

107TH CONGRESS  
1ST SESSION

# S. 1738

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

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## IN THE SENATE OF THE UNITED STATES

NOVEMBER 28, 2001

Mr. KERRY (for himself, Mr. MURKOWSKI, Mr. BAUCUS, Mr. GRASSLEY, Mr. JEFFORDS, Mr. INHOFE, Mrs. LINCOLN, Mr. THOMPSON, Mr. BREAUX, Mr. HUTCHINSON, Mr. DASCHLE, Mr. CRAIG, Mr. HOLLINGS, Mrs. MURRAY, Mr. CARPER, Mr. JOHNSON, Mr. BINGAMAN, and Mr. HATCH) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

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

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

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECUR-**  
 2 **RITY ACT; TABLE OF CONTENTS.**

3 (a) SHORT TITLE.—This Act may be cited as the  
 4 “Medicare Appeals, Regulatory, and Contracting Improve-  
 5 ment Act of 2001”.

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

12 (c) BIPA; SECRETARY.—In this Act:

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

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

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

Sec. 1. Short title; amendments to Social Security Act; table of contents.  
 Sec. 2. Findings.  
 Sec. 3. Construction.

**TITLE I—REGULATORY REFORM**

Sec. 101. Issuance of regulations.  
 Sec. 102. Compliance with changes in regulations and policies.  
 Sec. 103. Report on legal and regulatory inconsistencies.

**TITLE II—APPEALS PROCESS REFORM**

Sec. 201. Transfer of responsibility for medicare appeals.

- Sec. 202. Expedited access to judicial review.
- Sec. 203. Expedited review of certain provider agreement determinations.
- Sec. 204. Revisions to medicare appeals process.
- Sec. 205. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement; consultation before changing provider enrollment forms.
- Sec. 206. Appeals by providers when there is no other party available.
- Sec. 207. Study and report to Congress on ways to improve the medicare appeals processes.

### TITLE III—CONTRACTING REFORM

- Sec. 301. Increased flexibility in medicare administration.

### TITLE IV—EDUCATION AND OUTREACH IMPROVEMENTS

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

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

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

### TITLE VI—OTHER PROVISIONS

- Sec. 601. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 602. Emergency Medical Treatment and Active Labor Act (EMTALA) Task Force.
- Sec. 603. Review and report to Congress on reducing medicare reporting burdens.
- Sec. 604. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.
- Sec. 605. One year delay in lock in procedures for Medicare+Choice plans.
- Sec. 606. Temporary moratorium on requirement of home health agencies to collect OASIS data from non-medicare patients.
- Sec. 607. Coordinated survey demonstration program.

## 1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

- 3 (1) The overwhelming majority of providers of
- 4 services, physicians, practitioners, and suppliers in
- 5 the United States are law-abiding persons who pro-

1       vide important health care services to patients each  
2       day.

3               (2) The Secretary should place greater empha-  
4       sis on education of, and outreach to, health care pro-  
5       viders under the medicare program in order to in-  
6       crease understanding and compliance with the regu-  
7       lations and requirements under such program. The  
8       Secretary should also ensure that new Medicare pro-  
9       gram requirements are communicated clearly and  
10      consistently throughout the country.

11              (3) Beneficiaries and health care providers  
12      under the medicare program currently struggle to  
13      navigate the medicare appeals processes for the pur-  
14      pose of settling billing, payment, and enforcement  
15      disputes. Such appeals processes suffer from a lack  
16      of oversight, inadequate resources, and structural  
17      deficiencies. For example, the average adjudication  
18      time for a medicare appeal before an administrative  
19      law judge is 382 days. Changes to the medicare ap-  
20      peals processes should result in more timely deci-  
21      sions. Further, Congress should create needed over-  
22      sight of, and reporting requirements for, such ap-  
23      peals process in order to provide information for fu-  
24      ture improvements.

1           (4) Administration of the medicare program is  
2           hampered by antiquated restrictions on the con-  
3           tracting authority of the Secretary. These restric-  
4           tions impose burdens and inefficiencies on contrac-  
5           tors, taxpayers, providers, and beneficiaries. The  
6           Secretary should have more flexibility in medicare  
7           contracting and should have contracting authority  
8           consistent with other Federal agencies.

9   **SEC. 3. CONSTRUCTION.**

10          (a) NO EFFECT ON LEGAL AUTHORITY.—Nothing in  
11          this Act shall be construed to compromise or affect exist-  
12          ing legal remedies for addressing fraud or abuse, whether  
13          it be criminal prosecution, civil enforcement, or adminis-  
14          trative remedies, including under sections 3729 through  
15          3733 of title 31, United States Code (known as the False  
16          Claims Act).

17          (b) NO EFFECT ON MEDICARE WASTE, FRAUD, AND  
18          ABUSE EFFORTS.—Nothing in this Act shall be construed  
19          to prevent or impede the Department of Health and  
20          Human Services in any way from its ongoing efforts to  
21          eliminate waste, fraud, and abuse in the medicare pro-  
22          gram.

# 1 **TITLE I—REGULATORY REFORM**

## 2 **SEC. 101. ISSUANCE OF REGULATIONS.**

3 (a) CONSOLIDATION OF PROMULGATION TO ONCE A  
4 MONTH.—

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

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

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

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

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

21 If the Secretary makes a finding under this paragraph,  
22 the Secretary shall include such finding, and brief state-  
23 ment of the reasons for such finding, in the issuance of  
24 such regulation.”.

1           (2) REPORT ON PUBLICATION OF REGULATIONS  
 2           ON A QUARTERLY BASIS.—Not later than 2 years  
 3           after the date of the enactment of this Act, the Sec-  
 4           retary shall submit to Congress a report on the fea-  
 5           sibility of requiring that regulations described in sec-  
 6           tion 1871(d) of the Social Security Act only be pro-  
 7           mulgated on a single day every calendar quarter.

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

12          (b) REGULAR TIMELINE FOR PUBLICATION OF  
 13          FINAL REGULATIONS.—

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

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

22          “(B) With respect to publication of final regulations  
 23          based on the previous publication of a proposed regulation,  
 24          such timeline may vary among different regulations based  
 25          on differences in the complexity of the regulation, the

1 number and scope of comments received, and other rel-  
2 evant factors.

3 “(C)(i) With respect to the publication of final regu-  
4 lations based on the previous publication of an interim  
5 final regulation—

6 “(I) subject to clause (ii), the Secretary shall  
7 publish the final regulation within the 12-month pe-  
8 riod that begins on the date of publication of the in-  
9 terim final regulation;

10 “(II) if a final regulation is not published by  
11 the deadline established under this subparagraph,  
12 the interim final regulation shall not continue in ef-  
13 fect unless the Secretary publishes a notice described  
14 in clause (ii) by such deadline; and

15 “(III) the final regulation shall include re-  
16 sponses to comments submitted in response to the  
17 interim final regulation.

18 “(ii) If the Secretary determines before the deadline  
19 otherwise established in this subparagraph that there is  
20 good cause, specified in a notice published before such  
21 deadline, for delaying the deadline otherwise applicable  
22 under this subparagraph, the deadline otherwise estab-  
23 lished under this subparagraph shall be extended for such  
24 period (not to exceed 12 months) as the Secretary specifies  
25 in such notice.”.



1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) shall take effect on the date of the  
3           enactment of this Act and shall apply to proposed  
4           regulations and interim final regulations published  
5           on or after such date.

6           (3) STATUS OF PENDING INTERIM FINAL REGU-  
7           LATIONS.—Not later than six months after the date  
8           of the enactment of this Act, the Secretary shall  
9           publish a notice in the Federal Register that pro-  
10          vides the status of each interim final regulation that  
11          was published on or before the date of the enact-  
12          ment of this Act and for which no final regulation  
13          has been published. Such notice shall include the  
14          date by which the Secretary plans to publish the  
15          final regulation that is based on the interim final  
16          rule.

17          (c) LIMITATIONS ON NEW MATTER IN FINAL REGU-  
18          LATIONS.—

19               (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
20               1395hh(a)), as amended by subsection (b), is further  
21               amended by adding at the end the following new  
22               paragraph:

23               “(4) Insofar as a final regulation (other than  
24               an interim final regulation) includes a provision that  
25               is not a logical outgrowth of the relevant notice of

1       proposed rulemaking relating to such regulation,  
 2       that provision shall be treated as a proposed regula-  
 3       tion and shall not take effect until there is the fur-  
 4       ther opportunity for public comment and a publica-  
 5       tion of the provision again as a final regulation.”.

6               (2) EFFECTIVE DATE.—The amendment made  
 7       by paragraph (1) shall apply to final regulations  
 8       published on or after the date of the enactment of  
 9       this Act.

10 **SEC. 102. COMPLIANCE WITH CHANGES IN REGULATIONS**  
 11 **AND POLICIES.**

12       (a) NO RETROACTIVE APPLICATION OF SUB-  
 13 STANTIVE CHANGES.—

14               (1) IN GENERAL.—Section 1871 (42 U.S.C.  
 15       1395hh), as amended by section 101(a), is amended  
 16       by adding at the end the following new subsection:

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

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

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

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

7           (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE  
8           CHANGES AFTER NOTICE.—

9           (1) IN GENERAL.—Section 1871(e)(1), as  
10          added by subsection (a), is further amended by add-  
11          ing at the end the following:

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

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

22          “(ii) The Secretary may provide for a substantive  
23          change to take effect on a date that precedes the end of  
24          the 30-day period under clause (i) if the Secretary finds  
25          that waiver of such 30-day period is necessary to comply

1 with statutory requirements or that the application of such  
 2 30-day period is contrary to the public interest. If the Sec-  
 3 retary provides for an earlier effective date pursuant to  
 4 this clause, the Secretary shall include in the issuance or  
 5 publication of the substantive change a finding described  
 6 in the first sentence, and a brief statement of the reasons  
 7 for such finding.”.

8 (2) EFFECTIVE DATE.—The amendment made  
 9 by paragraph (1) shall apply to compliance actions  
 10 undertaken on or after the date of the enactment of  
 11 this Act.

12 **SEC. 103. REPORT ON LEGAL AND REGULATORY INCON-**  
 13 **SISTENCIES.**

14 Section 1871 (42 U.S.C. 1395hh), as amended by  
 15 sections 101(a) and 102, is amended by adding at the end  
 16 the following new subsection:

17 “(f)(1) Not later than 2 years after the date of the  
 18 enactment of this subsection, and every 2 years thereafter,  
 19 the Secretary shall submit to Congress a report with re-  
 20 spect to the administration of this title and areas of incon-  
 21 sistency or conflict among the various provisions under  
 22 law and regulation.

