

108TH CONGRESS  
1ST SESSION

# S. 1332

To amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the medicare program, and for other purposes.

---

IN THE SENATE OF THE UNITED STATES

JUNE 25, 2003

Mr. HATCH introduced the following bill; which was read twice and referred to the Committee on Finance

---

## A BILL

To amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the medicare program, and for other purposes.

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

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) **SHORT TITLE.**—This Act may be cited as the  
5       “Medicare Education, Regulatory Reform, and Con-  
6       tracting Improvement Act of 2003”.

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

Sec. 1. Short title; table of contents.

#### TITLE I—REGULATORY REFORM

- Sec. 101. Compliance with changes in regulations and policies.
- Sec. 102. Report on legal and regulatory inconsistencies.
- Sec. 103. Status of pending interim final regulations.

#### TITLE II—APPEALS PROCESS REFORM

- Sec. 201. Submission of plan for transfer of responsibility for medicare appeals.
- Sec. 202. Expedited access to judicial review.
- Sec. 203. Cost report reform.
- Sec. 204. Expedited review of certain provider agreement determinations.
- Sec. 205. Revisions to medicare appeals process.
- Sec. 206. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement; consultation before changing provider enrollment forms.
- Sec. 207. Appeals by providers when there is no other party available.
- Sec. 208. Provider access to review of local coverage determinations.

#### TITLE III—CONTRACTING REFORM

- Sec. 301. Increased flexibility in medicare administration.

#### TITLE IV—EDUCATION AND OUTREACH IMPROVEMENTS

- Sec. 401. Provider education and technical assistance.
- Sec. 402. Access to and prompt responses from medicare contractors.
- Sec. 403. Reliance on guidance.
- Sec. 404. Medicare provider ombudsman; medicare beneficiary ombudsman.
- Sec. 405. Beneficiary outreach demonstration program.

#### TITLE V—REVIEW, RECOVERY, AND ENFORCEMENT REFORM

- Sec. 501. Prepayment review.
- Sec. 502. Recovery of overpayments.
- Sec. 503. Process for correction of minor errors and omissions on claims without pursuing appeals process.
- Sec. 504. Authority to waive a program exclusion.
- Sec. 505. Recovery of overpayments.

#### TITLE VI—OTHER IMPROVEMENTS

- Sec. 601. Inclusion of additional information in notices to beneficiaries about skilled nursing facility and hospital benefits.
- Sec. 602. Information on medicare-certified skilled nursing facilities in hospital discharge plans.
- Sec. 603. Evaluation and management documentation guidelines consideration.
- Sec. 604. Improvement in oversight of technology and coverage.
- Sec. 605. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 606. EMTALA improvements.
- Sec. 607. Emergency Medical Treatment and Active Labor Act (EMTALA) technical advisory group.
- Sec. 608. Authorizing use of arrangements to provide core hospice services in certain circumstances.
- Sec. 609. Coverage of hospice consultation services.

Sec. 610. Application of OSHA bloodborne pathogens standard to certain hospitals.

Sec. 611. BIPA-related technical amendments and corrections.

Sec. 612. Treatment of certain dental claims.

Sec. 613. Revisions to reassignment provisions.

Sec. 614. GAO study and report regarding Illinois Council decision.

# 1 **TITLE I—REGULATORY REFORM**

## 2 **SEC. 101. COMPLIANCE WITH CHANGES IN REGULATIONS**

### 3 **AND POLICIES.**

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

6 (1) IN GENERAL.—Section 1871 (42 U.S.C.  
7 1395hh) is amended by adding at the end the fol-  
8 lowing new subsection:

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

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

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

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

1 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE  
2 CHANGES AFTER NOTICE.—

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

6 “(B) A compliance action may be made against a pro-  
7 vider of services, physician, practitioner, or other supplier  
8 with respect to noncompliance with such a substantive  
9 change only for items and services furnished on or after  
10 the effective date of the change.

11 “(C)(i) Except as provided in clause (ii), a sub-  
12 stantive change may not take effect until not earlier than  
13 the date that is the end of the 30-day period that begins  
14 on the date that the Secretary has issued or published,  
15 as the case may be, the substantive change.

16 “(ii) The Secretary may provide for a substantive  
17 change to take effect on a date that precedes the end of  
18 the 30-day period under clause (i) if the Secretary finds  
19 that waiver of such 30-day period is necessary to comply  
20 with statutory requirements or that the application of such  
21 30-day period is contrary to the public interest. If the Sec-  
22 retary provides for an earlier effective date pursuant to  
23 this clause, the Secretary shall include in the issuance or  
24 publication of the substantive change a finding described

1 in the first sentence, and a brief statement of the reasons  
2 for such finding.”.

3 (2) EFFECTIVE DATE.—The amendment made  
4 by paragraph (1) shall apply to compliance actions  
5 undertaken on or after the date of the enactment of  
6 this Act.

7 **SEC. 102. REPORT ON LEGAL AND REGULATORY INCON-**  
8 **SISTENCIES.**

9 Section 1871 (42 U.S.C. 1395hh), as amended by  
10 section 101(a)(1), is amended by adding at the end the  
11 following new subsection:

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

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

20 “(A) information from beneficiaries, providers  
21 of services, physicians, practitioners, and other sup-  
22 pliers with respect to such areas of inconsistency  
23 and conflict; and

24 “(B) information from medicare contractors  
25 that tracks the nature of communications and cor-

1        response, including the communications and cor-  
2        response required under section 1874A.

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

9        **SEC. 103. STATUS OF PENDING INTERIM FINAL REGULA-**  
10        **TIONS.**

11        Section 1871 (42 U.S.C. 1395hh) as amended by sec-  
12        tions 101 and 102, is amended by adding at the end the  
13        following new subsection:

14        “(f) The Secretary shall publish in the Federal Reg-  
15        ister at least once every 6 months a list that provides the  
16        status of each interim final regulation for which no final  
17        regulation has been published. Such list shall include the  
18        date by which the Secretary plans to publish the final reg-  
19        ulation that is based on the interim final regulation.”.

20        **TITLE II—APPEALS PROCESS**  
21        **REFORM**

22        **SEC. 201. SUBMISSION OF PLAN FOR TRANSFER OF RE-**  
23        **SPONSIBILITY FOR MEDICARE APPEALS.**

24        (a) SUBMISSION OF TRANSITION PLAN.—

1           (1) IN GENERAL.—Not later than April 1,  
2           2004, the Commissioner of Social Security and the  
3           Secretary shall develop and transmit to Congress  
4           and the Comptroller General of the United States a  
5           plan under which the functions of administrative law  
6           judges responsible for hearing cases under title  
7           XVIII of the Social Security Act (and related provi-  
8           sions in title XI of such Act) are transferred from  
9           the responsibility of the Commissioner and the So-  
10          cial Security Administration to the Secretary and  
11          the Department of Health and Human Services.

12          (2) CONTENTS.—The plan shall include infor-  
13          mation on the following:

14                (A) WORKLOAD.—The number of such ad-  
15                ministrative law judges and support staff re-  
16                quired now and in the future to hear and decide  
17                such cases in a timely manner, taking into ac-  
18                count the current and anticipated claims vol-  
19                ume, appeals, number of beneficiaries, and stat-  
20                utory changes.

21                (B) COST PROJECTIONS AND FINANC-  
22                ING.—Funding levels required for fiscal year  
23                2005 and subsequent fiscal years to carry out  
24                the functions transferred under the plan and  
25                how such transfer should be financed.

1           (C) TRANSITION TIMETABLE.—A timetable  
2 for the transition.

3           (D) REGULATIONS.—The establishment of  
4 specific regulations to govern the appeals proc-  
5 ess.

6           (E) CASE TRACKING.—The development of  
7 a unified case tracking system that will facili-  
8 tate the maintenance and transfer of case spe-  
9 cific data across both the fee-for-service and  
10 managed care components of the medicare pro-  
11 gram.

12          (F) FEASIBILITY OF PRECEDENTIAL AU-  
13 THORITY.—The feasibility of developing a proc-  
14 ess to give decisions of the Departmental Ap-  
15 peals Board in the Department of Health and  
16 Human Services addressing broad legal issues  
17 binding, precedential authority.

18          (G) ACCESS TO ADMINISTRATIVE LAW  
19 JUDGES.—The feasibility of—

20           (i) filing appeals with administrative  
21 law judges electronically; and

22           (ii) conducting hearings using tele- or  
23 video-conference technologies.

24          (H) INDEPENDENCE OF JUDGES.—The  
25 steps that should be taken to ensure that

1 judges who perform the administrative law  
2 judge functions after the transfer under the  
3 plan maintain their independence from the Cen-  
4 ters for Medicare & Medicaid Services and its  
5 contractors.

6 (I) GEOGRAPHIC DISTRIBUTION.—The  
7 steps that should be taken to provide for an ap-  
8 propriate geographic distribution of judges per-  
9 forming the administrative law judge functions  
10 that are transferred under the plan throughout  
11 the United States to ensure timely access to  
12 such judges.

13 (J) HIRING.—The steps that should be  
14 taken to hire judges (and support staff) to per-  
15 form the administrative law judge functions  
16 that are transferred under the plan.

17 (K) PERFORMANCE STANDARDS.—The es-  
18 tablishment of performance standards for  
19 judges performing the administrative law judge  
20 functions that are transferred under the plan  
21 with respect to timelines for decisions in cases  
22 under title XVIII.

23 (L) SHARED RESOURCES.—The feasibility  
24 of the Secretary entering into such arrange-  
25 ments with the Commissioner of Social Security

1 as may be appropriate with respect to trans-  
2 ferred functions under the plan to share office  
3 space, support staff, and other resources, with  
4 appropriate reimbursement.

5 (M) TRAINING.—The training that should  
6 be provided to judges performing the adminis-  
7 trative law judge functions that are transferred  
8 under the plan with respect to laws and regula-  
9 tions under title XVIII.

10 (3) ADDITIONAL INFORMATION.—The plan may  
11 also include recommendations for further congres-  
12 sional action, including modifications to the require-  
13 ments and deadlines established under section 1869  
14 of the Social Security Act (as amended by sections  
15 521 and 522 of BIPA (114 Stat. 2763A–534) and  
16 this Act).

17 (b) GAO EVALUATION.—The Comptroller General of  
18 the United States shall—

19 (1) evaluate the plan submitted under sub-  
20 section (a); and

21 (2) not later than 6 months after such submis-  
22 sion, submit to Congress a report on such evalua-  
23 tion.

1 **SEC. 202. EXPEDITED ACCESS TO JUDICIAL REVIEW.**

2 (a) IN GENERAL.—Section 1869(b) (42 U.S.C.  
3 1395ff(b)) is amended—

4 (1) in paragraph (1)(A), by inserting “, subject  
5 to paragraph (2),” before “to judicial review of the  
6 Secretary’s final decision”; and

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

9 “(2) EXPEDITED ACCESS TO JUDICIAL RE-  
10 VIEW.—

11 “(A) IN GENERAL.—The Secretary shall  
12 establish a process under which a provider of  
13 services or supplier that furnishes an item or  
14 service or a beneficiary who has filed an appeal  
15 under paragraph (1) (other than an appeal filed  
16 under paragraph (1)(F)(i)) may obtain access  
17 to judicial review when a review entity (de-  
18 scribed in subparagraph (D)), on its own mo-  
19 tion or at the request of the appellant, deter-  
20 mines that the Departmental Appeals Board  
21 does not have the authority to decide the ques-  
22 tion of law or regulation relevant to the matters  
23 in controversy and that there is no material  
24 issue of fact in dispute. The appellant may  
25 make such request only once with respect to a

1 question of law or regulation for a specific mat-  
2 ter in dispute in a case of an appeal.

3 “(B) PROMPT DETERMINATIONS.—If, after  
4 or coincident with appropriately filing a request  
5 for an administrative hearing, the appellant re-  
6 quests a determination by the appropriate re-  
7 view entity that the Departmental Appeals  
8 Board does not have the authority to decide the  
9 question of law or regulations relevant to the  
10 matters in controversy and that there is no ma-  
11 terial issue of fact in dispute and if such re-  
12 quest is accompanied by the documents and  
13 materials as the appropriate review entity shall  
14 require for purposes of making such determina-  
15 tion, such review entity shall make a determina-  
16 tion on the request in writing within 60 days  
17 after the date such review entity receives the re-  
18 quest and such accompanying documents and  
19 materials. Such a determination by such review  
20 entity shall be considered a final decision and  
21 not subject to review by the Secretary.

22 “(C) ACCESS TO JUDICIAL REVIEW.—

23 “(i) IN GENERAL.—If the appropriate  
24 review entity—

1           “(I) determines that there are no  
2 material issues of fact in dispute and  
3 that the only issue is one of law or  
4 regulation that the Departmental Ap-  
5 peals Board does not have authority  
6 to decide; or

7           “(II) fails to make such deter-  
8 mination within the period provided  
9 under subparagraph (B);

10 then the appellant may bring a civil action  
11 as described in this subparagraph.

12           “(ii) DEADLINE FOR FILING.—Such  
13 action shall be filed, in the case described  
14 in—

15           “(I) clause (i)(I), within 60 days  
16 of the date of the determination de-  
17 scribed in such clause; or

18           “(II) clause (i)(II), within 60  
19 days of the end of the period provided  
20 under subparagraph (B) for the deter-  
21 mination.

22           “(iii) VENUE.—Such action shall be  
23 brought in the district court of the United  
24 States for the judicial district in which the  
25 appellant is located (or, in the case of an

1 action brought jointly by more than one  
2 applicant, the judicial district in which the  
3 greatest number of applicants are located)  
4 or in the district court for the District of  
5 Columbia.

6 “(iv) INTEREST ON ANY AMOUNTS IN  
7 CONTROVERSY.—Where a provider of serv-  
8 ices or supplier is granted judicial review  
9 pursuant to this paragraph, the amount in  
10 controversy (if any) shall be subject to an-  
11 nual interest beginning on the first day of  
12 the first month beginning after the 60-day  
13 period as determined pursuant to clause  
14 (ii) and equal to the rate of interest on ob-  
15 ligations issued for purchase by the Fed-  
16 eral Supplementary Medical Insurance  
17 Trust Fund for the month in which the  
18 civil action authorized under this para-  
19 graph is commenced, to be awarded by the  
20 reviewing court in favor of the prevailing  
21 party. No interest awarded pursuant to the  
22 preceding sentence shall be deemed income  
23 or cost for the purposes of determining re-  
24 imbursement due providers of services,

1 physicians, practitioners, and other sup-  
2 pliers under this Act.

3 “(D) REVIEW ENTITY DEFINED.—For pur-  
4 poses of this subsection, the term ‘review entity’  
5 means an entity of up to 3 qualified reviewers  
6 drawn from existing appeals levels other than  
7 the redetermination level.”.

8 (b) APPLICATION TO PROVIDER AGREEMENT DETER-  
9 MINATIONS.—Section 1866(h)(1) (42 U.S.C.  
10 1395cc(h)(1)) is amended—

11 (1) by inserting “(A)” after “(h)(1)”; and

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

14 “(B) An institution or agency described in subpara-  
15 graph (A) that has filed for a hearing under subparagraph  
16 (A) shall have expedited access to judicial review under  
17 this subparagraph in the same manner as providers of  
18 services, suppliers, and beneficiaries may obtain expedited  
19 access to judicial review under the process established  
20 under section 1869(b)(2). Nothing in this subparagraph  
21 shall be construed to affect the application of any remedy  
22 imposed under section 1819 during the pendency of an  
23 appeal under this subparagraph.”.

1           (c)           CONFORMING           AMENDMENT.—Section  
2 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is  
3 amended to read as follows:

4                           “(ii) REFERENCE TO EXPEDITED AC-  
5                           CESS TO JUDICIAL REVIEW.—For the pro-  
6                           vision relating to expedited access to judi-  
7                           cial review, see paragraph (2).”.

