

Calendar No. 627

107TH CONGRESS
2^D SESSION

S. 3018

To amend title XVIII of the Social Security Act to enhance beneficiary access to quality health care services under the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 1, 2002

Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. BINGAMAN, Mr. KYL, Mr. ROCKEFELLER, and Mr. JEFFORDS) introduced the following bill; which was read the first time

OCTOBER 2, 2002

Read the second time and placed on the calendar

A BILL

To amend title XVIII of the Social Security Act to enhance beneficiary access to quality health care services 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; REFERENCES TO BIPA AND SEC-**
 3 **RETARY; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
 5 “Beneficiary Access to Care and Medicare Equity Act of
 6 2002”.

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

13 (c) **BIPA; SECRETARY.**—In this Act:

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

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

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

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—RURAL HEALTH CARE IMPROVEMENTS

Sec. 101. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.

Sec. 102. Adjustment to wage index.

Sec. 103. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.

- Sec. 104. One-year extension of hold harmless provisions for small rural hospitals under medicare prospective payment system for hospital outpatient department services.
- Sec. 105. Temporary increase in payments for certain services furnished by small rural hospitals under medicare prospective payment system for hospital outpatient department services.
- Sec. 106. Two-year treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital.
- Sec. 107. Improvements to critical access hospital program.
- Sec. 108. Temporary relief for certain non-teaching hospitals.
- Sec. 109. Physician fee schedule geographic adjustment factor revision.
- Sec. 110. Medicare incentive payment program improvements.
- Sec. 111. GAO study of geographic differences in payments for physicians' services.
- Sec. 112. Extension of temporary increase for home health services furnished in a rural area.
- Sec. 113. Ten percent increase in payment for hospice care furnished in a frontier area.
- Sec. 114. Exclusion of certain rural health clinic and Federally qualified health center services from the medicare PPS for skilled nursing facilities.
- Sec. 115. Capital infrastructure revolving loan program.

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 201. Revision of acute care hospital payment updates.
- Sec. 202. More frequent updates in weights used in hospital market basket.
- Sec. 203. Three-year increase in level of adjustment for indirect costs of medical education (IME).
- Sec. 204. Revision of Federal rate for hospitals in Puerto Rico.
- Sec. 205. Increase in graduate medical education limitations for certain geriatric residents.
- Sec. 206. Increase for hospitals with disproportionate indigent care revenues.

Subtitle B—Skilled Nursing Facility Services

- Sec. 211. Payment for covered skilled nursing facility services.
- Sec. 212. Improving the availability of nursing facility staffing information.

Subtitle C—Hospice

- Sec. 221. Coverage of hospice consultation services.
- Sec. 222. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

- Sec. 301. Revision of updates for physicians' services.
- Sec. 302. Three-year extension of treatment of certain physician pathology services under medicare.

Subtitle B—Other Services

- Sec. 311. Competitive acquisition of certain items and services.

- Sec. 312. Two-year extension of moratorium on therapy caps; provisions relating to reports.
- Sec. 313. Acceleration of reduction of beneficiary copayment for hospital outpatient department services.
- Sec. 314. Renal dialysis services.
- Sec. 315. Improved payment for certain mammography services.
- Sec. 316. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 317. Coverage of cholesterol and blood lipid screening.
- Sec. 318. Temporary increase for ground ambulance services.
- Sec. 319. Ensuring appropriate coverage of air ambulance services under ambulance fee schedule.
- Sec. 320. Adjustments to local fee schedules for clinical laboratory tests for improvement in cervical cancer detection.
- Sec. 321. Coverage of immunosuppressive drugs for all medicare beneficiaries.
- Sec. 322. Medicare complex clinical care management payment demonstration.
- Sec. 323. Study and report on new technology payments under the prospective payment system for hospital outpatient department services.

TITLE IV—PROVISION RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 401. Elimination of 15 percent reduction in payment rates under the prospective payment system.
- Sec. 402. Update in home health services.

Subtitle B—Other Provisions

- Sec. 411. Information technology demonstration project.
- Sec. 412. Modifications to Medicare Payment Advisory Commission (MedPAC).
- Sec. 413. Retaining diversity of local coverage determinations.

TITLE V—MEDICARE+CHOICE AND RELATED PROVISIONS

- Sec. 501. Revision in minimum percentage increase for 2003 and 2004.
- Sec. 502. Clarification of authority regarding disapproval of unreasonable beneficiary cost-sharing.
- Sec. 503. Extension of reasonable cost contracts.
- Sec. 504. Extension of social health maintenance organization (SHMO) demonstration project.
- Sec. 505. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 506. Extension of new entry bonus.
- Sec. 507. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
- Sec. 508. Reference to implementation of certain Medicare+Choice program provisions in 2003.

TITLE VI—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

- Sec. 601. Rules for the publication of a final regulation based on the previous publication of an interim final regulation.
- Sec. 602. Compliance with changes in regulations and policies.
- Sec. 603. Report on legal and regulatory inconsistencies.

Subtitle B—Appeals Process Reform

- Sec. 611. Submission of plan for transfer of responsibility for medicare appeals.
- Sec. 612. Expedited access to judicial review.
- Sec. 613. Expedited review of certain provider agreement determinations.
- Sec. 614. Revisions to medicare appeals process.
- Sec. 615. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement; consultation before changing provider enrollment forms.
- Sec. 616. Appeals by providers when there is no other party available.
- Sec. 617. Provider access to review of local coverage determinations.

Subtitle C—Contracting Reform

- Sec. 621. Increased flexibility in medicare administration.

Subtitle D—Education and Outreach Improvements

- Sec. 631. Provider education and technical assistance.
- Sec. 632. Access to and prompt responses from medicare contractors.
- Sec. 633. Reliance on guidance.
- Sec. 634. Medicare provider ombudsman; medicare beneficiary ombudsman.
- Sec. 635. Beneficiary outreach demonstration program.

Subtitle E—Review, Recovery, and Enforcement Reform

- Sec. 641. Prepayment review.
- Sec. 642. Recovery of overpayments.
- Sec. 643. Process for correction of minor errors and omissions on claims without pursuing appeals process.
- Sec. 644. Authority to waive a program exclusion.

TITLE VII—MEDICAID/SCHIP

- Sec. 701. Medicaid DSH allotments.
- Sec. 702. Temporary increase in floor for treatment as an extremely low DSH State.
- Sec. 703. Extension of medicare cost-sharing for part B premium for certain additional low-income medicare beneficiaries.
- Sec. 704. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.
- Sec. 705. SCHIP allotments.
- Sec. 706. Improvement of the process for the development and implementation of medicaid and SCHIP waivers.
- Sec. 707. Temporary State fiscal relief.

TITLE VIII—OTHER PROVISIONS

- Sec. 801. Increase in appropriations for special diabetes programs for type I diabetes and Indians.
- Sec. 802. Disregard of certain payments under the Emergency Supplemental Act, 2000 in the administration of Federal programs and federally assisted programs.
- Sec. 803. Safety Net Organizations and Patient Advisory Commission.
- Sec. 804. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

Sec. 805. Federal reimbursement of emergency health services furnished to undocumented aliens.

