such meeting, develops and makes available to the  
6       public (through an Internet site and other appro-  
7       priate mechanisms) a list of proposed determinations  
8       with respect to the appropriate basis for establishing  
9       a payment amount under this subsection for each  
10      such code, together with an explanation of the rea-  
11      sons for each such determination, the data on which  
12      the determinations are based, and a request for pub-  
13      lic written comments on the proposed determination;  
14      and

15              “(v) taking into account the comments received  
16      during the public comment period, develops and  
17      makes available to the public (through an Internet  
18      site and other appropriate mechanisms) a list of  
19      final determinations of the payment amounts for  
20      such tests under this subsection, together with the  
21      rationale for each such determination, the data on  
22      which the determinations are based, and responses  
23      to comments and suggestions received from the pub-  
24      lic.

1 “(C) Under the procedures established pursuant to  
2 subparagraph (A), the Secretary shall—

3 “(i) set forth the criteria for making determina-  
4 tions under subparagraph (A); and

5 “(ii) make available to the public the data  
6 (other than proprietary data) considered in making  
7 such determinations.

8 “(D) The Secretary may convene such further public  
9 meetings to receive public comments on payment amounts  
10 for new tests under this subsection as the Secretary deems  
11 appropriate.

12 “(E) For purposes of this paragraph:

13 “(i) The term ‘HCPCS’ refers to the Health  
14 Care Procedure Coding System.

15 “(ii) A code shall be considered to be ‘substan-  
16 tially revised’ if there is a substantive change to the  
17 definition of the test or procedure to which the code  
18 applies (such as a new analyte or a new methodology  
19 for measuring an existing analyte-specific test).”.

20 **SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**  
21 **ICES UNDER MEDICARE SECONDARY PAYOR**  
22 **(MSP) PROVISIONS.**

23 (a) **IN GENERAL.**—The Secretary shall not require  
24 a hospital (including a critical access hospital) to ask ques-  
25 tions (or obtain information) relating to the application

1 of section 1862(b) of the Social Security Act (relating to  
2 medicare secondary payor provisions) in the case of ref-  
3 erence laboratory services described in subsection (b), if  
4 the Secretary does not impose such requirement in the  
5 case of such services furnished by an independent labora-  
6 tory.

7 (b) REFERENCE LABORATORY SERVICES DE-  
8 SCRIBED.—Reference laboratory services described in this  
9 subsection are clinical laboratory diagnostic tests (or the  
10 interpretation of such tests, or both) furnished without a  
11 face-to-face encounter between the individual entitled to  
12 benefits under part A or enrolled under part B, or both,  
13 and the hospital involved and in which the hospital sub-  
14 mits a claim only for such test or interpretation.

15 **SEC. 844. EMTALA IMPROVEMENTS.**

16 (a) PAYMENT FOR EMTALA-MANDATED SCREEN-  
17 ING AND STABILIZATION SERVICES.—

18 (1) IN GENERAL.—Section 1862 (42 U.S.C.  
19 1395y) is amended by inserting after subsection (c)  
20 the following new subsection:

21 “(d) For purposes of subsection (a)(1)(A), in the case  
22 of any item or service that is required to be provided pur-  
23 suant to section 1867 to an individual who is entitled to  
24 benefits under this title, determinations as to whether the  
25 item or service is reasonable and necessary shall be made

1 on the basis of the information available to the treating  
2 physician or practitioner (including the patient's pre-  
3 senting symptoms or complaint) at the time the item or  
4 service was ordered or furnished by the physician or prac-  
5 titioner (and not on the patient's principal diagnosis).  
6 When making such determinations with respect to such  
7 an item or service, the Secretary shall not consider the  
8 frequency with which the item or service was provided to  
9 the patient before or after the time of the admission or  
10 visit.”.

11           (2) EFFECTIVE DATE.—The amendment made  
12       by paragraph (1) shall apply to items and services  
13       furnished on or after January 1, 2003.