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

1           “(A) information from beneficiaries, providers  
 2           of services, physicians, practitioners, and other sup-  
 3           pliers with respect to such areas of inconsistency  
 4           and conflict; and

5           “(B) information from medicare contractors  
 6           that tracks the nature of all communications and  
 7           correspondence.

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

## 14           **TITLE II—APPEALS PROCESS** 15           **REFORM**

### 16   **SEC. 201. TRANSFER OF RESPONSIBILITY FOR MEDICARE** 17           **APPEALS.**

18           (a) TRANSITION PLAN.—

19           (1) IN GENERAL.—Not later than October 1,  
 20           2002, the Commissioner of Social Security and the  
 21           Secretary shall develop and transmit to Congress  
 22           and the Comptroller General of the United States a  
 23           plan under which the functions of administrative law  
 24           judges responsible for hearing cases under title  
 25           XVIII of the Social Security Act (and related provi-

1 sions in title XI of such Act) are transferred from  
2 the responsibility of the Commissioner and the So-  
3 cial Security Administration to the Secretary and  
4 the Department of Health and Human Services.

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

7 (A) WORKLOAD.—The number of such ad-  
8 ministrative law judges and support staff re-  
9 quired now and in the future to hear and decide  
10 such cases in a timely manner, taking into ac-  
11 count the current and anticipated claims vol-  
12 ume, appeals, number of beneficiaries, and stat-  
13 utory changes.

14 (B) COST PROJECTIONS.—Funding levels  
15 required for fiscal year 2004 and subsequent  
16 fiscal years under this subsection to hear such  
17 cases in a timely manner.

18 (C) TRANSITION TIMETABLE.—A timetable  
19 for the transition.

20 (D) REGULATIONS.—The establishment of  
21 specific regulations to govern the appeals proc-  
22 ess.

23 (E) CASE TRACKING.—The development of  
24 a unified case tracking system that will facili-  
25 tate the maintenance and transfer of case spe-

1           cific data across both the fee-for-service and  
2           managed care components of the medicare pro-  
3           gram.

4           (F) FEASIBILITY OF PRECEDENTIAL AU-  
5           THORITY.—The feasibility of developing a proc-  
6           ess to give decisions of the Departmental Ap-  
7           peals Board in the Department of Health and  
8           Human Services addressing broad legal issues  
9           binding, precedential authority.

10          (G) ACCESS TO ADMINISTRATIVE LAW  
11          JUDGES.—The feasibility of filing appeals with  
12          administrative law judges electronically, and the  
13          feasibility of conducting hearings using tele- or  
14          video-conference technologies.

15          (3) ADDITIONAL INFORMATION.—The plan may  
16          also include recommendations for further Congres-  
17          sional action, including modifications to the require-  
18          ments and deadlines established under section 1869  
19          of the Social Security Act (as amended by sections  
20          521 and 522 of BIPA, 114 Stat. 2763A–534).

21          (4) GAO EVALUATION.—The Comptroller Gen-  
22          eral of the United States shall evaluate the plan  
23          and, not later than April 1, 2003, shall submit to  
24          Congress a report on such evaluation.

25          (b) TRANSFER OF ADJUDICATION AUTHORITY.—

1           (1) IN GENERAL.—Not earlier than July 1,  
2           2003, and not later than October 1, 2003, the Com-  
3           missioner of Social Security and the Secretary shall  
4           implement the transition plan developed under sub-  
5           section (a) and transfer the administrative law judge  
6           functions described in such subsection from the So-  
7           cial Security Administration to the Secretary.

8           (2) ASSURING INDEPENDENCE OF JUDGES.—  
9           The Secretary shall assure the independence of  
10          judges performing the administrative law judge  
11          functions transferred under paragraph (1) from the  
12          Centers for Medicare & Medicaid Services and its  
13          contractors.

14          (3) GEOGRAPHIC DISTRIBUTION.—The Sec-  
15          retary shall provide for an appropriate geographic  
16          distribution of judges performing the administrative  
17          law judge functions transferred under paragraph (1)  
18          throughout the United States to ensure timely ac-  
19          cess to such judges.

20          (4) HIRING AUTHORITY.—Subject to the  
21          amounts provided in advance in appropriations Act,  
22          the Secretary shall have authority to hire adminis-  
23          trative law judges to hear cases under title XVIII of  
24          the Social Security Act and to hire support staff for  
25          such judges.



1           (5) PERFORMANCE STANDARDS.—The Sec-  
2       retary shall establish performance standards for ad-  
3       ministrative law judges hearing cases under title  
4       XVIII of the Social Security Act with respect to—

5           (A) timelines for decisions in such cases;

6           and

7           (B) adherence to laws and regulations re-  
8       lated to such title.

9           (6) FINANCING.—Amounts payable under law  
10      to the Commissioner of Social Security for judges  
11      performing the administrative law judge functions  
12      transferred under paragraph (1) from the Federal  
13      Hospital Insurance Trust Fund and the Federal  
14      Supplementary Medical Insurance Trust Fund shall  
15      become payable to the Secretary for the functions so  
16      transferred.

17          (7) SHARED RESOURCES.—The Secretary shall  
18      enter into such arrangements with the Commissioner  
19      of Social Security as may be appropriate with re-  
20      spect to transferred functions of administrative law  
21      judges to share office space, support staff, and other  
22      resources, with appropriate reimbursement from the  
23      Trust Funds described in paragraph (5).

24          (c) INCREASED FINANCIAL SUPPORT.—In addition to  
25      any amounts otherwise appropriated, to ensure timely ac-

tion on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), 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 as are necessary for fiscal year 2003 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA 114 Stat. 2763A–543, is amended by striking “of the Social Security Administration” in the matter preceding subclause (I).

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

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 521 of BIPA, 114 Stat. 2763A–534, is amended—

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

4           (2) by adding at the end the following new  
5           paragraph:

6           “(2) EXPEDITED ACCESS TO JUDICIAL RE-  
7           VIEW.—

8           “(A) IN GENERAL.—The Secretary shall  
9           establish a process under which a provider of  
10          services or supplier that furnishes an item or  
11          service or a beneficiary who has filed an appeal  
12          under paragraph (1) (other than an appeal filed  
13          under paragraph (1)(F)) may obtain access to  
14          judicial review when a review panel (described  
15          in subparagraph (D)), on its own motion or at  
16          the request of the appellant, determines that  
17          the Departmental Appeals Board does not have  
18          the authority to decide the question of law or  
19          regulation relevant to the matters in con-  
20          troversy and that there is no material issue of  
21          fact in dispute. The appellant may make such  
22          request only once with respect to a question of  
23          law or regulation for a specific matter in dis-  
24          pute in a case of an appeal.

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

20           “(C) ACCESS TO JUDICIAL REVIEW.—

21           “(i) IN GENERAL.—If the appropriate  
22          review panel—

23                   “(I) determines that there are no  
24                   material issues of fact in dispute and  
25                   that the only issue is one of law or

1 regulation that the Departmental Ap-  
2 peals Board does not have authority  
3 to decide; or

4 “(II) fails to make such deter-  
5 mination within the period provided  
6 under subparagraph (B);

7 then the appellant may bring a civil action  
8 as described in this subparagraph.

9 “(ii) DEADLINE FOR FILING.—Such  
10 action shall be filed, in the case described  
11 in—

12 “(I) clause (i)(I), within 60 days  
13 of date of the determination described  
14 in such clause; or

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

19 “(iii) VENUE.—Such action shall be  
20 brought in the district court of the United  
21 States for the judicial district in which the  
22 appellant is located (or, in the case of an  
23 action brought jointly by more than one  
24 applicant, the judicial district in which the  
25 greatest number of applicants are located)

1 or in the district court for the District of  
2 Columbia.

3 “(iv) INTEREST ON ANY AMOUNTS IN  
4 CONTROVERSY.—Where a provider of serv-  
5 ices or supplier seeks judicial review pursu-  
6 ant to this paragraph, the amount in con-  
7 troversy (if any) shall be subject to annual  
8 interest beginning on the first day of the  
9 first month beginning after the 60-day pe-  
10 riod as determined pursuant to clause (ii)  
11 and equal to the rate of interest on obliga-  
12 tions issued for purchase by the Federal  
13 Supplementary Medical Insurance Trust  
14 Fund for the month in which the civil ac-  
15 tion authorized under this paragraph is  
16 commenced, to be awarded by the review-  
17 ing court in favor of the prevailing party.  
18 No interest awarded pursuant to the pre-  
19 ceding sentence shall be deemed income or  
20 cost for the purposes of determining reim-  
21 bursement due providers of services, physi-  
22 cians, practitioners, and other suppliers  
23 under this Act.

24 “(D) REVIEW PANEL DEFINED.—For pur-  
25 poses of this subsection, a ‘review panel’ is a

1 panel of 3 members from the Departmental Ap-  
 2 peals Board, selected for the purpose of making  
 3 determinations under this paragraph.”.

4 (b) APPLICATION TO PROVIDER AGREEMENT DETER-  
 5 MINATIONS.—Section 1866(h)(1) (42 U.S.C.  
 6 1395cc(h)(1)) is amended—

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

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

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

20 (c) EFFECTIVE DATE.—The amendments made by  
 21 this section shall apply to appeals filed on or after October  
 22 1, 2003.

1 **SEC. 203. EXPEDITED REVIEW OF CERTAIN PROVIDER**  
2 **AGREEMENT DETERMINATIONS.**

3 (a) **TERMINATION AND CERTAIN OTHER IMMEDIATE**  
4 **REMEDIES.—**

5 (1) **IN GENERAL.**—The Secretary shall develop  
6 and implement a process to expedite proceedings  
7 under sections 1866(h) of the Social Security Act  
8 (42 U.S.C. 1395cc(h)) in which—

9 (A) the remedy of termination of participa-  
10 tion has been imposed; or

11 (B) a sanction described in clause (i) or  
12 (iii) of section 1819(h)(2)(B) of such Act (42  
13 U.S.C. 1395i–3(h)(2)(B)) has been imposed,  
14 but only if such sanction has been imposed on  
15 an immediate basis.

16 (2) **PRIORITY FOR CASES OF TERMINATION.**—  
17 Under the process described in paragraph (1), pri-  
18 ority shall be provided in cases of termination de-  
19 scribed in subparagraph (A) of such paragraph.