Sec. 806. Extension of medicare municipal health services demonstration projects.

Sec. 807. Delayed implementation of certain provisions.

TITLE I—RURAL HEALTH CARE IMPROVEMENTS

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

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

(1) by striking “(iv) For discharges” and inserting “(iv)(I) Subject to the succeeding provisions of this clause, for discharges”; and

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

“(II) For discharges occurring during fiscal year 2003, the operating standardized amount for hospitals located other than in a large urban area shall be increased by $\frac{1}{2}$ of the difference between the operating standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

1 “(III) For discharges occurring in a fiscal year
 2 beginning with fiscal year 2004, the Secretary shall
 3 compute an operating standardized amount for hos-
 4 pitals located in any area within the United States
 5 and within each region equal to the operating stand-
 6 ardized amount computed for the previous fiscal
 7 year under this subparagraph for hospitals located
 8 in a large urban area (or, beginning with fiscal year
 9 2005, for hospitals located in any area) increased by
 10 the applicable percentage increase under subsection
 11 (b)(3)(B)(i) for the fiscal year involved.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) COMPUTING DRG-SPECIFIC RATES.—Section
 14 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is
 15 amended—

16 (A) in the heading, by striking “IN DIF-
 17 FERENT AREAS”;

18 (B) in the matter preceding clause (i), by
 19 striking “each of which is”;

20 (C) in clause (i)—

21 (i) in the matter preceding subclause
 22 (I), by inserting “for fiscal years before fis-
 23 cal year 2004,” before “for hospitals”; and

24 (ii) in subclause (II), by striking
 25 “and” after the semicolon at the end;

1 (D) in clause (ii)—

2 (i) in the matter preceding subclause
3 (I), by inserting “for fiscal years before fis-
4 cal year 2004,” before “for hospitals”; and

5 (ii) in subclause (II), by striking the
6 period at the end and inserting “; and”;
7 and

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

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

13 “(I) the applicable operating stand-
14 ardized amount (computed under subpara-
15 graph (A)), reduced under subparagraph
16 (B), and adjusted or reduced under sub-
17 paragraph (C) for the fiscal year; and

18 “(II) the weighting factor (determined
19 under paragraph (4)(B)) for that diag-
20 nosis-related group.”.

21 (2) TECHNICAL CONFORMING SUNSET.—Section
22 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

23 (A) in the matter preceding subparagraph
24 (A), by inserting “, for fiscal years before fiscal

1 year 1997,” before “a regional adjusted DRG
2 prospective payment rate”; and

3 (B) in subparagraph (D), in the matter
4 preceding clause (i), by inserting “, for fiscal
5 years before fiscal year 1997,” before “a re-
6 gional DRG prospective payment rate for each
7 region,”.

8 **SEC. 102. ADJUSTMENT TO WAGE INDEX.**

9 (a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C.
10 1395ww(d)(3)(E)) is amended—

11 (1) by striking “WAGE LEVELS.—The Sec-
12 retary” and inserting “WAGE LEVELS.—

13 “(i) IN GENERAL.—Except as provided in
14 clause (ii), the Secretary”; and

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

17 “(ii) ALTERNATIVE PROPORTION TO BE AD-
18 JUSTED IN FISCAL YEARS 2003, 2004, AND 2005.—

19 “(I) IN GENERAL.—Except as provided in
20 subclause (II), for discharges occurring on or
21 after October 1, 2002, and before October 1,
22 2005, the Secretary shall substitute ‘68 per-
23 cent’ for the proportion described in the first
24 sentence of clause (i).

1 “(II) HOLD HARMLESS FOR CERTAIN HOS-
 2 PITALS.—For discharges occurring on or after
 3 October 1, 2002, and before October 1, 2005,
 4 if the application of subclause (I) would result
 5 in lower payments to a hospital than would oth-
 6 erwise be made, then this subparagraph shall be
 7 applied as if this clause had not been enacted.

8 (b) WAIVING BUDGET NEUTRALITY.—Section
 9 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended
 10 by subsection (a), is amended by adding at the end of
 11 clause (i) the following new sentence: “The Secretary shall
 12 apply the previous sentence for any period as if the
 13 amendments made by section 102(a) of the Beneficiary
 14 Access to Care and Medicare Equity Act of 2002 had not
 15 been enacted.”.

16 (c) MEDPAC STUDY AND REPORT.—

17 (1) STUDY.—The Medicare Payment Advisory
 18 Commission shall—

19 (A) conduct a study of the methodology
 20 used to determine the proportion of hospitals’
 21 costs attributable to wages and wage-related
 22 costs (as determined under section
 23 1886(d)(3)(E) of the Social Security Act (42
 24 U.S.C. 1395ww(d)(3)(E)), as amended by sub-
 25 sections (a) and (b)), which is used to adjust

1 payments under such section, in order to deter-
 2 mine whether such methodology is appropriate;
 3 and

4 (B) if the Commission determines that
 5 such methodology is not appropriate, develop
 6 recommendations on the establishment of a
 7 methodology to be used by the Secretary to de-
 8 termine the appropriate portion of hospitals'
 9 costs which are attributable to wages and wage-
 10 related for purposes of adjusting payments
 11 under such section.

12 (2) REPORT.—Not later than 1 year after the
 13 date of the enactment of this Act, the Commission
 14 shall submit to Congress a report on the study con-
 15 ducted under paragraph (1) together with any rec-
 16 ommendation developed under paragraph (1)(B).

17 **SEC. 103. ENHANCED DISPROPORTIONATE SHARE HOS-**
 18 **PITAL (DSH) TREATMENT FOR RURAL HOS-**
 19 **PITALS AND URBAN HOSPITALS WITH FEWER**
 20 **THAN 100 BEDS.**

21 (a) BLENDING OF PAYMENT AMOUNTS.—

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

1 “(xiv)(I) In the case of discharges in a fiscal year
 2 beginning on or after October 1, 2002, subject to sub-
 3 clause (II), there shall be substituted for the dispropor-
 4 tionate share adjustment percentage otherwise determined
 5 under clause (iv) (other than subclause (I)) or under
 6 clause (viii), (x), (xi), (xii), or (xiii), the old blend propor-
 7 tion (specified under subclause (III)) of the dispropor-
 8 tionate share adjustment percentage otherwise determined
 9 under the respective clause and 100 percent minus such
 10 old blend proportion of the disproportionate share adjust-
 11 ment percentage determined under clause (vii) (relating
 12 to large, urban hospitals).

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

17 “(III) For purposes of subclause (I), the old blend
 18 proportion for fiscal year 2003 is 90 percent, for each sub-
 19 sequent year (through 2011) is the old blend proportion
 20 under this subclause for the previous year minus 10 per-
 21 centage points, and for each year beginning with 2012 is
 22 0 percent.”.