14       (b) NOTIFICATION OF PROVIDERS WHEN EMTALA  
15 INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C.  
16 1395dd(d)) is amended by adding at the end the following  
17 new paragraph:

18           “(4) NOTICE UPON CLOSING AN INVESTIGA-  
19       TION.—The Secretary shall establish a procedure to  
20       notify hospitals and physicians when an investigation  
21       under this section is closed.”.

22       (c) PRIOR REVIEW BY PEER REVIEW ORGANIZA-  
23 TIONS IN EMTALA CASES INVOLVING TERMINATION OF  
24 PARTICIPATION.—

1           (1) IN GENERAL.—Section 1867(d)(3) (42  
2 U.S.C. 1395dd(d)(3)) is amended—

3           (A) in the first sentence, by inserting “or  
4 in terminating a hospital’s participation under  
5 this title” after “in imposing sanctions under  
6 paragraph (1)”; and

7           (B) by adding at the end the following new  
8 sentences: “Except in the case in which a delay  
9 would jeopardize the health or safety of individ-  
10 uals, the Secretary shall also request such a re-  
11 view before making a compliance determination  
12 as part of the process of terminating a hos-  
13 pital’s participation under this title for viola-  
14 tions related to the appropriateness of a med-  
15 ical screening examination, stabilizing treat-  
16 ment, or an appropriate transfer as required by  
17 this section, and shall provide a period of 5  
18 days for such review. The Secretary shall pro-  
19 vide a copy of the organization’s report to the  
20 hospital or physician consistent with confiden-  
21 tiality requirements imposed on the organiza-  
22 tion under such part B.”.

23           (2) EFFECTIVE DATE.—The amendments made  
24 by paragraph (1) shall apply to terminations of par-

1 participation initiated on or after the date of the enact-  
2 ment of this Act.

3 **SEC. 845. EMERGENCY MEDICAL TREATMENT AND LABOR**  
4 **ACT (EMTALA) TECHNICAL ADVISORY GROUP.**

5 (a) ESTABLISHMENT.—The Secretary shall establish  
6 a Technical Advisory Group (in this section referred to  
7 as the “Advisory Group”) to review issues related to the  
8 Emergency Medical Treatment and Labor Act  
9 (EMTALA) and its implementation. In this section, the  
10 term “EMTALA” refers to the provisions of section 1867  
11 of the Social Security Act (42 U.S.C. 1395dd).

12 (b) MEMBERSHIP.—The Advisory Group shall be  
13 composed of 19 members, including the Administrator of  
14 the Centers for Medicare & Medicaid Services and the In-  
15 spector General of the Department of Health and Human  
16 Services and of which—

17 (1) 4 shall be representatives of hospitals, in-  
18 cluding at least one public hospital, that have experi-  
19 ence with the application of EMTALA and at least  
20 2 of which have not been cited for EMTALA viola-  
21 tions;

22 (2) 7 shall be practicing physicians drawn from  
23 the fields of emergency medicine, cardiology or  
24 cardiothoracic surgery, orthopedic surgery, neuro-  
25 surgery, obstetrics-gynecology, and psychiatry, with

1 not more than one physician from any particular  
2 field;

3 (3) 2 shall represent patients;

4 (4) 2 shall be staff involved in EMTALA inves-  
5 tigations from different regional offices of the Cen-  
6 ters for Medicare & Medicaid Services; and

7 (5) 1 shall be from a State survey office in-  
8 volved in EMTALA investigations and 1 shall be  
9 from a peer review organization, both of whom shall  
10 be from areas other than the regions represented  
11 under paragraph (4).

12 In selecting members described in paragraphs (1) through  
13 (3), the Secretary shall consider qualified individuals nom-  
14 inated by organizations representing providers and pa-  
15 tients.

