

SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, *supra*.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTT) proposed an amendment to the bill S. 1, *supra*.

SA 1122. Mr. BROWNBACK (for himself and Mr. NELSON, of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, *supra*.

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1124. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1125. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1126. Mrs. DOLE (for herself and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, *supra*.

SA 1127. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1128. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by Mr. Daschle to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1130. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, *supra*; which was ordered to lie on the table.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1, *supra*.

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, *supra*.

TEXT OF AMENDMENTS

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 637, line 1, strike "no debt" and all that follows through line 5, and insert the following: "the sponsor of such an alien shall be responsible for paying 100 percent of the costs attributable to the provision of such assistance, unless the sponsor demonstrates that the sponsor has an extreme and unusual financial hardship that prevents the sponsor from paying such costs."

SA 1095. Mr. REID (for himself and Mr. COCHRAN) proposed an amendment

to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. ____ MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

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

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the assessment program.

(c) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary may contract with more than 1 qualified pharmacist at each site.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—Under a contract entered into under subsection (c), the Secretary shall pay qualified pharmacists a fee for providing medication therapy management services.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The Secretary shall, in consultation with national pharmacist and pharmacy associations, design the fee paid under paragraph (1) to test various payment methodologies applicable with respect to medication therapy management services, including a payment methodology that applies a relative value scale and fee-schedule with respect to such services that take into account the differences in—

(A) the time required to perform the different types of medication therapy management services;

(B) the level of risk associated with the use of particular outpatient prescription drugs or groups of drugs; and

(C) the health status of individuals to whom such services are provided.

(e) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the assessment program under this section.

(2) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the

Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the assessment program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the assessment program under this section.

(g) AVAILABILITY OF DATA.—During the period in which the assessment program is conducted, the Secretary annually shall make available data regarding—

(1) the geographic areas and sites designated under subsection (a)(2);

(2) the number of eligible beneficiaries participating in the program under subsection (b) and the level and types medication therapy management services used by such beneficiaries;

(3) the number of qualified pharmacists with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists; and

(4) the types of payment methodologies being tested under subsection (d)(2).

(h) REPORT.—

(1) IN GENERAL.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(i) DEFINITIONS.—In this section:

(1) MEDICATION THERAPY MANAGEMENT SERVICES.—The term "medication therapy management services" means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulation, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(3) QUALIFIED PHARMACIST.—The term "qualified pharmacist" means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.

SA 1096. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend the title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) **AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.**—The Secretary shall waive such provisions of the Medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the Medicare program.

(b) **CLINICS DESCRIBED.**—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) **DEFINITIONS.**—In this section, the terms “hospital” and “critical access hospital” have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1097. Mr. MCCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medical program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. . . . PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) **SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.**—If the individual is a qualified Medicare beneficiary (as defined in section 1860D-19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(2) **SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.**—If the individual is a specified low income Medicare beneficiary (as defined in paragraph 1860D-19(4)(B) of such Act) or a qualifying individual (as de-

finied in paragraph 1860D-19(4)(C) of such Act) who is diagnosed with cancer, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D-17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(2) of such Act.

(3) **SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only \$50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D-19(a)(3)(A).

(4) **ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer, such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of \$275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of \$4,500; and

(C) for 2006, an annual out-of-pocket limit of \$3,700 with 10 percent cost-sharing after that limit is reached.

SA 1098. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(1) (42 U.S.C. 1395m(1)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

“(10) **TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

“(B) **ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.**—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area described in subparagraph (C), the fee schedule

established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by the higher of either 20 percent of the rate determined after the application of subparagraph (C), in addition to the increase provided under subparagraph (A).

“(C) **DETERMINATION OF RURAL AREAS BASED ON POPULATION DENSITY WITHIN POSTAL ZIP CODES.**—With respect to ground ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (9) shall be applied by substituting ‘(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)’ for ‘(as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))’. Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

“(D) **APPLICATION OF INCREASED PAYMENTS AFTER 2007.**—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

“(11) **CONVERSION FACTOR ADJUSTMENTS.**—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.”.

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) **TECHNICAL AMENDMENT CONCERNING SECRETARY’S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.**—

(1) **IN GENERAL.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking “promptly (as determined in accordance with regulations)”;

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) **AUTHORITY TO MAKE CONDITIONAL PAYMENT.**—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) **CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.";

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity."

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (i) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1099. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:
SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) of the Social Security Act (42 U.S.C. §1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs.

"(10) TEMPORARY INCREASE FOR AMBULANCE SERVICES.—

"(A) GROUND AMBULANCE SERVICES.—Notwithstanding any other provision of this subsection, in the case of ground ambulance

services furnished on or after January 1, 2004 and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established shall be increased by 21.5 percent.

"(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, for which the transportation originates in a rural area described in paragraph (10)(C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established shall be increased by the higher of either 20 percent or the following section:

"(C) BASING RURAL AREAS ON POPULATION DENSITY BY POSTAL ZIP CODES."

(a) IN GENERAL.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended in paragraph (9), as so redesignated by section 2(a)(1), by striking "(as defined in section 1886(d)(2)(D))" and all that follows through "(57 Fed. Reg. 6725)" and inserting "(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)".

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services, taking into account the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall implement such increase in addition to the increase under subparagraph (A). The Secretary shall establish the classification system described in the amendment made by subsection (a) by not later than December 31, 2003. Such amendment shall apply to services furnished on or after such date, not later than 30 days after the establishment of such system, as the Secretary shall provide by regulation.

"(D) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph."

"(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor."

SA 1100. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. . INCREASE IN DRUG BENEFIT.

Notwithstanding any other provision of law, the Secretary shall use \$12,000,000,000 to improve the prescription drug benefit added under part D of title XVIII of the Social Security Act (as added by section 101) by eliminating coverage gaps, reducing the premium or cost-sharing, or expanding subsidies for low-income beneficiaries in lieu of conducting any demonstration projects or making any increased payments to providers authorized under this Act or the amendments made by this Act.

SA 1101. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

On page 134, strike line 9 and insert the following:

under paragraph (1).

"(d) IMPLEMENTATION OF PART D.—

"(1) IN GENERAL.—Notwithstanding section 1860D–1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2005, unless the Secretary certifies in writing to Congress, by not later than March 1, 2004, that such implementation is not possible. If such implementation is possible by January 1, 2005, the Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall implement sections 1807 and 1807A until the date of implementation as certified by the Secretary.

"(2) CERTIFICATION REQUIREMENTS.—A certification by the Secretary under paragraph (1) that implementation of this part is not possible by January 1, 2005, shall declare the reasons for the impossibility and a new date certain (which in no event shall be later than January 1, 2006) for implementation of this part.

SA 1102. Mr. McCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. . PROTECTING SENIORS WITH ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph

(1) or (2) of section 1860D-17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(2) of such Act.

(3) **SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only \$50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D-19(a)(3)(A).

(4) **ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.**—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of \$275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of \$4,500; and

(C) for 2006, an annual out-of-pocket limit of \$3,700 with 10 percent cost-sharing after that limit is reached.

SA 1103. Mr. DORGAN (for himself and Mr. PRYOR) proposed an amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

In lieu of the matter proposed to be inserted, insert the following:

SEC. . AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D-17, as added by section 101, is amended by adding at the end the following:

“(d) **AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.**—The Administrator shall for each year (beginning with 2009) determine a percentage which—

“(1) shall apply in lieu of the applicable percent otherwise determined under subsection (c) for that year, and

“(2) will result in a decrease of \$2,400,000,000 for that year in the aggregate monthly beneficiary obligations otherwise required of all eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage plan that provides qualified prescription drug coverage.5

This subsection shall not apply in determining the applicable percent under subsection (c) for purposes of section 1860D-21.”.

SA 1104. Mr. KOHL (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. 6. . ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) **IN GENERAL.**—

(1) **SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.**—

(A) **MEDICARE PROGRAM.**—Section 1819(b) (42 U.S.C. 1395i-3(b)) is amended by adding at the end the following:

“(8) **SCREENING OF SKILLED NURSING FACILITY WORKERS.**—

“(A) **BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.**—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) **PROHIBITION ON HIRING OF ABUSIVE WORKERS.**—

“(i) **IN GENERAL.**—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) **PROVISIONAL EMPLOYMENT.**—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

“(iii) **EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.**—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with pro-

viders of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) **REPORTING REQUIREMENTS.**—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) **USE OF INFORMATION.**—

“(i) **IN GENERAL.**—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) **IMMUNITY FROM LIABILITY.**—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) **CRIMINAL PENALTY.**—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) **CIVIL PENALTY.**—

“(i) **IN GENERAL.**—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, \$2,000; and

“(II) for the second and each subsequent violation within any 5-year period, \$5,000.

“(ii) **KNOWING RETENTION OF WORKER.**—In addition to any civil penalty under clause (i), a skilled nursing facility that—

“(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed \$5,000 for the first such violation, and \$10,000 for the second and each subsequent violation within any 5-year period.

“(F) **DEFINITIONS.**—In this paragraph:

“(i) **CONVICTION FOR A RELEVANT CRIME.**—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) **DISQUALIFYING INFORMATION.**—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) **FINDING OF PATIENT OR RESIDENT ABUSE.**—The term ‘finding of patient or resident abuse’ means any substantiated finding

by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”.

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

“(8) SCREENING OF NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker’s fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check

against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker’s provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

“(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, \$2,000; and

“(II) for the second and each subsequent violation within any 5-year period, \$5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

“(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed \$5,000 for the first such violation, and \$10,000 for the second and each subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers,

representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) NURSING FACILITY WORKER.—The term ‘nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”.

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A-585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i-3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i-3(e)) is amended by adding at the end the following:

“(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the skilled nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or \$50. Such fees shall be available to the Attorney General, or, in the Attorney General’s discretion, to the Federal Bureau of Investigation until expended.

“(II) STATE.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

“(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

“(E) REGULATIONS.—

“(i) IN GENERAL.—In addition to the Secretary’s authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General’s responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, de-

struction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

“(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee’s or employee’s criminal record.

“(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

“(i) the number of requests for searches and exchanges of records made under this section;

“(ii) the disposition of such requests; and

“(iii) the cost of responding to such requests.”.

(2) MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

“(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or \$50. Such fees shall be

available to the Attorney General, or, in the Attorney General’s discretion, to the Federal Bureau of Investigation, until expended.

“(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

“(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

“(E) REGULATIONS.—

“(i) IN GENERAL.—In addition to the Secretary’s authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General’s responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

“(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee’s or employee’s criminal record.

“(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

“(i) the number of requests for searches and exchanges of records made under this section;

“(ii) the disposition of such requests; and

“(iii) the cost of responding to such requests.”.

(c) APPLICATION TO OTHER ENTITIES PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

“APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

“SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a ‘medicare beneficiary’).

“(b) SUPERVISION OF PROVISIONAL EMPLOYEES.—

“(1) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or

1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

“(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

“(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

“(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

“(i) Follow-up telephone calls to the medicare beneficiary.

“(ii) Unannounced visits to the medicare beneficiary’s home while the provisional employee is serving the medicare beneficiary.

“(iii) To the extent practicable, limiting the provisional employee’s duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

“(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.”

(2) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking “and” at the end;

(B) in paragraph (66), by striking the period and inserting “; and”; and

(C) by inserting after paragraph (66) the following:

“(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).”

(3) EXPANSION OF STATE NURSE AIDE REGISTRY.—

(A) MEDICARE.—Section 1819 (42 U.S.C. 1395i-3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking “NURSE AIDE REGISTRY” and inserting “EMPLOYEE REGISTRY”;

(II) in subparagraph (A)—

(aa) by striking “By not later than January 1, 1989, the” and inserting “The”;

(bb) by striking “a registry of all individuals” and inserting “a registry of (i) all individuals”; and

(cc) by inserting before the period the following: “, (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this

title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property”; and

(III) in subparagraph (C), by striking “a nurse aide” and inserting “an individual”; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: “The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).”; and

(II) in the fourth sentence of subparagraph (C), by inserting “or described in subsection (e)(2)(A)(iii)” after “used by the facility”; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking “NURSE AIDE”; and

(bb) in clause (i), in the matter preceding subclause (I), by striking “a nurse aide” and inserting “an individual”; and

(cc) in clause (i)(I), by striking “nurse aide” and inserting “individual”.

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking “NURSE AIDE REGISTRY” and inserting “EMPLOYEE REGISTRY”;

(II) in subparagraph (A)—

(aa) by striking “By not later than January 1, 1989, the” and inserting “The”;

(bb) by striking “a registry of all individuals” and inserting “a registry of (i) all individuals”; and

(cc) by inserting before the period the following: “, (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property”; and

(III) in subparagraph (C), by striking “a nurse aide” and inserting “an individual”; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: “The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).”; and

(II) in the fourth sentence of subparagraph (C), by inserting “or described in subsection (e)(2)(A)(iii)” after “used by the facility”; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking “NURSE AIDE”; and

(bb) in clause (i), in the matter preceding subclause (I), by striking “a nurse aide” and inserting “an individual”; and

(cc) in clause (i)(I), by striking “nurse aide” and inserting “individual”.