23 (2) CONFORMING AMENDMENTS.—Section
 24 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is
 25 amended—

1 (A) in each of subclauses (II), (III), (IV),
 2 (V), and (VI) of clause (iv), by inserting “sub-
 3 ject to clause (xiv) and” before “for discharges
 4 occurring”;

5 (B) in clause (viii), by striking “The for-
 6 mula” and inserting “Subject to clause (xiv),
 7 the formula”; and

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

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

14 **SEC. 104. ONE-YEAR EXTENSION OF HOLD HARMLESS PRO-**
 15 **VISIONS FOR SMALL RURAL HOSPITALS**
 16 **UNDER MEDICARE PROSPECTIVE PAYMENT**
 17 **SYSTEM FOR HOSPITAL OUTPATIENT DE-**
 18 **PARTMENT SERVICES.**

19 Section 1833(t)(7)(D)(i) (42 U.S.C.
 20 1395l(t)(7)(D)(i)) is amended by striking “2004” and in-
 21 serting “2005”.

1 **SEC. 105. TEMPORARY INCREASE IN PAYMENTS FOR CER-**
2 **TAIN SERVICES FURNISHED BY SMALL**
3 **RURAL HOSPITALS UNDER MEDICARE PRO-**
4 **SPECTIVE PAYMENT SYSTEM FOR HOSPITAL**
5 **OUTPATIENT DEPARTMENT SERVICES.**

6 (a) INCREASE.—

7 (1) IN GENERAL.—In the case of an applicable
8 covered OPD service (as defined in paragraph (2))
9 that is furnished by a hospital described in para-
10 graph (7)(D)(i) of section 1833(t) of the Social Se-
11 curity Act (42 U.S.C. 1395l(t)) on or after January
12 1, 2003, and before January 1, 2006, the Secretary
13 of Health and Human Services shall increase the
14 medicare OPD fee schedule amount (as determined
15 under paragraph (4)(A) of such section) that is ap-
16 plicable for such service in that year (determined
17 without regard to any increase under this section in
18 a previous year) by 5 percent.

19 (2) APPLICABLE COVERED OPD SERVICES DE-
20 FINED.—For purposes of this section, the term “ap-
21 plicable covered OPD service” means a covered clinic
22 or emergency room visit that is classified within the
23 groups of covered OPD services (as defined in para-
24 graph (1)(B) of section 1833(t) of the Social Secu-
25 rity Act (42 U.S.C. 1395l(t))) established under
26 paragraph (2)(B) of such section.

1 (b) NO EFFECT ON COPAYMENT AMOUNT.—The Sec-
2 retary of Health and Human Services shall compute the
3 copayment amount for applicable covered OPD services
4 under section 1833(t)(8)(A) of the Social Security Act (42
5 U.S.C. 1395l(t)(8)(A)) as if this section had not been en-
6 acted.

7 (c) NO EFFECT ON INCREASE UNDER HOLD HARM-
8 LESS OR OUTLIER PROVISIONS.—The Secretary of Health
9 and Human Services shall apply the temporary hold harm-
10 less provision under paragraph (7)(D)(i) of section
11 1833(t) of the Social Security Act (42 U.S.C. 1395l(t))
12 and the outlier provision under paragraph (5) of such sec-
13 tion as if this section had not been enacted.

14 (d) WAIVING BUDGET NEUTRALITY AND NO REVI-
15 SION OR ADJUSTMENTS.—The Secretary of Health and
16 Human Services shall not make any revision or adjust-
17 ment under subparagraph (A), (B), or (C) of section
18 1833(t)(9) of the Social Security Act (42 U.S.C.
19 1395l(t)(9)) because of the application of subsection
20 (a)(1).

21 (e) NO EFFECT ON PAYMENTS AFTER INCREASE PE-
22 RIOD ENDS.—The Secretary of Health and Human Serv-
23 ices shall not take into account any payment increase pro-
24 vided under subsection (a)(1) in determining payments for
25 covered OPD services (as defined in paragraph (1)(B) of

1 section 1833(t) of the Social Security Act (42 U.S.C.
 2 1395l(t))) under such section that are furnished after
 3 January 1, 2006.

4 (f) TECHNICAL AMENDMENT.—Section
 5 1833(t)(2)(B) (42 U.S.C. 1395l(t)(2)(B)) is amended by
 6 inserting “(and periodically revise such groups pursuant
 7 to paragraph (9)(A))” after “establish groups”.

8 **SEC. 106. TWO-YEAR TREATMENT OF CERTAIN CLINICAL DI-**
 9 **AGNOSTIC LABORATORY TESTS FURNISHED**
 10 **BY A SOLE COMMUNITY HOSPITAL.**

11 Notwithstanding subsections (a)(1)(D) and (h) of
 12 section 1833 of the Social Security Act (42 U.S.C. 1395l)
 13 and section 1834(d)(1) of such Act (42 U.S.C.
 14 1395m(d)(1)), in the case of a clinical diagnostic labora-
 15 tory test covered under part B of title XVIII of such Act
 16 that is furnished in 2004 or 2005 by a sole community
 17 hospital (as defined in section 1886(d)(5)(D)(iii) of such
 18 Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services
 19 provided to patients of the hospital, the following rules
 20 shall apply:

21 (1) PAYMENT BASED ON REASONABLE COSTS.—

22 The amount of payment for such test shall be 100
 23 percent of the reasonable costs of the hospital in fur-
 24 nishing such test.

1 (2) NO BENEFICIARY COST-SHARING.—No coin-
 2 surance, deductible, copayment, or other cost-shar-
 3 ing otherwise applicable under such part B shall
 4 apply with respect to such test.

5 **SEC. 107. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**
 6 **PROGRAM.**

7 (a) AUTHORIZATION OF PERIODIC INTERIM PAY-
 8 MENT (PIP).—Section 1815(e)(2) (42 U.S.C.
 9 1395g(e)(2)) is amended—

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

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

14 (3) by inserting after subparagraph (D) the fol-
 15 lowing new subparagraph:

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

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

21 “The Secretary may not require, as a condition for
 22 applying subparagraph (B) with respect to a critical
 23 access hospital, that each physician providing profes-
 24 sional services in the critical access hospital must as-
 25 sign billing rights with respect to such services, ex-

cept that such subparagraph shall not apply to those physicians who have not assigned such billing rights.”.

(c) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(1) in the heading—

(A) by inserting “CERTAIN” before “EMERGENCY”; and

(B) by striking “PHYSICIANS” and inserting “PROVIDERS”;

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

(3) by striking “physicians’ services” and inserting “services covered under this title”.

(d) PROHIBITION OF RETROACTIVE RECOUPMENT.—

The Secretary shall not recoup (or otherwise seek to recover) overpayments made for outpatient critical access hospital services under part B of title XVIII of the Social Security Act, for services furnished in cost reporting periods that began before October 1, 2002, insofar as such

1 overpayments are attributable to payment being based on
 2 80 percent of reasonable costs (instead of 100 percent of
 3 reasonable costs minus 20 percent of charges).