16 (c) GENERAL RESPONSIBILITIES.—The Advisory  
17 Group—

18 (1) shall review EMTALA regulations;

19 (2) may provide advice and recommendations to  
20 the Secretary with respect to those regulations and  
21 their application to hospitals and physicians;

22 (3) shall solicit comments and recommendations  
23 from hospitals, physicians, and the public regarding  
24 the implementation of such regulations; and

1           (4) may disseminate information on the applica-  
2           tion of such regulations to hospitals, physicians, and  
3           the public.

4           (d) ADMINISTRATIVE MATTERS.—

5           (1) CHAIRPERSON.—The members of the Advi-  
6           sory Group shall elect a member to serve as chair-  
7           person of the Advisory Group for the life of the Ad-  
8           visory Group.

9           (2) MEETINGS.—The Advisory Group shall first  
10          meet at the direction of the Secretary. The Advisory  
11          Group shall then meet twice per year and at such  
12          other times as the Advisory Group may provide.

13          (e) TERMINATION.—The Advisory Group shall termi-  
14          nate 30 months after the date of its first meeting.

15          (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The  
16          Secretary shall establish the Advisory Group notwith-  
17          standing any limitation that may apply to the number of  
18          advisory committees that may be established (within the  
19          Department of Health and Human Services or otherwise).

1 **SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH**  
2 **OTHER HOSPICE PROGRAMS TO PROVIDE**  
3 **CORE HOSPICE SERVICES IN CERTAIN CIR-**  
4 **CUMSTANCES.**

5 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.  
6 1395x(dd)(5)) is amended by adding at the end the fol-  
7 lowing new subparagraph:

8 “(D) In extraordinary, exigent, or other non-routine  
9 circumstances, such as unanticipated periods of high pa-  
10 tient loads, staffing shortages due to illness or other  
11 events, or temporary travel of a patient outside a hospice  
12 program’s service area, a hospice program may enter into  
13 arrangements with another hospice program for the provi-  
14 sion by that other program of services described in para-  
15 graph (2)(A)(ii)(I). The provisions of paragraph  
16 (2)(A)(ii)(II) shall apply with respect to the services pro-  
17 vided under such arrangements.”.

18 (b) CONFORMING PAYMENT PROVISION.—Section  
19 1814(i) (42 U.S.C. 1395f(i)), as amended by section  
20 421(b), is amended by adding at the end the following new  
21 paragraph:

22 “(5) In the case of hospice care provided by a hospice  
23 program under arrangements under section  
24 1861(dd)(5)(D) made by another hospice program, the  
25 hospice program that made the arrangements shall bill  
26 and be paid for the hospice care.”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to hospice care provided on or after  
3 the date of the enactment of this Act.

4 **SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHO-**  
5 **GENS STANDARD TO CERTAIN HOSPITALS.**

6 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)  
7 is amended—

8 (1) in subsection (a)(1)—

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

11 (B) in subparagraph (S), by striking the  
12 period at the end and inserting “, and”; and

13 (C) by inserting after subparagraph (S)  
14 the following new subparagraph:

15 “(T) in the case of hospitals that are not other-  
16 wise subject to the Occupational Safety and Health  
17 Act of 1970, to comply with the Bloodborne Patho-  
18 gens standard under section 1910.1030 of title 29 of  
19 the Code of Federal Regulations (or as subsequently  
20 redesignated).”; and

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

23 “(4)(A) A hospital that fails to comply with the re-  
24 quirement of subsection (a)(1)(T) (relating to the  
25 Bloodborne Pathogens standard) is subject to a civil

1 money penalty in an amount described in subparagraph  
2 (B), but is not subject to termination of an agreement  
3 under this section.

4 “(B) The amount referred to in subparagraph (A) is  
5 an amount that is similar to the amount of civil penalties  
6 that may be imposed under section 17 of the Occupational  
7 Safety and Health Act of 1970 for a violation of the  
8 Bloodborne Pathogens standard referred to in subsection  
9 (a)(1)(T) by a hospital that is subject to the provisions  
10 of such Act.