(d) REIMBURSEMENT OF COSTS FOR BACKGROUND CHECKS.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)), as added by this section.

(e) INCLUSION OF ABUSIVE ACTS WITHIN A LONG-TERM CARE FACILITY OR PROVIDER IN THE NATIONAL HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.—

(1) IN GENERAL.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a-7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

“(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient’s or resident’s property.”

(2) COVERAGE OF LONG-TERM CARE FACILITY OR PROVIDER EMPLOYEES.—Section 1128E(g)(2) (42 U.S.C. 1320a-7e(g)(2)) is amended by inserting “, and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)” before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a-7e(b)(1)) is amended by striking “and health plan” and inserting “, health plan, and long-term care facility or provider”.

(B) CORRECTION OF INFORMATION.—Section 1128E(c)(2) (42 U.S.C. 1320a-7e(c)(2)) is amended by striking “and health plan” and inserting “, health plan, and long-term care facility or provider”.

(4) ACCESS TO REPORTED INFORMATION.—Section 1128E(d)(1) (42 U.S.C. 1320a-7e(d)(1)) is amended by striking “and health plans” and inserting “, health plans, and long-term care facilities or providers”.

(5) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—Section 1128E(d) (42 U.S.C. 1320a-7e(d)) is amended by adding at the end the following:

“(3) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants).”

(6) DEFINITION OF LONG-TERM CARE FACILITY OR PROVIDER.—Section 1128E(g) (42 U.S.C. 1320a-7e(g)) is amended by adding at the end the following:

“(6) LONG-TERM CARE FACILITY OR PROVIDER.—The term ‘long-term care facility or provider’ means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX.”.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the amendments made by this subsection, \$10,200,000 for fiscal year 2004.

(f) PREVENTION AND TRAINING DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—With respect to a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a))), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) LONG-TERM CARE FACILITIES AND PROVIDERS.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a-7e(g)(6)) (as added by subsection (e)), this section and the amendments made

by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SA 1105. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 486, line 3, insert “and” after the semicolon at the end.

On page 486, line 4, insert “(I)” after “(ii)”.

On page 486, line 8, strike “and” and insert “or”.

On page 486, line 9, strike “(iii)” and insert “(II)”.

SA 1106. Mr. HATCH (for himself and Mr. WYDEN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:
SEC. ____ HEALTH CARE THAT WORKS FOR ALL AMERICANS-CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation’s wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this Act are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens’ Health Care Working Group (referred to in this Act as the “Working Group”).

(d) APPOINTMENT.—Not later than 45 days after the date of enactment of this Act, the Speaker and Minority Leader of the House of Representatives and the Majority Leader and Minority Leader of the Senate (in this section referred to as the “leadership”) shall each appoint individuals to serve as members of the Working Group in accordance with subsections (e), (f), and (g).

(e) MEMBERSHIP CRITERIA.—

(1) APPOINTED MEMBERS.—

(A) SEPARATE APPOINTMENTS.—The Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate, shall each appoint 1 member of the Working Group described in subparagraphs (A), (G), (J), (K), and (M) of paragraph (2).

(B) JOINT APPOINTMENTS.—Members of the Working Group described in subparagraphs (B), (C), (D), (E), (F), (I), and (N) of paragraph (2) shall be appointed jointly by the leadership.

(C) COMBINED APPOINTMENTS.—Members of the Working Group described in subparagraphs (H) and (L) shall be appointed in the following manner:

(i) One member of the Working Group in each of such subparagraphs shall be appointed jointly by the leadership.

(ii) The remaining appointments of the members in each of such subparagraphs shall be divided equally such that the Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate each appoint an equal number of members.

(2) CATEGORIES OF APPOINTED MEMBERS.—Members of the Working Group shall be appointed as follows:

(A) 2 members shall be patients or family members of patients who, at least 1 year prior to the date of enactment of this Act, have had no health insurance.

(B) 1 member shall be a representative of children.

(C) 1 member shall be a representative of the mentally ill.

(D) 1 member shall be a representative of the disabled.

(E) 1 member shall be over the age of 65 and a beneficiary under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(F) 1 member shall be a recipient of benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(G) 2 members shall be State health officials.

(H) 3 members shall be employers, including—

(i) 1 large employer (an employer who employed 50 or more employees on business days during the preceding calendar year and who employed at least 50 employees on the first of the year);

(ii) 1 small employer (an employer who employed an average of at least 2 employees but less than 50 employees on business days in the preceding calendar year and who employs at least 2 employees on the first of the year); and

(iii) 1 multi-state employer.

(I) 1 member shall be a representative of labor.

(J) 2 members shall be health insurance issuers.

(K) 2 members shall be health care providers.

(L) 5 members shall be appointed as follows:

(i) 1 economist.

(ii) 1 academician.

(iii) 1 health policy researcher.

(iv) 1 individual with expertise in pharmacoeconomics.

(v) 1 health technology expert.

(M) 2 members shall be representatives of community leaders who have developed State or local community solutions to the problems addressed by the Working Group.

(N) 1 member shall be a representative of a medical school.

(3) SECRETARY.—The Secretary, or the designee of the Secretary, shall be a member of the Working Group.

(f) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include members of Congress or other elected government officials (Federal, State, or local) other than those individuals specified in subsection (e). To the extent possible, individuals appointed to the Working Group shall have used the health care system within the previous 2 years and shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(g) APPOINTMENT CRITERIA.—

(1) HOUSE OF REPRESENTATIVES.—The Speaker and Minority Leader of the House of Representatives shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the House of Representatives:

(A) The Committee on Ways and Means.

(B) The Committee on Energy and Commerce.

(C) The Committee on Education and the Workforce.

(2) SENATE.—The Majority Leader and Minority Leader of the Senate shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the Senate:

(A) The Committee on Finance.

(B) The Committee on Health, Education, Labor, and Pensions.

(h) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a term of 2 years. Such term is renewable and any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(i) APPOINTMENT OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the leadership shall make a joint designation of the chairperson of the Working Group. If the leadership fails to make such designation within such time period, the Working Group Members shall, not later than 10 days after the end of such time period, designate a chairperson by majority vote.

(j) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(k) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of appointment of the chairperson under subsection (i), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this Act. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, "The Health Report to the American People". Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Working Group shall initiate health care community meetings throughout the United States (in this section referred to as "community meetings"). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following issues:

(I) The optimum way to balance costs and benefits so that affordable health coverage is available to as many people as possible.

(II) The identification of services that provide cost-effective, essential health care services to maintain and improve health and which should be included in health care coverage.

(III) The cost of providing increased benefits.

(IV) The mechanisms to finance health care coverage, including defining the appropriate financial role for individuals, businesses, and government.

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(1) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (k)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(m) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this Act. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) **POSTAL SERVICES.**—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(n) **DETAIL.**—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(o) **TEMPORARY AND INTERMITTENT SERVICES.**—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(p) **ANNUAL REPORT.**—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(q) **SUNSET OF WORKING GROUP.**—The Working Group shall terminate when the report described in subsection (l) is submitted to Congress.

(r) **ADMINISTRATION REVIEW AND COMMENTS.**—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (l), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(s) **REQUIRED CONGRESSIONAL ACTION.**—Not later than 45 days after receiving the report submitted by the President under subsection (r), each committee of jurisdiction of Congress shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (l).

(t) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—There are authorized to be appropriated to carry out this Act, other than subsection (k)(3), \$3,000,000 for each of fiscal years 2004, 2005, and 2006.

(2) **HEALTH REPORT TO THE AMERICAN PEOPLE.**—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (k)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SA 1107. Mr. COCHRAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. ____ . AUTHORIZATION OF APPROPRIATIONS TO CONTINUE THE EXISTING CMS MEDICATION MONITORING SYSTEM.

There are authorized to be appropriated such sums as are necessary to continue the Prescription Continuity of Care medication

monitoring system in cooperation with the CMS Mississippi Quality Improvement Organization, Information Healthcare, and the University of Mississippi.

SA 1108. Mr. DURBIN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ____ . ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D–26, as added by section 101, is amended by adding at the end the following:

“(d) **ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.**—

“(1) **PROGRAM.**—Subject to paragraph (2), the Administrator shall implement a program (for the period beginning on January 1, 2009, and ending on September 30, 2013) to provide additional assistance to applicable eligible beneficiaries who have reached the initial coverage limit described in section 1860D–6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)) for the year in order to reduce the cost-sharing requirement during this coverage gap.

“(2) **FUNDING LIMITATION.**—The Administrator shall implement the program described in paragraph (1) in such a manner that will result in a decrease of \$12,000,000,000 in cost-sharing for covered drugs under part D by applicable eligible beneficiaries during the period described in such paragraph. The Administrator shall take appropriate steps to ensure that the costs of the program during such period do not exceed \$12,000,000,000.

“(3) **APPLICABLE ELIGIBLE BENEFICIARY.**—For purposes of this subsection, the term ‘applicable eligible beneficiary’ means an eligible beneficiary with cardiovascular disease, diabetes and its complications, cancer, or Alzheimer’s disease who is enrolled under part D.”

SA 1109. Mr. BURNS (for himself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on table; as follows:

On page 68, between lines 5 and 6, insert the following:

“(E) Not be less than 1,000,000 eligible beneficiaries shall reside in each service area.

On page 354, between lines 19 and 20, insert the following:

“(F) Not be less than 1,000,000 Medicare Advantage eligible individuals shall reside in each region.

SA 1110. Mr. BAUCUS (for Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that bene-

ficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan or entering private insurance under this act.

SA 1111. Mr. BAUCUS (for Mr. LEVIN (for himself, Ms. STABENOW, and Mrs. CLINTON)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that the 37% of current retirees who have prescription drug coverage, estimated by the Congressional Budget Office who will lose their current employer retiree coverage as a result of the enactment of this legislation will have the option to enter either a Medicare backup plan or private insurance under this act.

SA 1112. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

After section 404, insert the following:

SEC. 404A. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) **DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE.**—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking “35 percent” and inserting “35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)”.

(b) **CAPITAL COSTS.**—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking “and” at the end;

(2) in clause (iv), by striking the period at the end and inserting “, and”; and

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

“(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).”

SA 1113. Mr. GRASSLEY proposed an amendment to the bill S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children’s Health Insurance Programs; as follows:

At the end, add the following:

SEC. 2. TECHNICAL CORRECTION.

(a) **TEMPORARY INCREASE OF THE MEDICAID FMAP.**—Section 401(a)(6)(A) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027) is amended by inserting “after September 2, 2003,” after “(42 U.S.C. 1315)”.

(b) **RETROACTIVE EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as if included in the enactment of section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027).

SA 1114. Mr. KYL submitted an amendment intended to be proposed by

him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G-7 COUNTRIES.

(a) **STUDY.**—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) The proportion of the cost for innovation borne by American consumers compared with consumers in the other six countries;

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production (“Ramsey prices”);

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(b) **REPORT.**—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (A).

SA 1115. Mr. KYL (for himself, Mr. HATCH, and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) **FINDINGS.**—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2% in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4% cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991–2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation as measured by Medicare’s own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) **SENSE OF THE SENATE.**—It is the Sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

SA 1116. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

“(10) **TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

“(B) **ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.**—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area described in subparagraph (C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by the higher of either 20 percent of the rate determined after the application of

subparagraph (C), in addition to the increase provided under subparagraph (A).

“(C) **DETERMINATION OF RURAL AREAS BASED ON POPULATION DENSITY WITHIN POSTAL ZIP CODES.**—With respect to ground ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (9) shall be applied by substituting ‘(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)’ for ‘(as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))’. Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

“(D) **APPLICATION OF INCREASED PAYMENTS AFTER 2007.**—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

“(11) **CONVERSION FACTOR ADJUSTMENTS.**—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.”.

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) **TECHNICAL AMENDMENT CONCERNING SECRETARY’S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.**—

(1) **IN GENERAL.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking “promptly (as determined in accordance with regulations)”;

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) **AUTHORITY TO MAKE CONDITIONAL PAYMENT.**—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) **CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be

deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.”; and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received”; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.”.

(C) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

SA 1117. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, add the following:

SEC. ____ . SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

“PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

“SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

“SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the ‘Commission’).

“(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

“(1) REVIEW.—The Commission shall conduct an ongoing review of the health care

safety net programs (as described in paragraph (3)(C)) by—

“(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

“(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

“(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

“(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

“(E) supporting the development of new data systems where existing data are insufficient or inadequate;

“(F) developing criteria and indicators of impending core health care safety net failures;

“(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

“(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

“(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

“(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

“(ii) the degree to which these plans may be overburdened by adverse selection; and

“(iii) the degree to which emergency departments are used by enrollees of these plans; and

“(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

“(2) REPORTS.—

“(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

“(i) the health care needs of the uninsured; and

“(ii) the financial and infrastructure stability of the Nation’s core health care safety net.

“(B) AGENDA AND ADDITIONAL REVIEWS.—

“(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission’s agenda and progress toward achieving the agenda.