4 (e) INCREASED FLEXIBILITY FOR STATES WITH RE-
 5 SPECT TO CERTAIN FRONTIER CRITICAL ACCESS HOS-
 6 PITALS.—Section 1820(c) (42 U.S.C. 1395i–4(c)) is
 7 amended—

8 (1) in paragraph (2)(B)(ii), by striking
 9 “makes” and inserting “subject to paragraph (3),
 10 makes”; and

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

13 “(3) STATE AUTHORITY TO TEMPORARILY
 14 WAIVE EMERGENCY COVERAGE REQUIREMENT.—

15 “(A) IN GENERAL.—A State may establish
 16 procedures under which the requirement under
 17 paragraph (2)(B)(ii) is temporarily waived with
 18 respect to a critical access hospital designated
 19 under paragraph (2) if such hospital—

20 “(i) complies with alternative emer-
 21 gency care procedures established by the
 22 State;

23 “(ii) is located in a frontier area (as
 24 defined in section 1814(i)(1)(D)); and

1 “(iii) has less than 500 emergency
 2 room visits (determined with respect to all
 3 patients and not just individuals receiving
 4 benefits under this title) per year (as de-
 5 termined by the State).”.

6 (f) PERMITTING HOSPITALS TO ALLOCATE SWING
 7 BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO
 8 A TOTAL LIMIT OF 25 BEDS.—

9 (1) IN GENERAL.—Section 1820(c)(2)(B)(iii)
 10 (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to
 11 read as follows:

12 “(iii) provides not more than a total
 13 of 25 extended care service beds (pursuant
 14 to an agreement under subsection (f)) or
 15 acute care inpatient beds (meeting such
 16 standards as the Secretary may establish)
 17 for providing inpatient care for a period
 18 that does not exceed, as determined on an
 19 annual, average basis, 96 hours per pa-
 20 tient;”.

21 (2) CONFORMING AMENDMENT.—Section
 22 1820(f) (42 U.S.C. 1395i–4(f)) is amended by strik-
 23 ing “and the number of beds used at any time for
 24 acute care inpatient services does not exceed 15
 25 beds”.

1 (g) PROVISIONS RELATED TO CERTAIN RURAL
2 GRANTS.—

3 (1) SMALL RURAL HOSPITAL IMPROVEMENT
4 PROGRAM.—Section 1820(g) (42 U.S.C. 1395i–4(g))
5 is amended—

6 (A) by redesignating paragraph (3)(F) as
7 paragraph (5) and redesignating and indenting
8 appropriately; and

9 (B) by inserting after paragraph (3) the
10 following new paragraph:

11 “(4) SMALL RURAL HOSPITAL IMPROVEMENT
12 PROGRAM.—

13 “(A) GRANTS TO HOSPITALS.—The Sec-
14 retary may award grants to hospitals that have
15 submitted applications in accordance with sub-
16 paragraph (B) to assist eligible small rural hos-
17 pitals (as defined in paragraph (3)(B)) in meet-
18 ing the costs of reducing medical errors, in-
19 creasing patient safety, protecting patient pri-
20 vacy, and improving hospital quality and per-
21 formance.

22 “(B) APPLICATION.—A hospital seeking a
23 grant under this paragraph shall submit an ap-
24 plication to the Secretary on or before such

1 date and in such form and manner as the Sec-
 2 retary specifies.

3 “(C) AMOUNT OF GRANT.—A grant to a
 4 hospital under this paragraph may not exceed
 5 \$50,000.

6 “(D) USE OF FUNDS.—A hospital receiv-
 7 ing a grant under this paragraph may use the
 8 funds for the purchase of computer software
 9 and hardware, the education and training of
 10 hospital staff, and obtaining technical assist-
 11 ance.”.

12 (2) FIVE-YEAR AUTHORIZATION FOR APPRO-
 13 PRIATIONS.—Section 1820(j) (42 U.S.C. 1395i–4(j))
 14 is amended to read as follows:

15 “(j) AUTHORIZATION OF APPROPRIATIONS.—

16 “(1) HI TRUST FUND.—There are authorized to
 17 be appropriated from the Federal Hospital Insur-
 18 ance Trust Fund for making grants to all States
 19 under—

20 “(A) subsection (g), \$25,000,000 in each
 21 of the fiscal years 1998 through 2002; and

22 “(B) paragraphs (1) and (2) of subsection
 23 (g), \$40,000,000 in each of the fiscal years
 24 2003 through 2007.

1 “(2) GENERAL REVENUES.—There are author-
 2 ized to be appropriated from amounts in the treas-
 3 ury not otherwise appropriated for making grants to
 4 all States under subsection (g)(4), \$25,000,000 in
 5 each of the fiscal years 2003 through 2007.”.

6 (3) REQUIREMENT THAT STATES AWARDED
 7 GRANTS CONSULT WITH THE STATE HOSPITAL ASSO-
 8 CIATION AND RURAL HOSPITALS ON THE MOST AP-
 9 PROPRIATE WAYS TO USE SUCH GRANTS.—Section
 10 1820(g) (42 U.S.C. 1395i–4(g)), as amended by
 11 paragraph (1), is amended by adding at the end the
 12 following new paragraph:

13 “(6) REQUIRED CONSULTATION FOR STATES
 14 AWARDED GRANTS.—A State awarded a grant under
 15 paragraph (1) or (2) shall consult with the hospital
 16 association of such State and rural hospitals located
 17 in such State on the most appropriate ways to use
 18 the funds under such grant.”.

19 (h) COORDINATED SURVEY DEMONSTRATION PRO-
 20 GRAM.—

21 (1) ESTABLISHMENT.—

22 (A) IN GENERAL.—The Secretary shall es-
 23 tablish a demonstration program to test and
 24 evaluate the effectiveness of permitting all the
 25 entities within a health care organization to be

1 subject to a coordinated survey for purposes of
2 determining whether such entities are in com-
3 pliance with the requirements for participation
4 under the medicare and medicaid programs
5 with respect to all items and services provided
6 by those entities under such programs rather
7 than being subject to multiple surveys for dif-
8 ferent types of items and services provided by
9 such entities under such programs.

10 (B) DEVELOPMENT OF GUIDELINES FOR
11 COORDINATED SURVEY.—

12 (i) SUBMISSION OF PROPOSALS BY
13 STATES PARTICIPATING IN THE DEM-
14 ONSTRATION PROGRAM.—Under the dem-
15 onstration program under this subsection a
16 State participating in the demonstration
17 (as determined by the Secretary pursuant
18 to subparagraph (C)) shall submit to the
19 Secretary a proposal for guidelines with re-
20 spect to the coordinated survey described
21 in subparagraph (A) that will be applicable
22 to health care organizations located in the
23 State. Such proposal shall be submitted to
24 the Secretary at such time and in such

1 manner as the Secretary determines appro-
2 priate.

3 (ii) REVIEW AND APPROVAL.—

4 (I) IN GENERAL.—Under the
5 demonstration program under this
6 subsection the Secretary shall estab-
7 lish procedures for reviewing and ap-
8 proving proposals submitted under
9 clause (i).

10 (II) CONSULTATION.—The Sec-
11 retary shall consult with State hos-
12 pital associations in establishing the
13 procedures under subclause (I).

14 (C) SITES.—The Secretary shall conduct
15 the demonstration program under this sub-
16 section in up to 5 States and shall ensure that
17 all health care organizations located in those
18 States are permitted at the option of the orga-
19 nization to participate in the program.

20 (D) DURATION.—The demonstration pro-
21 gram under this subsection shall be conducted
22 for not more than 5 years.

23 (2) WAIVER AUTHORITY.—The Secretary may
24 waive such requirements of titles XI, XVIII, and
25 XIX of the Social Security Act (42 U.S.C. 1301 et

seq.; 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this subsection.