11 “(C) A civil money penalty under this paragraph shall  
12 be imposed and collected in the same manner as civil  
13 money penalties under subsection (a) of section 1128A are  
14 imposed and collected under that section.”.

15 (b) EFFECTIVE DATE.—The amendments made by  
16 this subsection (a) shall apply to hospitals as of July 1,  
17 2003.

18 **SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND**  
19 **CORRECTIONS.**

20 (a) TECHNICAL AMENDMENTS RELATING TO ADVI-  
21 SORY COMMITTEE UNDER BIPA SECTION 522.—(1) Sub-  
22 section (i) of section 1114 (42 U.S.C. 1314)—

23 (A) is transferred to section 1862 and added at  
24 the end of such section; and

25 (B) is redesignated as subsection (j).

1 (2) Section 1862 (42 U.S.C. 1395y) is amended—

2 (A) in the last sentence of subsection (a), by  
3 striking “established under section 1114(f)”; and

4 (B) in subsection (j), as so transferred and re-  
5 designated—

6 (i) by striking “under subsection (f)”; and

7 (ii) by striking “section 1862(a)(1)” and  
8 inserting “subsection (a)(1)”.

9 (b) TERMINOLOGY CORRECTIONS.—(1) Section  
10 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as  
11 amended by section 521 of BIPA, is amended—

12 (A) in subclause (III), by striking “policy” and  
13 inserting “determination”; and

14 (B) in subclause (IV), by striking “medical re-  
15 view policies” and inserting “coverage determina-  
16 tions”.

17 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-  
18 22(a)(2)(C)) is amended by striking “policy” and “POL-  
19 ICY” and inserting “determination” each place it appears  
20 and “DETERMINATION”, respectively.

21 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4)  
22 (42 U.S.C. 1395ff(f)(4)), as added by section 522 of  
23 BIPA, is amended—

1 (1) in subparagraph (A)(iv), by striking “sub-  
2 clause (I), (II), or (III)” and inserting “clause (i),  
3 (ii), or (iii)”;

4 (2) in subparagraph (B), by striking “clause  
5 (i)(IV)” and “clause (i)(III)” and inserting “sub-  
6 paragraph (A)(iv)” and “subparagraph (A)(iii)”, re-  
7 spectively; and

8 (3) in subparagraph (C), by striking “clause  
9 (i)”, “subclause (IV)” and “subparagraph (A)” and  
10 inserting “subparagraph (A)”, “clause (iv)” and  
11 “paragraph (1)(A)”, respectively each place it ap-  
12 pears.

13 (d) OTHER CORRECTIONS.—Effective as if included  
14 in the enactment of section 521(c) of BIPA, section  
15 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking  
16 paragraph (5).

17 (e) EFFECTIVE DATE.—Except as otherwise pro-  
18 vided, the amendments made by this section shall be effec-  
19 tive as if included in the enactment of BIPA.

20 **SEC. 849. CONFORMING AUTHORITY TO WAIVE A PROGRAM**  
21 **EXCLUSION.**

22 The first sentence of section 1128(c)(3)(B) (42  
23 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows:  
24 “Subject to subparagraph (G), in the case of an exclusion  
25 under subsection (a), the minimum period of exclusion

1 shall be not less than five years, except that, upon the  
2 request of the administrator of a Federal health care pro-  
3 gram (as defined in section 1128B(f)) who determines  
4 that the exclusion would impose a hardship on individuals  
5 entitled to benefits under part A of title XVIII or enrolled  
6 under part B of such title, or both, the Secretary may  
7 waive the exclusion under subsection (a)(1), (a)(3), or  
8 (a)(4) with respect to that program in the case of an indi-  
9 vidual or entity that is the sole community physician or  
10 sole source of essential specialized services in a commu-  
11 nity.”.