20 (b) **INCREASED FINANCIAL SUPPORT.**—In addition  
21 to any amounts otherwise appropriated, to reduce by 50  
22 percent the average time for administrative determina-  
23 tions on appeals under section 1866(h) of the Social Secu-  
24 rity Act (42 U.S.C. 1395cc(h)), there are authorized to  
25 be appropriated (in appropriate part from the Federal  
26 Hospital Insurance Trust Fund and the Federal Supple-



1 mentary Medical Insurance Trust Fund) to the Secretary  
 2 such sums for fiscal year 2003 and each subsequent fiscal  
 3 year as may be necessary to increase the number of ad-  
 4 ministrative law judges (and their staffs) at the Depart-  
 5 mental Appeals Board of the Department of Health and  
 6 Human Services and to educate such judges and staff on  
 7 long-term care issues.

8 **SEC. 204. REVISIONS TO MEDICARE APPEALS PROCESS.**

9 (a) TIMEFRAMES FOR THE COMPLETION OF THE  
 10 RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as  
 11 amended by section 521 of BIPA, 114 Stat. 2763A–534,  
 12 and as amended in section 202(a), is further amended by  
 13 adding at the end the following new paragraph:

14 “(3) TIMELY COMPLETION OF THE RECORD.—

15 “(A) DEADLINE.—Subject to subpara-  
 16 graph (B), the deadline to complete the record  
 17 in a hearing before an administrative law judge  
 18 or a review by the Departmental Appeals Board  
 19 is 90 days after the date the request for the ap-  
 20 peal is filed.

21 “(B) EXTENSIONS FOR GOOD CAUSE.—

22 The person filing a request under subparagraph  
 23 (A) may request an extension of such deadline  
 24 for good cause. The administrative law judge,  
 25 in the case of a hearing, and the Departmental

1 Appeals Board, in the case of a review, may ex-  
 2 tend such deadline based upon a finding of  
 3 good cause to a date specified by the judge or  
 4 Board, as the case may be.

5 “(C) DELAY IN DECISION DEADLINES  
 6 UNTIL COMPLETION OF RECORD.—Notwith-  
 7 standing any other provision of this section, the  
 8 deadlines otherwise established under sub-  
 9 section (d) for the making of determinations in  
 10 hearings or review under this section shall begin  
 11 on the date on which the record is complete.

12 “(D) COMPLETE DESCRIBED.—For pur-  
 13 poses of this paragraph, a record is complete  
 14 when the administrative law judge, in the case  
 15 of a hearing, or the Departmental Appeals  
 16 Board, in the case of a review, has received—

17 “(i) written or testimonial evidence, or  
 18 both, submitted by the person filing the re-  
 19 quest,

20 “(ii) written or oral argument, or  
 21 both, is presented,

22 “(iii) the decision of, and the record  
 23 for, the prior level of appeal, and

24 “(iv) such other evidence as such  
 25 judge or Board, as the case may be, deter-

1                    mines is required to make a determination  
 2                    on the request.”.

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

7            (c) NOTICE REQUIREMENTS FOR MEDICARE AP-  
 8 PEALS.—

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

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

21                    “(A) the specific reasons for the deter-  
 22 mination, including, as appropriate—

23                    “(i) upon request in the case of an  
 24 initial determination, a summary of the

clinical or scientific evidence used in making the determination; and

“(ii) in the case of a redetermination, such a summary;

“(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 calculated to be understood by the beneficiary and shall include—

“(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision,

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

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

12 (3) APPEALS.—Section 1869(d) (42 U.S.C.  
 13 1395ff(d)) is amended—

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

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

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

22 “(A) the specific reasons for the deter-  
 23 mination (including, to the extent appropriate,  
 24 a summary of the clinical or scientific evidence  
 25 used in making the determination);

1 “(B) the procedures for obtaining addi-  
 2 tional information concerning the decision; and

3 “(C) notification of the right to appeal the  
 4 decision and instructions on how to initiate  
 5 such an appeal under this section.”.

6 (4) PREPARATION OF RECORD FOR APPEAL.—  
 7 Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J))  
 8 by striking “such information as is required for an  
 9 appeal” and inserting “the record for the appeal”.

10 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

11 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED  
 12 INDEPENDENT CONTRACTORS.—Section 1869(c) (42  
 13 U.S.C. 1395ff(c)) is amended—

14 (A) in paragraph (2)—

15 (i) by inserting “(except in the case of  
 16 a utilization and quality control peer re-  
 17 view organization, as defined in section  
 18 1152)” after “means an entity or organi-  
 19 zation that”; and

20 (ii) by striking the period at the end  
 21 and inserting the following: “and meets the  
 22 following requirements:

23 “(A) GENERAL REQUIREMENTS.—

24 “(i) The entity or organization has  
 25 (directly or through contracts or other ar-

1 rangements) sufficient medical, legal, and  
2 other expertise (including knowledge of the  
3 program under this title) and sufficient  
4 staffing to carry out duties of a qualified  
5 independent contractor under this section  
6 on a timely basis.

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

15 “(iii) The entity or organization meets  
16 such other requirements as the Secretary  
17 provides by regulation.

18 “(B) INDEPENDENCE REQUIREMENTS.—

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

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

1 “(II) does not have a material fa-  
2 milial, financial, or professional rela-  
3 tionship with such a party in relation  
4 to such case; and

5 “(III) does not otherwise have a  
6 conflict of interest with such a party  
7 (as determined under regulations).

8 “(ii) EXCEPTION FOR REASONABLE  
9 COMPENSATION.—Nothing in clause (i)  
10 shall be construed to prohibit receipt by a  
11 qualified independent contractor of com-  
12 pensation from the Secretary for the con-  
13 duct of activities under this section if the  
14 compensation is provided consistent with  
15 clause (iii).

16 “(iii) LIMITATIONS ON ENTITY COM-  
17 PENSATION.—Compensation provided by  
18 the Secretary to a qualified independent  
19 contractor in connection with reviews  
20 under this section shall—

21 “(I) not exceed a reasonable  
22 level; and

23 “(II) not be contingent on any  
24 decision rendered by the contractor or  
25 by any reviewing professional.”; and



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

5 (2) ELIGIBILITY REQUIREMENTS FOR REVIEW-  
 6 ERS.—Section 1869 (42 U.S.C. 1395ff) is  
 7 amended—

8 (A) by amending subsection (c)(3)(D) to  
 9 read as follows:

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

14 (B) by adding at the end the following new  
 15 subsection:

16 “(g) QUALIFICATIONS OF REVIEWERS.—

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

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

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

1           “(C) in the case of a review by a panel de-  
 2           scribed in subsection (c)(3)(B) composed of  
 3           physicians or other health care professionals  
 4           (each in this subsection referred to as a ‘review-  
 5           ing professional’), each reviewing professional  
 6           meets the qualifications described in paragraph  
 7           (4) and, if the request for review indicates that  
 8           the item or service involved was furnished (or  
 9           ordered to be furnished) by a physician, each  
 10          reviewing professional shall be a physician.

11          “(2) INDEPENDENCE.—

12           “(A) IN GENERAL.—Subject to subpara-  
 13          graph (B), each individual conducting a review  
 14          in a case shall—

15                  “(i) not be a related party (as defined  
 16                  in paragraph (5));

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

20                  “(iii) not otherwise have a conflict of  
 21                  interest with such a party (as determined  
 22                  under regulations).

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

1           “(i) prohibit an individual, solely on  
2           the basis of affiliation with a fiscal inter-  
3           mediary, carrier, or other contractor, from  
4           serving as an reviewing professional if—

5                   “(I) a non-affiliated individual is  
6                   not reasonably available;

7                   “(II) the affiliated individual is  
8                   not involved in the provision of items  
9                   or services in the case under review;

10                  “(III) the fact of such an affili-  
11                  ation is disclosed to the Secretary and  
12                  the beneficiary (or authorized rep-  
13                  resentative) and neither party objects;  
14                  and

15                  “(IV) the affiliated individual is  
16                  not an employee of the intermediary,  
17                  carrier, or contractor and does not  
18                  provide services exclusively or pri-  
19                  marily to or on behalf of such inter-  
20                  mediary, carrier, or contractor;

21           “(ii) prohibit an individual who has  
22           staff privileges at the institution where the  
23           treatment involved takes place from serv-  
24           ing as a reviewer merely on the basis of  
25           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—

“(A) not exceed a reasonable level; and

“(B) 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

1       respect to a case under this title involving an indi-  
2       vidual beneficiary, any of the following:

3               “(A) The Secretary, the medicare adminis-  
4               trative contractor involved, or any fiduciary, of-  
5               ficer, director, or employee of the Department  
6               of Health and Human Services, or of such con-  
7               tractor.

8               “(B) The individual (or authorized rep-  
9               resentative).

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

12              “(D) The institution at which the items or  
13              services (or treatment) involved in the case are  
14              provided.

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

18              “(F) Any other party determined under  
19              any regulations to have a substantial interest in  
20              the case involved.”.

21       (e) IMPLEMENTATION OF CERTAIN BIPA RE-  
22       FORMS.—

23              (1) 1-YEAR DELAY IN EFFECTIVE DATES.—(A)

24       Section 521(d) of BIPA (114 Stat. 2763A–543) is

1       amended by striking “October 1, 2002” and insert-  
2       ing “October 1, 2003”.

3               (B) Section 522(d) of BIPA (114 Stat. 2763A–  
4       547) is amended by striking “October 1, 2001” and  
5       inserting “October 1, 2002”.

6               (2) USE OF PEER REVIEW ORGANIZATIONS TO  
7       CONDUCT EXPEDITED REVIEW DURING TRANSITION  
8       PERIOD.—

9               (A) IN GENERAL.—Section 1154(e) (42  
10       U.S.C. 1320c–3(e)) is amended by adding at  
11       the end the following:

12       “(6)(A) In applying this subsection during the transi-  
13       tion period (described in subparagraph (C)), any reference  
14       in this subsection—

15               “(i) to a hospital is deemed a reference to a  
16       provider of services;

17               “(ii) to inpatient hospital care or services is  
18       deemed a reference to services of such a provider of  
19       services;

20               “(iii) a notice under paragraph (1) is deemed to  
21       include—

22               “(I) a notice to discharge the individual  
23       from the provider of services; or

24               “(II) a notice of termination of services by  
25       a provider of services, but only in the case in

1           which a physician certifies that failure to con-  
 2           tinue the provision of such services is likely to  
 3           place the individual’s health at significant risk;  
 4           and

5           “(iv) an inpatient is deemed a reference to a  
 6           patient.