(3) REPORT.—Not later than 6 months after the completion of the demonstration program under this subsection, the Secretary shall submit to Congress a report on such program, together with recommendations regarding whether to implement coordinated survey guidelines for health care organizations on a permanent basis.

(4) DEFINITIONS.—In this subsection:

(A) CRITICAL ACCESS HOSPITAL.—The term “critical access hospital” has the meaning given such term in section 1861(mm)(1) of the Social Security Act (42 U.S.C. 1395x(mm)(1)).

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

(i) a critical access hospital; and

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

(C) MEDICAID PROGRAM.—The term “medicaid program” means the health benefits

1 program under title XIX of the Social Security
2 Act (42 U.S.C. 1396 et seq.).

3 (D) MEDICARE PROGRAM.—The term
4 “medicare program” means the health benefits
5 program under title XVIII of the Social Secu-
6 rity Act (42 U.S.C. 1395 et seq.).

7 (i) EFFECTIVE DATES.—

8 (1) AUTHORIZATION OF PIP.—The amendments
9 made by subsection (a) shall apply to payments
10 made on or after January 1, 2003.

11 (2) PHYSICIAN PAYMENT ADJUSTMENT CONDI-
12 TION.—The amendment made by subsection (b)
13 shall take effect on January 1, 2003.

14 (3) EMERGENCY ROOM ON-CALL PROVIDER
15 COSTS.—The amendments made by subsection (c)
16 shall apply to costs incurred on or after the date of
17 the enactment of this Act.

18 (4) REQUIRED CONSULTATION FOR CERTAIN
19 RURAL GRANTS.—The amendment made by sub-
20 section (g)(3) shall take effect on the date of the en-
21 actment of this Act and shall apply to grants award-
22 ed on or after such date and to grants awarded prior
23 to such date to the extent that funds under such
24 grants have not been obligated as of such date.

1 **SEC. 108. TEMPORARY RELIEF FOR CERTAIN NON-TEACH-**
2 **ING HOSPITALS.**

3 (a) IN GENERAL.—In the case of a non-teaching hos-
4 pital that meets the condition of subsection (b), in each
5 of fiscal years 2003, 2004, and 2005, the amount of pay-
6 ment made to the hospital under section 1886(d) of the
7 Social Security Act for discharges occurring during such
8 fiscal year only shall be increased as though the applicable
9 percentage increase (otherwise applicable to discharges oc-
10 ccurring during such fiscal year under section
11 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C.
12 1395ww(b)(3)(B)(i)) had been increased by 5 percentage
13 points. The previous sentence shall be applied for each
14 such fiscal year separately without regard to its applica-
15 tion in a previous fiscal year and shall not affect payment
16 for discharges for any hospital occurring during a fiscal
17 year after fiscal year 2005.

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

20 (1) it is located in a rural area and the amount
21 of the aggregate payments under subsection (d) of
22 section 1886 of the Social Security Act for hospitals
23 located in rural areas in the State for their cost re-
24 porting periods beginning during fiscal year 1999 is
25 less than the aggregate allowable operating costs of
26 inpatient hospital services (as defined in subsection

1 (a)(4) of such section) for all subsection (d) hos-
 2 pitals in such areas in such State with respect to
 3 such cost reporting periods; or

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

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

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

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

of such section for discharges occurring during the period. A subsection (d) hospital that receives additional payments under subsection (d)(5)(B) or (h) of such section shall, for purposes of this section, also be treated as a non-teaching hospital unless a chairman of a department in the medical school with which the hospital is affiliated is serving or has been appointed as a clinical chief of service in the hospital.

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

SEC. 109. PHYSICIAN FEE SCHEDULE GEOGRAPHIC ADJUSTMENT FACTOR REVISION.

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

(1) in subparagraph (A), by striking “(B) and (C)” and inserting “(B), (C), and (D)” in the matter preceding clause (i);

(2) by redesignating subparagraph (D) as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

1 “(D) FLOOR FOR WORK GEOGRAPHIC INDI-
 2 CES.—

3 “(i) IN GENERAL.—Notwithstanding
 4 the work geographic index otherwise cal-
 5 culated under subparagraph (A)(iii) (after
 6 the application of the second sentence of
 7 subparagraph (C)), no such index applied
 8 for payment under this section shall be less
 9 than 1.000 for services furnished during
 10 2003, 2004, and 2005.

11 “(ii) EXEMPTION FROM LIMITATION
 12 ON ANNUAL ADJUSTMENTS.—The increase
 13 in expenditures attributable to clause (i)
 14 shall not be taken into account in applying
 15 subsection (c)(2)(B)(ii)(II).”.

16 **SEC. 110. MEDICARE INCENTIVE PAYMENT PROGRAM IM-**
 17 **PROVEMENTS.**

18 (a) PROCEDURES FOR SECRETARY, AND NOT PHYSI-
 19 CIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER
 20 MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE
 21 MADE.—Section 1833(m) (42 U.S.C. 1395l(m)) is amend-
 22 ed—

23 (1) by inserting “(1)” after “(m)”; and

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

1 “(2) The Secretary shall establish procedures under
 2 which the Secretary, and not the physician furnishing the
 3 service, is responsible for determining when a payment is
 4 required to be made under paragraph (1).”.

5 (b) EDUCATIONAL PROGRAM REGARDING THE MEDI-
 6 CARE INCENTIVE PAYMENT PROGRAM.—The Secretary
 7 shall establish and implement an ongoing educational pro-
 8 gram to provide education to physicians under the medi-
 9 care program on the medicare incentive payment program
 10 under section 1833(m) of the Social Security Act (42
 11 U.S.C. 1395l(m)).

12 (c) ONGOING STUDY AND ANNUAL REPORT ON THE
 13 MEDICARE INCENTIVE PAYMENT PROGRAM.—

14 (1) ONGOING STUDY.—The Secretary shall con-
 15 duct an ongoing study on the medicare incentive
 16 payment program under section 1833(m) of the So-
 17 cial Security Act (42 U.S.C. 1395l(m)). Such study
 18 shall focus on whether such program increases the
 19 access of medicare beneficiaries who reside in an
 20 area that is designated (under section 332(a)(1)(A)
 21 of the Public Health Service Act (42 U.S.C.
 22 254e(a)(1)(A))) as a health professional shortage
 23 area to physicians’ services under the medicare pro-
 24 gram.

1 (2) ANNUAL REPORTS.—Not later than 1 year
2 after the date of the enactment of this Act, and an-
3 nually thereafter, the Secretary shall submit to Con-
4 gress a report on the study conducted under para-
5 graph (1), together with recommendations for such
6 legislation and administrative action as the Sec-
7 retary considers appropriate.