12 **SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.**

13 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y)  
14 is amended by adding after subsection (g) the following  
15 new subsection:

16 “(h)(1) Subject to paragraph (2), a group health plan  
17 (as defined in subsection (a)(1)(A)(v)) providing supple-  
18 mental or secondary coverage to individuals also entitled  
19 to services under this title shall not require a medicare  
20 claims determination under this title for dental benefits  
21 specifically excluded under subsection (a)(12) as a condi-  
22 tion of making a claims determination for such benefits  
23 under the group health plan.

24 “(2) A group health plan may require a claims deter-  
25 mination under this title in cases involving or appearing

1 to involve inpatient dental hospital services or dental serv-  
 2 ices expressly covered under this title pursuant to actions  
 3 taken by the Secretary.”.

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

7 **SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL**  
 8 **COVERAGE DETERMINATIONS.**

9 The Secretary shall provide, in an appropriate annual  
 10 publication available to the public, a list of national cov-  
 11 erage determinations made under title XVIII of the Social  
 12 Security Act in the previous year and information on how  
 13 to get more information with respect to such determina-  
 14 tions.

15 **TITLE IX—MEDICAID**  
 16 **PROVISIONS**

17 **SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE FU-**  
 18 **TURE OF MEDICAID.**

19 (a) ESTABLISHMENT.—There is established a com-  
 20 mission to be known as the National Bipartisan Commis-  
 21 sion on the Future of Medicaid (in this section referred  
 22 to as the “Commission”).

23 (b) DUTIES OF THE COMMISSION.—The Commission  
 24 shall—

1           (1) review and analyze the long-term financial  
2           condition of the medicaid program under title XIX  
3           of the Social Security Act (42 U.S.C. 1396 et seq.);

4           (2) identify the factors that are causing, and  
5           the consequences of, increases in costs under the  
6           medicaid program, including—

7                   (A) the impact of these cost increases upon  
8                   State budgets, funding for other State pro-  
9                   grams, and levels of State taxes necessary to  
10                  fund growing expenditures under the medicaid  
11                  program;

12                  (B) the financial obligations of the Federal  
13                  government arising from the Federal matching  
14                  requirement for expenditures under the med-  
15                  icaid program; and

16                  (C) the size and scope of the current pro-  
17                  gram and how the program has evolved over  
18                  time;

19           (3) analyze potential policies that will ensure  
20           both the financial integrity of the medicaid program  
21           and the provision of appropriate benefits under such  
22           program;

23           (4) make recommendations for establishing in-  
24           centives and structures to promote enhanced effi-

1       ciencies and ways of encouraging innovative State  
2       policies under the medicaid program;

3           (5) make recommendations for establishing the  
4       appropriate balance between benefits covered, pay-  
5       ments to providers, State and Federal contributions  
6       and, where appropriate, recipient cost-sharing obli-  
7       gations;

8           (6) make recommendations on the impact of  
9       promoting increased utilization of competitive, pri-  
10      vate enterprise models to contain program cost  
11      growth, through enhanced utilization of private  
12      plans, pharmacy benefit managers, and other meth-  
13      ods currently being used to contain private sector  
14      health-care costs;

15          (7) make recommendations on the financing of  
16      prescription drug benefits currently covered under  
17      medicaid programs, including analysis of the current  
18      Federal manufacturer rebate program, its impact  
19      upon both private market prices as well as those  
20      paid by other government purchasers, recent State  
21      efforts to negotiate additional supplemental manu-  
22      facturer rebates and the ability of pharmacy benefit  
23      managers to lower drug costs;

1           (8) review and analyze such other matters relat-  
2           ing to the medicaid program as the Commission  
3           deems appropriate; and

4           (9) analyze the impact of impending demo-  
5           graphic changes upon medicaid benefits, including  
6           long term care services, and make recommendations  
7           for how best to appropriately divide State and Fed-  
8           eral responsibilities for funding these benefits.