7           “(B) After the transition period, paragraphs (2)  
 8           through (5) shall not apply.

9           “(C) For purposes of this paragraph and section  
 10          1869(b)(1)(F)(ii), the transition period, with respect to an  
 11          individual who resides in an area served by a peer review  
 12          organization—

13               “(i) begins on the date on which the last tri-  
 14          ennial contract with any peer review organization  
 15          under this part becomes effective during 2002; and

16               “(ii) ends on the date that the triennial con-  
 17          tract under this part with the organization that  
 18          serves such area expires in 2006.”.

19               (B) CONFORMING AMENDMENT TO BIPA.—  
 20          Subsection (c) of section 521 of BIPA is re-  
 21          pealed.

22               (C) CONFORMING AMENDMENT TO SEC-  
 23          TION 1869.—Section 1869(b)(1)(F) (42 U.S.C.  
 24          1395ff(b)(1)(F)), as amended by section 521 of

BIPA, is amended by striking clause (ii) and inserting the following:

“(ii) NO APPLICATION DURING TRANSITION PERIOD.—Clause (i) shall not apply during the transition period described in section 1154(e)(6)(C).”.

(D) SECTION 1155 TRANSITION.—Section 1155 (42 U.S.C. 1320c–4) is amended by adding at the end the following: “In the case of a determination made under section 1154(e)(6)(A) during the period in which the provisions of subsection (b) of section 1869 (as added by section 521 of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554) are in effect, this section shall not apply but the individual shall be entitled to a hearing on the determination before an administrative law judge under such subsection (b) in the same manner as such section applies to a hearing under subsection (a) of such section 1869.”.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enact-



1 ment of the respective provisions of subtitle C of title V  
2 of BIPA, 114 Stat. 2763A–534.

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

10 **SEC. 205. HEARING RIGHTS RELATED TO DECISIONS BY**  
11 **THE SECRETARY TO DENY OR NOT RENEW A**  
12 **MEDICARE ENROLLMENT AGREEMENT; CON-**  
13 **SULTATION BEFORE CHANGING PROVIDER**  
14 **ENROLLMENT FORMS.**

15 (a) HEARING RIGHTS.—

16 (1) IN GENERAL.—Section 1866 (42 U.S.C.  
17 1395cc) is amended by adding at the end the fol-  
18 lowing new subsection:

19 “(j) HEARING RIGHTS IN CASES OF DENIAL OR  
20 NON-RENEWAL.—The Secretary shall establish by regula-  
21 tion procedures under which—

22 “(1) there are deadlines for actions on applica-  
23 tions for enrollment (and, if applicable, renewal of  
24 enrollment); and

1           “(2) providers of services, physicians, practi-  
2           tioners, and suppliers whose application to enroll  
3           (or, if applicable, to renew enrollment) are denied  
4           are provided a mechanism to appeal such denial and  
5           a deadline for consideration of such appeals.”.

6           (2) EFFECTIVE DATE.—The Secretary shall  
7           provide for the establishment of the procedures  
8           under the amendment made by paragraph (1) within  
9           18 months after the date of the enactment of this  
10          Act.

11          (b) CONSULTATION BEFORE CHANGING PROVIDER  
12          ENROLLMENT FORMS.—Section 1871 (42 U.S.C.  
13          1395hh), as amended by sections 101(a), 102, and 103,  
14          is further amended by adding at the end the following new  
15          subsection:

16          “(g) The Secretary shall consult with providers of  
17          services, physicians, practitioners, and suppliers before  
18          making changes in the provider enrollment forms required  
19          of such providers, physicians, practitioners, and suppliers  
20          to be eligible to submit claims for which payment may be  
21          made under this title.”.

1 **SEC. 206. APPEALS BY PROVIDERS WHEN THERE IS NO**  
2 **OTHER PARTY AVAILABLE.**

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

6 “(h) Notwithstanding subsection (f) or any other pro-  
7 vision of law, the Secretary shall permit a provider of serv-  
8 ices, physician, practitioner, or other supplier to appeal  
9 any determination of the Secretary under this title relating  
10 to services rendered under this title to an individual who  
11 subsequently dies if there is no other party available to  
12 appeal such determination.”.

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

17 **SEC. 207. STUDY AND REPORT TO CONGRESS ON WAYS TO**  
18 **IMPROVE THE MEDICARE APPEALS PROC-**  
19 **ESSES.**

20 (a) STUDY.—The Secretary shall conduct a study on  
21 ways to improve the appeals processes under the medicare  
22 program under title XVIII of the Social Security Act for  
23 both beneficiaries and providers and suppliers under such  
24 program. In conducting such study, the Secretary shall  
25 consult with the relevant offices within the Department

1 of Health and Human Services that work on issues related  
2 to the medicare program.

3 (b) REPORT.—Not later than 18 months after the  
4 date of the enactment of this Act, the Secretary shall sub-  
5 mit a report on the findings of the study conducted under  
6 subsection (a) to the Committee on Ways and Means and  
7 the Committee on Energy and Commerce of the House  
8 of Representatives and the Committee on Finance of the  
9 Senate. Such report shall include such recommendations  
10 for legislation and administrative action that the Secretary  
11 determines are appropriate.

## 12 **TITLE III—CONTRACTING** 13 **REFORM**

### 14 **SEC. 301. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-** 15 **TRATION.**

16 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE  
17 ADMINISTRATION.—

18 (1) IN GENERAL.—Title XVIII is amended by  
19 inserting after section 1874 the following new sec-  
20 tion:

21 “CONTRACTS WITH MEDICARE ADMINISTRATIVE  
22 CONTRACTORS

23 “SEC. 1874A. (a) AUTHORITY.—

24 “(1) AUTHORITY TO ENTER INTO CON-  
25 TRACTS.—The Secretary may enter into contracts  
26 with any eligible entity to serve as a medicare ad-

1       ministrative contractor with respect to the perform-  
 2       ance of any or all of the functions described in para-  
 3       graph (4) or parts of those functions (or, to the ex-  
 4       tent provided in a contract, to secure performance  
 5       thereof by other entities).

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

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

12               “(B) the entity complies with such conflict  
 13       of interest standards as are generally applicable  
 14       to Federal acquisition and procurement;

15               “(C) the entity has sufficient assets to fi-  
 16       nancially support the performance of such func-  
 17       tion; and

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

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

22               “(A) IN GENERAL.—The term ‘medicare  
 23       administrative contractor’ means an agency, or-  
 24       ganization, or other person with a contract  
 25       under this section.

1                   “(B) APPROPRIATE MEDICARE ADMINIS-  
2                   TRATIVE CONTRACTOR.—With respect to the  
3                   performance of a particular function in relation  
4                   to an individual entitled to benefits under part  
5                   A or enrolled under part B, or both, a specific  
6                   provider of services, physician, practitioner, fa-  
7                   cility, or supplier (or class of such providers of  
8                   services, physicians, practitioners, facilities, or  
9                   suppliers), the ‘appropriate’ medicare adminis-  
10                  trative contractor is the medicare administra-  
11                  tive contractor that has a contract under this  
12                  section with respect to the performance of that  
13                  function in relation to that individual, provider  
14                  of services, physician, practitioner, facility, or  
15                  supplier or class of provider of services, physi-  
16                  cian, practitioner, facility, or supplier.

17                  “(4) FUNCTIONS DESCRIBED.—The functions  
18                  referred to in paragraphs (1) and (2) are payment  
19                  functions, provider services functions, and bene-  
20                  ficiary services functions as follows:

21                  “(A) DETERMINATION OF PAYMENT  
22                  AMOUNTS.—Determining (subject to the provi-  
23                  sions of section 1878 and to such review by the  
24                  Secretary as may be provided for by the con-  
25                  tracts) the amount of the payments required

1           pursuant to this title to be made to providers  
2           of services, physicians, practitioners, facilities,  
3           suppliers, and individuals.

4           “(B) MAKING PAYMENTS.—Making pay-  
5           ments described in subparagraph (A) (including  
6           receipt, disbursement, and accounting for funds  
7           in making such payments).

8           “(C) BENEFICIARY EDUCATION AND AS-  
9           SISTANCE.—Serving as a center for, and com-  
10          municating to individuals entitled to benefits  
11          under part A or enrolled under part B, or both,  
12          with respect to education and outreach for  
13          those individuals, and assistance with specific  
14          issues, concerns, or problems of those individ-  
15          uals.

16          “(D) PROVIDER CONSULTATIVE SERV-  
17          ICES.—Providing consultative services to insti-  
18          tutions, agencies, and other persons to enable  
19          them to establish and maintain fiscal records  
20          necessary for purposes of this title and other-  
21          wise to qualify as providers of services, physi-  
22          cians, practitioners, facilities, or suppliers.

23          “(E) COMMUNICATION WITH PRO-  
24          VIDERS.—Serving as a center for, and commu-  
25          nicating to providers of services, physicians,

1 practitioners, facilities, and suppliers, any infor-  
 2 mation or instructions furnished to the medi-  
 3 care administrative contractor by the Secretary,  
 4 and serving as a channel of communication  
 5 from such providers, physicians, practitioners,  
 6 facilities, and suppliers to the Secretary.

7 “(F) PROVIDER EDUCATION AND TECH-  
 8 NICAL ASSISTANCE.—Performing the functions  
 9 described in subsections (e) and (f), relating to  
 10 education, training, and technical assistance to  
 11 providers of services, physicians, practitioners,  
 12 facilities, and suppliers.

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

16 “(5) RELATIONSHIP TO MIP CONTRACTS.—

17 “(A) NONDUPLICATION OF DUTIES.—In  
 18 entering into contracts under this section, the  
 19 Secretary shall assure that functions of medi-  
 20 care administrative contractors in carrying out  
 21 activities under parts A and B do not duplicate  
 22 functions carried out under the Medicare Integ-  
 23 rity Program under section 1893. The previous  
 24 sentence shall not apply with respect to the ac-  
 25 tivity described in section 1893(b)(5) (relating



1 to prior authorization of certain items of dura-  
 2 ble medical equipment under section  
 3 1834(a)(15)).

4 “(B) CONSTRUCTION.—An entity shall not  
 5 be treated as a medicare administrative con-  
 6 tractor merely by reason of having entered into  
 7 a contract with the Secretary under section  
 8 1893.