8 **SEC. 111. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN**
9 **PAYMENTS FOR PHYSICIANS' SERVICES.**

10 (a) STUDY.—The Comptroller General of the United
11 States shall conduct a study of differences in payment
12 amounts under the physician fee schedule under section
13 1848 of the Social Security Act (42 U.S.C. 1395w–4) for
14 physicians' services in different geographic areas. Such
15 study shall include—

16 (1) an assessment of the validity of the geo-
17 graphic adjustment factors used for each component
18 of the fee schedule;

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

21 (3) an evaluation of the methods used to deter-
22 mine professional liability insurance costs used in
23 computing the malpractice component, including a
24 review of increases in professional liability insurance
25 premiums and variation in such increases by State

1 and physician specialty and methods used to update
2 the geographic cost of practice index and relative
3 weights for the malpractice component;

4 (4) an evaluation of whether there is a sound
5 economic basis for the implementation of the adjust-
6 ment under section 1848(e)(1)(D) of the Social Se-
7 curity Act, as added by section 109, in those areas
8 in which the adjustment applies;

9 (5) an evaluation of the effect of such adjust-
10 ment on physician location and retention in areas af-
11 fected by such adjustment, taking into account—

12 (A) differences in recruitment costs and re-
13 tention rates for physicians, including special-
14 ists, between large urban areas and other areas;
15 and

16 (B) the mobility of physicians, including
17 specialists, over the last decade; and

18 (6) an evaluation of appropriateness of extend-
19 ing such adjustment or making such adjustment per-
20 manent.

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

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

4 **SEC. 112. EXTENSION OF TEMPORARY INCREASE FOR**
 5 **HOME HEALTH SERVICES FURNISHED IN A**
 6 **RURAL AREA.**

7 (a) IN GENERAL.—Section 508(a) of BIPA (114
 8 Stat. 2763A–533) is amended—

9 (1) by striking “24-MONTH INCREASE BEGIN-
 10 NING APRIL 1, 2001” and inserting “IN GENERAL”;
 11 and

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

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

19 **SEC. 113. TEN PERCENT INCREASE IN PAYMENT FOR HOS-**
 20 **PICE CARE FURNISHED IN A FRONTIER AREA.**

21 Section 1814(i)(1) (42 U.S.C. 1395f(i)(1)) is amend-
 22 ed by adding at the end the following new subparagraph:

23 “(D) With respect to hospice care furnished in a fron-
 24 tier area on or after January 1, 2003, and before January
 25 1, 2008, the payment rates otherwise established for such

1 care shall be increased by 10 percent. For purposes of this
 2 subparagraph, the term ‘frontier area’ means an area with
 3 fewer than 6 residents per square mile (based on the latest
 4 population data published by the Bureau of the Census)
 5 and that does not include a metropolitan statistical area.”.

6 **SEC. 114. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC**
 7 **AND FEDERALLY QUALIFIED HEALTH CEN-**
 8 **TER SERVICES FROM THE MEDICARE PPS**
 9 **FOR SKILLED NURSING FACILITIES.**

10 (a) IN GENERAL.—Section 1888(e) (42 U.S.C.
 11 1395yy(e)) is amended—

12 (1) in paragraph (2)(A)(i)(II), by striking
 13 “clauses (ii) and (iii)” and inserting “clauses (ii),
 14 (iii), and (iv)”; and

15 (2) by adding at the end of paragraph (2)(A)
 16 the following new clause:

17 “(iv) EXCLUSION OF CERTAIN RURAL
 18 HEALTH CLINIC AND FEDERALLY QUALI-
 19 FIED HEALTH CENTER SERVICES.—Serv-
 20 ices described in this clause are—

21 “(I) rural health clinic services
 22 (as defined in paragraph (1) of sec-
 23 tion 1861(aa)); and

1 “(II) Federally qualified health
 2 center services (as defined in para-
 3 graph (3) of such section);
 4 that would be described in clause (ii) if
 5 such services were furnished by a physician
 6 or practitioner not affiliated with a rural
 7 health clinic or a Federally qualified health
 8 center.”.

9 (b) EFFECTIVE DATE.—The amendments made by
 10 subsection (a) shall apply to services furnished on or after
 11 July 1, 2003.

12 **SEC. 115. CAPITAL INFRASTRUCTURE REVOLVING LOAN**
 13 **PROGRAM.**

14 (a) IN GENERAL.—Part A of title XVI of the Public
 15 Health Service Act (42 U.S.C. 300q et seq.) is amended
 16 by adding at the end the following new section:

17 “CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

18 “SEC. 1603. (a) AUTHORITY TO MAKE AND GUAR-
 19 ANTEE LOANS.—

20 “(1) AUTHORITY TO MAKE LOANS.—The Sec-
 21 retary may make loans from the fund established
 22 under section 1602(d) to any rural entity for
 23 projects for capital improvements, including—

24 “(A) the acquisition of land necessary for
 25 the capital improvements;

1 “(B) the renovation or modernization of
2 any building;

3 “(C) the acquisition or repair of fixed or
4 major movable equipment; and

5 “(D) such other project expenses as the
6 Secretary determines appropriate.

7 “(2) AUTHORITY TO GUARANTEE LOANS.—

8 “(A) IN GENERAL.—The Secretary may
9 guarantee the payment of principal and interest
10 for loans made to rural entities for projects for
11 any capital improvement described in paragraph
12 (1) to any non-Federal lender.

13 “(B) INTEREST SUBSIDIES.—In the case
14 of a guarantee of any loan made to a rural enti-
15 ty under subparagraph (A), the Secretary may
16 pay to the holder of such loan and for and on
17 behalf of the project for which the loan was
18 made, amounts sufficient to reduce by not more
19 than 3 percent of the net effective interest rate
20 otherwise payable on such loan.

21 “(b) AMOUNT OF LOAN.—The principal amount of
22 a loan directly made or guaranteed under subsection (a)
23 for a project for capital improvement may not exceed
24 \$5,000,000.

25 “(c) FUNDING LIMITATIONS.—

1 “(1) GOVERNMENT CREDIT SUBSIDY EXPO-
 2 SURE.—The total of the Government credit subsidy
 3 exposure under the Credit Reform Act of 1990 scor-
 4 ing protocol with respect to the loans outstanding at
 5 any time with respect to which guarantees have been
 6 issued, or which have been directly made, under sub-
 7 section (a) may not exceed \$50,000,000 per year.

8 “(2) TOTAL AMOUNTS.—Subject to paragraph
 9 (1), the total of the principal amount of all loans di-
 10 rectly made or guaranteed under subsection (a) may
 11 not exceed \$250,000,000 per year.

12 “(d) CAPITAL ASSESSMENT AND PLANNING
 13 GRANTS.—

14 “(1) NONREPAYABLE GRANTS.—Subject to
 15 paragraph (2), the Secretary may make a grant to
 16 a rural entity, in an amount not to exceed \$50,000,
 17 for purposes of capital assessment and business
 18 planning.

19 “(2) LIMITATION.—The cumulative total of
 20 grants awarded under this subsection may not ex-
 21 ceed \$2,500,000 per year.

22 “(e) TERMINATION OF AUTHORITY.—The Secretary
 23 may not directly make or guarantee any loan under sub-
 24 section (a) or make a grant under subsection (d) after
 25 September 30, 2006.”.