8           (d) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to appeals filed on or after October  
10 1, 2004.

11 **SEC. 203. COST REPORT REFORM.**

12           (a) REPORT.—Not later than the date that is 1 year  
13 after the date of enactment of this Act, the Secretary shall  
14 submit to the Committee on Finance of the Senate and  
15 the Committees on Ways and Means and Energy and  
16 Commerce of the House of Representatives a report rec-  
17 ommending specific ways to modernize the cost reporting  
18 system under the medicare program under title XVIII of  
19 the Social Security Act (42 U.S.C. 1395 et seq.). Such  
20 report shall be consistent with the recommendations of the  
21 Secretary’s Advisory Committee on Regulatory Reform,  
22 including the use of Generally Accepted Accounting Prin-  
23 ciples.

24           (b) CONSULTATION.—In developing the report sub-  
25 mitted under subsection (a), the Secretary shall consult

1 with representatives of the hospital industry, the Medicare  
 2 Payment Advisory Commission, the General Accounting  
 3 Office, and such other individuals and entities as the Sec-  
 4 retary determines to be appropriate.

5 **SEC. 204. EXPEDITED REVIEW OF CERTAIN PROVIDER**  
 6 **AGREEMENT DETERMINATIONS.**

7 (a) **TERMINATION AND CERTAIN OTHER IMMEDIATE**  
 8 **REMEDIES.—**

9 (1) **IN GENERAL.—**The Secretary shall develop  
 10 and implement a process to expedite proceedings  
 11 under sections 1866(h) of the Social Security Act  
 12 (42 U.S.C. 1395cc(h)) in which—

13 (A) the remedy of termination of participa-  
 14 tion has been imposed;

15 (B) a sanction described in clause (i) or  
 16 (iii) of section 1819(h)(2)(B) of such Act (42  
 17 U.S.C. 1395i-3(h)(2)(B)) has been imposed,  
 18 but only if such sanction has been imposed on  
 19 an immediate basis; or

20 (C) the Secretary has required a skilled  
 21 nursing facility to suspend operations of a  
 22 nurse aide training program.

23 (2) **PRIORITY FOR CASES OF TERMINATION.—**

24 Under the process described in paragraph (1), pri-

1 ority shall be provided in cases of termination de-  
 2 scribed in subparagraph (A) of such paragraph.

3 (b) INCREASED FINANCIAL SUPPORT.—In addition  
 4 to any amounts otherwise appropriated, to reduce by 50  
 5 percent the average time for administrative determina-  
 6 tions on appeals under section 1866(h) of the Social Secu-  
 7 rity Act (42 U.S.C. 1395cc(h)), there are authorized to  
 8 be appropriated (in appropriate part from the Federal  
 9 Hospital Insurance Trust Fund and the Federal Supple-  
 10 mentary Medical Insurance Trust Fund) to the Secretary  
 11 such sums for fiscal year 2004 and each subsequent fiscal  
 12 year as may be necessary to increase the number of ad-  
 13 ministrative law judges (and their staffs) at the Depart-  
 14 mental Appeals Board of the Department of Health and  
 15 Human Services and to educate such judges and staff on  
 16 long-term care issues.

17 **SEC. 205. REVISIONS TO MEDICARE APPEALS PROCESS.**

18 (a) TIMEFRAMES FOR THE COMPLETION OF THE  
 19 RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as  
 20 amended by section 202(a)(2), is amended by adding at  
 21 the end the following new paragraph:

22 “(3) TIMELY COMPLETION OF THE RECORD.—  
 23 “(A) DEADLINE.—Subject to subpara-  
 24 graph (B), the deadline to complete the record  
 25 in a hearing before an administrative law judge

1 or a review by the Departmental Appeals Board  
2 is 90 days after the date the request for the re-  
3 view or hearing is filed.

4 “(B) EXTENSIONS FOR GOOD CAUSE.—  
5 The person filing a request under subparagraph  
6 (A) may request an extension of such deadline  
7 for good cause. The administrative law judge,  
8 in the case of a hearing, and the Departmental  
9 Appeals Board, in the case of a review, may ex-  
10 tend such deadline based upon a finding of  
11 good cause to a date specified by the judge or  
12 Board, as the case may be.

13 “(C) DELAY IN DECISION DEADLINES  
14 UNTIL COMPLETION OF RECORD.—Notwith-  
15 standing any other provision of this section, the  
16 deadlines otherwise established under sub-  
17 section (d) for the making of determinations in  
18 hearings or review under this section are 90  
19 days after the date on which the record is com-  
20 plete.

21 “(D) COMPLETE RECORD DESCRIBED.—  
22 For purposes of this paragraph, a record is  
23 complete when the administrative law judge, in  
24 the case of a hearing, or the Departmental Ap-

1 peals Board, in the case of a review, has re-  
2 ceived—

3 “(i) written or testimonial evidence, or  
4 both, submitted by the person filing the re-  
5 quest,

6 “(ii) written or oral argument, or  
7 both,

8 “(iii) the decision of, and the record  
9 for, the prior level of appeal, and

10 “(iv) such other evidence as such  
11 judge or Board, as the case may be, deter-  
12 mines is required to make a determination  
13 on the request.”.

14 (b) REVISIONS TO APPEALS TIMEFRAMES.—Section  
15 1869 (42 U.S.C. 1395ff) is amended—

16 (1) in subsection (a)(3)(C)(ii), by striking “30-  
17 day period” each place it appears and inserting “60-  
18 day period”;

19 (2) in subsection (c)(3)(C)(i), by striking “30-  
20 day period” and inserting “60-day period”;

21 (3) in subsection (d)(1)(A), by striking “90-day  
22 period” and inserting “120-day period”; and

23 (4) in subsection (d)(2)(A), by striking “90-day  
24 period” and inserting “120-day period”.

1           (c) USE OF PATIENTS' MEDICAL RECORDS.—Section  
 2 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amend-  
 3 ed by inserting “(including the medical records of the indi-  
 4 vidual involved)” after “clinical experience”.

5           (d) NOTICE REQUIREMENTS FOR MEDICARE AP-  
 6 PEALS.—

7           (1) INITIAL DETERMINATIONS AND REDETER-  
 8 MINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a))  
 9 is amended by adding at the end the following new  
 10 paragraph:

11           “(4) REQUIREMENTS OF NOTICE OF DETER-  
 12 MINATIONS AND REDETERMINATIONS.—A written  
 13 notice of a determination on an initial determination  
 14 or on a redetermination, insofar as such determina-  
 15 tion or redetermination results in a denial of a claim  
 16 for benefits, shall be provided in printed form and  
 17 written in a manner to be understood by the bene-  
 18 ficiary and shall include—

19           “(A) the reasons for the determination, in-  
 20 cluding, as appropriate—

21           “(i) upon request in the case of an  
 22 initial determination, the provision of the  
 23 policy, manual, or regulation that resulted  
 24 in the denial; and

1                   “(ii) upon request, in the case of a re-  
2                   determination, a summary of the clinical or  
3                   scientific evidence used in making the de-  
4                   termination (as appropriate);

5                   “(B) the procedures for obtaining addi-  
6                   tional information concerning the determination  
7                   or redetermination; and

8                   “(C) notification of the right to seek a re-  
9                   determination or otherwise appeal the deter-  
10                  mination and instructions on how to initiate  
11                  such a redetermination or appeal under this  
12                  section.”.

13                  (2)                   RECONSIDERATIONS.—Section  
14                  1869(e)(3)(E) (42 U.S.C. 1395ff(e)(3)(E)) is  
15                  amended to read as follows:

16                  “(E) EXPLANATION OF DECISION.—Any  
17                  decision with respect to a reconsideration of a  
18                  qualified independent contractor shall be in  
19                  writing in a manner to be understood by the  
20                  beneficiary and shall include—

21                  “(i) to the extent appropriate, an ex-  
22                  planation of the decision as well as a dis-  
23                  cussion of the pertinent facts and applica-  
24                  ble regulations applied in making such de-  
25                  cision;

1           “(ii) a notification of the right to ap-  
2           peal such determination and instructions  
3           on how to initiate such appeal under this  
4           section; and

5           “(iii) in the case of a determination of  
6           whether an item or service is reasonable  
7           and necessary for the diagnosis or treat-  
8           ment of illness or injury (under section  
9           1862(a)(1)(A)) an explanation of the deci-  
10          sion.”.

11          (3) APPEALS.—Section 1869(d) (42 U.S.C.  
12          1395ff(d)) is amended—

13                (A) in the heading, by inserting “; NO-  
14                TICE” after “SECRETARY”; and

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

17                “(4) NOTICE.—Notice of the decision of an ad-  
18                ministrative law judge shall be in writing in a man-  
19                ner to be understood by the beneficiary and shall in-  
20                clude—

21                    “(A) the specific reasons for the deter-  
22                    mination; and

23                    “(B) notification of the right to appeal the  
24                    decision and instructions on how to initiate  
25                    such an appeal under this section.”.

1           (4) PREPARATION OF RECORD FOR APPEAL.—  
2           Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is  
3           amended by striking “such information as is re-  
4           quired for an appeal” and inserting “the record for  
5           the appeal”.

6           (e) QUALIFIED INDEPENDENT CONTRACTORS.—

7           (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED  
8           INDEPENDENT CONTRACTORS.—Section 1869(c) (42  
9           U.S.C. 1395ff(c)) is amended—

10                   (A) in paragraph (2)—

11                           (i) by inserting “(except in the case of  
12                           a utilization and quality control peer re-  
13                           view organization, as defined in section  
14                           1152)” after “means an entity or organi-  
15                           zation that”; and

16                           (ii) by striking the period at the end  
17                           and inserting the following: “and meets the  
18                           following requirements:

19                                   “(A) GENERAL REQUIREMENTS.—

20   “(i) The entity or organization has  
21   (directly or through contracts or other ar-  
22   rangements) sufficient medical, legal, and  
23   other expertise (including knowledge of the  
24   program under this title) and sufficient  
25   staffing to carry out duties of a qualified

1 independent contractor under this section  
2 on a timely basis.

3 “(ii) The entity or organization has  
4 provided assurances that it will conduct ac-  
5 tivities consistent with the applicable re-  
6 quirements of this section, including that it  
7 will not conduct any activities in a case un-  
8 less the independence requirements of sub-  
9 paragraph (B) are met with respect to the  
10 case.

11 “(iii) The entity or organization meets  
12 such other requirements as the Secretary  
13 provides by regulation.

14 “(B) INDEPENDENCE REQUIREMENTS.—

15 “(i) IN GENERAL.—Subject to clause  
16 (ii), an entity or organization meets the  
17 independence requirements of this sub-  
18 paragraph with respect to any case if the  
19 entity—

20 “(I) is not a related party (as de-  
21 fined in subsection (g)(5));

22 “(II) does not have a material fa-  
23 miliary, financial, or professional rela-  
24 tionship with such a party in relation  
25 to such case; and

1                   “(III) does not otherwise have a  
2                   conflict of interest with such a party  
3                   (as determined under regulations).

4                   “(ii) EXCEPTION FOR COMPENSA-  
5                   TION.—Nothing in clause (i) shall be con-  
6                   strued to prohibit receipt by a qualified  
7                   independent contractor of compensation  
8                   from the Secretary for the conduct of ac-  
9                   tivities under this section if the compensa-  
10                  tion is provided consistent with clause (iii).

11                  “(iii) LIMITATIONS ON ENTITY COM-  
12                  PENSATION.—Compensation provided by  
13                  the Secretary to a qualified independent  
14                  contractor in connection with reviews  
15                  under this section shall not be contingent  
16                  on any decision rendered by the contractor  
17                  or by any reviewing professional.”; and

18                  (B) in paragraph (3)(A), by striking “,  
19                  and shall have sufficient training and expertise  
20                  in medical science and legal matters to make  
21                  reconsiderations under this subsection”.

22                  (2) ELIGIBILITY REQUIREMENTS OF REVIEW-  
23                  ERS.—Section 1869 (42 U.S.C. 1395ff) is amend-  
24                  ed—

1 (A) in subsection (c)(3)(B)(i), by striking  
2 “a panel of physicians or other appropriate  
3 health care professionals” and inserting “a phy-  
4 sician or another appropriate health care pro-  
5 fessional”;

6 (B) by striking subsection (c)(3)(D) and  
7 inserting the following:

8 “(D) QUALIFICATIONS FOR REVIEWERS.—  
9 The requirements of subsection (g) shall be met  
10 (relating to qualifications of reviewing profes-  
11 sionals).”; and

12 (C) by adding at the end the following new  
13 subsection:

14 “(g) QUALIFICATIONS OF REVIEWERS.—

15 “(1) IN GENERAL.—In reviewing determina-  
16 tions under this section, a qualified independent con-  
17 tractor shall ensure that—

18 “(A) each individual conducting a review  
19 shall meet the qualifications of paragraph (2);

20 “(B) compensation provided by the con-  
21 tractor to each such reviewer is consistent with  
22 paragraph (3); and

23 “(C) in the case of a review described in  
24 subsection (c)(3)(B) and conducted by a physi-  
25 cian or another health care professional (each

1 in this subsection referred to as a ‘reviewing  
2 professional’), that the reviewing professional  
3 meets the qualifications described in paragraph  
4 (4).

5 “(2) INDEPENDENCE.—

6 “(A) IN GENERAL.—Subject to subpara-  
7 graph (B), each individual conducting a review  
8 in a case shall—

9 “(i) not be a related party (as defined  
10 in paragraph (5));

11 “(ii) not have a material familial, fi-  
12 nancial, or professional relationship with  
13 such a party in the case under review; and

14 “(iii) not otherwise have a conflict of  
15 interest with such a party (as determined  
16 under regulations).

17 “(B) EXCEPTION.—Nothing in subpara-  
18 graph (A) shall be construed to—

19 “(i) prohibit an individual, solely on  
20 the basis of affiliation with a fiscal inter-  
21 mediary, carrier, or other contractor, from  
22 serving as a reviewing professional if—

23 “(I) a nonaffiliated individual is  
24 not reasonably available;

1           “(II) the affiliated individual is  
2 not involved in the provision of items  
3 or services in the case under review;

4           “(III) the fact of such an affili-  
5 ation is disclosed to the Secretary and  
6 the beneficiary (or authorized rep-  
7 resentative) and neither party objects;  
8 and

9           “(IV) the affiliated individual is  
10 not an employee of the intermediary,  
11 carrier, or contractor and does not  
12 provide services exclusively or pri-  
13 marily to or on behalf of such inter-  
14 mediary, carrier, or contractor;

15           “(ii) prohibit an individual who has  
16 staff privileges at the institution where the  
17 treatment involved takes place from serv-  
18 ing as a reviewer merely on the basis of  
19 such affiliation if the affiliation is disclosed  
20 to the Secretary and the beneficiary (or  
21 authorized representative), and neither  
22 party objects; or

23           “(iii) prohibit receipt of compensation  
24 by a reviewing professional from a con-

1 tractor if the compensation is provided  
2 consistent with paragraph (3).

3 “(3) LIMITATIONS ON REVIEWER COMPENSA-  
4 TION.—Compensation provided by a qualified inde-  
5 pendent contractor to a reviewer in connection with  
6 a review under this section shall not be contingent  
7 on the decision rendered by the reviewer.

8 “(4) LICENSURE AND EXPERTISE.—Each re-  
9 viewing professional shall be a physician (allopathic  
10 or osteopathic) or health care professional who—

11 “(A) is appropriately credentialed or li-  
12 censed in 1 or more States to deliver health  
13 care services; and

14 “(B) has medical expertise in the field of  
15 practice that is appropriate for the items or  
16 services at issue.