9 “(6) APPLICATION OF FEDERAL ACQUISITION  
 10 REGULATION.—Except to the extent inconsistent  
 11 with a specific requirement of this title, the Federal  
 12 Acquisition Regulation applies to contracts under  
 13 this title.

14 “(b) CONTRACTING REQUIREMENTS.—

15 “(1) USE OF COMPETITIVE PROCEDURES.—

16 “(A) IN GENERAL.—Except as provided in  
 17 laws with general applicability to Federal acqui-  
 18 sition and procurement or in subparagraph (B),  
 19 the Secretary shall use competitive procedures  
 20 when entering into contracts with medicare ad-  
 21 ministrative contractors under this section.

22 “(B) RENEWAL OF CONTRACTS.—The Sec-  
 23 retary may renew a contract with a medicare  
 24 administrative contractor under this section  
 25 from term to term without regard to section 5

1 of title 41, United States Code, or any other  
2 provision of law requiring competition, if the  
3 medicare administrative contractor has met or  
4 exceeded the performance requirements applica-  
5 ble with respect to the contract and contractor,  
6 except that the Secretary shall provide for the  
7 application of competitive procedures under  
8 such a contract not less frequently than once  
9 every six years.

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

23 “(D) INCENTIVES FOR QUALITY.—The  
24 Secretary may provide incentives for medicare

1 administrative contractors to provide quality  
2 service and to promote efficiency.

3 “(2) COMPLIANCE WITH REQUIREMENTS.—No  
4 contract under this section shall be entered into with  
5 any medicare administrative contractor unless the  
6 Secretary finds that such medicare administrative  
7 contractor will perform its obligations under the con-  
8 tract efficiently and effectively and will meet such  
9 requirements as to financial responsibility, legal au-  
10 thority, and other matters as the Secretary finds  
11 pertinent.

12 “(3) PERFORMANCE REQUIREMENTS.—

13 “(A) DEVELOPMENT OF SPECIFIC PER-  
14 FORMANCE REQUIREMENTS.—The Secretary  
15 shall develop contract performance require-  
16 ments to carry out the specific requirements ap-  
17 plicable under this title to a function described  
18 in subsection (a)(4) and shall develop standards  
19 for measuring the extent to which a contractor  
20 has met such requirements. The Secretary shall  
21 publish in the Federal Register such perform-  
22 ance requirements and measurement standards.

23 “(B) CONSIDERATIONS.—The Secretary  
24 may include as one of the standards satisfaction

1 level as measured by provider and beneficiary  
2 surveys.

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

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

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

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

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

22 “(A) to furnish to the Secretary such time-  
23 ly information and reports as the Secretary may  
24 find necessary in performing his functions  
25 under this title; and

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

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

16          “(c) TERMS AND CONDITIONS.—

17               “(1) IN GENERAL.—A contract with any medi-  
18               care administrative contractor under this section  
19               may contain such terms and conditions as the Sec-  
20               retary finds necessary or appropriate and may pro-  
21               vide for advances of funds to the medicare adminis-  
22               trative contractor for the making of payments by it  
23               under subsection (a)(4)(B).

24               “(2) PROHIBITION ON MANDATES FOR CERTAIN  
25               DATA COLLECTION.—The Secretary may not require,

1 as a condition of entering into, or renewing, a con-  
2 tract under this section, that the medicare adminis-  
3 trative contractor match data obtained other than in  
4 its activities under this title with data used in the  
5 administration of this title for purposes of identi-  
6 fying situations in which the provisions of section  
7 1862(b) may apply.

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

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

16 “(2) DISBURSING OFFICER.—No disbursing of-  
17 ficer shall, in the absence of gross negligence or in-  
18 tent to defraud the United States, be liable with re-  
19 spect to any payment by such officer under this sec-  
20 tion if it was based upon an authorization (which  
21 meets the applicable requirements for such internal  
22 controls established by the Comptroller General) of  
23 a certifying officer designated as provided in para-  
24 graph (1) of this subsection.

1           “(3) LIABILITY OF MEDICARE ADMINISTRATIVE  
2           CONTRACTOR.—No medicare administrative con-  
3           tractor shall be liable to the United States for a pay-  
4           ment by a certifying or disbursing officer unless in  
5           connection with such payment or in the supervision  
6           of or selection of such officer the medicare adminis-  
7           trative contractor acted with gross negligence.

8           “(4) INDEMNIFICATION BY SECRETARY.—

9           “(A) IN GENERAL.—Notwithstanding any  
10          other provision of law and subject to the suc-  
11          ceeding provisions of this paragraph, in the case  
12          of a medicare administrative contractor (or a  
13          person who is a director, officer, or employee of  
14          such a contractor or who is engaged by the con-  
15          tractor to participate directly in the claims ad-  
16          ministration process) who is made a party to  
17          any judicial or administrative proceeding aris-  
18          ing from, or relating directly to, the claims ad-  
19          ministration process under this title, the Sec-  
20          retary may, to the extent specified in the con-  
21          tract with the contractor, indemnify the con-  
22          tractor (and such persons).

23          “(B) CONDITIONS.—The Secretary may  
24          not provide indemnification under subparagraph  
25          (A) insofar as the liability for such costs arises

1 directly from conduct that is determined by the  
2 Secretary to be criminal in nature, fraudulent,  
3 or grossly negligent.

4 “(C) SCOPE OF INDEMNIFICATION.—In-  
5 demnification by the Secretary under subpara-  
6 graph (A) may include payment of judgements,  
7 settlements (subject to subparagraph (D)),  
8 awards, and costs (including reasonable legal  
9 expenses).

10 “(D) WRITTEN APPROVAL FOR SETTLE-  
11 MENTS.—A contractor or other person de-  
12 scribed in subparagraph (A) may not propose to  
13 negotiate a settlement or compromise of a pro-  
14 ceeding described in such subparagraph without  
15 the prior written approval of the Secretary to  
16 negotiate a settlement. Any indemnification  
17 under subparagraph (A) with respect to  
18 amounts paid under a settlement are condi-  
19 tioned upon the Secretary’s prior written ap-  
20 proval of the final settlement.

21 “(E) CONSTRUCTION.—Nothing in this  
22 paragraph shall be construed—

23 “(i) to change any common law immu-  
24 nity 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 inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

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

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

“PROVISIONS RELATING TO THE ADMINISTRATION OF  
PART A”.

(2) Subsection (a) is amended to read as follows:

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

4               (3) Subsection (b) is repealed.

5               (4) Subsection (c) is amended—

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

7                       (B) in each of paragraphs (2)(A) and  
 8               (3)(A), by striking “agreement under this sec-  
 9               tion” and inserting “contract under section  
 10              1874A that provides for making payments  
 11              under this part”.

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

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

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

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

22              (7) Subsection (l) is repealed.

23              (c) CONFORMING AMENDMENTS TO SECTION 1842  
 24       (RELATING TO CARRIERS).—Section 1842 (42 U.S.C.  
 25       1395u) is amended as follows:

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

10 (A) by striking paragraph (1);  
11 (B) in paragraph (2)—  
12 (i) by striking subparagraphs (A) and  
13 (B);  
14 (ii) in subparagraph (C), by striking  
15 “carriers” and inserting “medicare admin-  
16 istrative contractors”; and  
17 (iii) by striking subparagraphs (D)  
18 and (E);  
19 (C) in paragraph (3)—

(ii) by striking “will” the first place it  
appears in each of subparagraphs (A), (B),

1 (F), (G), (H), and (L) and inserting  
2 “shall”;

3 (iii) in subparagraph (B), in the mat-  
4 ter before clause (i), by striking “to the  
5 policyholders and subscribers of the car-  
6 rier” and inserting “to the policyholders  
7 and subscribers of the medicare adminis-  
8 trative contractor”;

9 (iv) by striking subparagraphs (C),  
10 (D), and (E);

11 (v) in subparagraph (H)—

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

15 (II) by striking “carrier” and in-  
16 serting “medicare administrative con-  
17 tractor”;

18 (vi) by striking subparagraph (I);

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

21 (viii) in the first sentence, after sub-  
22 paragraph (L), by striking “and shall con-  
23 tain” and all that follows through the pe-  
24 riod; and

1 (ix) in the seventh sentence, by insert-  
2 ing “medicare administrative contractor,”  
3 after “carrier,”; and

4 (D) by striking paragraph (5);

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

8 (F) in paragraph (7), by striking “the car-  
9 rier” and inserting “the Secretary” each place  
10 it appears.

11 (4) Subsection (c) is amended—

12 (A) by striking paragraph (1);

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

19 (C) in paragraph (3)(A), by striking “sub-  
20 section (a)(1)(B)” and inserting “section  
21 1874A(a)(3)(B)”;

22 (D) in paragraph (4), by striking “carrier”  
23 and inserting “medicare administrative con-  
24 tractor”;

(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 sub-

1 section (a)” and inserting “medicare ad-  
2 ministrative contractor having a contract  
3 under section 1874A that provides for  
4 making payments under this part”; and

5 (ii) by striking “such carrier” and in-  
6 serting “such contractor”;

7 (C) in paragraph (3)(B)—

8 (i) by striking “a carrier” and insert-  
9 ing “a medicare administrative contractor”  
10 each place it appears; and

11 (ii) by striking “the carrier” and in-  
12 serting “the contractor” each place it ap-  
13 pears; and

14 (D) in paragraphs (5)(A) and (5)(B)(iii),  
15 by striking “carriers” and inserting “medicare  
16 administrative contractors” each place it ap-  
17 pears.

18 (8) Subsection (l) is amended—

19 (A) in paragraph (1)(A)(iii), by striking  
20 “carrier” and inserting “medicare administra-  
21 tive contractor”; and

22 (B) in paragraph (2), by striking “carrier”  
23 and inserting “medicare administrative con-  
24 tractor”.

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

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

6       (d) EFFECTIVE DATE; TRANSITION RULE.—

7           (1) EFFECTIVE DATE.—

8           (A) APPLICATION TO COMPETITIVELY BID  
 9       CONTRACTS.—The amendments made by this  
 10       section shall apply to contracts that are com-  
 11       petitively bid on or after such date (but not  
 12       later than 2 years after the date of the enact-  
 13       ment of this Act) as the Secretary specifies.

14          (B) CONSTRUCTION FOR CURRENT CON-  
 15       TRACTS.—Such amendments shall not apply to  
 16       contracts in effect before the date specified  
 17       under subparagraph (A) that continue to retain  
 18       the terms and conditions in effect on such date  
 19       until such date as the contract is let out for  
 20       competitive bidding under such amendments.