“(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and

submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

“(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

“(II) If the Commission deems such additional reviews and reports appropriate.

“(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

“(3) DEFINITIONS.—In this section:

“(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

“(B) CORE HEALTH CARE SAFETY NET.—The term ‘core health care safety net’ means any health care provider that—

“(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

“(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

“(C) HEALTH CARE SAFETY NET PROGRAMS.—The term ‘health care safety net programs’ includes the following:

“(i) MEDICAID.—The medicaid program under title XIX.

“(ii) SCHIP.—The State children’s health insurance program under title XXI.

“(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

“(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(1)(2)(B)) receives funds.

“(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(1)(1)) receives funds.

“(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

“(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

“(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

“(D) VULNERABLE POPULATIONS.—The term ‘vulnerable populations’ includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

“(c) MEMBERSHIP.—

“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the ‘Comptroller General’), in consultation with the appropriate committees of Congress.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

“(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

- “(i) four to serve a term of 1 year;
- “(ii) four to serve a term of 2 years; and
- “(iii) five to serve a term of 3 years.

“(B) VACANCIES.—

“(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

“(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

“(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

“(4) COMPENSATION.—

“(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

“(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

“(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

“(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of

the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

“(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

“(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

“(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

“(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

“(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

“(4) make advance, progress, and other payments which relate to the work of the Commission;

“(5) provide transportation and subsistence for persons serving without compensation; and

“(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

“(e) POWERS.—

“(1) OBTAINING OFFICIAL DATA.—

“(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

“(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

“(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

“(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

“(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

“(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comp-

troller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

“(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.”.

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system \$58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by \$36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the

Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 443 and insert the following:
SEC. 443. MEDICARE COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.

(a) PART B COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

(2) in subparagraph (V)(iii), by adding “and” after the semicolon at the end; and

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

“(W) care coordination and assessment services (as defined in subsection (ww)).”

(b) CARE COORDINATION AND ASSESSMENT SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Care Coordination and Assessment Services
“(ww)(1) The term ‘care coordination and assessment services’ means services that are furnished to an eligible individual (as defined in paragraph (2)) by a care coordinator (as defined in paragraph (3)) under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment, which may include any of the following services:

“(A) an initial assessment of an individual’s medical condition, functional and cognitive capacity and environmental and psychological needs and an annual assessment thereafter.

“(B) Management of transitions of care across practice settings and between providers.

“(C) Coordination of, and referral for, medical and other health-related services, including—

“(i) multidisciplinary care conferences;

“(ii) coordination with other providers, including telephone consultations with physicians; and

“(iii) monitoring and management of medications, with special emphasis on clients using multiple prescriptions (including coordination with the entity managing benefits for the individual).

“(D) Patient and family care-giver education and counseling (through office visits or telephone consultation), including self-management services and risk appraisal to identify behavioral risk factors through self assessment.

“(E) Providing information about end of life care, including referral to hospice services, when appropriate, including patient and family caregiver education and counseling about hospice, and managing and facilitating transition to hospice when elected.

“(F) Referral to and coordination with community resources.

“(G) Such other services for which payment would not otherwise be made under

this title as the Secretary shall determine to be appropriate including, but not limited to, activities to facilitate continuity of care and patient adherence to plans of care.

“(2) For purposes of this subsection, the term ‘eligible individual’ means an individual who a care coordinator annually certifies has multiple chronic conditions and meets eligibility criteria determined by the Secretary.

“(3)(A) For purposes of this subsection, the term ‘care coordinator’ means an individual or entity that—

“(i) is—

“(I) a physician who provides care to at least 50 eligible individuals; or

“(II) an independent nurse practitioner who provides care to at least 50 eligible individuals;

“(ii) has entered into a care coordination agreement with the Secretary; and

“(iii) has appropriate office staffing, operating under the direction of the eligible provider, which is sufficient in size and expertise to address the complex clinical care coordination needs of participating beneficiaries in the practice;

“(iv) has an ability and process to identify eligible beneficiaries;

“(v) has an ability to coordinate care for participating beneficiaries;

“(vi) has an ability to maintain and update patient records to ensure that care provided by other treating providers (including the instructions of other treating providers and any related lab results, prescription orders, and ancillary treatment services) is included in the record;

“(vii) has an ability to periodically review the medical record of participating beneficiaries to identify problems related to transitions, poly-pharmacy, and care continuity and to respond to resolve identified problems;

“(viii) is capable of referring to and coordinating with community-based supportive services;

“(ix) has an ability to communicate with participating beneficiaries or family caregivers as needed and appropriate, using telephonic and/or electronic communications; and

“(x) agrees to coordinate care for participating beneficiaries, consult with other treating providers (including but not limited to other treating physicians, other medical professionals involved in patient care, residential and inpatient facilities, and pharmacies), and community service providers;

“(xi) agrees to recognize patient treatment preferences; and

“(xii) is certified by the Secretary as meeting standards defined by the Secretary and being capable of coordinating clinical care for eligible beneficiaries.

“(B) For purposes of subparagraph (A)(ii), each care coordination agreement shall—

“(i) be entered into for a period of 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in subparagraph (A);

“(ii) contain such other terms and conditions as the Secretary may require.

“(4) For purposes of this subsection, the Secretary shall send quarterly reports to each eligible provider that inform, in aggregate, on the provider’s participating beneficiary caseload, using measures determined by the Secretary that are derived from existing Medicare data sources. In preparing the reports under this paragraph, the Secretary shall consider—

“(A) the average number of emergency room and nursing home visits relative to geographic norms for all eligible beneficiaries; and

“(B) the average number of unique physician visits relative to geographic norms for all eligible beneficiaries.

“(5) For purposes of this subsection, the term ‘functional limitations’ means each of the following:

“(A) Eating.

“(B) Toileting.

“(C) Transferring.

“(D) Bathing.

“(E) Dressing.

“(F) Contingence.

“(6) Rural health clinics and Federally qualified health centers shall be eligible sites at which care coordination and assessment services may be provided.

“(7) For purposes of this subsection, the term ‘chronic condition’ means an illness, functional limitation, or cognitive impairment that is expected to last at least 1 year and limits what a person can do, and requires ongoing care.

“(8) For purposes of this subsection, the Secretary shall establish eligibility criteria for the care management benefit that would target approximately 5 percent of elderly Medicare fee-for-service enrollees. The eligibility criteria should identify enrollees who need care management because they have multiple chronic conditions that result in high use of Medicare services, high use of prescription medications, and high Medicare costs. Inability to manage one’s own care due to cognitive impairment should be considered as an additional indicator of need for care management.

(c) PAYMENT AND ELIMINATION OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking “and” before “(U)”; and

(B) by inserting before the semicolon at the end the following: “, and (V) with respect to assessment services described in section 1861(s)(2)(W), the amounts paid shall be 100 percent of the lesser of the actual charge for the service or the amount determined under the payment basis determined under section 1848 by the Secretary for such service and an administrative fee shall be developed for care coordination services”.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting “(2)(W),” after “(2)(S).”

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after “1861(s)(10)(A)” the following: “, with respect to care coordination and assessment services (as defined in section 1861(ww)(1)).”

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

“(vii) A care coordinator (as defined in section 1861(ww)(3)) that is not a physician.”

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

“(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICAL CARE.—In the case of a designated health service, if the designated health service is—

“(A) a care coordination and assessment service (as defined in section 1861(ww)(1)); and

“(B) provided by a care coordinator (as defined in paragraph (3) of such section).”

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms

and establish such procedures as the Secretary determines necessary to implement the provisions of this section.

(g) **EFFECTIVE DATE.**—The amendments made by this section shall apply to care coordination and assessment services furnished on or after January 1, 2006, and before January 1, 2011.

At the end of subtitle B of title IV, add the following:

SEC. . . . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) **TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.**—

(1) **IN GENERAL.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking “promptly (as determined in accordance with regulations)”;

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) **AUTHORITY TO MAKE CONDITIONAL PAYMENT.**—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) **CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.**—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.”; and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received”;

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under

this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.”.

(c) **CLERICAL AMENDMENTS.**—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(1) (42 U.S.C. 1395m(1)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

“(10) **TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007 for which the transportation originates in—

“(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

“(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent

“(B) **APPLICATION OF INCREASED PAYMENTS AFTER 2007.**—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.”.

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTT) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) **FINDINGS.**—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong Medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the “baby boom” generation will dramatically increase the costs of providing Medicare benefits. Medicare costs will double relative to the size of the economy from 2% of GDP today to 4% in 2025 and double again to 8% of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and a host of other advances. Reforming Medicare to create a more self-adjusting, innovative structure is essential to improve Medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of America's seniors, not the government, and would create a powerful incentive for private-sector Medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and federal employees with excellent health care choices.

(6) Unlike the Medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) **SENSE OF THE SENATE.**—It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2006 to ensure the long and short term viability of such options for America's seniors.

(3) Develop a payment system for the Medicare Advantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the Medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the \$400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended consequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9) Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.

SA 1122. Mr. BROWNBACk (for himself, and Mr. NELSON of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. —. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

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

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals that furnish rural community hospital services to medicare beneficiaries.

(2) DESIGNATION OF RCHs.—

(A) APPLICATION.—Each hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) DESIGNATION.—The Secretary shall designate any hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section as a rural community hospital for purposes of the demonstration program.

(C) DEMONSTRATION AREAS.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

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

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

(b) PAYMENT.—

(1) INPATIENT HOSPITAL SERVICES.—The amount of payment under the demonstration program for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge; or

(B) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) OUTPATIENT SERVICES.—The amount of payment under the demonstration program for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U) of the Social Security Act (42 U.S.C. 1395x(v)(1)(U)); or

(B) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(3) HOME HEALTH SERVICES.—In determining payments under the demonstration program

for home health services furnished by a qualified RCH-based home health agency (as defined in paragraph (2))—

(A) the agency may make a one-time election to waive application of the prospective payment system established under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to such services furnished by the agency; and

(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(4) CONSOLIDATED BILLING.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(5) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—In determining the reasonable costs for rural community hospitals, section 1861(v)(1)(T) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)) shall not apply.

(6) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under the demonstration program shall be as follows:

(A) For items and services that would have been paid under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

(B) For items and services that would have been paid under section 1833(h) of such Act (42 U.S.C. 1395l(h)) if furnished by a provider or supplier, no cost-sharing shall apply.

(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.

(7) RETURN ON EQUITY.—

(A) IN GENERAL.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(B) SERVICES DESCRIBED.—The services referred to in subclause (I) are rural community hospital services.

(C) DISREGARD OF PROPRIETARY PROVIDER STATUS.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(8) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY RCH FACILITIES.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit rural community hospitals to establish distinct part units for purposes of applying such section.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be

appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

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

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

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

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL.—

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

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

(ii) subject to subparagraph (B), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

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

(iv) subject to subparagraph (C), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

(v) applies to the Secretary for such designation.

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

(C) TYPES OF HOSPITALS THAT MAY PARTICIPATE.—Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

(i) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

(ii) A facility obtaining a new provider number pursuant to a change of ownership.

(iii) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

(D) INCLUSION OF CAHS.—Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) and section 1866 of such Act (42 U.S.C. 1395cc).

(2) QUALIFIED RCH-BASED HOME HEALTH AGENCY DEFINED.—The term “qualified RCH-based home health agency” is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554; Appendix F, 114 Stat. 2763A-506)) of a rural community hospital that is located—

(A) in a county in which no main or branch office of another home health agency is located; or

(B) at least 35 miles from any main or branch office of another home health agency. **SEC. 500. CRITICAL ACCESS HOSPITAL IMPROVEMENT DEMONSTRATION PROGRAM.**

(a) **ESTABLISHMENT OF CRITICAL ACCESS HOSPITAL DEMONSTRATION PROGRAM.—**

(1) **IN GENERAL.—**The Secretary shall establish a demonstration program to test various methods to improve the critical access hospital program under section 1820 of the Social Security Act (42 U.S.C. 1395i-4).

(2) **CRITICAL ACCESS HOSPITAL IMPROVEMENT.—**In conducting the demonstration program under this section, the Secretary shall apply rules with respect to critical access hospitals participating in the program as follows:

(A) **EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—**In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subsections (c)(2)(B)(iii) and (f) of section 1820 of the Social Security Act (42 U.S.C. 1395i-4), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.

(B) **EXCLUSION FROM HOME HEALTH PPS.—**Notwithstanding section 1895 of the Social Security Act (42 U.S.C. 1395fff), in determining payments under the demonstration program for home health services furnished by a home health agency that is owned and operated by a critical access hospital participating in the demonstration program—

(i) the agency may make an election to waive application of the prospective payment system established under such section to such services furnished by the agency; and

(ii) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(C) **EXEMPTION OF CAH FACILITIES FROM PPS.—**Notwithstanding section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), in determining payments under this part for covered skilled nursing facility services furnished by a skilled nursing facility that is a distinct part unit of a critical access hospital participating in the demonstration program or is owned and operated by a critical access hospital participating in the demonstration program—

(i) the prospective payment system established under such section shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(D) **CONSOLIDATED BILLING.—**The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(E) **EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—**Notwithstanding section 1886(b) of the Social Security Act (42 U.S.C. 1395ww(b)), in determining payments under the demonstration program for inpatient hospital services furnished by a distinct part psychiatric or rehabilitation unit (described in the matter following section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v))) of a critical access hos-

pital participating in the demonstration program—

(i) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(F) **RETURN ON EQUITY.—**

(i) **IN GENERAL.—**Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital participating in the demonstration program for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(ii) **SERVICES DESCRIBED.—**The services referred to in subclause (I) are inpatient critical access hospital services, outpatient critical access hospital services, extended care services, posthospital extended care services, home health services, ambulance services, and inpatient hospital services.