17 “(5) RELATED PARTY DEFINED.—For purposes  
18 of this section, the term ‘related party’ means, with  
19 respect to a case under this title involving an indi-  
20 vidual beneficiary, any of the following:

21 “(A) The Secretary, the medicare adminis-  
22 trative contractor involved, or any fiduciary, of-  
23 ficer, director, or employee of the Department  
24 of Health and Human Services, or of such con-  
25 tractor.

1           “(B) The individual (or authorized rep-  
2           representative).

3           “(C) The health care professional that pro-  
4           vides the items or services involved in the case.

5           “(D) The institution at which the items or  
6           services (or treatment) involved in the case are  
7           provided.

8           “(E) The manufacturer of any drug or  
9           other item that is included in the items or serv-  
10          ices involved in the case.

11          “(F) Any other party determined under  
12          any regulations to have a substantial interest in  
13          the case involved.”.

14          (3) NUMBER OF QUALIFIED INDEPENDENT  
15          CONTRACTORS.—Section 1869(c)(4) (42 U.S.C.  
16          1395ff(c)(4)) is amended by striking “12” and in-  
17          serting “4”.

18          (e) IMPLEMENTATION OF CERTAIN BIPA RE-  
19          FORMS.—

20          (1) DELAY IN CERTAIN BIPA REFORMS.—Sec-  
21          tion 521(d) of BIPA (114 Stat. 2763A–543) is  
22          amended to read as follows:

23          “(d) EFFECTIVE DATE.—

24          “(1) IN GENERAL.—Except as specified in  
25          paragraph (2), the amendments made by this section

1 shall apply with respect to initial determinations  
2 made on or after January 1, 2005.

3 “(2) EXPEDITED PROCEEDINGS AND RECONSID-  
4 ERATION REQUIREMENTS.—The amendments made  
5 by subsection (a) shall apply with respect to initial  
6 determinations made on or after October 1, 2003  
7 under the following provisions:

8 “(A) Subsection (b)(1)(F)(i) of section  
9 1869 of the Social Security Act.

10 “(B) Subsection (c)(3)(C)(iii) of such sec-  
11 tion.

12 “(C) Subsection (c)(3)(C)(iv) of such sec-  
13 tion to the extent that it applies to expedited  
14 reconsiderations under subsection (c)(3)(C)(iii)  
15 of such section.

16 “(3) TRANSITIONAL USE OF PEER REVIEW OR-  
17 GANIZATIONS TO CONDUCT EXPEDITED RECONSID-  
18 ERATIONS UNTIL QICS ARE OPERATIONAL.—Expe-  
19 dited reconsiderations of initial determinations under  
20 section 1869(c)(3)(C)(iii) of the Social Security Act  
21 shall be made by peer review organizations until  
22 qualified independent contractors are available for  
23 such expedited reconsiderations.”.

24 (2) CONFORMING AMENDMENT.—Section  
25 521(c) of BIPA (114 Stat. 2763A–543) and section

1 1869(e)(3)(C)(iii)(III) of the Social Security Act (42  
2 U.S.C. 1395ff(e)(3)(C)(iii)(III)), as added by section  
3 521 of BIPA, are repealed.

4 (f) EFFECTIVE DATE.—The amendments made by  
5 this section shall be effective as if included in the enact-  
6 ment of the respective provisions of subtitle C of title V  
7 of BIPA, 114 Stat. 2763A–534.

8 (g) TRANSITION.—In applying section 1869(g) of the  
9 Social Security Act (as added by subsection (d)(2)), any  
10 reference to a medicare administrative contractor shall be  
11 deemed to include a reference to a fiscal intermediary  
12 under section 1816 of the Social Security Act (42 U.S.C.  
13 1395h) and a carrier under section 1842 of such Act (42  
14 U.S.C. 1395u).

15 **SEC. 206. HEARING RIGHTS RELATED TO DECISIONS BY**  
16 **THE SECRETARY TO DENY OR NOT RENEW A**  
17 **MEDICARE ENROLLMENT AGREEMENT; CON-**  
18 **SULTATION BEFORE CHANGING PROVIDER**  
19 **ENROLLMENT FORMS.**

20 (a) HEARING RIGHTS.—

21 (1) IN GENERAL.—Section 1866 (42 U.S.C.  
22 1395cc) is amended by adding at the end the fol-  
23 lowing new subsection:

1       “(j) HEARING RIGHTS IN CASES OF DENIAL OR  
2 NONRENEWAL.—The Secretary shall establish by regula-  
3 tion procedures under which—

4               “(1) there are deadlines for actions on applica-  
5 tions for enrollment (and, if applicable, renewal of  
6 enrollment); and

7               “(2) a provider of services or supplier whose ap-  
8 plication to enroll (or, if applicable, to renew enroll-  
9 ment) under this title is denied may have a hearing  
10 and judicial review of such denial under the proce-  
11 dures that apply under subsection (h)(1)(A) to a  
12 provider of services that is dissatisfied with a deter-  
13 mination by the Secretary.”.

14               (2) EFFECTIVE DATE.—The Secretary shall  
15 provide for the establishment of the procedures  
16 under the amendment made by paragraph (1) within  
17 18 months after the date of the enactment of this  
18 Act.

19       (b) CONSULTATION BEFORE CHANGING PROVIDER  
20 ENROLLMENT FORMS.—Section 1871 (42 U.S.C.  
21 1395hh), as amended by sections 101, 102, and 103, is  
22 amended by adding at the end the following new sub-  
23 section:

24               “(g) The Secretary shall consult with providers of  
25 services, physicians, practitioners, and suppliers before

1 making changes in the provider enrollment forms required  
2 of such providers, physicians, practitioners, and suppliers  
3 to be eligible to submit claims for which payment may be  
4 made under this title.”.

5 **SEC. 207. APPEALS BY PROVIDERS WHEN THERE IS NO**  
6 **OTHER PARTY AVAILABLE.**

7 (a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg)  
8 is amended by adding at the end the following new sub-  
9 section:

10 “(h) Notwithstanding subsection (f) or any other pro-  
11 vision of law, the Secretary shall permit a provider of serv-  
12 ices, physician, practitioner, or other supplier to appeal  
13 any determination of the Secretary under this title relating  
14 to services rendered under this title to an individual who  
15 subsequently dies if there is no other party available to  
16 appeal such determination and the provider of services,  
17 physician, practitioner, or other supplier would be preju-  
18 diced by the determination.”.

19 (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) shall take effect on the date of the enact-  
21 ment of this Act and shall apply to items and services fur-  
22 nished on or after such date.

1 **SEC. 208. PROVIDER ACCESS TO REVIEW OF LOCAL COV-**  
 2 **ERAGE DETERMINATIONS.**

3 (a) PROVIDER ACCESS TO REVIEW OF LOCAL COV-  
 4 ERAGE DETERMINATIONS.—Section 1869(f)(5) (42  
 5 U.S.C. 1395ff(f)(5)) is amended to read as follows:

6 “(5) AGGRIEVED PARTY DEFINED.—In this sec-  
 7 tion, with respect to a national or local coverage de-  
 8 termination, the term ‘aggrieved party’ means—

9 “(A) an individual entitled to benefits  
 10 under part A, or enrolled under part B, or both,  
 11 who is in need of the items or services that are  
 12 the subject of the coverage determination; or

13 “(B) a provider of services, physician,  
 14 practitioner, or supplier that is adversely af-  
 15 fected by such a determination.”.

16 (b) CLARIFICATION OF LOCAL COVERAGE DETER-  
 17 MINATION DEFINITION.—Section 1869(f)(2)(B) (42  
 18 U.S.C. 1395ff(f)(2)(B)) is amended by inserting “, includ-  
 19 ing, where appropriate, a clear explanation of the reasons  
 20 for the denial” before the period at the end.

21 (c) REQUEST FOR LOCAL COVERAGE DETERMINA-  
 22 TIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff),  
 23 as amended by section 205(d)(2)(B), is amended by add-  
 24 ing at the end the following new subsection:

25 “(h) REQUEST FOR LOCAL COVERAGE DETERMINA-  
 26 TIONS BY PROVIDERS.—

1           “(1) ESTABLISHMENT OF PROCESS.—The Sec-  
2           retary shall establish a process under which a pro-  
3           vider of services, physician, practitioner, or supplier  
4           who certifies that they meet the requirements estab-  
5           lished in paragraph (3) may request a local coverage  
6           determination in accordance with the succeeding  
7           provisions of this subsection.

8           “(2) PROVIDER LOCAL COVERAGE DETERMINA-  
9           TION REQUEST DEFINED.—In this subsection, the  
10          term ‘provider local coverage determination request’  
11          means a request, filed with the Secretary, at such  
12          time and in such form and manner as the Secretary  
13          may specify, that the Secretary, pursuant to para-  
14          graph (4)(A), require a fiscal intermediary, carrier,  
15          or program safeguard contractor to make or revise  
16          a local coverage determination under this section  
17          with respect to an item or service.

18          “(3) REQUEST REQUIREMENTS.—Under the  
19          process established under paragraph (1), by not  
20          later than 30 days after the date on which a pro-  
21          vider local coverage determination request is filed  
22          under paragraph (1), the Secretary shall determine  
23          whether such request establishes that—

24                         “(A) there have been at least 5 reversals of  
25                         redeterminations made by a fiscal intermediary

1 or carrier after a hearing before an administra-  
2 tive law judge on claims submitted by the pro-  
3 vider in at least 2 different cases before an ad-  
4 ministrative law judge;

5 “(B) each reversal described in subpara-  
6 graph (A) involves substantially similar mate-  
7 rial facts;

8 “(C) each reversal described in subpara-  
9 graph (A) involves the same medical necessity  
10 issue; and

11 “(D) at least 50 percent of the total num-  
12 ber of claims submitted by such provider within  
13 the past year involving the substantially similar  
14 material facts described in subparagraph (B)  
15 and the same medical necessity issue described  
16 in subparagraph (C) have been denied and have  
17 been reversed by an administrative law judge.

18 “(4) APPROVAL OR REJECTION OF REQUEST.—

19 “(A) APPROVAL OF REQUEST.—If the Sec-  
20 retary determines that subparagraphs (A)  
21 through (D) of paragraph (3) have been satis-  
22 fied, the Secretary shall require the fiscal inter-  
23 mediary, carrier, or program safeguard con-  
24 tractor identified in the provider local coverage  
25 determination request, to make or revise a local

1 coverage determination with respect to the item  
2 or service that is the subject of the request not  
3 later than the date that is 210 days after the  
4 date on which the Secretary makes the deter-  
5 mination. Such fiscal intermediary, carrier, or  
6 program safeguard contractor shall retain the  
7 discretion to determine whether or not, and/or  
8 the circumstances under which, to cover the  
9 item or service for which a local coverage deter-  
10 mination is requested. Nothing in this sub-  
11 section shall be construed to require a fiscal  
12 intermediary, carrier or program safeguard con-  
13 tractor to develop a local coverage determina-  
14 tion that is inconsistent with any national cov-  
15 erage determination, or any coverage provision  
16 in this title or in regulation, manual, or inter-  
17 pretive guidance of the Secretary.

18 “(B) REJECTION OF REQUEST.—If the  
19 Secretary determines that subparagraphs (A)  
20 through (D) of paragraph (3) have not been  
21 satisfied, the Secretary shall reject the provider  
22 local coverage determination request and shall  
23 notify the provider of services, physician, practi-  
24 tioner, or supplier that filed the request of the  
25 reason for such rejection and no further pro-

1           ceedings in relation to such request shall be  
2           conducted.”.

3           (d) STUDY AND REPORT ON THE USE OF CONTRAC-  
4           TORS TO MONITOR MEDICARE APPEALS.—

5           (1) STUDY.—The Secretary of Health and  
6           Human Services (in this section referred to as the  
7           “Secretary”) shall conduct a study on the feasibility  
8           and advisability of requiring fiscal intermediaries  
9           and carriers to monitor and track—

10                   (A) the subject matter and status of claims  
11                   denied by the fiscal intermediary or carrier (as  
12                   applicable) that are appealed under section  
13                   1869 of the Social Security Act (42 U.S.C.  
14                   1395ff), as added by section 522 of BIPA (114  
15                   Stat. 2763A–543) and amended by this Act;  
16                   and

17                   (B) any final determination made with re-  
18                   spect to such claims.

19           (2) REPORT.—Not later than the date that is  
20           1 year after the date of the enactment of this Act,  
21           the Secretary shall submit to Congress a report on  
22           the study conducted under paragraph (1) together  
23           with such recommendations for legislation and ad-  
24           ministrative action as the Commission determines  
25           appropriate.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
2 are authorized to be appropriated such sums as are nec-  
3 essary to carry out the amendments made by subsections  
4 (a), (b), and (c).

5 (f) EFFECTIVE DATES.—

6 (1) PROVIDER ACCESS TO REVIEW OF LOCAL  
7 COVERAGE DETERMINATIONS.—The amendments  
8 made by subsections (a) and (b) shall apply to—

9 (A) any review of any local coverage deter-  
10 mination filed on or after January 1, 2004;

11 (B) any request to make such a determina-  
12 tion made on or after such date; or

13 (C) any local coverage determination made  
14 on or after such date.

15 (2) PROVIDER LOCAL COVERAGE DETERMINA-  
16 TION REQUESTS.—The amendment made by sub-  
17 section (c) shall apply with respect to provider local  
18 coverage determination requests (as defined in sec-  
19 tion 1869(h)(2) of the Social Security Act, as added  
20 by subsection (c)) filed on or after the date of the  
21 enactment of this Act.

1           **TITLE III—CONTRACTING**  
2                           **REFORM**

3   **SEC. 301. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-**  
4                           **TRATION.**

5           (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE  
6 ADMINISTRATION.—

7           (1) IN GENERAL.—Title XVIII is amended by  
8 inserting after section 1874 the following new sec-  
9 tion:

10           “CONTRACTS WITH MEDICARE ADMINISTRATIVE  
11                           CONTRACTORS

12           “SEC. 1874A. (a) AUTHORITY.—

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

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

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

3           “(B) the entity complies with such conflict  
4           of interest standards as are generally applicable  
5           to Federal acquisition and procurement;

6           “(C) the entity has sufficient assets to fi-  
7           nancially support the performance of such func-  
8           tion; and

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

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

13                 “(A) IN GENERAL.—The term ‘medicare  
14                 administrative contractor’ means an agency, or-  
15                 ganization, or other person with a contract  
16                 under this section.

17                 “(B) APPROPRIATE MEDICARE ADMINIS-  
18                 TRATIVE CONTRACTOR.—With respect to the  
19                 performance of a particular function in relation  
20                 to an individual entitled to benefits under part  
21                 A or enrolled under part B, or both, a specific  
22                 provider of services, physician, practitioner, fa-  
23                 cility, or supplier (or class of such providers of  
24                 services, physicians, practitioners, facilities, or  
25                 suppliers), the ‘appropriate’ medicare adminis-

1           trative contractor is the medicare administra-  
2           tive contractor that has a contract under this  
3           section with respect to the performance of that  
4           function in relation to that individual, provider  
5           of services, physician, practitioner, facility, or  
6           supplier or class of provider of services, physi-  
7           cian, practitioner, facility, or supplier.

8           “(4) FUNCTIONS DESCRIBED.—The functions  
9           referred to in paragraphs (1) and (2) are payment  
10          functions, provider services functions, and bene-  
11          ficiary services functions as follows:

12                 “(A) DETERMINATION OF PAYMENT  
13                 AMOUNTS.—Determining (subject to the provi-  
14                 sions of section 1878 and to such review by the  
15                 Secretary as may be provided for by the con-  
16                 tracts) the amount of the payments required  
17                 pursuant to this title to be made to providers  
18                 of services, physicians, practitioners, facilities,  
19                 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.—Serving as a center for, and com-

1           communicating to individuals entitled to benefits  
2           under part A or enrolled under part B, or both,  
3           with respect to education and outreach for  
4           those individuals, and assistance with specific  
5           issues, concerns, or problems of those individ-  
6           uals.