21          (C) DEADLINE FOR COMPETITIVE BID-  
 22       DING.—The Secretary shall provide for the let-  
 23       ting by competitive bidding of all contracts for  
 24       functions of medicare administrative contrac-



tors for annual contract periods that begin on or after October 1, 2008.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO CONTRACTS.—Prior to the date described in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u).

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and 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 ROLLOVER 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

1       any reference in such provisions to an agreement or  
 2       contract shall be deemed to include a contract under  
 3       section 1874A of such Act, as inserted by subsection  
 4       (a)(1), that continues the activities referred to in  
 5       such provisions.

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

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

20      (g) REPORTS ON IMPLEMENTATION.—

21           (1) PROPOSAL FOR IMPLEMENTATION.—At  
 22      least 1 year before the date the Secretary proposes  
 23      to first implement the plan for implementation of  
 24      the amendments made by this section, the Secretary  
 25      shall submit a report to Congress and the Comp-

1       troller General of the United States that describes  
2       such plan. The Comptroller General shall conduct an  
3       evaluation of such plan and shall submit to Con-  
4       gress, not later than 6 months after the date the re-  
5       port is received, a report on such evaluation and  
6       shall include in such report such recommendations  
7       as the Comptroller General deems appropriate.

8               (2) STATUS OF IMPLEMENTATION.—The Sec-  
9       retary shall submit a report to Congress not later  
10      than October 1, 2006, that describes the status of  
11      implementation of such amendments and that in-  
12      cludes a description of the following:

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

15               (B) The distribution of functions among  
16      contracts and contractors.

17               (C) A timeline for complete transition to  
18      full competition.

19               (D) A detailed description of how the Sec-  
20      retary has modified oversight and management  
21      of medicare contractors to adapt to full com-  
22      petition.

1       **TITLE IV—EDUCATION AND**  
2       **OUTREACH IMPROVEMENTS**

3       **SEC. 401. PROVIDER EDUCATION AND TECHNICAL ASSIST-**  
4       **ANCE.**

5       (a) COORDINATION OF EDUCATION FUNDING.—

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

9       “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

10       “SEC. 1889. (a) COORDINATION OF EDUCATION  
11       FUNDING.—The Secretary shall coordinate the edu-  
12       cational activities provided through medicare contractors  
13       (as defined in subsection (e), including under section  
14       1893) in order to maximize the effectiveness of Federal  
15       education efforts for providers of services, physicians,  
16       practitioners, and suppliers.”.

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

20           (3) REPORT.—Not later than October 1, 2002,  
21       the Secretary shall submit to Congress a report that  
22       includes a description and evaluation of the steps  
23       taken to coordinate the funding of provider edu-  
24       cation under section 1889(a) of the Social Security  
25       Act, as added by paragraph (1).

1 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-  
2 FORMANCE.—

3 (1) IN GENERAL.—Section 1874A, as added by  
4 section 301(a)(1), is amended by adding at the end  
5 the following new subsection:

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

8 “(1) METHODOLOGY TO MEASURE CONTRACTOR  
9 ERROR RATES.—In order to give medicare contrac-  
10 tors (as defined in paragraph (3)) an incentive to  
11 implement effective education and outreach pro-  
12 grams for providers of services, physicians, practi-  
13 tioners, and suppliers, the Secretary shall develop  
14 and implement by October 1, 2002, a methodology  
15 to measure the specific claims payment error rates  
16 of such contractors in the processing or reviewing  
17 of medicare claims.

18 “(2) GAO REVIEW OF METHODOLOGY.—The  
19 Comptroller General of the United States shall re-  
20 view, and make recommendations to the Secretary,  
21 regarding the adequacy of such methodology.

22 “(3) MEDICARE CONTRACTOR DEFINED.—For  
23 purposes of this subsection, the term ‘medicare con-  
24 tractor’ includes a medicare administrative con-  
25 tractor, a fiscal intermediary with a contract under

1 section 1816, and a carrier with a contract under  
2 section 1842.”.

3 (2) REPORT.—The Secretary shall submit to  
4 Congress a report that describes how the Secretary  
5 intends to use the methodology developed under sec-  
6 tion 1874A(e)(1) of the Social Security Act, as  
7 added by paragraph (1), in assessing medicare con-  
8 tractor performance in implementing effective edu-  
9 cation and outreach programs, including whether to  
10 use such methodology as a basis for performance bo-  
11 nuses.

12 (c) IMPROVED PROVIDER EDUCATION AND TRAIN-  
13 ING.—

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

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

21 (B) in subparagraph (B), by striking “The  
22 amount appropriated” and inserting “Subject  
23 to subparagraph (C), the amount appro-  
24 priated”; and

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

3 “(C) ENHANCED PROVIDER EDUCATION  
4 AND TRAINING.—

5 “(i) IN GENERAL.—In addition to the  
6 amount appropriated under subparagraph  
7 (B), the amount appropriated under sub-  
8 paragraph (A) for a fiscal year (beginning  
9 with fiscal year 2003) is increased by  
10 \$35,000,000.

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

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

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

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

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

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

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

23 “(B) a physician, practitioner, or supplier  
 24 with fewer than 10 full-time-equivalent employ-  
 25 ees.”.



1 (B) EFFECTIVE DATE.—The amendment  
2 made by subparagraph (A) shall take effect on  
3 October 1, 2002.

4 (d) ADDITIONAL PROVIDER EDUCATION PROVI-  
5 SIONS.—

6 (1) IN GENERAL.—Section 1889, as added by  
7 subsection (a) and as amended by subsection (c)(2),  
8 is further amended by adding at the end the fol-  
9 lowing new subsections:

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

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

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

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

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

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

11 “(2) An eligible entity with a contract under  
 12 section 1893.

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

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

21 **SEC. 402. ACCESS TO AND PROMPT RESPONSES FROM**  
 22 **MEDICARE CONTRACTORS.**

23 (a) IN GENERAL.—Section 1874A, as added by sec-  
 24 tion 301 and as amended by section 401(b)(1), is further

1 amended by adding at the end the following new sub-  
2 section:

3 “(f) COMMUNICATING WITH BENEFICIARIES AND  
4 PROVIDERS.—

5 “(1) COMMUNICATION PROCESS.—The Sec-  
6 retary shall develop a process for communicating  
7 with beneficiaries and with providers of services,  
8 physicians, practitioners, and suppliers under this  
9 title.

10 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each  
11 medicare contractor (as defined in paragraph (5))  
12 shall provide general written responses (which may  
13 be through electronic transmission) in a clear, con-  
14 cise, and accurate manner to inquiries by bene-  
15 ficiaries, providers of services, physicians, practi-  
16 tioners, and suppliers concerning the programs  
17 under this title within 45 business days of the date  
18 of receipt of such inquiries.

19 “(3) RESPONSE TO TOLL-FREE LINES.—The  
20 Secretary shall ensure that medicare contractors  
21 provide a toll-free telephone number at which bene-  
22 ficiaries, providers, physicians, practitioners, and  
23 suppliers may obtain information regarding billing,  
24 coding, claims, coverage, and other appropriate in-  
25 formation under this title.

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

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

7           “(i) maintain a system for identifying  
8 who provides the information referred to in  
9 paragraphs (2) and (3); and

10          “(ii) monitor the accuracy, consist-  
11 ency, and timeliness of the information so  
12 provided.

13          “(B) DEVELOPMENT OF STANDARDS.—

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

22          “(ii) EVALUATION.—In conducting  
23 evaluations of individual medicare contrac-  
24 tors, the Secretary shall take into account  
25 the results of the monitoring conducted

1 under subparagraph (A) taking into ac-  
 2 count as performance requirements the  
 3 standards established under clause (i).

4 “(C) DIRECT MONITORING.—Nothing in  
 5 this paragraph shall be construed as preventing  
 6 the Secretary from directly monitoring the ac-  
 7 curacy, consistency, and timeliness of the infor-  
 8 mation so provided.

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

13 (b) EFFECTIVE DATE.—The amendment made by  
 14 subsection (a) shall take effect October 1, 2002.

15 **SEC. 403. RELIANCE ON GUIDANCE.**

16 (a) IN GENERAL.—Section 1871(e), as added by sec-  
 17 tion 102(a), is further amended by adding at the end the  
 18 following new paragraph:

19 “(2) If—

20 “(A) a provider of services, physician, practi-  
 21 tioner, or other supplier follows written guidance  
 22 provided—

23 “(i) by the Secretary; or

24 “(ii) by a medicare contractor (as defined  
 25 in section 1889(e) and whether in the form of

1           a written response to a written inquiry under  
2           section 1874A(f)(1) or otherwise) acting within  
3           the scope of the contractor’s contract authority,  
4       in response to a written inquiry with respect to the  
5       furnishing of items or services or the submission of  
6       a claim for benefits for such items or services;

7           “(B) the Secretary determines that—

8               “(i) the provider of services, physician,  
9               practitioner, or supplier has accurately pre-  
10              sented the circumstances relating to such items,  
11              services, and claim to the Secretary or the con-  
12              tractor in the written guidance; and

13               “(ii) there is no indication of fraud or  
14              abuse committed by the provider of services,  
15              physician, practitioner, or supplier against the  
16              program under this title; and

17           “(C) the guidance was in error;

18 the provider of services, physician, practitioner, or supplier  
19 shall not be subject to any penalty or interest under this  
20 title (or the provisions of title XI insofar as they relate  
21 to this title) relating to the provision of such items or serv-  
22 ice or such claim if the provider of services, physician,  
23 practitioner, or supplier reasonably relied on such guid-  
24 ance. In applying this paragraph with respect to guidance  
25 in the form of general responses to frequently asked ques-

1 tions, the Secretary retains authority to determine the ex-  
 2 tent to which such general responses apply to the par-  
 3 ticular circumstances of individual claims.”.