(iii) **DISREGARD OF PROPRIETARY PROVIDER STATUS.—**Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(G) **REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CAH FACILITIES.—**Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit critical access hospitals participating in the demonstration program to establish distinct part units for purposes of applying such section.

(3) **PARTICIPATION OF CAHS.—**

(A) **APPLICATION.—**Each critical access hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) **PARTICIPATION.—**The Secretary shall permit any critical access hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section to participate in the demonstration program.

(C) **DEMONSTRATION AREAS.—**There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

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

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

(b) **FUNDING.—**

(1) **IN GENERAL.—**The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) **BUDGET NEUTRALITY.—**In conducting the demonstration program under this section, the Secretary shall ensure that the agree-

gate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(c) **WAIVER AUTHORITY.—**The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

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

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. 500. SENSE OF THE SENATE REGARDING THE PRESERVATION OF BENEFICIARY CHOICES UNDER MEDICAREADVANTAGE; ESTABLISHMENT OF STANDARDS.

(a) **SENSE OF THE SENATE.—**It is the sense of the Senate that medicare beneficiaries should have a choice among multiple types of health plans under the MedicareAdvantage program, including regional preferred provider organizations and local health maintenance organization plans in markets where such plans naturally occur.

(b) **ESTABLISHMENT OF STANDARDS.—**The Secretary shall establish standards with respect to the participation of private health plans in the MedicareAdvantage program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) that—

(1) encourage fair competition among such plans;

(2) ensure that beneficiaries who desire to elect health benefits coverage under such a plan are provided with benefits that are actuarially equivalent to the benefits provided under other beneficiary options for health benefits coverage available under the medicare program; and

(3) equally apply incentives to promote health plan participation to all plans desiring to participate in the MedicareAdvantage program.

SA 1125. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike title V and insert the following:

TITLE V—MEDICARE EDUCATION, REGULATORY REFORM, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 500. SHORT TITLE.

This title may be cited as the “Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003”.

SEC. 501. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

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

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

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

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

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

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

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

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

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

“(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.”.

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

SEC. 502. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 501(a)(1), is amended by adding at the end the following new subsection:

“(e)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

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

“(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

“(B) information from medicare contractors that tracks the nature of communications and correspondence, including the communications and correspondence required under section 1874A.

“(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation

or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.”.

SEC. 503. STATUS OF PENDING INTERIM FINAL REGULATIONS.

Section 1871 (42 U.S.C. 1395hh) as amended by sections 501 and 502, is amended by adding at the end the following new subsection:

“(f) The Secretary shall publish in the Federal Register at least once every 6 months a list that provides the status of each interim final regulation for which no final regulation has been published. Such list shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.”.

Subtitle B—Appeals Process Reform**SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.**

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

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

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

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

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

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

(H) INDEPENDENCE OF JUDGES.—The steps that should be taken to ensure that judges who perform the administrative law judge functions after the transfer under the plan maintain their independence from the Centers for Medicare & Medicaid Services and its contractors.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of judges performing the administrative law judge functions that are transferred under the plan throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire judges (and support staff) to perform

the administrative law judge functions that are transferred under the plan.

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for judges performing the administrative law judge functions that are transferred under the plan with respect to timelines for decisions in cases under title XVIII.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to judges performing the administrative law judge functions that are transferred under the plan with respect to laws and regulations under title XVIII.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

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

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress a report on such evaluation.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

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

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

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

“(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

“(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

“(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

“(C) ACCESS TO JUDICIAL REVIEW.—

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

“(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide; or

“(II) fails to make such determination within the period provided under subparagraph (B); then the appellant may bring a civil action as described in this subparagraph.

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

“(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

“(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

“(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

“(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

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

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

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

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

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

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

“(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).”

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

SEC. 513. COST REPORT REFORM.

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representa-

tives a report recommending specific ways to modernize the cost reporting system under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall be consistent with the recommendations of the Secretary’s Advisory Committee on Regulatory Reform, including the use of Generally Accepted Accounting Principles.

(b) CONSULTATION.—In developing the report submitted under subsection (a), the Secretary shall consult with representatives of the hospital industry, the Medicare Payment Advisory Commission, the General Accounting Office, and such other individuals and entities as the Secretary determines to be appropriate.

SEC. 514. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

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

(A) the remedy of termination of participation has been imposed;

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

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

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 515. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

“(3) TIMELY COMPLETION OF THE RECORD.—

“(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

“(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

“(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hear-

ings or review under this section are 90 days after the date on which the record is complete.

“(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

“(i) written or testimonial evidence, or both, submitted by the person filing the request,

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

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

“(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.”

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

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

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

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

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

(c) USE OF PATIENTS’ MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting “(including the medical records of the individual involved)” after “clinical experience”.

(d) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

“(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

“(A) the reasons for the determination, including, as appropriate—

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

“(ii) upon request, in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

“(B) the procedures for obtaining additional information concerning the determination or redetermination; and

“(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.”

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

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

“(i) to the extent appropriate, an explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

“(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

“(iii) in the case of a determination of whether an item or service is reasonable and

necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the decision.”.

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

(A) in the heading, by inserting “; NOTICE” after “SECRETARY”; and

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

“(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

“(A) the specific reasons for the determination; and

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

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

(e) QUALIFIED INDEPENDENT CONTRACTORS.—

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

(A) in paragraph (2)—

(i) by inserting “(except in the case of a utilization and quality control peer review organization, as defined in section 1152)” after “means an entity or organization that”;

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

“(A) GENERAL REQUIREMENTS.—

“(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

“(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

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

“(B) INDEPENDENCE REQUIREMENTS.—

“(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

“(I) is not a related party (as defined in subsection (g)(5));

“(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

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

“(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

“(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.”; and

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

(2) ELIGIBILITY REQUIREMENTS OF REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) in subsection (c)(3)(B)(i), by striking “a panel of physicians or other appropriate health care professionals” and inserting “a physician or another appropriate health care professional”;

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

“(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).”;

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

“(g) QUALIFICATIONS OF REVIEWERS.—

“(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall ensure that—

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

“(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

“(C) in the case of a review described in subsection (c)(3)(B) and conducted by a physician or another health care professional (each in this subsection referred to as a ‘reviewing professional’), that the reviewing professional meets the qualifications described in paragraph (4).

“(2) INDEPENDENCE.—

“(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

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

“(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

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

“(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

“(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

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

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

“(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

“(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

“(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

“(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

“(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

“(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

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

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

“(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

“(B) The individual (or authorized representative).

“(C) The health care professional that provides the items or services involved in the case.

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

“(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

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

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking “12” and inserting “4”.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

“(d) EFFECTIVE DATE.—

“(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after January 1, 2005.

“(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—The amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003 under the following provisions:

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

“(B) Subsection (c)(3)(C)(iii) of such section.

“(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

“(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.”.

(2) CONFORMING AMENDMENT.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

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

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

SEC. 516. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

“(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

“(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

“(2) a provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.”.

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

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 501, 502, and 503, is amended by adding at the end the following new subsection:

“(g) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.”.

SEC. 517. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

“(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination and the provider of services, physician, practitioner, or other supplier would be prejudiced by the determination.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 518. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

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

“(5) AGGRIEVED PARTY DEFINED.—In this section, with respect to a national or local coverage determination, the term ‘aggrieved party’ means—

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

“(B) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.”.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting “, including, where appropriate, a clear explanation of the reasons for the denial” before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 515(d)(2)(B), is amended by adding at the end the following new subsection:

“(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

“(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

“(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term ‘provider local coverage determination request’ means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

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

“(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

“(B) each reversal described in subparagraph (A) involves substantially similar material facts;

“(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

“(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

“(4) APPROVAL OR REJECTION OF REQUEST.—

“(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

“(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection

and no further proceedings in relation to such request shall be conducted.”.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

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

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

(B) any final determination made with respect to such claims.

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

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

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

(A) any review of any local coverage determination filed on or after January 1, 2004;

(B) any request to make such a determination made on or after such date; or

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

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of the enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

“CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

“SEC. 1874A. (a) AUTHORITY.—

“(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

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

“(A) the entity has demonstrated capability to carry out such function;

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

“(C) the entity has sufficient assets to financially support the performance of such function; and

“(D) the entity meets such other requirements as the Secretary may impose.

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

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

“(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the ‘appropriate’ medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

“(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions as follows:

“(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

“(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

“(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

“(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

“(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

“(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

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

“(5) RELATIONSHIP TO MIP CONTRACTS.—

“(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5)

(relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

“(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

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

“(b) CONTRACTING REQUIREMENTS.—

“(1) USE OF COMPETITIVE PROCEDURES.—

“(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

“(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures, unless laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation authorize the use of other procedures, under such a contract not less frequently than once every 8 years.

“(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

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

“(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

“(3) PERFORMANCE REQUIREMENTS.—

“(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

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

“(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

“(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

“(ii) shall be used for evaluating contractor performance under the contract; and

“(iii) shall be consistent with the written statement of work provided under the contract.

“(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

“(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

“(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

“(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

“(c) TERMS AND CONDITIONS.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

“(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

“(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

“(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

“(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

“(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United

States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

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

“(5) INDEMNIFICATION BY SECRETARY.—

“(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

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

“(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

“(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

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

“(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

“(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.”.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

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

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

“PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

(2) Subsection (a) is amended to read as follows:

“(a) The administration of this part shall be conducted through contracts with medi-

care administrative contractors under section 1874A.”.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

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

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

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

(A) by striking “An agreement with an agency or organization under this section” and inserting “A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part”; and

(B) by striking “such agency or organization” and inserting “such medicare administrative contractor” each place it appears.

(7) Subsection (l) is repealed.

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

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

“PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

(2) Subsection (a) is amended to read as follows:

“(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.”.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

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

(ii) in subparagraph (C), by striking “carriers” and inserting “medicare administrative contractors”; and

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

(C) in paragraph (3)—

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

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

(iii) in subparagraph (B), in the matter before clause (i), by striking “to the policyholders and subscribers of the carrier” and inserting “to the policyholders and subscribers of the medicare administrative contractor”;

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

(v) in subparagraph (H)—

(I) by striking “if it makes determinations or payments with respect to physicians' services.”; and

(II) by striking “carrier” and inserting “medicare administrative contractor”;

(vi) by striking subparagraph (I);

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

(viii) in the first sentence, after subparagraph (L), by striking “and shall contain” and all that follows through the period; and

(ix) in the seventh sentence, by inserting “medicare administrative contractor,” after “carrier.”;

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking “carrier” and inserting “medicare administrative contractor”; and

(F) in paragraph (7), by striking “the carrier” and inserting “the Secretary” each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking “contract under this section which provides for the disbursement of funds, as described in sub-

section (a)(1)(B).” and inserting “contract under section 1874A that provides for making payments under this part”;

(C) in paragraph (3)(A), by striking “subsection (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;

(D) in paragraph (4), by striking “carrier” and inserting “medicare administrative contractor”;

(E) in paragraph (5), by striking “contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier” and “carrier responses” and inserting “contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor” and “contractor responses”, respectively; and

(F) by striking paragraph (6).

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

(6) Subsection (g) is amended by striking “carrier or carriers” and inserting “medicare administrative contractor or contractors”.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking “Each carrier having an agreement with the Secretary under subsection (a)” and inserting “The Secretary”; and

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

(B) in paragraph (3)(A)—

(i) by striking “a carrier having an agreement with the Secretary under subsection (a)” and inserting “medicare administrative contractor having a contract under section 1874A that provides for making payments under this part”; and

(ii) by striking “such carrier” and inserting “such contractor”;

(C) in paragraph (3)(B)—

(i) by striking “a carrier” and inserting “a medicare administrative contractor” each place it appears; and

(ii) by striking “the carrier” and inserting “the contractor” each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(ii), by striking “carriers” and inserting “medicare administrative contractors” each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking “carrier” and inserting “medicare administrative contractor”; and

(B) in paragraph (2), by striking “carrier” and inserting “medicare administrative contractor”.

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

(10) Subsection (q)(1)(A) is amended by striking “carrier”.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for

functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

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

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

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

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

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

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

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

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

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

“PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

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

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

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

“(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

“(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

“(2) IG REVIEW OF METHODOLOGY.—The Inspector General of the Department of Health and Human Services shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

“(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.”

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”; and

(B) in subparagraph (B), by striking “The amount appropriated” and inserting “Subject to subparagraph (C), the amount appropriated”; and

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

“(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

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

“(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.”