9           (c) MEMBERSHIP.—

10           (1) NUMBER AND APPOINTMENT.—The Com-  
11           mission shall be composed of 17 members, of  
12           whom—

13                   (A) four shall be appointed by the Presi-  
14                   dent;

15                   (B) six shall be appointed by the Majority  
16                   Leader of the Senate, in consultation with the  
17                   Minority Leader of the Senate, of whom not  
18                   more than 4 shall be of the same political party;

19                   (C) six shall be appointed by the Speaker  
20                   of the House of Representatives, in consultation  
21                   with the Minority Leader of the House of Rep-  
22                   resentatives, of whom not more than 4 shall be  
23                   of the same political party; and

24                   (D) one, who shall serve as Chairman of  
25                   the Commission, appointed jointly by the Presi-

1           dent, Majority Leader of the Senate, and the  
2           Speaker of the House of Representatives.

3           (2) DEADLINE FOR APPOINTMENT.—Members  
4           of the Commission shall be appointed by not later  
5           than December 1, 2002.

6           (3) TERMS OF APPOINTMENT.—The term of  
7           any appointment under paragraph (1) to the Com-  
8           mission shall be for the life of the Commission.

9           (4) MEETINGS.—The Commission shall meet at  
10          the call of its Chairman or a majority of its mem-  
11          bers.

12          (5) QUORUM.—A quorum shall consist of 8  
13          members of the Commission, except that 4 members  
14          may conduct a hearing under subsection (e).

15          (6) VACANCIES.—A vacancy on the Commission  
16          shall be filled in the same manner in which the origi-  
17          nal appointment was made not later than 30 days  
18          after the Commission is given notice of the vacancy  
19          and shall not affect the power of the remaining  
20          members to execute the duties of the Commission.

21          (7) COMPENSATION.—Members of the Commis-  
22          sion shall receive no additional pay, allowances, or  
23          benefits by reason of their service on the Commis-  
24          sion.

1           (8) EXPENSES.—Each member of the Commis-  
2           sion shall receive travel expenses and per diem in  
3           lieu of subsistence in accordance with sections 5702  
4           and 5703 of title 5, United States Code.

5           (d) STAFF AND SUPPORT SERVICES.—

6           (1) EXECUTIVE DIRECTOR.—

7           (A) APPOINTMENT.—The Chairman shall  
8           appoint an executive director of the Commis-  
9           sion.

10          (B) COMPENSATION.—The executive direc-  
11          tor shall be paid the rate of basic pay for level  
12          V of the Executive Schedule.

13          (2) STAFF.—With the approval of the Commis-  
14          sion, the executive director may appoint such per-  
15          sonnel as the executive director considers appro-  
16          priate.

17          (3) APPLICABILITY OF CIVIL SERVICE LAWS.—  
18          The staff of the Commission shall be appointed with-  
19          out regard to the provisions of title 5, United States  
20          Code, governing appointments in the competitive  
21          service, and shall be paid without regard to the pro-  
22          visions of chapter 51 and subchapter III of chapter  
23          53 of such title (relating to classification and Gen-  
24          eral Schedule pay rates).

1           (4) EXPERTS AND CONSULTANTS.—With the  
2 approval of the Commission, the executive director  
3 may procure temporary and intermittent services  
4 under section 3109(b) of title 5, United States Code.

5           (5) PHYSICAL FACILITIES.—The Administrator  
6 of the General Services Administration shall locate  
7 suitable office space for the operation of the Com-  
8 mission. The facilities shall serve as the head-  
9 quarters of the Commission and shall include all  
10 necessary equipment and incidentals required for the  
11 proper functioning of the Commission.

12       (e) POWERS OF COMMISSION.—

13           (1) HEARINGS AND OTHER ACTIVITIES.—For  
14 the purpose of carrying out its duties, the Commis-  
15 sion may hold such hearings and undertake such  
16 other activities as the Commission determines to be  
17 necessary to carry out its duties.