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

14          “(E) COMMUNICATION WITH PRO-  
15          VIDERS.—Serving as a center for, and commu-  
16          nicating to providers of services, physicians,  
17          practitioners, facilities, and suppliers, any infor-  
18          mation or instructions furnished to the medi-  
19          care administrative contractor by the Secretary,  
20          and serving as a channel of communication  
21          from such providers, physicians, practitioners,  
22          facilities, and suppliers to the Secretary.

23          “(F) PROVIDER EDUCATION AND TECH-  
24          NICAL ASSISTANCE.—Performing the functions  
25          described in subsections (e) and (f), relating to

1 education, training, and technical assistance to  
2 providers of services, physicians, practitioners,  
3 facilities, and suppliers.

4 “(G) ADDITIONAL FUNCTIONS.—Per-  
5 forming such other functions, including (subject  
6 to paragraph (5)) functions under the Medicare  
7 Integrity Program under section 1893, as are  
8 necessary to carry out the purposes of this title.

9 “(5) RELATIONSHIP TO MIP CONTRACTS.—

10 “(A) NONDUPLICATION OF ACTIVITIES.—  
11 In entering into contracts under this section,  
12 the Secretary shall assure that activities of  
13 medicare administrative contractors do not du-  
14 plicate activities carried out under contracts en-  
15 tered into under the Medicare Integrity Pro-  
16 gram under section 1893. The previous sen-  
17 tence shall not apply with respect to the activity  
18 described in section 1893(b)(5) (relating to  
19 prior authorization of certain items of durable  
20 medical equipment under section 1834(a)(15)).

21 “(B) CONSTRUCTION.—An entity shall not  
22 be treated as a medicare administrative con-  
23 tractor merely by reason of having entered into  
24 a contract with the Secretary under section  
25 1893.

1           “(6) APPLICATION OF FEDERAL ACQUISITION  
2 REGULATION.—Except to the extent inconsistent  
3 with a specific requirement of this title, the Federal  
4 Acquisition Regulation applies to contracts under  
5 this title.

6           “(b) CONTRACTING REQUIREMENTS.—

7           “(1) USE OF COMPETITIVE PROCEDURES.—

8           “(A) IN GENERAL.—Except as provided in  
9 laws with general applicability to Federal acqui-  
10 sition and procurement, the Federal Acquisition  
11 Regulation, or in subparagraph (B), the Sec-  
12 retary shall use competitive procedures when  
13 entering into contracts with medicare adminis-  
14 trative contractors under this section.

15           “(B) RENEWAL OF CONTRACTS.—The Sec-  
16 retary may renew a contract with a medicare  
17 administrative contractor under this section  
18 from term to term without regard to section 5  
19 of title 41, United States Code, or any other  
20 provision of law requiring competition, if the  
21 medicare administrative contractor has met or  
22 exceeded the performance requirements applica-  
23 ble with respect to the contract and contractor,  
24 except that the Secretary shall provide for the  
25 application of competitive procedures, unless

1 laws with general applicability to Federal acqui-  
2 sition and procurement or the Federal Acquisi-  
3 tion Regulation authorize the use of other pro-  
4 cedures, under such a contract not less fre-  
5 quently than once every 8 years.

6 “(C) TRANSFER OF FUNCTIONS.—The  
7 Secretary may transfer functions among medi-  
8 care administrative contractors without regard  
9 to any provision of law requiring competition.  
10 The Secretary shall ensure that performance  
11 quality is considered in such transfers. The Sec-  
12 retary shall provide notice (whether in the Fed-  
13 eral Register or otherwise) of any such transfer  
14 (including a description of the functions so  
15 transferred and contact information for the  
16 contractors involved) to providers of services,  
17 physicians, practitioners, facilities, and sup-  
18 pliers affected by the transfer.

19 “(D) INCENTIVES FOR QUALITY.—The  
20 Secretary may provide incentives for medicare  
21 administrative contractors to provide quality  
22 service and to promote efficiency.

23 “(2) COMPLIANCE WITH REQUIREMENTS.—No  
24 contract under this section shall be entered into with  
25 any medicare administrative contractor unless the

1 Secretary finds that such medicare administrative  
2 contractor will perform its obligations under the con-  
3 tract efficiently and effectively and will meet such  
4 requirements as to financial responsibility, legal au-  
5 thority, and other matters as the Secretary finds  
6 pertinent.

7 “(3) PERFORMANCE REQUIREMENTS.—

8 “(A) DEVELOPMENT OF SPECIFIC PER-  
9 FORMANCE REQUIREMENTS.—The Secretary  
10 shall develop contract performance require-  
11 ments to carry out the specific requirements ap-  
12 plicable under this title to a function described  
13 in subsection (a)(4) and shall develop standards  
14 for measuring the extent to which a contractor  
15 has met such requirements. In developing such  
16 performance requirements and standards for  
17 measurement, the Secretary shall consult with  
18 providers of services, organizations representa-  
19 tive of beneficiaries under this title, and organi-  
20 zations and agencies performing functions nec-  
21 essary to carry out the purposes of this section  
22 with respect to such performance requirements.  
23 The Secretary shall make such performance re-  
24 quirements and measurement standards avail-  
25 able to the public.

1           “(B) CONSIDERATIONS.—The Secretary  
2 shall include, as one of the standards, provider  
3 and beneficiary satisfaction levels.

4           “(C) INCLUSION IN CONTRACTS.—All con-  
5 tractor performance requirements shall be set  
6 forth in the contract between the Secretary and  
7 the appropriate medicare administrative con-  
8 tractor. Such performance requirements—

9                   “(i) shall reflect the performance re-  
10                   quirements published under subparagraph  
11                   (A), but may include additional perform-  
12                   ance requirements;

13                   “(ii) shall be used for evaluating con-  
14                   tractor performance under the contract;  
15                   and

16                   “(iii) shall be consistent with the writ-  
17                   ten statement of work provided under the  
18                   contract.

19           “(4) INFORMATION REQUIREMENTS.—The Sec-  
20 retary shall not enter into a contract with a medi-  
21 care administrative contractor under this section un-  
22 less the contractor agrees—

23                   “(A) to furnish to the Secretary such time-  
24                   ly information and reports as the Secretary may

1 find necessary in performing his functions  
2 under this title; and

3 “(B) to maintain such records and afford  
4 such access thereto as the Secretary finds nec-  
5 essary to assure the correctness and verification  
6 of the information and reports under subpara-  
7 graph (A) and otherwise to carry out the pur-  
8 poses of this title.

9 “(5) SURETY BOND.—A contract with a medi-  
10 care administrative contractor under this section  
11 may require the medicare administrative contractor,  
12 and any of its officers or employees certifying pay-  
13 ments or disbursing funds pursuant to the contract,  
14 or otherwise participating in carrying out the con-  
15 tract, to give surety bond to the United States in  
16 such amount as the Secretary may deem appro-  
17 priate.

18 “(c) TERMS AND CONDITIONS.—

19 “(1) IN GENERAL.—Subject to subsection  
20 (a)(6), a contract with any medicare administrative  
21 contractor under this section may contain such  
22 terms and conditions as the Secretary finds nec-  
23 essary or appropriate and may provide for advances  
24 of funds to the medicare administrative contractor

1 for the making of payments by it under subsection  
2 (a)(4)(B).

3 “(2) PROHIBITION ON MANDATES FOR CERTAIN  
4 DATA COLLECTION.—The Secretary may not require,  
5 as a condition of entering into, or renewing, a con-  
6 tract under this section, that the medicare adminis-  
7 trative contractor match data obtained other than in  
8 its activities under this title with data used in the  
9 administration of this title for purposes of identi-  
10 fying situations in which the provisions of section  
11 1862(b) may apply.

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

14 “(1) CERTIFYING OFFICER.—No individual des-  
15 ignated pursuant to a contract under this section as  
16 a certifying officer shall, in the absence of the reck-  
17 less disregard of the individual’s obligations or the  
18 intent by that individual to defraud the United  
19 States, be liable with respect to any payments cer-  
20 tified by the individual under this section.

21 “(2) DISBURSING OFFICER.—No disbursing of-  
22 ficer shall, in the absence of the reckless disregard  
23 of the officer’s obligations or the intent by that offi-  
24 cer to defraud the United States, be liable with re-  
25 spect to any payment by such officer under this sec-

1       tion if it was based upon an authorization (which  
2       meets the applicable requirements for such internal  
3       controls established by the Comptroller General) of  
4       a certifying officer designated as provided in para-  
5       graph (1) of this subsection.

6           “(3) LIABILITY OF MEDICARE ADMINISTRATIVE  
7       CONTRACTOR.—No medicare administrative con-  
8       tractor shall be liable to the United States for a pay-  
9       ment by a certifying or disbursing officer unless, in  
10      connection with such a payment, the medicare ad-  
11      ministrative contractor acted with reckless disregard  
12      of its obligations under its medicare administrative  
13      contract or with intent to defraud the United States.

14          “(4) RELATIONSHIP TO FALSE CLAIMS ACT.—  
15      Nothing in this subsection shall be construed to limit  
16      liability for conduct that would constitute a violation  
17      of sections 3729 through 3731 of title 31, United  
18      States Code (commonly known as the “False Claims  
19      Act”).

20          “(5) INDEMNIFICATION BY SECRETARY.—

21           “(A) IN GENERAL.—Notwithstanding any  
22      other provision of law and subject to the suc-  
23      ceeding provisions of this paragraph, in the case  
24      of a medicare administrative contractor (or a  
25      person who is a director, officer, or employee of

1 such a contractor or who is engaged by the con-  
2 tractor to participate directly in the claims ad-  
3 ministration process) who is made a party to  
4 any judicial or administrative proceeding aris-  
5 ing from, or relating directly to, the claims ad-  
6 ministration process under this title, the Sec-  
7 retary may, to the extent specified in the con-  
8 tract with the contractor, indemnify the con-  
9 tractor (and such persons).

10 “(B) CONDITIONS.—The Secretary may  
11 not provide indemnification under subparagraph  
12 (A) insofar as the liability for such costs arises  
13 directly from conduct that is determined by the  
14 Secretary to be criminal in nature, fraudulent,  
15 or grossly negligent.

16 “(C) SCOPE OF INDEMNIFICATION.—In-  
17 demnification by the Secretary under subpara-  
18 graph (A) may include payment of judgments,  
19 settlements (subject to subparagraph (D)),  
20 awards, and costs (including reasonable legal  
21 expenses).

22 “(D) WRITTEN APPROVAL FOR SETTLE-  
23 MENTS.—A contractor or other person de-  
24 scribed in subparagraph (A) may not propose to  
25 negotiate a settlement or compromise of a pro-

1           ceeding described in such subparagraph without  
2           the prior written approval of the Secretary to  
3           negotiate a settlement. Any indemnification  
4           under subparagraph (A) with respect to  
5           amounts paid under a settlement are condi-  
6           tioned upon the Secretary’s prior written ap-  
7           proval of the final settlement.

8           “(E) CONSTRUCTION.—Nothing in this  
9           paragraph shall be construed—

10                   “(i) to change any common law immu-  
11                   nity that may be available to a medicare  
12                   administrative contractor or person de-  
13                   scribed in subparagraph (A); or

14                   “(ii) to permit the payment of costs  
15                   not otherwise allowable, reasonable, or allo-  
16                   cable under the Federal Acquisition Regu-  
17                   lations.”.

18           (2) CONSIDERATION OF INCORPORATION OF  
19           CURRENT LAW STANDARDS.—In developing contract  
20           performance requirements under section 1874A(b)  
21           of the Social Security Act (as added by paragraph  
22           (1)) the Secretary shall consider inclusion of the per-  
23           formance standards described in sections 1816(f)(2)  
24           of such Act (relating to timely processing of recon-  
25           siderations and applications for exemptions) and sec-



1 (A) by striking “An agreement with an  
2 agency or organization under this section” and  
3 inserting “A contract with a medicare adminis-  
4 trative contractor under section 1874A with re-  
5 spect to the administration of this part”; and

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

9 (7) Subsection (l) is repealed.

10 (c) CONFORMING AMENDMENTS TO SECTION 1842  
11 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C.  
12 1395u) is amended as follows:

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

14 “PROVISIONS RELATING TO THE ADMINISTRATION OF  
15 PART B”.

16 (2) Subsection (a) is amended to read as fol-  
17 lows:

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

21 (3) Subsection (b) is amended—

22 (A) by striking paragraph (1);

23 (B) in paragraph (2)—

24 (i) by striking subparagraphs (A) and

25 (B);

- 1           (ii) in subparagraph (C), by striking  
2           “carriers” and inserting “medicare admin-  
3           istrative contractors”; and
- 4           (iii) by striking subparagraphs (D)  
5           and (E);  
6           (C) in paragraph (3)—
- 7           (i) in the matter before subparagraph  
8           (A), by striking “Each such contract shall  
9           provide that the carrier” and inserting  
10          “The Secretary”;
- 11          (ii) by striking “will” the first place it  
12          appears in each of subparagraphs (A), (B),  
13          (F), (G), (H), and (L) and inserting  
14          “shall”;
- 15          (iii) in subparagraph (B), in the mat-  
16          ter before clause (i), by striking “to the  
17          policyholders and subscribers of the car-  
18          rier” and inserting “to the policyholders  
19          and subscribers of the medicare adminis-  
20          trative contractor”;
- 21          (iv) by striking subparagraphs (C),  
22          (D), and (E);
- 23          (v) in subparagraph (H)—

1 (I) by striking “if it makes deter-  
2 minations or payments with respect to  
3 physicians’ services,”; and

4 (II) by striking “carrier” and in-  
5 serting “medicare administrative con-  
6 tractor”;

7 (vi) by striking subparagraph (I);

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

10 (viii) in the first sentence, after sub-  
11 subparagraph (L), by striking “and shall con-  
12 tain” and all that follows through the pe-  
13 riod; and

14 (ix) in the seventh sentence, by insert-  
15 ing “medicare administrative contractor,”  
16 after “carrier,”;

17 (D) by striking paragraph (5);

18 (E) in paragraph (6)(D)(iv), by striking  
19 “carrier” and inserting “medicare administra-  
20 tive contractor”; and

21 (F) in paragraph (7), by striking “the car-  
22 rier” and inserting “the Secretary” each place  
23 it appears.

24 (4) Subsection (c) is amended—

25 (A) by striking paragraph (1);

1 (B) in paragraph (2), by striking “contract  
2 under this section which provides for the dis-  
3 bursement of funds, as described in subsection  
4 (a)(1)(B),” and inserting “contract under sec-  
5 tion 1874A that provides for making payments  
6 under this part”;

7 (C) in paragraph (3)(A), by striking “sub-  
8 section (a)(1)(B)” and inserting “section  
9 1874A(a)(3)(B)”;

10 (D) in paragraph (4), by striking “carrier”  
11 and inserting “medicare administrative con-  
12 tractor”;

13 (E) in paragraph (5), by striking “contract  
14 under this section which provides for the dis-  
15 bursement of funds, as described in subsection  
16 (a)(1)(B), shall require the carrier” and “car-  
17 rier responses” and inserting “contract under  
18 section 1874A that provides for making pay-  
19 ments under this part shall require the medi-  
20 care administrative contractor” and “contractor  
21 responses”, respectively; and

22 (F) by striking paragraph (6).