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

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

“(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

“(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

“(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term ‘small provider of services or supplier’ means—

“(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

“(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.”

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

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

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

“(c) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

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

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

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

“(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term ‘medicare contractor’ includes the following:

“(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

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

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

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

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

“(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

“(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare

contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

“(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within a contractual timeframe established by the Secretary.

“(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

“(4) MONITORING OF CONTRACTOR RESPONSES.—

“(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

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

“(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

“(B) DEVELOPMENT OF STANDARDS.—

“(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

“(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

“(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

“(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in subsection (e)(3).”

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

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

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 501, is amended by adding at the end the following new paragraph:

“(2) If—

“(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

“(i) by the Secretary; or

“(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting with-

in the scope of the contractor’s contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

“(B) the Secretary determines that—

“(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

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

“(C) the guidance was in error; the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.”

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

SEC. 534. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

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

(1) by adding at the end of the heading the following: “; MEDICARE PROVIDER OMBUDSMAN”;

(2) by inserting “PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)” after “(a)”;

(3) in paragraph (1), as so redesignated under paragraph (2), by striking “in this section” and inserting “in this subsection”;

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

(5) by adding at the end the following new subsection:

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

“(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

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

“(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration);

“(B) recommendations to provide for an appropriate and consistent response (includ-

ing not providing for audits) in cases of self-identified overpayments by providers of services and suppliers; and

“(C) recommendations to improve communication between providers, contractors, and the Centers for Medicare & Medicaid Services.

“(c) STAFF.—The Secretary shall provide appropriate staff to assist in performing the duties described in subsection (b).”

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

“MEDICARE BENEFICIARY OMBUDSMAN

“SEC. 1807. (a) IN GENERAL.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman (including support staff) who shall have expertise and experience in the fields of health care and advocacy.

“(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

“(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

“(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

“(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

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

“(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.”

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by adding at the end the following: “By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.”

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the “demonstration program”) under which medicare specialists

employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

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

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 3 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

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

(d) EVALUATION AND REPORT.—

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

(A) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

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

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

“(g) CONDUCT OF PREPAYMENT REVIEW.—

“(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

“(2) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

“(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

“(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

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

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of the enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

“(h) RECOVERY OF OVERPAYMENTS.—

“(1) USE OF REPAYMENT PLANS.—

“(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

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

“(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

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

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

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

“(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

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

“(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

“(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

“(2) LIMITATION ON RECOUPMENT.—

“(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

“(B) PAYMENT OF INTEREST.—

“(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

“(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

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

“(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in section 1889(e).

“(3) PAYMENT AUDITS.—

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

“(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

“(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

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

“(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

“(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

“(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be over utilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

“(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

“(6) CONSENT SETTLEMENT REFORMS.—

“(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

“(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

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

“(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

“(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

“(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

“(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

“(I) the opportunity for a statistically valid random sample; or

“(II) a consent settlement.

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

“(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term ‘consent settlement’ means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.”.

(b) EFFECTIVE DATES AND DEADLINES.—

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

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

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of the enactment of this Act.

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

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a-7(c)(3)(B)) is amended to read as follows: “Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.”.

SEC. 545. RECOVERY OF OVERPAYMENTS.

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

“(f) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

“(1) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

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

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

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

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

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

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

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

(A) by striking “hospice services” and inserting “hospice care and post-hospital extended care services”; and

(B) by inserting before the period at the end the following: “and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides”.

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

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

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

SEC. 554. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

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

“(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

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

“(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians

and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

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

“(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.”

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

“(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as ‘new tests’).

“(B) Determinations under subparagraph (A) shall be made only after the Secretary—

“(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

“(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

“(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

“(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

“(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

“(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

“(i) set forth the criteria for making determinations under subparagraph (A); and

“(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

“(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

“(E) For purposes of this paragraph:

“(i) The term ‘HCPCS’ refers to the Health Care Procedure Coding System.

“(ii) A code shall be considered to be ‘substantially revised’ if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).”

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

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

SEC. 555. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 556. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

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

“(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient’s presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient’s principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency

with which the item or service was provided to the patient before or after the time of the admission or visit.”

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

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

“(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.”

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

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

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

(B) by adding at the end the following new sentences: “Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital’s participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization’s report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.”

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 557. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the “Advisory Group”) to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term “EMTALA” refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

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

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

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

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

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

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

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

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

SEC. 558. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

“(D) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program’s service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

“(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services provided by or under the supervision of a registered professional nurse and are provided nonroutinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.”

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

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

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

SEC. 559. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

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

(2) by striking the period at the end of paragraph (4) and inserting “; and”; and

(3) by inserting after paragraph (4) the following new paragraph:

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

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

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

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

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

“(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under part A shall be the amount determined under a fee schedule established by the Secretary.”

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

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

SEC. 560. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

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

(1) in subsection (a)(1)—

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

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

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

“(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 or a State occupational safety and health plan that is approved under section 18(b) of such Act, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).”; and

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

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

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

“(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.”

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 561. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking “established under section 1114(f)”; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking “under subsection (f)”; and

(ii) by striking “section 1862(a)(1)” and inserting “subsection (a)(1)”.

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

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

(B) in subclause (IV), by striking “medical review policies” and inserting “coverage determinations”.

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

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

(1) in subparagraph (A)(iv), by striking “subclause (I), (II), or (III)” and inserting “clause (i), (ii), or (iii)”; and

(2) in subparagraph (B), by striking “clause (i)(IV)” and “clause (i)(II)” and inserting “subparagraph (A)(iv)” and “subparagraph (A)(iii)”, respectively; and

(3) in subparagraph (C), by striking “clause (i)”, “subclause (IV)” and “subparagraph (A)” and inserting “subparagraph (A)”, “clause (iv)” and “paragraph (1)(A)”, respectively each place it appears.

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

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 562. TREATMENT OF CERTAIN DENTAL CLAIMS.

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

“(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

“(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.”

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

SEC. 563. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: “(ii) where the service was provided under a contractual arrangement between such physician or other person and a qualified entity (as defined by the Secretary) or other person, to the entity or other person if under such arrangement such entity or individual submits the bill for such service and such arrangement (I) includes

joint and several liability for overpayment by such physician or other person and such entity or other person, and (II) meets such other program integrity and other safeguards as the Secretary may determine to be appropriate.”.

(b) CONFORMING AMENDMENTS.—

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

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

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

SEC. 564. GAO STUDY AND REPORT REGARDING ILLINOIS COUNCIL DECISION.

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

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislative or administrative action as the Comptroller General determines to be appropriate.

SA 1126. Mrs. DOLE (for herself, and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ____ . TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(w)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such pay-

ments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, preclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) CONSTRUCTION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

SA 1127. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ____ . BRACHYTHERAPY DEVICES.

(a) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395i(t)(2)) is amended—

(1) in subparagraph (F), by striking “and” at the end;

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

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

“(H) with respect to devices of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number of such devices furnished separately for palladium-103 and iodine-125.”.

(b) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by subsection (a), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this subsection, and shall include specific

recommendations for appropriate payments for such devices.

SA 1128. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 133, after line 25, insert the following:

“(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

“(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a Medicare Advantage organization offering a Medicare Advantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

“(B) ELECTION.—Under the process established under section 1860D-3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or Medicare Advantage plan through the existing State pharmaceutical assistance program.

“(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—In this paragraph, the term ‘existing State pharmaceutical assistance program’ means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by Mr. DASCHLE to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ____ . SENSE OF THE SENATE REGARDING PARITY OF MENTAL HEALTH SERVICES UNDER MEDICARE.

(a) FINDINGS.—The Senate finds the following:

(1) Beneficiaries of the Medicare program under title XVIII of the Social Security Act pay 50 percent coinsurance for outpatient psychiatric services.

(2) In comparison, such beneficiaries pay 20 percent coinsurance for all other medical services.

(3) There is no scientific or medical justification for this discriminatory inequity.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Congress should work to achieve parity under the Medicare program under title XVIII of the Social Security Act between mental health services and other medical services as soon as practicable.

SA 1130. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill to S. 1, to amend title XVIII of the Social Security Act to

provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table, as follows:

At the appropriate place in title II, insert the following:

SEC. ____ . STUDY ON TRENDS IN EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.

(a) **STUDY.**—The Comptroller General of the United States, in consultation with employers, health benefit experts, academia, human resource professionals, State and local government officials, and employer consulting firms, shall conduct a study to determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage (as such term is defined in section 1860D-20(e)(4)(B) of the Social Security Act). Such study shall examine the following:

(1) Trends in employment-based retiree health coverage, as such trends relate to retirees who are eligible for coverage under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) The extent to which health care coverage, including coverage under Medicare+Choice, MedicareAdvantage, and fee-for-service prescription drug plans under the Medicare program, are available to retirees who are eligible for coverage under the Medicare program.

(3) The extent to which geographic location plays a role in the structure and availability of retiree health benefit coverage.

(4) Whether incentives built into this Act (and the amendments made by this Act) are sufficient to induce employers to maintain employment-based retiree health coverage, and whether other voluntary incentives exist to encourage employers to maintain such coverage.

(5) Whether obstacles exist to employers providing employment-based retiree health coverage, including administrative burden, the cost of prescription drugs, and the increasing overall health care costs.

(6) Whether—

(A) employment-based retiree health coverage has changed because of the implementation of the MedicareAdvantage and Medicare fee-for-service programs under the amendments made by this Act;

(B) such coverage continues to maintain the employment-based retiree health benefit packages that were available prior to the implementation of such programs;

(C) employers conduct health fairs or provide other educational opportunities for their retirees to encourage retirees to obtain coverage under MedicareAdvantage or other prescription drug plans that are available; and

(D) employers offer retirees financial incentive to obtain coverage under MedicareAdvantage or other prescription drug plans, including premium subsidies.

(7) Whether the availability of MedicareAdvantage and Medicare fee-for-service prescription drug coverage acts as an incentive to employers that did not previously offer employment-based retiree health coverage to offer such coverage to retirees.

(8) Whether other tools are used by employers to help future employees afford health benefits and prescription drug coverage once such employees reach retirement age.

(b) **INFORMATION.**—In conducting the study under subsection (a), the Comptroller General shall determine the effect of the amendments made by this Act on the provision of

employment-based retiree health coverage using information available for the period—

(1) beginning on the date of enactment of this Act and ending on January 1, 2005; and

(2) beginning on January 1, 2006 and ending on January 1, 2007.

(c) **REPORT.**—Not later than July 1, 2007, the Comptroller General shall submit to the Secretary and the appropriate committees of Congress a report based on the study conducted under subsection (a).

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ____ . USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES.

(a) **IN GENERAL.**—The Secretary shall revise the regulation promulgated under section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A-350) so that, in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w-4), the Secretary recognizes all costs of clinical staff employed by cardio-thoracic surgeons (net of any reimbursements for staff for whom there is direct reimbursement under part B of such Act (42 U.S.C. 1395j et seq.)), regardless of the site at which such costs are incurred and notwithstanding any other provision of law or regulation. For purposes of revising such regulation, the Secretary shall use validated data collected by organizations and entities (other than the Department of Health and Human Services) on all costs incurred by physicians, including data from the Socioeconomic Monitoring System of the American Medical Association and from supplemental surveys accepted by the Department of Health and Human Services as consistent with sound data practices prior to the date of enactment of this Act.

(b) **EFFECTIVE DATE.**—The regulation revised under subsection (a) shall apply with respect to payments for physicians' services furnished on and after January 1, 2004.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

On page 343, between lines 15 and 16, insert the following:

“(f) **ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR ELIGIBLE BENEFICIARIES ENROLLED IN MEDICAREADVANTAGE PLANS.**—

“(1) **IN GENERAL.**—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, the plan makes available such coverage with the following modifications:

“(A) **NO PREMIUM.**—Notwithstanding subsection (d) or sections 1860D-13(e)(2) and 1860D-17, the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage shall be zero.

“(B) **BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.**—Notwithstanding section 1860D-6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

“(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

“(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection, ‘\$ ____’ shall be substituted for ‘\$3,700’ in subparagraph (B)(i)(I) of such subsection.

“(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

“(C) **APPLICATION OF LOW-INCOME SUBSIDIES.**—Notwithstanding subsection (f) or section 1860D-19, the Administrator shall not apply the following provisions of subsection (a) of such section:

“(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

“(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

“(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

“(2) **PENALTY FOR ENROLLING IN A ZERO PREMIUM STOP-LOSS PROTECTION PLANS AFTER INITIAL ELIGIBILITY FOR SUCH ENROLLMENT.**—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D-2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

“(3) **PROCEDURES.**—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

“(4) **NO EFFECT ON MEDICARE DRUG PLANS.**—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug plan or under a contract under section 1860D-13(e).”

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 8, line 12, insert “(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator)” before the semicolon.

On page 46, line 9, after the end period insert: “Such requirement shall not apply to

enrollees of a Medicare Prescription Drug plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D-20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement."