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

7 **SEC. 404. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**  
 8 **BENEFICIARY OMBUDSMAN.**

9 (a) MEDICARE PROVIDER OMBUDSMAN.—Section  
 10 1868 (42 U.S.C. 1395ee) is amended—

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

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

15 (3) in paragraph (1), as so redesignated under  
 16 paragraph (2), by striking “in this section” and in-  
 17 serting “in this subsection”;

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

20 (5) by adding at the end the following new sub-  
 21 section:

22 “(b) MEDICARE PROVIDER OMBUDSMAN.—By not  
 23 later than 1 year after the date of the enactment of the  
 24 Medicare Appeals, Regulatory, and Contracting Improve-

1 ment Act of 2001, the Secretary shall appoint a Medicare  
2 Provider Ombudsman. The Ombudsman shall—

3 “(1) provide assistance, on a confidential basis,  
4 to providers of services and suppliers with respect to  
5 complaints, grievances, and requests for information  
6 concerning the programs under this title (including  
7 provisions of title XI insofar as they relate to this  
8 title and are not administered by the Office of the  
9 Inspector General of the Department of Health and  
10 Human Services) and in the resolution of unclear or  
11 conflicting guidance given by the Secretary and  
12 medicare contractors to such providers of services  
13 and suppliers regarding such programs and provi-  
14 sions and requirements under this title and such  
15 provisions; and

16 “(2) submit recommendations to the Secretary  
17 for improvement in the administration of this title  
18 and such provisions, including—

19 “(A) recommendations to respond to recur-  
20 ring patterns of confusion in this title and such  
21 provisions (including recommendations regard-  
22 ing suspending imposition of sanctions where  
23 there is widespread confusion in program ad-  
24 ministration), and



1           “(B) recommendations to provide for an  
 2           appropriate and consistent response (including  
 3           not providing for audits) in cases of self-identi-  
 4           fied overpayments by providers of services and  
 5           suppliers.”.

6           (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title  
 7 XVIII is amended by inserting after section 1806 the fol-  
 8 lowing new section:

9           “MEDICARE BENEFICIARY OMBUDSMAN

10          “SEC. 1807. (a) IN GENERAL.—By not later than 1  
 11 year after the date of the enactment of the Medicare Ap-  
 12 peals, Regulatory, and Contracting Improvement Act of  
 13 2001, the Secretary shall appoint within the Department  
 14 of Health and Human Services a Medicare Beneficiary  
 15 Ombudsman who shall have expertise and experience in  
 16 the fields of health care and advocacy.

17          “(b) DUTIES.—The Medicare Beneficiary Ombuds-  
 18 man shall—

19           “(1) receive complaints, grievances, and re-  
 20 quests for information submitted by a medicare ben-  
 21 eficiary, with respect to any aspect of the medicare  
 22 program;

23           “(2) provide assistance with respect to com-  
 24 plaints, grievances, and requests referred to in para-  
 25 graph (1), including—

1           “(A) assistance in collecting relevant infor-  
 2           mation for such beneficiaries, to seek an appeal  
 3           of a decision or determination made by a fiscal  
 4           intermediary, carrier, Medicare+Choice organi-  
 5           zation, or the Secretary; and

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

9           “(3) submit annual reports to Congress and the  
 10          Secretary that describe the activities of the Office  
 11          and that include such recommendations for improve-  
 12          ment in the administration of this title as the Om-  
 13          budsman determines appropriate.”.

14          (c) FUNDING.—There are authorized to be appro-  
 15          priated to the Secretary (in appropriate part from the  
 16          Federal Hospital Insurance Trust Fund and the Federal  
 17          Supplementary Medical Insurance Trust Fund) to carry  
 18          out the provisions of subsection (b) of section 1868 of the  
 19          Social Security Act (relating to the Medicare Provider  
 20          Ombudsman), as added by subsection (a)(5) and section  
 21          1807 of such Act (relating to the Medicare Beneficiary  
 22          Ombudsman), as added by subsection (b), such sums as  
 23          are necessary for fiscal year 2002 and each succeeding fis-  
 24          cal year.

1       (d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-  
 2 MEDICARE).—Section 1804(b) (42 U.S.C. 1395b-2(b))  
 3 is amended by adding at the end the following: “By not  
 4 later than 1 year after the date of the enactment of the  
 5 Medicare Appeals, Regulatory, and Contracting Improve-  
 6 ment Act of 2001, the Secretary shall provide, through  
 7 the toll-free number 1-800-MEDICARE, for a means by  
 8 which individuals seeking information about, or assistance  
 9 with, such programs who phone such toll-free number are  
 10 transferred (without charge) to appropriate entities for the  
 11 provision of such information or assistance. Such toll-free  
 12 number shall be the toll-free number listed for general in-  
 13 formation and assistance in the annual notice under sub-  
 14 section (a) instead of the listing of numbers of individual  
 15 contractors.”.

16 **SEC. 405. BENEFICIARY OUTREACH DEMONSTRATION PRO-**  
 17 **GRAM.**

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

25       (b) LOCATIONS.—

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

7           (2) ASSISTANCE FOR RURAL BENEFICIARIES.—  
 8       The Secretary shall provide for the selection of at  
 9       least 2 rural areas to participate in the demonstra-  
 10      tion program. In conducting the demonstration pro-  
 11      gram in such rural areas, the Secretary shall provide  
 12      for medicare specialists to travel among local offices  
 13      in a rural area on a scheduled basis.

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

16      (d) EVALUATION AND REPORT.—

17           (1) EVALUATION.—The Secretary shall provide  
 18      for an evaluation of the demonstration program.  
 19      Such evaluation shall include an analysis of—

20           (A) utilization of, and beneficiary satisfac-  
 21      tion with, the assistance provided under the  
 22      program; and

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

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

6       **TITLE V—REVIEW, RECOVERY,**  
 7       **AND ENFORCEMENT REFORM**

8       **SEC. 501. PREPAYMENT REVIEW.**

9       (a) IN GENERAL.—Section 1874A, as added by sec-  
 10      tion 301 and as amended by sections 401(b)(1) and 402,  
 11      is further amended by adding at the end the following new  
 12      subsection:

13       “(g) CONDUCT OF PREPAYMENT REVIEW.—

14       “(1) STANDARDIZATION OF RANDOM PREPAY-  
 15      MENT REVIEW.—A medicare administrative con-  
 16      tractor shall conduct random prepayment review  
 17      only in accordance with a standard protocol for ran-  
 18      dom prepayment audits developed by the Secretary.

19       “(2) LIMITATIONS ON INITIATION OF NON-RAN-  
 20      DOM PREPAYMENT REVIEW.—A medicare adminis-  
 21      trative contractor may not initiate non-random pre-  
 22      payment review of a provider of services, physician,  
 23      practitioner, or supplier based on the initial identi-  
 24      fication by that provider of services, physician, prac-  
 25      titioner, or supplier of an improper billing practice

1 unless there is a likelihood of sustained or high level  
2 of payment error (as defined by the Secretary).

3 “(3) TERMINATION OF NON-RANDOM PREPAY-  
4 MENT REVIEW.—The Secretary shall issue regula-  
5 tions relating to the termination, including termi-  
6 nation dates, of non-random prepayment review.  
7 Such regulations may vary such a termination date  
8 based upon the differences in the circumstances trig-  
9 gering prepayment review.

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

22 “(5) RANDOM PREPAYMENT REVIEW DE-  
23 FINED.—For purposes of this subsection, the term  
24 ‘random prepayment review’ means a demand for

1 the production of records or documentation absent  
2 cause with respect to a claim.”.

3 (b) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in this  
5 subsection, the amendment made by subsection (a)  
6 shall take effect on the date of the enactment of this  
7 Act.

8 (2) DEADLINE FOR PROMULGATION OF CER-  
9 TAIN REGULATIONS.—The Secretary shall first issue  
10 regulations under section 1874A(g) of the Social Se-  
11 curity Act, as added by subsection (a), by not later  
12 than 1 year after the date of the enactment of this  
13 Act.

14 (3) APPLICATION OF STANDARD PROTOCOLS  
15 FOR RANDOM PREPAYMENT REVIEW.—Section  
16 1874A(g)(1) of the Social Security Act, as added by  
17 subsection (a), shall apply to random prepayment re-  
18 views conducted on or after such date (not later  
19 than 1 year after the date of the enactment of this  
20 Act) as the Secretary shall specify. The Secretary  
21 shall develop and publish the standard protocol  
22 under such section by not later than 1 year after the  
23 date of the enactment of this Act.

1 **SEC. 502. RECOVERY OF OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1874A, as added by sec-  
 3 tion 301 and as amended by sections 401(b)(1), 402, and  
 4 501(a), is further amended by adding at the end the fol-  
 5 lowing new subsection:

6 “(h) RECOVERY OF OVERPAYMENTS.—

7 “(1) USE OF REPAYMENT PLANS.—

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



1           “(B) DEVELOPMENT OF STANDARDS.—

2           The Secretary shall develop standards for the  
3           recovery of overpayments. Such standards  
4           shall—

5                   “(i) include a requirement that the  
6                   Secretary take into account (and weigh in  
7                   favor of the use of a repayment plan) the  
8                   reliance (as described in section  
9                   1871(e)(2)) by a provider of services, phy-  
10                  sician, practitioner, and supplier on guid-  
11                  ance when determining whether a repay-  
12                  ment plan should be offered; and

13                   “(ii) provide for consideration of the  
14                   financial hardship imposed on a provider of  
15                   services, physician, practitioner, or supplier  
16                   in considering such a repayment plan.

17           In developing standards with regard to financial  
18           hardship with respect to a provider of services,  
19           physician, practitioner, or supplier, the Sec-  
20           retary shall take into account the amount of the  
21           proposed recovery as a proportion of payments  
22           made to that provider, physician, practitioner,  
23           or supplier.

24                   “(C) EXCEPTIONS.—Subparagraph (A)  
25           shall not apply if—

1 “(i) the Secretary has reason to sus-  
 2 pect that the provider of services, physi-  
 3 cian, practitioner, or supplier may file for  
 4 bankruptcy or otherwise cease to do busi-  
 5 ness or discontinue participation in the  
 6 program under this title; or

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

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

17 “(E) RELATION TO NO FAULT PROVI-  
 18 SION.—Nothing in this paragraph shall be con-  
 19 strued as affecting the application of section  
 20 1870(c) (relating to no adjustment in the cases  
 21 of certain overpayments).

22 “(2) LIMITATION ON RECOUPMENT.—

23 “(A) NO RECOUPMENT UNTIL RECONSID-  
 24 ERATION EXERCISED.—In the case of a pro-  
 25 vider of services, physician, practitioner, or sup-

1 plier that is determined to have received an  
2 overpayment under this title and that seeks a  
3 reconsideration of such determination by a  
4 qualified independent contractor under section  
5 1869(c), the Secretary may not take any action  
6 (or authorize any other person, including any  
7 medicare contractor, as defined in subpara-  
8 graph (C)) to recoup the overpayment until the  
9 date the decision on the reconsideration has  
10 been rendered.