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

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

4           (7) Subsection (h) is amended—

5                   (A) in paragraph (2)—

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

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

12                   (B) in paragraph (3)(A)—

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

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

21                   (C) in paragraph (3)(B)—

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

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

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

8 (8) Subsection (l) is amended—

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

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

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

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

20 (d) EFFECTIVE DATE; TRANSITION RULE.—

21 (1) EFFECTIVE DATE.—

22 (A) IN GENERAL.—Except as otherwise  
23 provided in this subsection, the amendments  
24 made by this section shall take effect on Octo-  
25 ber 1, 2005, and the Secretary is authorized to

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

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

13 (C) DEADLINE FOR COMPETITIVE BID-  
14 DING.—The Secretary shall provide for the let-  
15 ting by competitive bidding of all contracts for  
16 functions of medicare administrative contrac-  
17 tors for annual contract periods that begin on  
18 or after October 1, 2011.

19 (2) GENERAL TRANSITION RULES.—

20 (A) AUTHORITY TO CONTINUE TO ENTER  
21 INTO NEW AGREEMENTS AND CONTRACTS AND  
22 WAIVER OF PROVIDER NOMINATION PROVISIONS  
23 DURING TRANSITION.—Prior to the date speci-  
24 fied in paragraph (1)(A), the Secretary may,  
25 consistent with subparagraph (B), continue to

1 enter into agreements under section 1816 and  
2 contracts under section 1842 of the Social Se-  
3 curity Act (42 U.S.C. 1395h, 1395u). The Sec-  
4 retary may enter into new agreements under  
5 section 1816 during the time period without re-  
6 gard to any of the provider nomination provi-  
7 sions of such section.

8 (B) APPROPRIATE TRANSITION.—The Sec-  
9 retary shall take such steps as are necessary to  
10 provide for an appropriate transition from  
11 agreements under section 1816 and contracts  
12 under section 1842 of the Social Security Act  
13 (42 U.S.C. 1395h, 1395u) to contracts under  
14 section 1874A, as added by subsection (a)(1).

15 (3) AUTHORIZING CONTINUATION OF MIP AC-  
16 TIVITIES UNDER CURRENT CONTRACTS AND AGREE-  
17 MENTS AND UNDER TRANSITION CONTRACTS.—The  
18 provisions contained in the exception in section  
19 1893(d)(2) of the Social Security Act (42 U.S.C.  
20 1395ddd(d)(2)) shall continue to apply notwith-  
21 standing the amendments made by this section, and  
22 any reference in such provisions to an agreement or  
23 contract shall be deemed to include agreements and  
24 contracts entered into pursuant to paragraph (2)(A).

1           (e) REFERENCES.—On and after the effective date  
2 provided under subsection (d)(1), any reference to a fiscal  
3 intermediary or carrier under title XI or XVIII of the So-  
4 cial Security Act (or any regulation, manual instruction,  
5 interpretative rule, statement of policy, or guideline issued  
6 to carry out such titles) shall be deemed a reference to  
7 an appropriate medicare administrative contractor (as  
8 provided under section 1874A of the Social Security Act).

9           (f) SECRETARIAL SUBMISSION OF LEGISLATIVE PRO-  
10 POSAL.—Not later than 6 months after the date of the  
11 enactment of this Act, the Secretary shall submit to the  
12 appropriate committees of Congress a legislative proposal  
13 providing for such technical and conforming amendments  
14 in the law as are required by the provisions of this section.

15           (g) REPORTS ON IMPLEMENTATION.—

16           (1) PROPOSAL FOR IMPLEMENTATION.—At  
17 least 1 year before the date specified in subsection  
18 (d)(1)(A), the Secretary shall submit a report to  
19 Congress and the Comptroller General of the United  
20 States that describes a plan for an appropriate tran-  
21 sition. The Comptroller General shall conduct an  
22 evaluation of such plan and shall submit to Con-  
23 gress, not later than 6 months after the date the re-  
24 port is received, a report on such evaluation and

1 shall include in such report such recommendations  
2 as the Comptroller General deems appropriate.

3 (2) STATUS OF IMPLEMENTATION.—The Sec-  
4 retary shall submit a report to Congress not later  
5 than October 1, 2008, that describes the status of  
6 implementation of such amendments and that in-  
7 cludes a description of the following:

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

10 (B) The distribution of functions among  
11 contracts and contractors.

12 (C) A timeline for complete transition to  
13 full competition.

14 (D) A detailed description of how the Sec-  
15 retary has modified oversight and management  
16 of medicare contractors to adapt to full com-  
17 petition.

18 **TITLE IV—EDUCATION AND**  
19 **OUTREACH IMPROVEMENTS**

20 **SEC. 401. PROVIDER EDUCATION AND TECHNICAL ASSIST-**  
21 **ANCE.**

22 (a) COORDINATION OF EDUCATION FUNDING.—

23 (1) IN GENERAL.—Title XVIII is amended by  
24 inserting after section 1888 the following new sec-  
25 tion:

1 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

2 “SEC. 1889. (a) COORDINATION OF EDUCATION  
3 FUNDING.—The Secretary shall coordinate the edu-  
4 cational activities provided through medicare contractors  
5 (as defined in subsection (e), including under section  
6 1893) in order to maximize the effectiveness of Federal  
7 education efforts for providers of services, physicians,  
8 practitioners, and suppliers.”.

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

12 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-  
13 FORMANCE.—Section 1874A, as added by section  
14 301(a)(1), is amended by adding at the end the following  
15 new subsection:

16 “(e) INCENTIVES TO IMPROVE CONTRACTOR PER-  
17 FORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

18 “(1) METHODOLOGY TO MEASURE CONTRACTOR  
19 ERROR RATES.—In order to give medicare contrac-  
20 tors (as defined in paragraph (3)) an incentive to  
21 implement effective education and outreach pro-  
22 grams for providers of services, physicians, practi-  
23 tioners, and suppliers, the Secretary shall develop  
24 and implement by October 1, 2004, a methodology  
25 to measure the specific claims payment error rates

1 of such contractors in the processing or reviewing of  
2 medicare claims.

3 “(2) IG REVIEW OF METHODOLOGY.—The In-  
4 spector General of the Department of Health and  
5 Human Services shall review, and make rec-  
6 ommendations to the Secretary, regarding the ade-  
7 quacy of such methodology.

8 “(3) MEDICARE CONTRACTOR DEFINED.—For  
9 purposes of this subsection, the term ‘medicare con-  
10 tractor’ includes a medicare administrative con-  
11 tractor, a fiscal intermediary with a contract under  
12 section 1816, and a carrier with a contract under  
13 section 1842.”.

14 (c) IMPROVED PROVIDER EDUCATION AND TRAIN-  
15 ING.—

16 (1) INCREASED FUNDING FOR ENHANCED EDU-  
17 CATION AND TRAINING THROUGH MEDICARE INTEG-  
18 RITY PROGRAM.—Section 1817(k)(4) (42 U.S.C.  
19 1395i(k)(4)) is amended—

20 (A) in subparagraph (A), by striking “sub-  
21 paragraph (B)” and inserting “subparagraphs  
22 (B) and (C)”;

23 (B) in subparagraph (B), by striking “The  
24 amount appropriated” and inserting “Subject

1 to subparagraph (C), the amount appro-  
2 priated”; and

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

5 “(C) ENHANCED PROVIDER EDUCATION  
6 AND TRAINING.—

7 “(i) IN GENERAL.—In addition to the  
8 amount appropriated under subparagraph  
9 (B), the amount appropriated under sub-  
10 subparagraph (A) for a fiscal year (beginning  
11 with fiscal year 2004) is increased by  
12 \$35,000,000.

13 “(ii) USE.—The funds made available  
14 under this subparagraph shall be used only  
15 to increase the conduct by medicare con-  
16 tractors of education and training of pro-  
17 viders of services, physicians, practitioners,  
18 and suppliers regarding billing, coding, and  
19 other appropriate items and may also be  
20 used to improve the accuracy, consistency,  
21 and timeliness of contractor responses to  
22 written and phone inquiries from providers  
23 of services, physicians, practitioners, and  
24 suppliers.”.

1           (2) TAILORING EDUCATION AND TRAINING FOR  
2 SMALL PROVIDERS OR SUPPLIERS.—

3           (A) IN GENERAL.—Section 1889, as added  
4 by subsection (a), is amended by adding at the  
5 end the following new subsection:

6           “(b) TAILORING EDUCATION AND TRAINING ACTIVI-  
7 TIES FOR SMALL PROVIDERS OR SUPPLIERS.—

8           “(1) IN GENERAL.—Insofar as a medicare con-  
9 tractor conducts education and training activities, it  
10 shall take into consideration the special needs of  
11 small providers of services or suppliers (as defined in  
12 paragraph (2)). Such education and training activi-  
13 ties for small providers of services and suppliers may  
14 include the provision of technical assistance (such as  
15 review of billing systems and internal controls to de-  
16 termine program compliance and to suggest more ef-  
17 ficient and effective means of achieving such compli-  
18 ance).

19           “(2) SMALL PROVIDER OF SERVICES OR SUP-  
20 PLIER.—In this subsection, the term ‘small provider  
21 of services or supplier’ means—

22           “(A) an institutional provider of services  
23 with fewer than 25 full-time-equivalent employ-  
24 ees; or

1           “(B) a physician, practitioner, or supplier  
2           with fewer than 10 full-time-equivalent employ-  
3           ees.”.

4           (B) EFFECTIVE DATE.—The amendment  
5           made by subparagraph (A) shall take effect on  
6           January 1, 2004.

7           (d) ADDITIONAL PROVIDER EDUCATION PROVI-  
8           SIONS.—

9           (1) IN GENERAL.—Section 1889, as added by  
10          subsection (a) and as amended by subsection (c)(2),  
11          is amended by adding at the end the following new  
12          subsections:

13          “(c) ENCOURAGEMENT OF PARTICIPATION IN EDU-  
14          CATION PROGRAM ACTIVITIES.—A medicare contractor  
15          may not use a record of attendance at (or failure to at-  
16          tend) educational activities or other information gathered  
17          during an educational program conducted under this sec-  
18          tion or otherwise by the Secretary to select or track pro-  
19          viders of services, physicians, practitioners, or suppliers  
20          for the purpose of conducting any type of audit or prepay-  
21          ment review.

22          “(d) CONSTRUCTION.—Nothing in this section or sec-  
23          tion 1893(g) shall be construed as providing for disclosure  
24          by a medicare contractor—

1           “(1) of the screens used for identifying claims  
2           that will be subject to medical review; or

3           “(2) of information that would compromise  
4           pending law enforcement activities or reveal findings  
5           of law enforcement-related audits.

6           “(e) DEFINITIONS.—For purposes of this section and  
7           section 1817(k)(4)(C), the term ‘medicare contractor’ in-  
8           cludes the following:

9           “(1) A medicare administrative contractor with  
10          a contract under section 1874A, a fiscal inter-  
11          mediary with a contract under section 1816, and a  
12          carrier with a contract under section 1842.

13          “(2) An eligible entity with a contract under  
14          section 1893.

15          Such term does not include, with respect to activities of  
16          a specific provider of services, physician, practitioner, or  
17          supplier an entity that has no authority under this title  
18          or title XI with respect to such activities and such provider  
19          of services, physician, practitioner, or supplier.”.

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

1 **SEC. 402. ACCESS TO AND PROMPT RESPONSES FROM**  
2 **MEDICARE CONTRACTORS.**

3 (a) IN GENERAL.—Section 1874A, as added by sec-  
4 tion 301(a)(1) and as amended by section 401(b)(1), is  
5 amended by adding at the end the following new sub-  
6 section:

7 “(f) COMMUNICATING WITH BENEFICIARIES AND  
8 PROVIDERS.—

9 “(1) COMMUNICATION PROCESS.—The Sec-  
10 retary shall develop a process for medicare contrac-  
11 tors to communicate with beneficiaries and with pro-  
12 viders of services, physicians, practitioners, and sup-  
13 pliers under this title.

14 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each  
15 medicare contractor (as defined in paragraph (5))  
16 shall provide general written responses (which may  
17 be through electronic transmission) in a clear, con-  
18 cise, and accurate manner to inquiries by bene-  
19 ficiaries, providers of services, physicians, practi-  
20 tioners, and suppliers concerning the programs  
21 under this title within a contractual timeframe es-  
22 tablished by the Secretary.

23 “(3) RESPONSE TO TOLL-FREE LINES.—The  
24 Secretary shall ensure that medicare contractors  
25 provide a toll-free telephone number at which bene-  
26 ficiaries, providers, physicians, practitioners, and

1 suppliers may obtain information regarding billing,  
2 coding, claims, coverage, and other appropriate in-  
3 formation under this title.

4 “(4) MONITORING OF CONTRACTOR RE-  
5 SPONSES.—

6 “(A) IN GENERAL.—Each medicare con-  
7 tractor shall, consistent with standards devel-  
8 oped by the Secretary under subparagraph  
9 (B)—

10 “(i) maintain a system for identifying  
11 who provides the information referred to in  
12 paragraphs (2) and (3); and

13 “(ii) monitor the accuracy, consist-  
14 ency, and timeliness of the information so  
15 provided.

16 “(B) DEVELOPMENT OF STANDARDS.—

17 “(i) IN GENERAL.—The Secretary  
18 shall establish (and publish in the Federal  
19 Register) standards regarding the accu-  
20 racy, consistency, and timeliness of the in-  
21 formation provided in response to inquiries  
22 under this subsection. Such standards shall  
23 be consistent with the performance require-  
24 ments established under subsection (b)(3).

1                   “(ii) EVALUATION.—In conducting  
2                   evaluations of individual medicare contrac-  
3                   tors, the Secretary shall take into account  
4                   the results of the monitoring conducted  
5                   under subparagraph (A) taking into ac-  
6                   count as performance requirements the  
7                   standards established under clause (i). The  
8                   Secretary shall, in consultation with orga-  
9                   nizations representing providers of serv-  
10                  ices, suppliers, and individuals entitled to  
11                  benefits under part A or enrolled under  
12                  part B, or both, establish standards relat-  
13                  ing to the accuracy, consistency, and time-  
14                  liness of the information so provided.

15                  “(C) DIRECT MONITORING.—Nothing in  
16                  this paragraph shall be construed as preventing  
17                  the Secretary from directly monitoring the ac-  
18                  curacy, consistency, and timeliness of the infor-  
19                  mation so provided.

20                  “(5) MEDICARE CONTRACTOR DEFINED.—For  
21                  purposes of this subsection, the term ‘medicare con-  
22                  tractor’ has the meaning given such term in sub-  
23                  section (e)(3).”.

24                  (b) EFFECTIVE DATE.—The amendment made by  
25                  subsection (a) shall take effect October 1, 2004.

1 (c) AUTHORIZATION OF APPROPRIATIONS.—There  
2 are authorized to be appropriated such sums as may be  
3 necessary to carry out section 1874A(f) of the Social Secu-  
4 rity Act, as added by subsection (a).

5 **SEC. 403. RELIANCE ON GUIDANCE.**

6 (a) IN GENERAL.—Section 1871(d), as added by sec-  
7 tion 101, is amended by adding at the end the following  
8 new paragraph:

9 “(2) If—

10 “(A) a provider of services, physician, practi-  
11 tioner, or other supplier follows written guidance  
12 provided—

13 “(i) by the Secretary; or

14 “(ii) by a medicare contractor (as defined  
15 in section 1889(e) and whether in the form of  
16 a written response to a written inquiry under  
17 section 1874A(f)(1) or otherwise) acting within  
18 the scope of the contractor’s contract authority,  
19 in response to a written inquiry with respect to the  
20 furnishing of items or services or the submission of  
21 a claim for benefits for such items or services;

22 “(B) the Secretary determines that—

23 “(i) the provider of services, physician,  
24 practitioner, or supplier has accurately pre-  
25 sented the circumstances relating to such items,

1 services, and claim to the Secretary or the con-  
 2 tractor in the written guidance; and

3 “(ii) there is no indication of fraud or  
 4 abuse committed by the provider of services,  
 5 physician, practitioner, or supplier against the  
 6 program under this title; and

7 “(C) the guidance was in error;  
 8 the provider of services, physician, practitioner, or supplier  
 9 shall not be subject to any penalty or interest under this  
 10 title (or the provisions of title XI insofar as they relate  
 11 to this title) relating to the provision of such items or serv-  
 12 ice or such claim if the provider of services, physician,  
 13 practitioner, or supplier reasonably relied on such guid-  
 14 ance. In applying this paragraph with respect to guidance  
 15 in the form of general responses to frequently asked ques-  
 16 tions, the Secretary retains authority to determine the ex-  
 17 tent to which such general responses apply to the par-  
 18 ticular circumstances of individual claims.”.