On page 51, line 19, insert "(but only with respect to the percentage of such costs that the individual is responsible for under that section)" after "1860D-19".

On page 56, strike lines 3 through 19, and insert the following:

"(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part—

"(i) the medical assistance for such a drug shall be disregarded for purposes of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the drug under title XIX; and

"(ii) the prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a Medicare Advantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D-20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

On page 74, strike lines 14 through 16, and insert the following:

"(D) the average aggregate projected cost of covered drugs under the plan relative to other Medicare Prescription Drug plans and Medicare Advantage plans; or

"(E) other factors determined appropriate by the Administrator.

Beginning on page 88, strike lines 9 through page 89, line 10, and insert the following:

"(I) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under clause (i) for the year—

"(I) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(II) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(B) CERTAIN EXPENSES NOT INCLUDED.—The amount under subparagraph (A)(i) may not include—

"(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

"(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D-6(a)(2);

"(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D-20; or

"(iv) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in subparagraph (A)(i).

On page 78, beginning on line 20, strike "An entity" and all that follows through line 24.

On page 84, line 6, strike "(including a contract under)".

Beginning on page 92, strike line 20 through page 93, line 25, and insert the following:

"(3) ESTABLISHMENT OF ALLOWABLE COSTS.—For each year, the Administrator shall establish the allowable costs for each Medicare

Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year.

On page 116, strike lines 11 and 12, and insert the following:

"(i) is eligible for medicare cost-sharing described in section 1905(p)(3) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1905(p)(1), as determined under such plan (or under a waiver of plan); and

On page 117, strike lines 1 and 2, and insert the following:

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iii), as determined under such plan (or under a waiver of plan); and

On page 117, strike lines 14 through 17, and insert the following:

"(i) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX), as determined under such plan (or under a waiver of such plan); and

On page 120, line 11, strike "such individuals" and insert "in the case of such an individual who is not a resident of the 50 States or the District of Columbia, such individual".

Beginning on page 123, strike line 10 through page 124, line 6, and insert the following:

"(B) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under subparagraph (A) for the year—

"(i) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(ii) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(2) CERTAIN EXPENSES NOT INCLUDED.—The amount under paragraph (1)(A) may not include—

"(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A);

"(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D-6(a)(2); or

"(C) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in paragraph (1)(A).

On page 124, on line 15, insert "(or 65 percent with respect to a qualifying covered individual described in subsection (e)(2)(D))" after "80 percent".

Beginning on page 124, strike line 18 through page 125, line 13, and insert the following:

"(2) ESTABLISHMENT OF ALLOWABLE COSTS.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year.

Beginning on page 126, strike line 7 through page 127, line 9, and insert the following:

"(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

"(A) is enrolled in this part and in a Medicare Prescription Drug plan;

"(B) is enrolled in this part and in a Medicare Advantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage);

"(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan; or

"(D) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified State pharmaceutical assistance program.

"(3) QUALIFYING ENTITY.—The term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

"(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

"(B) A Medicare Advantage organization offering a Medicare Advantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

"(C) The sponsor of a qualified retiree prescription drug plan.

"(D) A State offering a qualified State pharmaceutical assistance program.

On page 127, beginning with line 18, strike all through page 128, line 2, and insert:

"(i) ATTESTATION OF ACTUARIAL VALUE OF COVERAGE.—The sponsor of the plan shall, annually or at such other time as the Administrator may require, provide the Administrator an attestation, in accordance with the procedures established under section 1860D-6(f), that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard prescription drug coverage.

"(ii) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Administrator access to) such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this part to and by the plan.

On page 128, between lines 12 and 13, insert the following:

"(6) QUALIFIED STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The term 'qualified State pharmaceutical assistance program' means a State pharmaceutical assistance program if, with respect to a qualifying covered individual who is covered under the program, the following requirements are met:

"(i) ASSURANCE.—The State offering the program shall, annually or at such other times as the Administrator may require, provide the Administrator an attestation that, in accordance with the procedures established under section 1860D-6(f), that—

"(I) the actuarial value of prescription drug coverage under the program is at least equal to the actuarial value of standard prescription drug coverage; and

"(II) the actuarial value of subsidies to individuals provided under the program are at least equal to the actuarial value of the subsidies that would apply under section 1860D-19 if the individual was enrolled under this part rather than under the program.

"(ii) DISCLOSURE OF INFORMATION.—The State complies with the requirements described in clauses (i) and (ii) of section 1860D-16(b)(7)(A).

"(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of subparagraph (A), the term 'State pharmaceutical assistance program' means a program—

“(i) that is in operation as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003;

“(ii) that is sponsored and financed by a State; and

“(iii) that provides coverage for outpatient drugs for individuals in the State who meet income- and resource-related qualifications specified under such program.

On page 128, between lines 15 and 16, insert the following:

“(g) DISTRIBUTION OF REINSURANCE PAYMENT AMOUNTS.—

“(1) IN GENERAL.—Any sponsor meeting the requirements of subsection (e)(3) with respect to a quarter in a calendar year, but which is not an employer, shall distribute the reinsurance payments received for such quarter under subsection (c) to the employers contributing to the qualified retiree prescription drug plan maintained by such sponsor during that quarter, in the manner described in paragraphs (2) and (3).

“(2) ALLOCATION.—The reinsurance payments to be distributed pursuant to paragraph (1) shall be allocated proportionally among all employers who contribute to the plan during the quarter with respect to which the payments are received. The share allocated to each employer contributing to the plan during a quarter shall be determined by multiplying the total reinsurance payments received by the sponsor for the quarter by a fraction, the numerator of which is the total contributions made by an employer for that quarter, and the denominator of which is the total contributions required to be made to the plan by all employers for that quarter. Any share allocated to an employer required to contribute for a quarter who does not make the contributions required for that quarter on or before the date due shall be retained by the sponsor for the benefit of the plan as a whole.

“(3) TIMING.—Reinsurance payments required to be distributed to employers pursuant to this subsection shall be distributed as soon as practicable after received by the sponsor, but in no event later than the end of the quarter immediately following the quarter in which such reinsurance payments are received by the sponsor.

“(4) REGULATIONS.—The Secretary shall promulgate regulations providing that any sponsor subject to the requirements of this subsection who fails to meet such requirements shall not be eligible for a payment under this section.

On page 130, between lines 7 and 8, insert the following:

“DIRECT SUBSIDIES FOR QUALIFIED STATE OFFERING A STATE PHARMACEUTICAL ASSISTANCE PROGRAM FOR PROGRAM ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

“SEC. 1860D-22. (a) DIRECT SUBSIDY.—

“(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical assistance program (as defined in section 1860D-20(e)(6)) for each qualifying covered individual (described in subparagraph (D) of section 1860D-20(d)(4)(B)) enrolled in the program for each month for which such individual is so enrolled.

“(2) AMOUNT OF PAYMENT.—

“(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the amount of payment for the area and year made under section 1860D-21(a)(2).

“(b) ADDITIONAL SUBSIDY.—

“(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical program (as defined in section 1860D-20(e)(6)) for each applicable low-income individual enrolled in the program for each month for which such individual is so enrolled.

“(2) AMOUNT OF PAYMENT.—

“(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be the amount the Administrator estimates would have been made to an entity or organization under section 1860D-19 with respect to the applicable low-income individual if such individual was enrolled in this part and under a Medicare Prescription Drug plan or a Medicare Advantage plan.

“(B) MAXIMUM PAYMENTS.—In no case may the amount of the payment determined under subparagraph (A) with respect to an applicable low-income individual exceed, as estimated by the Administrator, the average amounts made in a year under section 1860D-19 on behalf of an eligible beneficiary enrolled under this part with income that is the same as the income of the applicable low-income individual.

“(3) APPLICABLE LOW-INCOME INDIVIDUAL.—For purposes of this subsection, the term ‘applicable low-income individual’ means an individual who is both—

“(A) a qualifying covered individual (described in subparagraph (D) of section 1860D-20(e)(2)); and

“(B) a qualified medicare beneficiary, a specified low income medicare beneficiary, or a subsidy-eligible individual, as such terms are defined in section 1860D-19(a)(4).

“(c) PAYMENT METHODS.—

“(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator’s best estimate of amounts that will be payable after obtaining all of the information.

“(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

“(d) CONSTRUCTION.—Nothing in this section or section 1860D-20 shall effect the provisions of section 1860D-26(b).

On page 134, between lines 9 and 10, insert:

“(d) WAIVER AUTHORITY.—The Secretary shall have authority similar to the waiver authority under section 1857(i) to facilitate the offering of Medicare Prescription Drug plans by employer or other group health plans as part of employment-based retiree health coverage (as defined in section 1860D-20(d)(4)(B)), including the authority to establish separate premium amounts for enrollees in a Medicare Prescription Drug plan by reason of such coverage.”

On page 142, beginning on line 16, strike “in a manner” and all that follows through line 19 and insert a semicolon.

On page 143, beginning on line 15, strike “in a manner” and all that follows through line 18 and insert a semicolon.

On page 144, between lines 10 and 11, insert the following:

“(4) SCREEN AND ENROLL INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (1) or (2), screen an individual who applies for such a determination for eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, enroll the individual under the State plan (or under a waiver of such plan).

On page 147, line 1, insert “and notwithstanding section 1905(b),” after “(4)”.

On page 147, beginning on line 6, strike “Secretary” and all that follows through “paying” on line 8, and insert “Federal medical assistance percentage shall be”.

On page 147, line 8, strike “of the” and insert “for”.

On page 147, strike lines 13 through 16, and insert the following:

“(B) whose income is at least the income required for an individual to be an eligible individual under section 1611 for purposes of the supplemental security income program (as determined under section 1612), but does not exceed 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

On page 149, line 1, insert “and notwithstanding section 1905(b),” after “(2)”.

On page 149, beginning on line 6, strike “Secretary” and all that follows through “paying” on line 8, and insert “Federal medical assistance percentage shall be”.

On page 149, line 8, strike “of the” and insert “for”.

On page 151, line 9, strike “\$22,500,000” and insert “\$37,500,000”.

On page 151, line 11, strike “\$30,000,000” and insert “\$50,000,000”.

On page 152, strike lines 8 through 11, and insert the following:

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting “and subsections (c)(1) and (d)(1) of section 1935” after “1933(d)”.

(B) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

On page 157, line 17, strike “and”.

On page 157, line 20, strike the period and insert “; and”.

On page 157, between lines 20 and 21, insert the following:

(C) by adding at the end the following:

“(3) AGREEMENTS TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—

“(A) IN GENERAL.—The Commissioner shall enter into an agreement with each State operating a State plan under title XIX (including under a waiver of such plan) to establish information and enrollment sites within all the Social Security field offices located in the State for purposes of—

“(i) the State determining the eligibility of individuals residing in the State for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933, the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D-19; and

“(ii) enrolling individuals who are determined eligible for such medical assistance, program, or subsidies in the State plan (or waiver), the transitional prescription drug assistance card program under section 1807A, or the appropriate category for premium and cost-sharing subsidies under section 1860D-19.

“(B) AGREEMENT TERMS.—The Secretary and the Commissioner jointly shall develop terms for the State agreements required under subparagraph (A) that shall specify the responsibilities of the State and the Commissioner in the establishment and operation of such sites.

“(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commissioner, such sums as may be necessary to carry out this paragraph.”

On page 159, line 19, insert the following before the closing quotation: “As part of such review, the Commission shall hold 3 field hearings in 2007.”

On page 174, line 14, insert “(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary)” before the comma.

Beginning on page 195, strike line 16 through page 196, line 7, and insert the following:

“(A) PATIENT MAY REQUEST A WRITTEN PRESCRIPTION.—The standards provide that—

“(i) a prescription shall be written and not transmitted electronically if the patient makes such a request; and

“(ii) no additional charges may be imposed on the patient for making such a request.

On page 199, strike lines 10 through 14, and insert the following:

“(A) IN GENERAL.—Individuals or entities that transmit or receive prescriptions electronically shall comply with the standards adopted or modified under this part.

On page 200, between lines 16 and 17, insert the following:

“(e) NO REQUIREMENT TO TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—Nothing in this part shall be construed to require an individual or entity to transmit or receive prescriptions electronically.

On page 254, line 25, insert “(other than deemed contracts or agreements under subsection (j)(6))” before “with a sufficient number”.

On page 255, line 7, before the period, insert the following: “, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan”.

On page 297, strike lines 5 through 9, and insert the following:

“(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

“(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting ‘102’ for ‘103’ in clause (v).”

On page 323, strike lines 1 through 3, and insert the following:

“(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3), or, with respect to a private fee-for-service plan (as described in section 1851(a)(2)(C)) under subparagraph (A)(i), (A)(ii)(III), or (B) of paragraph (2).

On page 326, line 11, after the end period insert: “Subject to the provisions of section 1858(h), such requirement shall not apply to enrollees of a MedicareAdvantage plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D-20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.”

On page 328, line 3, strike “or (C)”.

On page 328, line 20, strike “or (C)”.