1 (b) RURAL ENTITY DEFINED.—Section 1624 of the
 2 Public Health Service Act (42 U.S.C. 300s–3) is amended
 3 by adding at the end the following new paragraph:

4 “(15)(A) The term ‘rural entity’ includes—

5 “(i) a rural health clinic, as defined in sec-
 6 tion 1861(aa)(2) of the Social Security Act;

7 “(ii) any medical facility with at least 1,
 8 but less than 50 beds that is located in—

9 “(I) a county that is not part of a
 10 metropolitan statistical area; or

11 “(II) a rural census tract of a metro-
 12 politan statistical area (as determined
 13 under the most recent modification of the
 14 Goldsmith Modification, originally pub-
 15 lished in the Federal Register on February
 16 27, 1992 (57 Fed. Reg. 6725));

17 “(iii) a hospital that is classified as a
 18 rural, regional, or national referral center under
 19 section 1886(d)(5)(C) of the Social Security
 20 Act; and

21 “(iv) a hospital that is a sole community
 22 hospital (as defined in section
 23 1886(d)(5)(D)(iii) of the Social Security Act).

24 “(B) For purposes of subparagraph (A), the
 25 fact that a clinic, facility, or hospital has been geo-

graphically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).”.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting “or 1603(a)(2)(B)” after “1601(a)(2)(B)”; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking “section 1601(a)(2)(B)” and inserting “sections 1601(a)(2)(B) and 1603(a)(2)(B)”; and

(B) in paragraph (2)(A), by inserting “or 1603(a)(2)(B)” after “1601(a)(2)(B)”.

TITLE II—PROVISIONS RELATING TO PART A Subtitle A—Inpatient Hospital Services

SEC. 201. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

(a) IN GENERAL.—Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

1 “(XVIII) for fiscal year 2003, the market bas-
 2 ket percentage increase for sole community hospitals
 3 and such increase minus 0.25 percentage points for
 4 other hospitals, and”.

5 (b) GAO STUDY AND REPORT ON APPROPRIATENESS
 6 AND NEED TO REBASE UNDER THE PROSPECTIVE PAY-
 7 MENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.—

8 (1) STUDY.—The Comptroller General of the
 9 United States, using the most current data avail-
 10 able, shall conduct a study to determine—

11 (A) the appropriate level and distribution
 12 of payments under the prospective payment sys-
 13 tem under section 1886 of the Social Security
 14 Act (42 U.S.C. 1395ww) for inpatient hospital
 15 services furnished by subsection (d) hospitals
 16 (as defined subsection (d)(1)(B) of such sec-
 17 tion); and

18 (B) whether there is a need to adjust such
 19 payments under such system to reflect legiti-
 20 mate differences in costs across different geo-
 21 graphic areas and different hospitals.

22 (2) REPORT.—Not later than 18 months after
 23 the date of the enactment of this Act, the Comp-
 24 troller General of the United States shall submit to
 25 Congress a report on the study conducted under

1 paragraph (1) together with such recommendations
 2 for legislative and administrative action as the
 3 Comptroller General determines appropriate.

4 **SEC. 202. MORE FREQUENT UPDATES IN WEIGHTS USED IN**
 5 **HOSPITAL MARKET BASKET.**

6 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After
 7 revising the weights used in the hospital market basket
 8 under section 1886(b)(3)(B)(iii) of the Social Security Act
 9 (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most cur-
 10 rent data available, the Secretary shall establish a fre-
 11 quency for revising such weights in such market basket
 12 to reflect the most current data available more frequently
 13 than once every 5 years.

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

19 **SEC. 203. THREE-YEAR INCREASE IN LEVEL OF ADJUST-**
 20 **MENT FOR INDIRECT COSTS OF MEDICAL**
 21 **EDUCATION (IME).**

22 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
 23 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

24 (1) in subclause (VI)—

1 (A) by striking “fiscal year 2002” and in-
 2 serting “fiscal years 2002, 2003, and 2004”;
 3 and

4 (B) by striking “and” at the end;

5 (2) by redesignating subclause (VII) as sub-
 6 clause (VIII);

7 (3) in subclause (VIII) as so redesignated, by
 8 striking “2002” and inserting “2005”; and

9 (4) by inserting after subclause (VI) the fol-
 10 lowing new subclause:

11 “(VII) during fiscal year 2005, ‘c’ is equal
 12 to 1.47; and”.

13 (b) CONFORMING AMENDMENT RELATING TO DE-
 14 TERMINATION OF STANDARDIZED AMOUNT.—Section
 15 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is
 16 amended—

17 (1) by striking “1999 or” and inserting
 18 “1999,”; and

19 (2) by inserting “, or of section 203(a) of the
 20 Beneficiary Access to Care and Medicare Equity Act
 21 of 2002” after “2000”.

22 **SEC. 204. REVISION OF FEDERAL RATE FOR HOSPITALS IN**
 23 **PUERTO RICO.**

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

1 (1) in subparagraph (A)—

2 (A) in clause (i), by striking “for dis-
3 charges beginning on or after October 1, 1997,
4 50 percent (and for discharges between October
5 1, 1987, and September 30, 1997, 75 percent)”
6 and inserting “the applicable Puerto Rico per-
7 centage (specified in subparagraph (E))”; and

8 (B) in clause (ii), by striking “for dis-
9 charges beginning in a fiscal year beginning on
10 or after October 1, 1997, 50 percent (and for
11 discharges between October 1, 1987, and Sep-
12 tember 30, 1997, 25 percent)” and inserting
13 “the applicable Federal percentage (specified in
14 subparagraph (E))”; and

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

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

19 “(i) between October 1, 1987, and September
20 30, 1997, the applicable Puerto Rico percentage is
21 75 percent and the applicable Federal percentage is
22 25 percent;

23 “(ii) on or after October 1, 1997, and before
24 October 1, 2002, the applicable Puerto Rico percent-

1 age is 50 percent and the applicable Federal per-
 2 centage is 50 percent; and

3 “(iii) on or after October 1, 2002, the applica-
 4 ble Puerto Rico percentage is 25 percent and the ap-
 5 plicable Federal percentage is 75 percent.”.

6 **SEC. 205. INCREASE IN GRADUATE MEDICAL EDUCATION**
 7 **LIMITATIONS FOR CERTAIN GERIATRIC RESI-**
 8 **DENTS.**

9 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
 10 tion 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)) is
 11 amended by adding at the end the following new clauses:

12 “(iii) INCREASE IN LIMITATION FOR
 13 GERIATRIC FELLOWSHIPS.—For cost re-
 14 porting periods beginning on or after July
 15 1, 2003, in applying the limitations regard-
 16 ing the total number of full-time equivalent
 17 residents in the field of allopathic or osteo-
 18 pathic medicine under clause (i) for a hos-
 19 pital, the Secretary shall not take into ac-
 20 count a maximum of the applicable number
 21 of residents (as defined in clause (iv)) en-
 22 rolled in a fellowship in geriatric medicine
 23 within an approved medical residency
 24 training program to the extent that the
 25 hospital increases the number of geriatric

1 residents above the number of such resi-
 2 dents for the hospital's most recent cost
 3 reporting period ending before July 1,
 4 2003.

5 “(iv) APPLICABLE NUMBER OF RESI-
 6 DENTS.—For purposes of clause (i), the
 7 term ‘applicable number of residents’
 8 means—

9 “(I) for the period beginning on
 10 July 1, 2003, and ending on June 30,
 11 2005, one;

12 “(II) for the period beginning on
 13 July 1, 2005, and ending on June 30,
 14 2007, two; and

15 “(II) on or after July 1, 2007,
 16 three.”.