19 (b) EFFECTIVE DATE.—The amendment made by  
 20 subsection (a) shall apply to penalties imposed on or after  
 21 the date of the enactment of this Act.

22 **SEC. 404. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**  
 23 **BENEFICIARY OMBUDSMAN.**

24 (a) MEDICARE PROVIDER OMBUDSMAN.—Section  
 25 1868 (42 U.S.C. 1395ee) is amended—

1           (1) by adding at the end of the heading the fol-  
2           lowing: “; MEDICARE PROVIDER OMBUDSMAN”;

3           (2) by inserting “PRACTICING PHYSICIANS AD-  
4           VISORY COUNCIL.—(1)” after “(a)”;

5           (3) in paragraph (1), as so redesignated under  
6           paragraph (2), by striking “in this section” and in-  
7           serting “in this subsection”;

8           (4) by redesignating subsections (b) and (c) as  
9           paragraphs (2) and (3), respectively; and

10          (5) by adding at the end the following new sub-  
11          section:

12          “(b) MEDICARE PROVIDER OMBUDSMAN.—By not  
13          later than 1 year after the date of the enactment of the  
14          Medicare Education, Regulatory Reform, and Contracting  
15          Improvement Act of 2003, the Secretary shall appoint a  
16          Medicare Provider Ombudsman who shall have experience  
17          in health care. The Ombudsman shall—

18                 “(1) provide assistance, on a confidential basis,  
19                 to providers of services and suppliers with respect to  
20                 complaints, grievances, and requests for information  
21                 concerning the programs under this title (including  
22                 provisions of title XI insofar as they relate to this  
23                 title and are not administered by the Office of the  
24                 Inspector General of the Department of Health and  
25                 Human Services) and in the resolution of unclear or

1 conflicting guidance given by the Secretary and  
2 medicare contractors to such providers of services  
3 and suppliers regarding such programs and provi-  
4 sions and requirements under this title and such  
5 provisions; and

6 “(2) submit recommendations to the Secretary  
7 for improvement in the administration of this title  
8 and such provisions, including—

9 “(A) recommendations to respond to recur-  
10 ring patterns of confusion in this title and such  
11 provisions (including recommendations regard-  
12 ing suspending imposition of sanctions where  
13 there is widespread confusion in program ad-  
14 ministration);

15 “(B) recommendations to provide for an  
16 appropriate and consistent response (including  
17 not providing for audits) in cases of self-identi-  
18 fied overpayments by providers of services and  
19 suppliers; and

20 “(C) recommendations to improve commu-  
21 nication between providers, contractors, and the  
22 Centers for Medicare & Medicaid Services.

23 “(c) STAFF.—The Secretary shall provide appro-  
24 priate staff to assist in performing the duties described  
25 in subsection (b).”.

1 (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title  
2 XVIII is amended by inserting after section 1806 the fol-  
3 lowing new section:

4 “MEDICARE BENEFICIARY OMBUDSMAN

5 “SEC. 1807. (a) IN GENERAL.—By not later than 1  
6 year after the date of the enactment of the Medicare Edu-  
7 cation, Regulatory Reform, and Contracting Improvement  
8 Act of 2003, the Secretary shall appoint within the De-  
9 partment of Health and Human Services a Medicare Ben-  
10 eficiary Ombudsman (including support staff) who shall  
11 have expertise and experience in the fields of health care  
12 and advocacy.

13 “(b) DUTIES.—The Medicare Beneficiary Ombuds-  
14 man shall—

15 “(1) receive complaints, grievances, and re-  
16 quests for information submitted by a medicare ben-  
17 eficiary, with respect to any aspect of the medicare  
18 program;

19 “(2) provide assistance with respect to com-  
20 plaints, grievances, and requests referred to in para-  
21 graph (1), including—

22 “(A) assistance in collecting relevant infor-  
23 mation for such beneficiaries, to seek an appeal  
24 of a decision or determination made by a fiscal  
25 intermediary, carrier, Medicare+Choice organi-  
26 zation, or the Secretary; and

1           “(B) assistance to such beneficiaries with  
2           any problems arising from disenrollment from a  
3           Medicare+Choice plan under part C; and

4           “(3) submit annual reports to Congress and the  
5           Secretary that describe the activities of the Office  
6           and that include such recommendations for improve-  
7           ment in the administration of this title as the Om-  
8           budsman determines appropriate.”.

9           (c) FUNDING.—There are authorized to be appro-  
10          priated to the Secretary (in appropriate part from the  
11          Federal Hospital Insurance Trust Fund and the Federal  
12          Supplementary Medical Insurance Trust Fund) to carry  
13          out the provisions of subsection (b) of section 1868 of the  
14          Social Security Act (relating to the Medicare Provider  
15          Ombudsman), as added by subsection (a)(5) and section  
16          1807 of such Act (relating to the Medicare Beneficiary  
17          Ombudsman), as added by subsection (b), such sums as  
18          are necessary for fiscal year 2004 and each succeeding fis-  
19          cal year.

20          (d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-  
21          MEDICARE).—Section 1804(b) (42 U.S.C. 1395b-2(b))  
22          is amended by adding at the end the following: “By not  
23          later than 1 year after the date of the enactment of the  
24          Medicare Education, Regulatory Reform, and Contracting  
25          Improvement Act of 2003, the Secretary shall provide,

1 through the toll-free number 1-800-MEDICARE, for a  
2 means by which individuals seeking information about, or  
3 assistance with, such programs who phone such toll-free  
4 number are transferred (without charge) to appropriate  
5 entities for the provision of such information or assistance.  
6 Such toll-free number shall be the toll-free number listed  
7 for general information and assistance in the annual no-  
8 tice under subsection (a) instead of the listing of numbers  
9 of individual contractors.”.

10 **SEC. 405. BENEFICIARY OUTREACH DEMONSTRATION PRO-**  
11 **GRAM.**

12 (a) IN GENERAL.—The Secretary shall establish a  
13 demonstration program (in this section referred to as the  
14 “demonstration program”) under which medicare special-  
15 ists employed by the Department of Health and Human  
16 Services provide advice and assistance to medicare bene-  
17 ficiaries at the location of existing local offices of the So-  
18 cial Security Administration.

19 (b) LOCATIONS.—

20 (1) IN GENERAL.—The demonstration program  
21 shall be conducted in at least 6 offices or areas.  
22 Subject to paragraph (2), in selecting such offices  
23 and areas, the Secretary shall provide preference for  
24 offices with a high volume of visits by medicare  
25 beneficiaries.

1           (2) ASSISTANCE FOR RURAL BENEFICIARIES.—

2           The Secretary shall provide for the selection of at  
3           least 3 rural areas to participate in the demonstra-  
4           tion program. In conducting the demonstration pro-  
5           gram in such rural areas, the Secretary shall provide  
6           for medicare specialists to travel among local offices  
7           in a rural area on a scheduled basis.

8           (c) DURATION.—The demonstration program shall be  
9           conducted over a 3-year period.

10          (d) EVALUATION AND REPORT.—

11           (1) EVALUATION.—The Secretary shall provide  
12           for an evaluation of the demonstration program.  
13           Such evaluation shall include an analysis of—

14                   (A) utilization of, and beneficiary satisfac-  
15                   tion with, the assistance provided under the  
16                   program; and

17                   (B) the cost-effectiveness of providing ben-  
18                   eficiary assistance through out-stationing medi-  
19                   care specialists at local social security offices.

20           (2) REPORT.—The Secretary shall submit to  
21           Congress a report on such evaluation and shall in-  
22           clude in such report recommendations regarding the  
23           feasibility of permanently out-stationing medicare  
24           specialists at local social security offices.

1     **TITLE V—REVIEW, RECOVERY,**  
2     **AND ENFORCEMENT REFORM**

3     **SEC. 501. PREPAYMENT REVIEW.**

4           (a) IN GENERAL.—Section 1874A, as added by sec-  
5     tion 301(a)(1) and as amended by sections 401(b)(1) and  
6     402(a), is amended by adding at the end the following new  
7     subsection:

8           “(g) CONDUCT OF PREPAYMENT REVIEW.—

9                   “(1) STANDARDIZATION OF RANDOM PREPAY-  
10           MENT REVIEW.—A medicare administrative con-  
11           tractor shall conduct random prepayment review  
12           only in accordance with a standard protocol for ran-  
13           dom prepayment audits developed by the Secretary.

14                   “(2) LIMITATIONS ON INITIATION OF NON-  
15           RANDOM PREPAYMENT REVIEW.—A medicare admin-  
16           istrative contractor may not initiate nonrandom pre-  
17           payment review of a provider of services, physician,  
18           practitioner, or supplier based on the initial identi-  
19           fication by that provider of services, physician, prac-  
20           titioner, or supplier of an improper billing practice  
21           unless there is a likelihood of sustained or high level  
22           of payment error (as defined by the Secretary).

23                   “(3) TERMINATION OF NONRANDOM PREPAY-  
24           MENT REVIEW.—The Secretary shall establish proto-  
25           cols or standards relating to the termination, includ-

1 ing termination dates, of nonrandom prepayment re-  
2 view. Such regulations may vary such a termination  
3 date based upon the differences in the circumstances  
4 triggering prepayment review.

5 “(4) CONSTRUCTION.—Nothing in this sub-  
6 section shall be construed as preventing the denial of  
7 payments for claims actually reviewed under a ran-  
8 dom prepayment review. In the case of a provider of  
9 services, physician, practitioner, or supplier with re-  
10 spect to which amounts were previously overpaid,  
11 nothing in this subsection shall be construed as lim-  
12 iting the ability of a medicare administrative con-  
13 tractor to request the periodic production of records  
14 or supporting documentation for a limited sample of  
15 submitted claims to ensure that the previous prac-  
16 tice is not continuing.

17 “(5) RANDOM PREPAYMENT REVIEW DE-  
18 FINED.—For purposes of this subsection, the term  
19 ‘random prepayment review’ means a demand for  
20 the production of records or documentation absent  
21 cause with respect to a claim.”.

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 on the date of the enactment of this  
2 Act.

3 (2) DEADLINE FOR PROMULGATION OF CER-  
4 TAIN REGULATIONS.—The Secretary shall first issue  
5 regulations under section 1874A(g) 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(g)(1) of the Social Security Act, as added by  
12 subsection (a), shall apply to random prepayment re-  
13 views 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. The Secretary  
16 shall develop and publish the standard protocol  
17 under such section by not later than 1 year after the  
18 date of the enactment of this Act.

19 **SEC. 502. RECOVERY OF OVERPAYMENTS.**

20 (a) IN GENERAL.—Section 1874A, as added by sec-  
21 tion 301(a)(1) and as amended by sections 401(b)(1),  
22 402(a), and 501(a), is amended by adding at the end the  
23 following new subsection:

24 “(h) RECOVERY OF OVERPAYMENTS.—

25 “(1) USE OF REPAYMENT PLANS.—

1           “(A) IN GENERAL.—If the repayment,  
2           within the period otherwise permitted by a pro-  
3           vider of services, physician, practitioner, or  
4           other supplier, of an overpayment under this  
5           title meets the standards developed under sub-  
6           paragraph (B), subject to subparagraph (C),  
7           and the provider, physician, practitioner, or  
8           supplier requests the Secretary to enter into a  
9           repayment plan with respect to such overpay-  
10          ment, the Secretary shall enter into a plan with  
11          the provider, physician, practitioner, or supplier  
12          for the offset or repayment (at the election of  
13          the provider, physician, practitioner, or sup-  
14          plier) of such overpayment over a period of at  
15          least 1 year, but not longer than 3 years. Inter-  
16          est shall accrue on the balance through the pe-  
17          riod of repayment. The repayment plan shall  
18          meet terms and conditions determined to be ap-  
19          propriate by the Secretary.

20           “(B) DEVELOPMENT OF STANDARDS.—  
21          The Secretary shall develop standards for the  
22          recovery of overpayments. Such standards  
23          shall—

24                   “(i) include a requirement that the  
25                   Secretary take into account (and weigh in

1 favor of the use of a repayment plan) the  
2 reliance (as described in section  
3 1871(d)(2)) by a provider of services, phy-  
4 sician, practitioner, and supplier on guid-  
5 ance when determining whether a repay-  
6 ment plan should be offered; and

7 “(ii) provide for consideration of the  
8 financial hardship imposed on a provider of  
9 services, physician, practitioner, or supplier  
10 in considering such a repayment plan.

11 In developing standards with regard to financial  
12 hardship with respect to a provider of services,  
13 physician, practitioner, or supplier, the Sec-  
14 retary shall take into account the amount of the  
15 proposed recovery as a proportion of payments  
16 made to that provider, physician, practitioner,  
17 or supplier.

18 “(C) EXCEPTIONS.—Subparagraph (A)  
19 shall not apply if—

20 “(i) the Secretary has reason to sus-  
21 pect that the provider of services, physi-  
22 cian, practitioner, or supplier may file for  
23 bankruptcy or otherwise cease to do busi-  
24 ness or discontinue participation in the  
25 program under this title; or

1                   “(ii) there is an indication of fraud or  
2                   abuse committed against the program.

3                   “(D) IMMEDIATE COLLECTION IF VIOLA-  
4                   TION OF REPAYMENT PLAN.—If a provider of  
5                   services, physician, practitioner, or supplier fails  
6                   to make a payment in accordance with a repay-  
7                   ment plan under this paragraph, the Secretary  
8                   may immediately seek to offset or otherwise re-  
9                   cover the total balance outstanding (including  
10                  applicable interest) under the repayment plan.

11                  “(E) RELATION TO NO FAULT PROVI-  
12                  SION.—Nothing in this paragraph shall be con-  
13                  strued as affecting the application of section  
14                  1870(c) (relating to no adjustment in the cases  
15                  of certain overpayments).

16                  “(2) LIMITATION ON RECOUPMENT.—

17                  “(A) NO RECOUPMENT UNTIL RECONSID-  
18                  ERATION EXERCISED.—In the case of a pro-  
19                  vider of services, physician, practitioner, or sup-  
20                  plier that is determined to have received an  
21                  overpayment under this title and that seeks a  
22                  reconsideration of such determination by a  
23                  qualified independent contractor under section  
24                  1869(c), the Secretary may not take any action  
25                  (or authorize any other person, including any

1 medicare contractor, as defined in subpara-  
2 graph (C)) to recoup the overpayment until the  
3 date the decision on the reconsideration has  
4 been rendered. If the provisions of section  
5 1869(b)(1) (providing for such a reconsider-  
6 ation by a qualified independent contractor) are  
7 not in effect, in applying the previous sentence  
8 any reference to such a reconsideration shall be  
9 treated as a reference to a redetermination by  
10 the fiscal intermediary or carrier involved.

11 “(B) PAYMENT OF INTEREST.—

12 “(i) RETURN OF RECOUPED AMOUNT  
13 WITH INTEREST IN CASE OF REVERSAL.—

14 Insofar as such determination on appeal  
15 against the provider of services, physician,  
16 practitioner, or supplier is later reversed,  
17 the Secretary shall provide for repayment  
18 of the amount recouped plus interest for  
19 the period in which the amount was re-  
20 couped.