On page 343, strike lines 22 through 24, and insert:

Section 1858(h) (as added by section 211) is amended—

(1) by inserting “(including subsection (i) of such section)” after “section 1857”; and

(2) by adding at the end the following new sentence: “In applying the authority under section 1857(i) pursuant to this subsection, the Administrator may permit MedicareAdvantage plans to establish separate premium amounts for enrollees in an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D-20(d)(4)(B)).”

On page 349, between lines 4 and 5, insert the following:

(3) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w-23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

“(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

“(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting ‘102’ for ‘103’ in clause (v).”

On page 379, strike lines 9 through 13, and insert:

“(A) IN GENERAL.—The term ‘specialized Medicare+Choice plans for special needs beneficiaries’ means a Medicare+Choice plan that—

“(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

“(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

Beginning on page 411, strike line 5 through page 414, line 9, and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

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

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

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

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

(1) in subparagraph (A)—

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

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “and before October 1, 2003” after “October 1, 1997”; and

(ii) in the matter following clause (III), by striking the period at the end and inserting “, and”; and

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

“(iii) for discharges in a fiscal year beginning on or after October 1, 2003, 50 percent of the national standardized rate (determined under paragraph (3)(D)(iii)) for hospitals located in any area.”

(2) in subparagraph (C)—

(A) in clause (i)—

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

(ii) by adding at the end the following:

“(II) For discharges in fiscal year 2004, the Secretary shall compute an average stand-

ardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in an urban area, increased by the applicable percentage increase under subsection (b)(3)(B) for fiscal year 2004.

“(III) For discharges in a fiscal year after fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (II) or this subclause for the previous fiscal year, increased by the applicable percentage increase under subsection (b)(3)(B), adjusted to reflect the most recent case mix data.”

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

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

(c) CONFORMING AMENDMENTS.—

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

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

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

(C) in clause (i)—

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

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

(D) in clause (ii)—

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

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

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

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

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

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

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

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

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

On page 430, strike lines 19 through 21, and insert the following:

(b) PERMITTING NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CLINICAL NURSE SPECIALIST TO REVIEW HOSPICE PLANS OF CARE.—Section 1814(a)(7)(B) is amended by inserting “(or by a physician assistant, nurse practitioner or clinical nurse specialist who is not an employee of the hospice program, and whom the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care)” after “and is periodically reviewed by the individual’s attending physician”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care furnished on or after October 1, 2004.

On page 438, between lines 10 and 11, insert the following:

SEC. 414. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

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

(1) in subclause (VI), by striking “and” after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking “on or after October 1, 2002” and inserting “during fiscal year 2003”; and

(B) by striking the period at the end and inserting a semicolon; and

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

“(VIII) during each of fiscal years 2004 and 2005, ‘c’ is equal to 1.36; and

“(IX) on or after October 1, 2005, ‘c’ is equal to 1.355.”.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

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

(2) by inserting “, or the Prescription Drug and Medicare Improvement Act of 2003” after “2000”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 415. CALCULATION OF WAGE INDICES FOR HOSPITALS.

(a) IN GENERAL.—Notwithstanding any other provision of law, in the calculation of a wage index in a State for purposes of making payments for discharge waive such other criteria for re-classification as deemed appropriate by the Secretary.

SEC. 416. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

Section 1833(a)(3) (42 U.S.C. 1395(a)(3)) is amended by inserting “(which regulations shall exclude any cost incurred for the provision of services pursuant to a contract with an eligible entity (as defined in section 1860D(4)) operating a Medicare Prescription Drug plan or with an entity with a contract under section 1860D–13(e), for which payment is made by the entity)” after “the Secretary may prescribe in regulations”.

SEC. 417. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking “35 percent” and inserting “35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)”.

(b) CAPITAL COSTS.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking “and” at the end;

(2) in clause (iv), by striking the period at the end and inserting “, and”; and

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

“(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).”.

SEC. 418. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting “, and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under

this title or title XIX or for continued classification as a hospital described in clause (iv)” before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

On page 440, line 2, insert closing quotation marks and a period after the period at the end.

Beginning on page 441, strike line 19 and all that follows through page 442, line 2.

Beginning on page 445, strike line 5 and all that follows through page 446, line 6, and insert the following:

SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

“(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

“(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2005, and before January 1, 2008, for which the transportation originates in—

“(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

“(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent.

“(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

“(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.”.

Beginning on page 470, strike line 21 and all that follows through page 471, line 13, and insert the following:

“(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased by 1.6 percent.

“(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent and further increased by 1.6 percent.

“(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 and all subsequent years, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year, increased by 0.05 percent.

On page 486, line 3, insert “and” after the semicolon at the end.

On page 486, line 4, insert “(I)” after “(ii)”.

On page 486, line 8, strike “and” and insert “or”.

On page 486, line 9, strike “(iii)” and insert “(II)”.

On page 488, after line 25, add the following:

(c) LIMITATION OF EXPENDITURES IN YEARS PRIOR TO 2014.—

(1) IN GENERAL.—The Secretary shall ensure that the total amount of expenditures under title XVIII of the Social Security Act (including amounts expended by reason of this section) in a year prior to 2014 does not exceed the sum of—

(A) the total amount of expenditures under such title XVIII that would have made if this section had not been enacted; and

(B) the applicable amount.

(2) APPLICABLE AMOUNT.—For purposes of paragraph (1), the term “applicable amount” means—

(A) for 2005, \$32,000,000;

(B) for 2006, \$34,000,000;

(C) for 2007, \$36,000,000;

(D) for 2008, \$38,000,000;

(E) for 2009, \$40,000,000;

(F) for 2010, \$42,000,000;

(G) for 2011, \$44,000,000;

(H) for 2012, \$48,000,000; and

(I) for 2013, \$50,000,000.

(3) STEPS TO ENSURE FUNDING LIMITATION NOT VIOLATED.—If the Secretary determines that the application of this section will result in the funding limitation described in paragraph (1) being violated for any year, the Secretary shall take appropriate steps to stay within such funding limitation, including through limiting the number of clinical trials deemed under subsection (a) and only covering a portion of the routine costs described in such subsection.

On page 516, after line 22, add the following:

SEC. 446. AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) IN GENERAL.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking “for services described in paragraph (2)” and inserting “for all items and services for which payment may be made under such part”; and

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

SEC. 447. COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

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

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

“(W) cardiovascular screening tests (as defined in subsection (ww)(1));”.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Cardiovascular Screening Tests

“(ww)(1) The term ‘cardiovascular screening tests’ means the following diagnostic tests for the early detection of cardiovascular disease:

“(A) Tests for the determination of cholesterol levels.

“(B) Tests for the determination of lipid levels of the blood.

“(C) Such other tests for cardiovascular disease as the Secretary may approve.

“(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

“(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.”

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking “and” at the end of subparagraph (H);

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

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

“(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 448. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking “and” at the end;

(B) in subparagraph (V), by inserting “and” at the end; and

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

“(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians’ service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

“(ii) a self-injected drug that is used to treat multiple sclerosis;”.

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting “, except for any drug or biological described in subparagraph (W),” after “which”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

SEC. 449. EXTENSION OF MEDICARE SECONDARY PAYER RULES FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.

Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting “, and before January 1, 2004” after “prior to such date”; and

(2) by adding at the end the following new sentence: “Effective for items and services furnished on or after January 1, 2004 (with respect to periods beginning on or after June 1, 2002), clauses (i) and (ii) shall be applied by substituting ‘36-month’ for ‘12-month’ each place it appears in the first sentence.”

SEC. 450. REQUIRING THE INTERNAL REVENUE SERVICE TO DEPOSIT INSTALLMENT AGREEMENT AND OTHER FEES IN THE TREASURY AS MISCELLANEOUS RECEIPTS.

Notwithstanding any other provision of law, the Secretary of the Treasury is required to deposit in the Treasury as miscellaneous receipts any fee receipts, including fees from installment agreements and restructured installment agreements, collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-329,

the Treasury, Postal Service and General Government Appropriations Act, 1995. Fees collected under this section shall be available for use by the Internal Revenue Service only to the extent that such authority is provided in advance in an appropriations Act.

SEC. 450A. INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

“(VI) A skilled nursing facility (as defined in section 1819(a)).

“(VII) An assisted-living facility (as defined by the Secretary).

“(VIII) A board-and-care home (as defined by the Secretary).

“(IX) A county of community health clinic (as defined by the Secretary).

“(X) A community mental health center (as described in section 1861(ff)(2)(B)).

“(XI) A long-term care facility (as defined by the Secretary).

“(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.”

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term “telehealth service” has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms “physician” and “practitioner” have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term “medicare program” means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 450B. DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term “surgical first assisting services” means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term “certified registered

nurse first assistant” means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) PAYMENT RATES.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) for the same services if furnished by a physician.

(d) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) DURATION.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

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

(i) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 450C. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

“(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

“(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

“(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.”

SEC. 450D. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w-4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”; and

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

“(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

“(A) IN GENERAL.—With respect to physicians' services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, the fee schedule for such services shall be determined as follows:

“(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

“(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

“(II) in the case of services furnished in calendar year 2005, the amount determined under subclause (I) for 2004, increased by the annual update determined under subsection (d) for the year involved.

“(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

“(I) the amount of payment for the service that would otherwise apply under this section; plus

“(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

“(B) VA ALASKA FEE SCHEDULE AMOUNT.—For purposes of this paragraph, the term ‘VA Alaska fee schedule amount’ means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians' services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38.

“(C) APPLICABLE PERCENT.—For purposes of this paragraph, the term ‘applicable percent’ means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians' services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.”.

SEC. 450E. DEMONSTRATION PROJECT TO EXAMINE WHAT WEIGHT LOSS WEIGHT MANAGEMENT SERVICES CAN COST EFFECTIVELY REACH THE SAME RESULT AS THE NIH DIABETES PRIMARY PREVENTION TRIAL STUDY: A 50 PERCENT REDUCTION IN THE RISK FOR TYPE 2 DIABETES FOR INDIVIDUALS WHO HAVE IMPAIRED GLUCOSE TOLERANCE AND ARE OBESE.

(a) IN GENERAL.—Inasmuch as the NIH Diabetes Primary Prevention Trial study proved that the risk of type 2 diabetes could be cut in half when the Institute of Medicine definition of successful weight loss (5 percent weight loss maintained for a year) is achieved by individuals at risk for type 2 diabetes due to obesity and impaired glucose tolerance, the Secretary shall conduct a demonstration project to examine the cost effectiveness and health benefits of providing group weight loss management services to achieve the same result for beneficiaries under the medicare program under title XVIII of the Social Security Act who are obese and have impaired glucose tolerance.

(b) LIMITATION.—The cost of the group weight loss management services provided

under subsection (a) shall not exceed the cost per recipient per year of the medical nutritional therapy benefit currently available to medicare beneficiaries.

(c) SCOPE OF SERVICES.—

(1) DURATION.—The project shall be conducted for a period of 2 fiscal years.

(2) SITES.—The Secretary shall designate the sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in—

(A) rural areas; or

(B) areas that have a high concentration of Native Americans with type 2 diabetes.

(3) FUNDING.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(B) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed \$2,500,000 for each fiscal year in which the project is conducted under paragraph (1).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, medical nutrition therapy services furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

(2) PAYMENT.—Payment for such services shall be made at a rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the fee schedule amount provided under section 1843 of the Social Security Act (42 U.S.C. 139w-4) for the same services if such services were furnished by a physician.

(3) APPLICATION OF LIMITS OF BILLING.—The provisions of section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) shall apply to a group weight loss management professional furnishing services under the project in the same manner as they to a practitioner described in subparagraph (C) of such section furnishing services under title XVIII of such Act.

(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project not later than the date that is 6 months after the date on which the project concludes. The final report shall include an evaluation of the impact of the use of group weight loss management services as part of medical nutrition therapy on medicare beneficiaries and on the medicare program, including any impact on reducing costs under the program and improving the health of beneficiaries.

(f) DEFINITIONS.—For purposes of this section:

(1) The term “obesity” means that an individual has a Body Mass Index (BMI) of 30 and above.

(2) GROUP WEIGHT LOSS MANAGEMENT SERVICES.—The term “group weight loss management services” means comprehensive services furnished to individuals who have been diagnosed and referred by a physician as having impaired glucose tolerance and who are obese that consist of—

(A) assessment and treatment based on the needs of individuals as determined by a group weight loss management professional; or

(B) a specific program or method that has demonstrated its efficacy to produce and maintain weight loss through results pub-

lished in peer-reviewed scientific journals using recognized research methods and statistical analysis that provides—

(i) assessment of current body weight and recording of weight status at each meeting session;

(ii) provision of a healthy eating plan;

(iii) provision of an activity plan;

(iv) provision of a behavior modification plan; and

(v) a weekly group support meeting.