18           (2) STUDIES BY GAO.—Upon the request of the  
19 Commission, the Comptroller General shall conduct  
20 such studies or investigations as the Commission de-  
21 termines to be necessary to carry out its duties.

22           (3) COST ESTIMATES BY CONGRESSIONAL  
23 BUDGET OFFICE AND OFFICE OF THE CHIEF ACTU-  
24 ARY OF CMS.—

1           (A) The Director of the Congressional  
2 Budget Office or the Chief Actuary of the Cen-  
3 ters for Medicare & Medicaid Services, or both,  
4 shall provide to the Commission, upon the re-  
5 quest of the Commission, such cost estimates as  
6 the Commission determines to be necessary to  
7 carry out its duties.

8           (B) The Commission shall reimburse the  
9 Director of the Congressional Budget Office for  
10 expenses relating to the employment in the of-  
11 fice of the Director of such additional staff as  
12 may be necessary for the Director to comply  
13 with requests by the Commission under sub-  
14 paragraph (A).

15           (4) DETAIL OF FEDERAL EMPLOYEES.—Upon  
16 the request of the Commission, the head of any Fed-  
17 eral agency is authorized to detail, without reim-  
18 bursement, any of the personnel of such agency to  
19 the Commission to assist the Commission in car-  
20 rying out its duties. Any such detail shall not inter-  
21 rupt or otherwise affect the civil service status or  
22 privileges of the Federal employee.

23           (5) TECHNICAL ASSISTANCE.—Upon the re-  
24 quest of the Commission, the head of a Federal  
25 agency shall provide such technical assistance to the

1 Commission as the Commission determines to be  
2 necessary to carry out its duties.

3 (6) USE OF MAILS.—The Commission may use  
4 the United States mails in the same manner and  
5 under the same conditions as Federal agencies and  
6 shall, for purposes of the frank, be considered a  
7 commission of Congress as described in section 3215  
8 of title 39, United States Code.

9 (7) OBTAINING INFORMATION.—The Commis-  
10 sion may secure directly from any Federal agency  
11 information necessary to enable it to carry out its  
12 duties, if the information may be disclosed under  
13 section 552 of title 5, United States Code. Upon re-  
14 quest of the Chairman of the Commission, the head  
15 of such agency shall furnish such information to the  
16 Commission.

17 (8) ADMINISTRATIVE SUPPORT SERVICES.—  
18 Upon the request of the Commission, the Adminis-  
19 trator of General Services shall provide to the Com-  
20 mission on a reimbursable basis such administrative  
21 support services as the Commission may request.

22 (9) PRINTING.—For purposes of costs relating  
23 to printing and binding, including the cost of per-  
24 sonnel detailed from the Government Printing Of-



1           creased, subject to subparagraph (B) and  
2           paragraph (5), by the percentage change in  
3           the consumer price index for all urban con-  
4           sumers (all items; U.S. city average), for  
5           fiscal year 2001; and

6           “(ii) for each succeeding fiscal year is  
7           equal to the DSH allotment for the State  
8           for the previous fiscal year under this sub-  
9           paragraph increased, subject to subpara-  
10          graph (B) and paragraph (5), by 1.7 per-  
11          cent or, in the case of fiscal years begin-  
12          ning with the fiscal year specified in sub-  
13          paragraph (C) for that State, the percent-  
14          age change in the consumer price index for  
15          all urban consumers (all items; U.S. city  
16          average), for the previous fiscal year.”; and

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

19                 “(C) FISCAL YEAR SPECIFIED.—For pur-  
20                 poses of subparagraph (A)(ii), the fiscal year  
21                 specified in this subparagraph for a State is the  
22                 first fiscal year for which the Secretary esti-  
23                 mates that the DSH allotment for that State  
24                 will equal (or no longer exceed) the DSH allot-  
25                 ment for that State under the law as in effect

1           before the date of the enactment of this sub-  
2           paragraph.”.

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