21 “(ii) INTEREST IN CASE OF AFFIRMA-  
22 TION.—Insofar as the determination on  
23 such appeal is against the provider of serv-  
24 ices, physician, practitioner, or supplier, in-  
25 terest on the overpayment shall accrue on

1 and after the date of the original notice of  
2 overpayment.

3 “(iii) RATE OF INTEREST.—The rate  
4 of interest under this subparagraph shall  
5 be the rate otherwise applicable under this  
6 title in the case of overpayments.

7 “(C) MEDICARE CONTRACTOR DEFINED.—  
8 For purposes of this subsection, the term ‘medi-  
9 care contractor’ has the meaning given such  
10 term in section 1889(e).

11 “(3) PAYMENT AUDITS.—

12 “(A) WRITTEN NOTICE FOR POST-PAY-  
13 MENT AUDITS.—Subject to subparagraph (C), if  
14 a medicare contractor decides to conduct a  
15 post-payment audit of a provider of services,  
16 physician, practitioner, or supplier under this  
17 title, the contractor shall provide the provider of  
18 services, physician, practitioner, or supplier  
19 with written notice (which may be in electronic  
20 form) of the intent to conduct such an audit.

21 “(B) EXPLANATION OF FINDINGS FOR ALL  
22 AUDITS.—Subject to subparagraph (C), if a  
23 medicare contractor audits a provider of serv-  
24 ices, physician, practitioner, or supplier under  
25 this title, the contractor shall—

1           “(i) give the provider of services, phy-  
2           sician, practitioner, or supplier a full re-  
3           view and explanation of the findings of the  
4           audit in a manner that is understandable  
5           to the provider of services, physician, prac-  
6           titioner, or supplier and permits the devel-  
7           opment of an appropriate corrective action  
8           plan;

9           “(ii) inform the provider of services,  
10          physician, practitioner, or supplier of the  
11          appeal rights under this title as well as  
12          consent settlement options (which are at  
13          the discretion of the Secretary); and

14          “(iii) give the provider of services,  
15          physician, practitioner, or supplier an op-  
16          portunity to provide additional information  
17          to the contractor.

18          “(C) EXCEPTION.—Subparagraphs (A)  
19          and (B) shall not apply if the provision of no-  
20          tice or findings would compromise pending law  
21          enforcement activities, whether civil or criminal,  
22          or reveal findings of law enforcement-related  
23          audits.

24          “(4) NOTICE OF OVER-UTILIZATION OF  
25          CODES.—The Secretary shall establish, in consulta-

1       tion with organizations representing the classes of  
2       providers of services, physicians, practitioners, and  
3       suppliers, a process under which the Secretary pro-  
4       vides for notice to classes of providers of services,  
5       physicians, practitioners, and suppliers served by a  
6       medicare contractor in cases in which the contractor  
7       has identified that particular billing codes may be  
8       over utilized by that class of providers of services,  
9       physicians, practitioners, or suppliers under the pro-  
10      grams under this title (or provisions of title XI inso-  
11      far as they relate to such programs).

12           “(5) STANDARD METHODOLOGY FOR PROBE  
13      SAMPLING.—The Secretary shall establish a stand-  
14      ard methodology for medicare administrative con-  
15      tractors to use in selecting a sample of claims for re-  
16      view in the case of an abnormal billing pattern.

17           “(6) CONSENT SETTLEMENT REFORMS.—

18           “(A) IN GENERAL.—The Secretary may  
19      use a consent settlement (as defined in sub-  
20      paragraph (D)) to settle a projected overpay-  
21      ment.

22           “(B) OPPORTUNITY TO SUBMIT ADDI-  
23      TIONAL INFORMATION BEFORE CONSENT SET-  
24      TLEMENT OFFER.—Before offering a provider

1 of services, physician, practitioner, or supplier a  
2 consent settlement, the Secretary shall—

3 “(i) communicate to the provider of  
4 services, physician, practitioner, or supplier  
5 in a nonthreatening manner that, based on  
6 a review of the medical records requested  
7 by the Secretary, a preliminary evaluation  
8 of those records indicates that there would  
9 be an overpayment; and

10 “(ii) provide for a 45-day period dur-  
11 ing which the provider of services, physi-  
12 cian, practitioner, or supplier may furnish  
13 additional information concerning the med-  
14 ical records for the claims that had been  
15 reviewed.

16 “(C) CONSENT SETTLEMENT OFFER.—The  
17 Secretary shall review any additional informa-  
18 tion furnished by the provider of services, physi-  
19 cian, practitioner, or supplier under subpara-  
20 graph (B)(ii). Taking into consideration such  
21 information, the Secretary shall determine if  
22 there still appears to be an overpayment. If so,  
23 the Secretary—

24 “(i) shall provide notice of such deter-  
25 mination to the provider of services, physi-

1           cian, practitioner, or supplier, including an  
 2           explanation of the reason for such deter-  
 3           mination; and

4                   “(ii) in order to resolve the overpay-  
 5           ment, may offer the provider of services,  
 6           physician, practitioner, or supplier—

7                           “(I) the opportunity for a statis-  
 8                           tically valid random sample; or

9                           “(II) a consent settlement.

10           The opportunity provided under clause (ii)(I)  
 11           does not waive any appeal rights with respect to  
 12           the alleged overpayment involved.

13                   “(D) CONSENT SETTLEMENT DEFINED.—

14           For purposes of this paragraph, the term ‘con-  
 15           sent settlement’ means an agreement between  
 16           the Secretary and a provider of services, physi-  
 17           cian, practitioner, or supplier whereby both par-  
 18           ties agree to settle a projected overpayment  
 19           based on less than a statistically valid sample of  
 20           claims and the provider of services, physician,  
 21           practitioner, or supplier agrees not to appeal  
 22           the claims involved.”.

23           (b) EFFECTIVE DATES AND DEADLINES.—

24                   (1) Not later than 1 year after the date of the  
 25           enactment of this Act, the Secretary shall first—

1 (A) develop standards for the recovery of  
2 overpayments under section 1874A(h)(1)(B) of  
3 the Social Security Act, as added by subsection  
4 (a);

5 (B) establish the process for notice of over-  
6 utilization of billing codes under section  
7 1874A(h)(4) of the Social Security Act, as  
8 added by subsection (a); and

9 (C) establish a standard methodology for  
10 selection of sample claims for abnormal billing  
11 patterns under section 1874A(h)(5) of the So-  
12 cial Security Act, as added by subsection (a).

13 (2) Section 1874A(h)(2) of the Social Security  
14 Act, as added by subsection (a), shall apply to ac-  
15 tions taken after the date that is 1 year after the  
16 date of the enactment of this Act.

17 (3) Section 1874A(h)(3) of the Social Security  
18 Act, as added by subsection (a), shall apply to audits  
19 initiated after the date of the enactment of this Act.

20 (4) Section 1874A(h)(6) of the Social Security  
21 Act, as added by subsection (a), shall apply to con-  
22 sent settlements entered into after the date of the  
23 enactment of this Act.

1 **SEC. 503. PROCESS FOR CORRECTION OF MINOR ERRORS**  
2 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**  
3 **SUING APPEALS PROCESS.**

4 (a) **IN GENERAL.**—The Secretary shall develop, in  
5 consultation with appropriate medicare contractors (as de-  
6 fined in section 1889(e) of the Social Security Act, as  
7 added by section 401(d)(1)) and representatives of pro-  
8 viders of services, physicians, practitioners, facilities, and  
9 suppliers, a process whereby, in the case of minor errors  
10 or omissions (as defined by the Secretary) that are de-  
11 tected in the submission of claims under the programs  
12 under title XVIII of such Act, a provider of services, phy-  
13 sician, practitioner, facility, or supplier is given an oppor-  
14 tunity to correct such an error or omission without the  
15 need to initiate an appeal. Such process shall include the  
16 ability to resubmit corrected claims.

17 (b) **DEADLINE.**—Not later than 1 year after the date  
18 of the enactment of this Act, the Secretary shall first de-  
19 velop the process under subsection (a).

20 **SEC. 504. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.**

21 The first sentence of section 1128(c)(3)(B) (42  
22 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows:  
23 “Subject to subparagraph (G), in the case of an exclusion  
24 under subsection (a), the minimum period of exclusion  
25 shall be not less than 5 years, except that, upon the re-  
26 quest of an administrator of a Federal health care pro-

1 gram (as defined in section 1128B(f)) who determines  
 2 that the exclusion would impose a hardship on bene-  
 3 ficiaries of that program, the Secretary may waive the ex-  
 4 clusion under subsection (a)(1), (a)(3), or (a)(4) with re-  
 5 spect to that program in the case of an individual or entity  
 6 that is the sole community physician or sole source of es-  
 7 sential specialized services in a community.

8 **SEC. 505. RECOVERY OF OVERPAYMENTS.**

9 (a) IN GENERAL.—Section 1893 (42 U.S.C.  
 10 1395ddd) is amended by adding at the end the following  
 11 new subsection:

12 “(f) LIMITATION ON USE OF EXTRAPOLATION.—A  
 13 medicare contractor may not use extrapolation to deter-  
 14 mine overpayment amounts to be recovered by  
 15 recoupment, offset, or otherwise unless—

16 “(1) there is a sustained or high level of pay-  
 17 ment error (as defined by the Secretary by regula-  
 18 tion); or

19 “(2) documented educational intervention has  
 20 failed to correct the payment error (as determined  
 21 by the Secretary).”.

22 (b) EFFECTIVE DATE.—Section 1893(f) of the Social  
 23 Security Act, as added by subsection (a), shall apply to  
 24 statistically valid random samples initiated after the date  
 25 that is 1 year after the date of the enactment of this Act.

1                   **TITLE VI—OTHER**  
2                   **IMPROVEMENTS**

3   **SEC. 601. INCLUSION OF ADDITIONAL INFORMATION IN NO-**  
4                   **TICES TO BENEFICIARIES ABOUT SKILLED**  
5                   **NURSING FACILITY AND HOSPITAL BENE-**  
6                   **FITS.**

7           (a) IN GENERAL.—The Secretary shall provide that  
8 in medicare beneficiary notices provided (under section  
9 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a))  
10 with respect to the provision of post-hospital extended care  
11 services and inpatient hospital services under part A of  
12 title XVIII of the Social Security Act, there shall be in-  
13 cluded information on the number of days of coverage of  
14 such services remaining under such part for the medicare  
15 beneficiary and spell of illness involved.

16           (b) EFFECTIVE DATE.—Subsection (a) shall apply to  
17 notices provided during calendar quarters beginning more  
18 than 6 months after the date of the enactment of this Act.

19   **SEC. 602. INFORMATION ON MEDICARE-CERTIFIED**  
20                   **SKILLED NURSING FACILITIES IN HOSPITAL**  
21                   **DISCHARGE PLANS.**

22           (a) AVAILABILITY OF DATA.—The Secretary shall  
23 publicly provide information that enables hospital dis-  
24 charge planners, medicare beneficiaries, and the public to

1 identify skilled nursing facilities that are participating in  
2 the medicare program.

3 (b) INCLUSION OF INFORMATION IN CERTAIN HOS-  
4 PITAL DISCHARGE PLANS.—

5 (1) IN GENERAL.—Section 1861(ee)(2)(D) (42  
6 U.S.C. 1395x(ee)(2)(D)) is amended—

7 (A) by striking “hospice services” and in-  
8 serting “hospice care and post-hospital ex-  
9 tended care services”; and

10 (B) by inserting before the period at the  
11 end the following: “and, in the case of individ-  
12 uals who are likely to need post-hospital ex-  
13 tended care services, the availability of such  
14 services through facilities that participate in the  
15 program under this title and that serve the area  
16 in which the patient resides”.

17 (2) EFFECTIVE DATE.—The amendments made  
18 by paragraph (1) shall apply to discharge plans  
19 made on or after such date as the Secretary shall  
20 specify, but not later than 6 months after the date  
21 the Secretary provides for availability of information  
22 under subsection (a).

1 **SEC. 603. EVALUATION AND MANAGEMENT DOCUMENTA-**  
2 **TION GUIDELINES CONSIDERATION.**

3 The Secretary shall ensure, before making changes  
4 in documentation guidelines for, or clinical examples of,  
5 or codes to report evaluation and management physician  
6 services under title XVIII of Social Security Act, that the  
7 process used in developing such guidelines, examples, or  
8 codes was widely consultative among physicians, reflects  
9 a broad consensus among specialties, and would allow  
10 verification of reported and furnished services.

11 **SEC. 604. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**  
12 **AND COVERAGE.**

13 (a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—  
14 Section 1868 (42 U.S.C. 1395ee), as amended by section  
15 301(a), is amended by adding at the end the following new  
16 subsection:

17 “(c) COUNCIL FOR TECHNOLOGY AND INNOVA-  
18 TION.—

19 “(1) ESTABLISHMENT.—The Secretary shall es-  
20 tablish a Council for Technology and Innovation  
21 within the Centers for Medicare & Medicaid Services  
22 (in this section referred to as ‘CMS’).

23 “(2) COMPOSITION.—The Council shall be com-  
24 posed of senior CMS staff and clinicians and shall  
25 be chaired by the Executive Coordinator for Tech-

1 nology and Innovation (appointed or designated  
2 under paragraph (4)).

3 “(3) DUTIES.—The Council shall coordinate the  
4 activities of coverage, coding, and payment processes  
5 under this title with respect to new technologies and  
6 procedures, including new drug therapies, and shall  
7 coordinate the exchange of information on new tech-  
8 nologies between CMS and other entities that make  
9 similar decisions.

10 “(4) EXECUTIVE COORDINATOR FOR TECH-  
11 NOLOGY AND INNOVATION.—The Secretary shall ap-  
12 point (or designate) a noncareer appointee (as de-  
13 fined in section 3132(a)(7) of title 5, United States  
14 Code) who shall serve as the Executive Coordinator  
15 for Technology and Innovation. Such executive coor-  
16 dinator shall report to the Administrator of CMS,  
17 shall chair the Council, shall oversee the execution of  
18 its duties, and shall serve as a single point of con-  
19 tact for outside groups and entities regarding the  
20 coverage, coding, and payment processes under this  
21 title.”.

22 (b) METHODS FOR DETERMINING PAYMENT BASIS  
23 FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C.  
24 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, 2005 (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 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL  
21 DATA COLLECTION FOR USE IN THE MEDICARE INPA-  
22 TIENT PAYMENT SYSTEM.—

23 (1) STUDY.—The Comptroller General of the  
24 United States shall conduct a study that analyzes  
25 which external data can be collected in a shorter

1 time frame by the Centers for Medicare & Medicaid  
2 Services for use in computing payments for inpatient  
3 hospital services. The study may include an evalua-  
4 tion of the feasibility and appropriateness of using  
5 of quarterly samples or special surveys or any other  
6 methods. The study shall include an analysis of  
7 whether other executive agencies, such as the Bu-  
8 reau of Labor Statistics in the Department of Com-  
9 merce, are best suited to collect this information.

10 (2) REPORT.—By not later than October 1,  
11 2004, the Comptroller General shall submit a report  
12 to Congress on the study under paragraph (1).

13 **SEC. 605. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**  
14 **ICES UNDER MEDICARE SECONDARY PAYOR**  
15 **(MSP) PROVISIONS.**

16 (a) IN GENERAL.—The Secretary shall not require  
17 a hospital (including a critical access hospital) to ask ques-  
18 tions (or obtain information) relating to the application  
19 of section 1862(b) of the Social Security Act (relating to  
20 medicare secondary payor provisions) in the case of ref-  
21 erence laboratory services described in subsection (b), if  
22 the Secretary does not impose such requirement in the  
23 case of such services furnished by an independent labora-  
24 tory.