(3) GROUP WEIGHT LOSS MANAGEMENT PROFESSIONAL.—The term “group weight loss management professional” means an individual who has completed training to provide a program or method that has completed clinical trials and has demonstrated its efficacy through publications in peer-reviewed scientific journals who—

(A)(i) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) in nutrition social work, psychology with experience in behavioral modification methods to reduce obesity; or

(ii) has completed a curriculum of training for a specific behavioral based weight management program as described in section (4)(A)(2) and recommended in the NIH Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, chapter 4, section H, parts 1, 2, 3, 4, and pursuant to guidelines by the Secretary; and

(B)(i) is licensed or certified as a group weight loss management professional by the State in which the services are performed; or

(ii) is certified by an organization that meets such criteria as the Secretary establishes with—

(I) national organizations representing consumers such as the American Obesity Association and the elderly; and

(II) such other organizations as the Secretary determines appropriate.

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms “hospital” and “critical access hospital” have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SEC. 456. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking “promptly (as determined in accordance with regulations)”;

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and
(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.”; and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received”;

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a

primary plan or from the proceeds of a primary plan’s payment to any entity.”

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

SEC. 457. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the Medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of Medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SEC. 458. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

“(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

“(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

“(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).”

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following: “Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.”

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

SEC. 459. SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007. From 1991 through 2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by Medicare’s own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities, and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts in 2004 and the following years that result from the SGR formula.

On page 542, strike lines 18 through 23, and insert the following:

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

On page 569, between lines 3 and 4, insert the following:

SEC. 518. REVISIONS TO APPEALS TIMEFRAMES.

Section 1869 (42 U.S.C. 1395ff) is amended—

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

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

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

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

SEC. 519. ELIMINATION OF REQUIREMENT TO USE SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE LAW JUDGES.

The first sentence of section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking “of the Social Security Administration”.

SEC. 520. ELIMINATION OF REQUIREMENT FOR DE NOVO REVIEW BY THE DEPARTMENTAL APPEALS BOARD.

Section 1869(d)(2) (42 U.S.C. 1395ff(d)(2)) is amended to read as follows:

“(2) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.”

On page 595, strike lines 1 through 6.

On page 603, after line 25, insert the following:

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

On page 625, between lines 19 and 20, insert the following:

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

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

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

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

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

(A) by striking “hospice services” and inserting “hospice care and post-hospital extended care services”; and

(B) by inserting before the period at the end the following: “and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides”.

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

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

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

SEC. 554. COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534(a), is amended by adding at the end the following new subsection:

“(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

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

“(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

“(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and pay-

ment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

“(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.”.

SEC. 555. TREATMENT OF CERTAIN DENTAL CLAIMS.

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

“(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

“(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.”.

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

On page 629, between lines 17 and 18, insert the following:

(d) URBAN HEALTH PROVIDER ADJUSTMENT.—

(1) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r-4(f)).

(2) HOSPITAL DESCRIBED.—A hospital is described in this paragraph if the hospital—

(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(B) is located in Marion County, Indiana.

(3) LIMITATION.—The payment adjustment described in paragraph (1) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r-4(g)(1)(A)).

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

“(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with re-

spect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).”.

On page 676, after line 22, add the following:

SEC. 615. EMPLOYER FLEXIBILITY.

(a) MEDICARE.—Nothing in part D of title XVIII of the Social Security Act, as added by section 101, shall be construed as—

(1) preventing employment-based retiree health coverage (as defined in section 1860D-20(e)(4)(B) of such Act, as so added) from providing coverage that is supplemental to the benefits provided under a Medicare Prescription Drug plan under such part or a Medicare Advantage plan under part C of such title, as amended by this Act; or

(2) requiring employment-based retiree health coverage (as so defined) that provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act or under a plan maintained by a State or an agency thereof to provide medical benefits, or the same medical benefits, to retired participants who are so eligible.

(b) ADEA.—

(1) IN GENERAL.—Section 4(l) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(1)) is amended by adding at the end the following:

“(4) An employee benefit plan (as defined in section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3))) shall not be treated as violating subsection (a), (b), (c), or (e) solely because the plan provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a plan maintained by a State or an agency thereof, but does not provide medical benefits, or the same medical benefits, to retired participants who are so eligible.”.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply as of the date of the enactment of this Act.

SEC. 616. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting “, and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider” before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SEC. 617. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking “until December 31, 2002”, and

(2) by striking “Kent Community Hospital Complex in Michigan or.”.

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SEC. 618. GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G-7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. The study shall include the following:

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance.

(2) The proportion of the cost for innovation borne by American consumers, compared with consumers in the other 6 countries.

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production ("Ramsey prices").

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health.

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States.

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied.

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant.

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violations of intellectual property rights for prescription medicines.

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

SEC. 619. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

"PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

"(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

"(1) REVIEW.—The Commission shall conduct an ongoing review of the health care

safety net programs (as described in paragraph (3)(C)) by—

"(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

"(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

"(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

"(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

"(E) supporting the development of new data systems where existing data are insufficient or inadequate;

"(F) developing criteria and indicators of impending core health care safety net failure;

"(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

"(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

"(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

"(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

"(ii) the degree to which these plans may be overburdened by adverse selection; and

"(iii) the degree to which emergency departments are used by enrollees of these plans; and

"(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

"(2) REPORTS.—

"(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

"(i) the health care needs of the uninsured; and

"(ii) the financial and infrastructure stability of the Nation's core health care safety net.

"(B) AGENDA AND ADDITIONAL REVIEWS.—

"(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

"(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and

submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

"(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

"(II) If the Commission deems such additional reviews and reports appropriate.

"(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(3) DEFINITIONS.—In this section:

"(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

"(B) CORE HEALTH CARE SAFETY NET.—The term 'core health care safety net' means any health care provider that—

"(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

"(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

"(C) HEALTH CARE SAFETY NET PROGRAMS.—The term 'health care safety net programs' includes the following:

"(i) MEDICAID.—The medicaid program under title XIX.

"(ii) SCHIP.—The State children's health insurance program under title XXI.

"(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

"(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(1)(2)(B)) receives funds.

"(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(1)(1)) receives funds.

"(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

"(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

"(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

"(D) VULNERABLE POPULATIONS.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

"(c) MEMBERSHIP.—

“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the ‘Comptroller General’), in consultation with the appropriate committees of Congress.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

“(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

- “(i) four to serve a term of 1 year;
- “(ii) four to serve a term of 2 years; and
- “(iii) five to serve a term of 3 years.

“(B) VACANCIES.—

“(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

“(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

“(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

“(4) COMPENSATION.—

“(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

“(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

“(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

“(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of

the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

“(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

“(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

“(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

“(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

“(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

“(4) make advance, progress, and other payments which relate to the work of the Commission;

“(5) provide transportation and subsistence for persons serving without compensation; and

“(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

“(e) POWERS.—

“(1) OBTAINING OFFICIAL DATA.—

“(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

“(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

“(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

“(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

“(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

“(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comp-

troller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

“(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.”.

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SEC. 620. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—

(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i-3(b)) is amended by adding at the end the following:

“(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a

skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, \$2,000; and
“(II) for the second and each subsequent violation within any 5-year period, \$5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility that—

“(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed \$5,000 for the first such violation, and \$10,000 for the second and each subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking

into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396f(b)) is amended by adding at the end the following new paragraph:

“(8) SCREENING OF NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker's provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

“(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, \$2,000; and
“(II) for the second and each subsequent violation within any 5-year period, \$5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

“(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed \$5,000 for the first such violation, and \$10,000 for the second and each

subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) NURSING FACILITY WORKER.—The term ‘nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and non-licensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”.

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A-585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i-3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i-3(e)) is amended by adding at the end the following:

“(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the skilled nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or \$50. Such fees shall be available to the Attorney General, or, in the Attorney General’s discretion, to the Federal Bureau of Investigation until expended.

“(II) STATE.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

“(iii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or

an employee any charges relating to the performance of a background check under this paragraph.

“(E) REGULATIONS.—

“(i) IN GENERAL.—In addition to the Secretary’s authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General’s responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

“(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee’s or employee’s criminal record.

“(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

“(i) the number of requests for searches and exchanges of records made under this section;

“(ii) the disposition of such requests; and

“(iii) the cost of responding to such requests.”.

(2) MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

“(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the

existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or \$50. Such fees shall be available to the Attorney General, or, in the Attorney General’s discretion, to the Federal Bureau of Investigation, until expended.

“(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

“(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

“(E) REGULATIONS.—

“(i) IN GENERAL.—In addition to the Secretary’s authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General’s responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

“(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee’s or employee’s criminal record.

“(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

“(i) the number of requests for searches and exchanges of records made under this section;

“(ii) the disposition of such requests; and

“(iii) the cost of responding to such requests.”

(C) APPLICATION TO OTHER ENTITIES PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

“APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

“SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in

hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a ‘medicare beneficiary’).

“(b) SUPERVISION OF PROVISIONAL EMPLOYEES.—

“(1) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

“(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

“(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

“(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

“(i) Follow-up telephone calls to the medicare beneficiary.

“(ii) Unannounced visits to the medicare beneficiary’s home while the provisional employee is serving the medicare beneficiary.

“(iii) To the extent practicable, limiting the provisional employee’s duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

“(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.”

(2) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking “and” at the end;

(B) in paragraph (66), by striking the period and inserting “; and”; and

(C) by inserting after paragraph (66) the following:

“(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).”

(3) EXPANSION OF STATE NURSE AIDE REGISTRY.—

(A) MEDICARE.—Section 1819 (42 U.S.C. 1395i-3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking “NURSE AIDE REGISTRY” and inserting “EMPLOYEE REGISTRY”; and

(II) in subparagraph (A)—

(aa) by striking “By not later than January 1, 1989, the” and inserting “The”;

(bb) by striking “a registry of all individuals” and inserting “a registry of (i) all individuals”; and

(cc) by inserting before the period the following: “, (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property”; and

(III) in subparagraph (C), by striking “a nurse aide” and inserting “an individual”; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: “The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii).”; and

(II) in the fourth sentence of subparagraph (C), by inserting “or described in subsection (e)(2)(A)(iii)” after “used by the facility”; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking “NURSE AIDE”; and

(bb) in clause (i), in the matter preceding subclause (I), by striking “a nurse aide” and inserting “an individual”; and

(cc) in clause (i)(I), by striking “nurse aide” and inserting “individual”.

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking “NURSE AIDE REGISTRY” and inserting “EMPLOYEE REGISTRY”; and

(II) in subparagraph (A)—

(aa) by striking “By not later than January 1, 1989, the” and inserting “The”;

(bb) by striking “a registry of all individuals” and inserting “a registry of (i) all individuals”; and

(cc) by inserting before the period the following: “, (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property”; and

(III) in subparagraph (C), by striking “a nurse aide” and inserting “an individual”; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: “The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection,

for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (1), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(d) REIMBURSEMENT OF COSTS FOR BACKGROUND CHECKS.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)), as added by this section.

(e) INCLUSION OF ABUSIVE ACTS WITHIN A LONG-TERM CARE FACILITY OR PROVIDER IN THE NATIONAL HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.—

(1) IN GENERAL.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a-7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

"(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property."

(2) COVERAGE OF LONG-TERM CARE FACILITY OR PROVIDER EMPLOYEES.—Section 1128E(g)(2) (42 U.S.C. 1320a-7e(g)(2)) is amended by inserting "and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)" before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a-7e(b)(1)) is amended by striking "and health plan" and inserting "health plan, and long-term care facility or provider".

(B) CORRECTION OF INFORMATION.—Section 1128E(c)(2) (42 U.S.C. 1320a-7e(c)(2)) is amended by striking "and health plan" and inserting "health plan, and long-term care facility or provider".

(4) ACCESS TO REPORTED INFORMATION.—Section 1128E(d)(1) (42 U.S.C. 1320a-7e(d)(1)) is amended by striking "and health plans" and inserting "health plans, and long-term care facilities or providers".

(5) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—Section 1128E(d) (42 U.S.C. 1320a-7e(d)) is amended by adding at the end the following:

"(3) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—A long-term care facility or provider shall check the database maintained under this

section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)."

(6) DEFINITION OF LONG-TERM CARE FACILITY OR PROVIDER.—Section 1128E(g) (42 U.S.C. 1320a-7e(g)) is amended by adding at the end the following:

"(6) LONG-TERM CARE FACILITY OR PROVIDER.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX."

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the amendments made by this subsection, \$10,200,000 for fiscal year 2004.

(f) PREVENTION AND TRAINING DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—With respect to a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-

3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a))), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) LONG-TERM CARE FACILITIES AND PROVIDERS.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a-7e(g)(6)) (as added by subsection (e)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SEC. 621. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking "and" after the comma at the end;

(2) in paragraph (4), by inserting "and" after the comma at the end; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas."

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. McCONNELL. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to conduct a hearing during the session of the Senate on Thursday, June 26, 2003. The purpose of this hearing will be to review H.R. 1904, the Healthy Forests Restoration Act of 2003.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. McCONNELL. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 26, 2003, at 10:00 a.m. to conduct a hearing on "Affiliate Sharing Practices and Their Relationship with the Fair Credit Reporting Act."

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. McCONNELL. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on June 26, 2003, at 9:30 a.m. on pending committee business.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. McCONNELL. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session on Thursday,