11 “(B) PAYMENT OF INTEREST.—

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

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

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

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

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

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

11 “(3) PAYMENT AUDITS.—

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

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

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

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

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

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

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

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

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

17           “(6) CONSENT SETTLEMENT REFORMS.—

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

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

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

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

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

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

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

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

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

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

9                   “(II) a consent settlement.

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

13          “(D) CONSENT SETTLEMENT DEFINED.—

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

23          (b) EFFECTIVE DATES AND DEADLINES.—

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



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

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

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

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

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

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

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

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

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

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

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

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

## 8 **TITLE VI—OTHER PROVISIONS**

### 9 **SEC. 601. TREATMENT OF HOSPITALS FOR CERTAIN SERV-** 10 **ICES UNDER MEDICARE SECONDARY PAYOR** 11 **(MSP) PROVISIONS.**

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

21 (b) REFERENCE LABORATORY SERVICES DE-  
 22 SCRIBED.—Reference laboratory services described in this  
 23 subsection are clinical laboratory diagnostic tests (or the  
 24 interpretation of such tests, or both) furnished without a  
 25 face-to-face encounter between the beneficiary and the

1 hospital involved and in which the hospital submits a claim  
2 only for such test or interpretation.

3 **SEC. 602. PAYMENT FOR EMTALA-MANDATED SCREENING**  
4 **AND STABILIZATION SERVICES.**

5 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y)  
6 is amended by inserting after subsection (c) the following  
7 new subsection:

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

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall apply to items and services furnished  
25 on or after January 1, 2002.

1 **SEC. 603. REVIEW AND REPORT TO CONGRESS ON REDUC-**  
2 **ING MEDICARE REPORTING BURDENS.**

3 (a) REVIEW.—The Secretary shall conduct a review  
4 of the cost reports currently in use under the medicare  
5 program under title XVIII of the Social Security Act for  
6 the purpose of—

7 (1) establishing ways for reducing the reporting  
8 burden on providers and suppliers under such pro-  
9 gram; and

10 (2) creating documents which can be used for—

11 (A) financial reporting consistent with gen-  
12 erally accepted accounting principals; and

13 (B) cost analysis—

14 (i) necessary for the Medicare Pay-  
15 ment Advisory Commission and the Sec-  
16 retary to make recommendations to Con-  
17 gress regarding payment rates (including  
18 margin analysis and potential benefit ex-  
19 pansion); and

20 (ii) used by the Secretary to perform  
21 audits.

22 (b) REPORT.—Not later than October 1, 2003, the  
23 Secretary shall submit to Congress a report on the review  
24 conducted under subsection (a) together with such rec-  
25 ommendations for legislation and administrative action  
26 that the Secretary determines are appropriate.

1 **SEC. 604. AUTHORIZING USE OF ARRANGEMENTS WITH**  
2 **OTHER HOSPICE PROGRAMS TO PROVIDE**  
3 **CORE HOSPICE SERVICES IN CERTAIN CIR-**  
4 **CUMSTANCES.**

5 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.  
6 1395x(dd)(5)) is amended by adding at the end the fol-  
7 lowing new subparagraph:

8 “(D) In extraordinary, exigent, or other non-routine  
9 circumstances, such as unanticipated periods of high pa-  
10 tient loads, staffing shortages due to illness or other  
11 events, or temporary travel of a patient outside a hospice  
12 program’s service area, a hospice program may enter into  
13 arrangements with another hospice program for the provi-  
14 sion by that other program of services described in para-  
15 graph (2)(A)(ii)(I). The provisions of paragraph  
16 (2)(A)(ii)(II) shall apply with respect to the services pro-  
17 vided under such arrangements.”.

18 (b) CONFORMING PAYMENT PROVISION.—Section  
19 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the  
20 end the following new paragraph:

21 “(4) In the case of hospice care provided by a hospice  
22 program under arrangements under section  
23 1861(dd)(5)(D) made by another hospice program, the  
24 hospice program that made the arrangements shall bill  
25 and be paid for the hospice care.”.

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

4 **SEC. 605. ONE YEAR DELAY IN LOCK IN PROCEDURES FOR**  
 5 **MEDICARE+CHOICE PLANS.**

6 Section 1851(e) (42 U.S.C. 1395w–21(e)) is  
 7 amended—

8 (1) in paragraph (2)(A), by striking “THROUGH  
 9 2001” and “and 2001” and inserting “THROUGH  
 10 2002” and “2001, and 2002”, respectively;

11 (2) in paragraph (2)(B), by striking “DURING  
 12 2002” and inserting “DURING 2003”;

13 (3) in paragraphs (2)(B)(i) and (2)(C)(i), by  
 14 striking “2002” and inserting “2003” each place it  
 15 appears;

16 (4) in paragraph (2)(D), by striking “2001”  
 17 and inserting “2002”; and

18 (5) in paragraph (4), by striking “2002” and  
 19 inserting “2003” each place it appears.

20 **SEC. 606. TEMPORARY MORATORIUM ON REQUIREMENT OF**  
 21 **HOME HEALTH AGENCIES TO COLLECT OASIS**  
 22 **DATA FROM NON-MEDICARE PATIENTS.**

23 (a) MORATORIUM.—

24 (1) IN GENERAL.—During the period beginning  
 25 on the date of enactment of this Act and ending on

1 the date that the Secretary submits to Congress the  
 2 report described in subsection (b)(2), the data collec-  
 3 tion and reporting requirements under the Outcome  
 4 and Assessment Information Set (OASIS), required  
 5 by reason of section 4602(e) of Balanced Budget  
 6 Act of 1997 (42 U.S.C. 1395fff note), shall be op-  
 7 tional with respect to patients of home health agen-  
 8 cies who are not beneficiaries under the medicare  
 9 program under title XVIII of the Social Security  
 10 Act.

11 (2) RULE OF CONSTRUCTION REGARDING  
 12 STATE LAW.—Nothing in paragraph (1) shall pro-  
 13 hibit a State from requiring a home health agency  
 14 to collect and report the data described in such  
 15 paragraph during the period described in such para-  
 16 graph.

17 (b) STUDY AND REPORT.—

18 (1) STUDY.—The Secretary shall conduct a  
 19 study on whether the data collection and reporting  
 20 requirements under OASIS with respect to patients  
 21 of home health agencies who are not beneficiaries  
 22 under the medicare program under title XVIII of the  
 23 Social Security Act should be eliminated. In con-  
 24 ducting such study, the Secretary shall consult with



1 home health agencies and entities representing such  
2 agencies.

3 (2) REPORT.—Not later than 18 months after  
4 the date of the enactment of this Act, the Secretary  
5 shall submit to Congress a report on the study con-  
6 ducted under paragraph (1), together with rec-  
7 ommendations for such legislation and administra-  
8 tive actions as the Secretary considers appropriate.

9 **SEC. 607. COORDINATED SURVEY DEMONSTRATION PRO-**  
10 **GRAM.**

11 (a) ESTABLISHMENT.—

12 (1) IN GENERAL.—The Secretary shall establish  
13 a demonstration program to test and evaluate the ef-  
14 fectiveness of permitting all the entities within a  
15 health care organization to be subject to a coordi-  
16 nated survey for purposes of determining whether  
17 such entities are in compliance with the require-  
18 ments for participation under the medicare and med-  
19 icaid programs with respect to all items and services  
20 provided by those entities under such programs rath-  
21 er than being subject to multiple surveys for dif-  
22 ferent types of items and services provided by such  
23 entities under such programs.

24 (2) DEVELOPMENT OF GUIDELINES FOR CO-  
25 ORDINATED SURVEY.—

1           (A) SUBMISSION OF PROPOSALS BY  
2 STATES PARTICIPATING IN THE DEMONSTRA-  
3 TION PROGRAM.—Under the demonstration pro-  
4 gram under this section a State participating in  
5 the demonstration (as determined by the Sec-  
6 retary pursuant to paragraph (3)) shall submit  
7 to the Secretary a proposal for guidelines with  
8 respect to the coordinated survey described in  
9 paragraph (1) that will be applicable to health  
10 care organizations located in the State. Such  
11 proposal shall be submitted to the Secretary at  
12 such time and in such manner as the Secretary  
13 determines appropriate.

14           (B) REVIEW AND APPROVAL.—

15           (i) IN GENERAL.—Under the dem-  
16 onstration program under this section the  
17 Secretary shall establish procedures for re-  
18 viewing and approving proposals submitted  
19 under subparagraph (A).

20           (ii) CONSULTATION.—The Secretary  
21 shall consult with State hospital associa-  
22 tions in establishing the procedures under  
23 clause (i).

24           (3) SITES.—The Secretary shall conduct the  
25 demonstration program under this section in up to

1       5 States and shall ensure that all health care organi-  
2       zations located in those States are permitted at the  
3       option of the organization to participate in the pro-  
4       gram.

5           (4) DURATION.—The demonstration program  
6       under this section shall be conducted for not more  
7       than 5 years.

8           (b) WAIVER AUTHORITY.—The Secretary may waive  
9       such requirements of titles XI, XVIII, and XIX of the So-  
10      cial Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.;  
11      1396 et seq.) as may be necessary for the purpose of car-  
12      rying out the demonstration program under this section.

13          (c) REPORT.—Not later than 6 months after the com-  
14      pletion of the demonstration program under this section,  
15      the Secretary shall submit to Congress a report on such  
16      program, together with recommendations regarding  
17      whether to implement coordinated survey guidelines for  
18      health care organizations on a permanent basis.

19          (d) DEFINITIONS.—In this section:

20           (1) CRITICAL ACCESS HOSPITAL.—The term  
21      “critical access hospital” has the meaning given  
22      such term in section 1861(mm)(1) of the Social Se-  
23      curity Act (42 U.S.C. 1395x(mm)(1)).

1           (2) HEALTH CARE ORGANIZATION.—The term  
2       “health care organization” means a governing entity  
3       that includes—

4                   (A) a critical access hospital; and

5                   (B) at least 1 other provider or supplier  
6       that is certified to provide items or services  
7       under the medicare or medicaid program.

8           (3) MEDICAID PROGRAM.—The term “medicaid  
9       program” means the health benefits program under  
10      title XIX of the Social Security Act (42 U.S.C. 1396  
11      et seq.).

12          (4) MEDICARE PROGRAM.—The term “medicare  
13      program” means the health benefits program under  
14      title XVIII of the Social Security Act (42 U.S.C.  
15      1395 et seq.).

○