1 (b) REFERENCE LABORATORY SERVICES DE-  
2 SCRIBED.—Reference laboratory services described in this  
3 subsection are clinical laboratory diagnostic tests (or the  
4 interpretation of such tests, or both) furnished without a  
5 face-to-face encounter between the individual entitled to  
6 benefits under part A or enrolled under part B, or both,  
7 and the hospital involved and in which the hospital sub-  
8 mits a claim only for such test or interpretation.

9 **SEC. 606. EMTALA IMPROVEMENTS.**

10 (a) PAYMENT FOR EMTALA-MANDATED SCREEN-  
11 ING AND STABILIZATION SERVICES.—

12 (1) IN GENERAL.—Section 1862 (42 U.S.C.  
13 1395y) is amended by inserting after subsection (c)  
14 the following new subsection:

15 “(d) For purposes of subsection (a)(1)(A), in the case  
16 of any item or service that is required to be provided pur-  
17 suant to section 1867 to an individual who is entitled to  
18 benefits under this title, determinations as to whether the  
19 item or service is reasonable and necessary shall be made  
20 on the basis of the information available to the treating  
21 physician or practitioner (including the patient’s pre-  
22 senting symptoms or complaint) at the time the item or  
23 service was ordered or furnished by the physician or prac-  
24 titioner (and not on the patient’s principal diagnosis).  
25 When making such determinations with respect to such

1 an item or service, the Secretary shall not consider the  
2 frequency with which the item or service was provided to  
3 the patient before or after the time of the admission or  
4 visit.”.

5 (2) EFFECTIVE DATE.—The amendment made  
6 by paragraph (1) shall apply to items and services  
7 furnished on or after January 1, 2004.

8 (b) NOTIFICATION OF PROVIDERS WHEN EMTALA  
9 INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42  
10 U.S.C. 1395dd(d)) is amended by adding at the end the  
11 following new paragraph:

12 “(4) NOTICE UPON CLOSING AN INVESTIGA-  
13 TION.—The Secretary shall establish a procedure to  
14 notify hospitals and physicians when an investigation  
15 under this section is closed.”.

16 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZA-  
17 TIONS IN EMTALA CASES INVOLVING TERMINATION OF  
18 PARTICIPATION.—

19 (1) IN GENERAL.—Section 1867(d)(3) (42  
20 U.S.C. 1395dd(d)(3)) is amended—

21 (A) in the first sentence, by inserting “or  
22 in terminating a hospital’s participation under  
23 this title” after “in imposing sanctions under  
24 paragraph (1)”; and

1 (B) by adding at the end the following new  
2 sentences: “Except in the case in which a delay  
3 would jeopardize the health or safety of individ-  
4 uals, the Secretary shall also request such a re-  
5 view before making a compliance determination  
6 as part of the process of terminating a hos-  
7 pital’s participation under this title for viola-  
8 tions related to the appropriateness of a med-  
9 ical screening examination, stabilizing treat-  
10 ment, or an appropriate transfer as required by  
11 this section, and shall provide a period of 5  
12 days for such review. The Secretary shall pro-  
13 vide a copy of the organization’s report to the  
14 hospital or physician consistent with confiden-  
15 tiality requirements imposed on the organiza-  
16 tion under such part B.”.

17 (2) EFFECTIVE DATE.—The amendments made  
18 by paragraph (1) shall apply to terminations of par-  
19 ticipation initiated on or after the date of the enact-  
20 ment of this Act.

21 **SEC. 607. EMERGENCY MEDICAL TREATMENT AND ACTIVE**  
22 **LABOR ACT (EMTALA) TECHNICAL ADVISORY**  
23 **GROUP.**

24 (a) ESTABLISHMENT.—The Secretary shall establish  
25 a Technical Advisory Group (in this section referred to

1 as the “Advisory Group”) to review issues related to the  
2 Emergency Medical Treatment and Labor Act  
3 (EMTALA) and its implementation. In this section, the  
4 term “EMTALA” refers to the provisions of section 1867  
5 of the Social Security Act (42 U.S.C. 1395dd).

6 (b) MEMBERSHIP.—The Advisory Group shall be  
7 composed of 19 members, including the Administrator of  
8 the Centers for Medicare & Medicaid Services and the In-  
9 spector General of the Department of Health and Human  
10 Services and of which—

11 (1) 4 shall be representatives of hospitals, in-  
12 cluding at least one public hospital, that have experi-  
13 ence with the application of EMTALA and at least  
14 2 of which have not been cited for EMTALA viola-  
15 tions;

16 (2) 7 shall be practicing physicians drawn from  
17 the fields of emergency medicine, cardiology or  
18 cardiothoracic surgery, orthopedic surgery, neuro-  
19 surgery, pediatrics or a pediatric subspecialty, ob-  
20 stetrics-gynecology, and psychiatry, with not more  
21 than one physician from any particular field;

22 (3) 2 shall represent patients;

23 (4) 2 shall be staff involved in EMTALA inves-  
24 tigations from different regional offices of the Cen-  
25 ters for Medicare & Medicaid Services; and

1           (5) 1 shall be from a State survey office in-  
2           volved in EMTALA investigations and 1 shall be  
3           from a peer review organization, both of whom shall  
4           be from areas other than the regions represented  
5           under paragraph (4).

6 In selecting members described in paragraphs (1) through  
7 (3), the Secretary shall consider qualified individuals nom-  
8 inated by organizations representing providers and pa-  
9 tients.

10       (c) GENERAL RESPONSIBILITIES.—The Advisory  
11 Group—

12           (1) shall review EMTALA regulations;

13           (2) may provide advice and recommendations to  
14           the Secretary with respect to those regulations and  
15           their application to hospitals and physicians;

16           (3) shall solicit comments and recommendations  
17           from hospitals, physicians, and the public regarding  
18           the implementation of such regulations; and

19           (4) may disseminate information on the applica-  
20           tion of such regulations to hospitals, physicians, and  
21           the public.

22       (d) ADMINISTRATIVE MATTERS.—

23           (1) CHAIRPERSON.—The members of the Advi-  
24           sory Group shall elect a member to serve as chair-

1 person of the Advisory Group for the life of the Ad-  
2 visory Group.

3 (2) MEETINGS.—The Advisory Group shall first  
4 meet at the direction of the Secretary. The Advisory  
5 Group shall then meet twice per year and at such  
6 other times as the Advisory Group may provide.

7 (e) TERMINATION.—The Advisory Group shall termi-  
8 nate 30 months after the date of its first meeting.

9 (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The  
10 Secretary shall establish the Advisory Group notwith-  
11 standing any limitation that may apply to the number of  
12 advisory committees that may be established (within the  
13 Department of Health and Human Services or otherwise).

14 **SEC. 608. AUTHORIZING USE OF ARRANGEMENTS TO PRO-**  
15 **VIDE CORE HOSPICE SERVICES IN CERTAIN**  
16 **CIRCUMSTANCES.**

17 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.  
18 1395x(dd)(5)) is amended by adding at the end the fol-  
19 lowing:

20 “(D) In extraordinary, exigent, or other nonroutine  
21 circumstances, such as unanticipated periods of high pa-  
22 tient loads, staffing shortages due to illness or other  
23 events, or temporary travel of a patient outside a hospice  
24 program’s service area, a hospice program may enter into  
25 arrangements with another hospice program for the provi-

1 sion by that other program of services described in para-  
2 graph (2)(A)(ii)(I). The provisions of paragraph  
3 (2)(A)(ii)(II) shall apply with respect to the services pro-  
4 vided under such arrangements.

5 “(E) A hospice program may provide services de-  
6 scribed in paragraph (1)(A) other than directly by the pro-  
7 gram if the services are highly specialized services pro-  
8 vided by or under the supervision of a registered profes-  
9 sional nurse and are provided nonroutinely and so infre-  
10 quently so that the provision of such services directly  
11 would be impracticable and prohibitively expensive.”

12 (b) CONFORMING PAYMENT PROVISION.—Section  
13 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the  
14 end the following new paragraph:

15 “(4) In the case of hospice care provided by a hospice  
16 program under arrangements under section  
17 1861(dd)(5)(D) made by another hospice program, the  
18 hospice program that made the arrangements shall bill  
19 and be paid for the hospice care.”

20 (c) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply to hospice care provided on or after  
22 the date of the enactment of this Act.

1 **SEC. 609. COVERAGE OF HOSPICE CONSULTATION SERV-**  
2 **ICES.**

3 (a) COVERAGE OF HOSPICE CONSULTATION SERV-  
4 ICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amend-  
5 ed—

6 (1) by striking “and” at the end of paragraph  
7 (3);

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

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

12 “(5) for individuals who are terminally ill and  
13 who have not made an election under subsection  
14 (d)(1), services that are furnished by a physician  
15 who is either the medical director or an employee of  
16 a hospice program and that consist of—

17 “(A) an evaluation of the individual’s need  
18 for pain and symptom management, including  
19 the need for hospice care;

20 “(B) counseling the individual with respect  
21 to end-of-life issues, the benefits of hospice  
22 care, and care options; and

23 “(C) if appropriate, advising the individual  
24 regarding advanced care planning.”.

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

4 “(4) The amount paid to a hospice program with re-  
 5 spect to the services under section 1812(a)(5) for which  
 6 payment may be made under part A shall be the amount  
 7 determined under a fee schedule established by the Sec-  
 8 retary.”.

9 (c) CONFORMING AMENDMENT.—Section  
 10 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is  
 11 amended by inserting before the comma at the end the  
 12 following: “and services described in section 1812(a)(5)”.

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

16 **SEC. 610. APPLICATION OF OSHA BLOODBORNE PATHO-**  
 17 **GENS STANDARD TO CERTAIN HOSPITALS.**

18 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)  
 19 is amended—

20 (1) in subsection (a)(1)—

21 (A) in subparagraph (R), by striking  
 22 “and” at the end;

23 (B) in subparagraph (S), by striking the  
 24 period at the end and inserting “, and”; and

1 (C) by inserting after subparagraph (S)  
2 the following new subparagraph:

3 “(T) in the case of hospitals that are not other-  
4 wise subject to the Occupational Safety and Health  
5 Act of 1970 or a State occupational safety and  
6 health plan that is approved under section 18(b) of  
7 such Act, to comply with the Bloodborne Pathogens  
8 standard under section 1910.1030 of title 29 of the  
9 Code of Federal Regulations (or as subsequently re-  
10 designated).”; and

11 (2) by adding at the end of subsection (b) the  
12 following new paragraph:

13 “(4)(A) A hospital that fails to comply with the re-  
14 quirement of subsection (a)(1)(T) (relating to the  
15 Bloodborne Pathogens standard) is subject to a civil  
16 money penalty in an amount described in subparagraph  
17 (B), but is not subject to termination of an agreement  
18 under this section.

19 “(B) The amount referred to in subparagraph (A) is  
20 an amount that is similar to the amount of civil penalties  
21 that may be imposed under section 17 of the Occupational  
22 Safety and Health Act of 1970 for a violation of the  
23 Bloodborne Pathogens standard referred to in subsection  
24 (a)(1)(T) by a hospital that is subject to the provisions  
25 of such Act.



1 (b) TERMINOLOGY CORRECTIONS.—(1) Section  
2 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as  
3 amended by section 521 of BIPA, is amended—

4 (A) in subclause (III), by striking “policy” and  
5 inserting “determination”; and

6 (B) in subclause (IV), by striking “medical re-  
7 view policies” and inserting “coverage determina-  
8 tions”.

9 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-  
10 22(a)(2)(C)) is amended by striking “policy” and “POL-  
11 ICY” and inserting “determination” each place it appears  
12 and “DETERMINATION”, respectively.

13 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4)  
14 (42 U.S.C. 1395ff(f)(4)), as added by section 522 of  
15 BIPA, is amended—

16 (1) in subparagraph (A)(iv), by striking “sub-  
17 clause (I), (II), or (III)” and inserting “clause (i),  
18 (ii), or (iii)”;

19 (2) in subparagraph (B), by striking “clause  
20 (i)(IV)” and “clause (i)(III)” and inserting “sub-  
21 paragraph (A)(iv)” and “subparagraph (A)(iii)”, re-  
22 spectively; and

23 (3) in subparagraph (C), by striking “clause  
24 (i)”, “subclause (IV)” and “subparagraph (A)” and  
25 inserting “subparagraph (A)”, “clause (iv)” and

1 “paragraph (1)(A)”, respectively each place it ap-  
2 pears.

3 (d) OTHER CORRECTIONS.—Effective as if included  
4 in the enactment of section 521(c) of BIPA, section  
5 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking  
6 paragraph (5).

7 (e) EFFECTIVE DATE.—Except as otherwise pro-  
8 vided, the amendments made by this section shall be effec-  
9 tive as if included in the enactment of BIPA.

10 **SEC. 612. TREATMENT OF CERTAIN DENTAL CLAIMS.**

11 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y)  
12 is amended by adding after subsection (g) the following  
13 new subsection:

14 “(h)(1) Subject to paragraph (2), a group health plan  
15 (as defined in subsection (a)(1)(A)(v)) providing supple-  
16 mental or secondary coverage to individuals also entitled  
17 to services under this title shall not require a medicare  
18 claims determination under this title for dental benefits  
19 specifically excluded under subsection (a)(12) as a condi-  
20 tion of making a claims determination for such benefits  
21 under the group health plan.

22 “(2) A group health plan may require a claims deter-  
23 mination under this title in cases involving or appearing  
24 to involve inpatient dental hospital services or dental serv-

1 ices expressly covered under this title pursuant to actions  
2 taken by the Secretary.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall take effect on the date that is 60 days  
5 after the date of the enactment of this Act.

6 **SEC. 613. REVISIONS TO REASSIGNMENT PROVISIONS.**

7 (a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42  
8 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows:  
9 “(ii) where the service was provided under a contractual  
10 arrangement between such physician or other person and  
11 a qualified entity (as defined by the Secretary) or other  
12 person, to the entity or other person if under such ar-  
13 rangement such entity or individual submits the bill for  
14 such service and such arrangement (I) includes joint and  
15 several liability for overpayment by such physician or  
16 other person and such entity or other person, and (II)  
17 meets such other program integrity and other safeguards  
18 as the Secretary may determine to be appropriate,”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) The second sentence of section 1842(b)(6)  
21 (42 U.S.C. 1395u(b)(6)) is amended by striking “ex-  
22 cept to an employer or facility as described in clause  
23 (A)” and inserting “except to an employer, entity, or  
24 other person as described in subparagraph (A)”.

1           (2) Section 1842(b)(6) (42 U.S.C. 1395u(b)(6))  
2           is amended by adding at the end the following new  
3           sentence: “Nothing in subparagraph (A)(ii) shall be  
4           construed to prohibit requirements for joint and sev-  
5           eral liability for contractual arrangements where  
6           such requirements are not explicitly stated in a stat-  
7           ute.”.

8           (c) EFFECTIVE DATE.—The amendments made by  
9           this section shall apply to payments made on or after 1  
10          year after the date of the enactment of this Act.

11       **SEC. 614. GAO STUDY AND REPORT REGARDING ILLINOIS**  
12                               **COUNCIL DECISION.**

13          (a) STUDY.—The Comptroller General of the United  
14          States shall conduct a study on the access of health care  
15          providers and beneficiaries under the medicare program  
16          under title XVIII of the Social Security Act to judicial  
17          review of the actions of the Secretary of Health and  
18          Human Services and the effects of the decision of the Su-  
19          preme Court of the United States in *Shalala v. Illinois*  
20          *Council on Long Term Care, Inc.*, 529 U.S. 1 (1999) on  
21          such access.

22          (b) REPORT.—Not later than the date that is 1 year  
23          after the date of enactment of this Act, the Comptroller  
24          General of the United States shall submit to Congress a  
25          report on the study conducted under subsection (a) to-

- 1 gether with recommendations for such legislation or ad-
- 2 ministrative action as the Comptroller General determines
- 3 to be appropriate.