17 (b) INDIRECT MEDICAL EDUCATION.—Section
 18 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
 19 1395ww(d)(5)(B)) is amended by adding at the end the
 20 following new clause:

21 “(ix) Clause (iii) of subsection (h)(4)(F) shall
 22 apply to clause (v) in the same manner and for the
 23 same period as such clause (iii) applies to clause (i)
 24 of such subsection.”.

1 **SEC. 206. INCREASE FOR HOSPITALS WITH DISPROPOR-**
 2 **TIONATE INDIGENT CARE REVENUES.**

3 (a) DISPROPORTIONATE SHARE ADJUSTMENT PER-
 4 CENTAGE.—Section 1886(d)(5)(F)(iii) (42 U.S.C.
 5 1395ww(d)(5)(F)(iii)) is amended by striking “35 per-
 6 cent” and inserting “35 percent (or, for discharges occur-
 7 ring on or after April 1, 2003, 40 percent)”.

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

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

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

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

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

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

21 **SEC. 211. PAYMENT FOR COVERED SKILLED NURSING FA-**
 22 **CILITY SERVICES.**

23 (a) TEMPORARY INCREASE IN NURSING COMPONENT
 24 OF PPS FEDERAL RATE.—Section 312(a) of BIPA (114
 25 Stat. 2763A–498) is amended by adding at the end the
 26 following new sentence: “The Secretary of Health and

1 Human Services shall increase by 15, 13, and 11 percent
 2 the nursing component of the case-mix adjusted Federal
 3 prospective payment rate specified in Tables 3 and 4 of
 4 the final rule published in the Federal Register by the
 5 Health Care Financing Administration on July 31, 2000
 6 (65 Fed. Reg. 46770) and as subsequently updated under
 7 section 1888(e)(4)(E)(ii) of the Social Security Act (42
 8 U.S.C. 1395yy(e)(4)(E)(ii)), effective for services fur-
 9 nished during fiscal years 2003, 2004, and 2005, respec-
 10 tively.”.

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

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

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

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

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

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

11 (c) GAO AUDIT OF NURSE STAFFING RATIOS.—

12 (1) AUDIT.—The Comptroller General of the
13 United States shall conduct an audit of nurse staff-
14 ing ratios in a representative sample of medicare
15 skilled nursing facilities. Such sample shall cover se-
16 lected States and shall include broad representation
17 with respect to size, ownership, location, and medi-
18 care volume. Such audit shall include an examina-
19 tion of payroll records and medicaid cost reports of
20 individual facilities and the nurse staffing data sub-
21 mitted under sections 1819(b)(8)(D) and
22 1919(b)(8)(D) of the Social Security Act (as added
23 by paragraphs (1)(B) and (2)(B), respectively, of
24 section 212(a)).

1 (2) REPORT.—Not later than June 1, 2004, the
 2 Comptroller General shall submit to Congress a re-
 3 port on the audits conducted under paragraph (1).
 4 Such report shall include an assessment of the im-
 5 pact of the increased payments by reason of the
 6 amendments made by subsections (a) and (b) on in-
 7 creased nurse staffing ratios and shall make rec-
 8 ommendations as to whether increased payments
 9 under section 312(a) of BIPA (114 Stat. 2763A–
 10 498), as amended by subsection (a), should be con-
 11 tinued.

12 **SEC. 212. IMPROVING THE AVAILABILITY OF NURSING FA-**
 13 **CILITY STAFFING INFORMATION.**

14 (a) NURSING FACILITY STAFFING INFORMATION.—

15 (1) MEDICARE.—Section 1819(b)(8) (42 U.S.C.
 16 1395i–3(b)) is amended—

17 (A) in subparagraph (A), by adding at the
 18 end the following new sentence: “The informa-
 19 tion posted under this subparagraph shall in-
 20 clude information regarding nurse staffing with
 21 respect to beds made available by reason of an
 22 agreement under section 1883.”; and

23 (B) by adding at the end the following new
 24 subparagraphs:

1 “(C) SUBMISSION AND POSTING OF
2 DATA.—Beginning on July 1, 2003, a skilled
3 nursing facility shall submit to the Secretary in
4 a uniform manner (as prescribed by the Sec-
5 retary) the nurse staffing data described in sub-
6 paragraph (A) through electronic data submis-
7 sion not less frequently than quarterly and the
8 Secretary shall make such data publicly avail-
9 able, including by posting such data on an
10 Internet website.

11 “(D) AUDIT OF DATA.—As part of each
12 standard survey conducted under subsection
13 (g)(2)(A), there shall be an audit of the nurse
14 staffing data reported under subparagraph (C)
15 to ensure that such data are accurate.”.

16 (2) MEDICAID.—Section 1919(b)(8) (42 U.S.C.
17 1395r(b)(8)) is amended—

18 (A) in subparagraph (A), by adding at the
19 end the following new sentence: “The informa-
20 tion posted under this subparagraph shall in-
21 clude information regarding nurse staffing with
22 respect to beds made available by reason of an
23 agreement under section 1883.”; and

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

1 “(C) SUBMISSION AND POSTING OF
 2 DATA.—Beginning on July 1, 2003, a nursing
 3 facility shall submit to the Secretary in a uni-
 4 form manner (as prescribed by the Secretary)
 5 the nurse staffing data described in subpara-
 6 graph (A) through electronic data submission
 7 not less frequently than quarterly and the Sec-
 8 retary shall make such data publicly available,
 9 including by posting such data on an Internet
 10 website.

11 “(D) AUDIT OF DATA.—As part of each
 12 standard survey conducted under subsection
 13 (g)(2)(A), there shall be an audit of the nurse
 14 staffing data reported under subparagraph (C)
 15 to ensure that such data are accurate.”.

16 (3) REPORT.—Not later than October 1, 2003,
 17 the Secretary shall submit to Congress a report on—

18 (A) the manner in which the Secretary in-
 19 tends to implement reporting of additional
 20 nurse staffing variables such as unit worked,
 21 day of week (weekday and weekend), and type
 22 of care (direct or administrative) provided; and

23 (B) the most effective mechanisms for au-
 24 diting nurse staffing data under sections
 25 1819(b)(8)(D) and 1919(b)(8)(D) of the Social

1 Security Act (as added by paragraphs (1)(B)
2 and (2)(B), respectively).

3 (4) EFFECTIVE DATE.—The amendments made
4 by this subsection shall apply with respect to cal-
5 endar quarters beginning on and after January 1,
6 2003.

7 (b) CREATING A STAFFING QUALITY MEASURE FOR
8 CONSUMERS TO COMPARE NURSING FACILITIES.—

9 (1) IN GENERAL.—Beginning on October 1,
10 2003, and for as long as the Secretary publishes
11 quality measures to help the public compare the
12 quality of care that nursing facilities provide, these
13 quality measures shall include a quality measure for
14 nurse staffing that—

15 (A) includes the average daily total nursing
16 hours worked for the quarterly reporting period
17 for which data is submitted under sections
18 1819(b)(8)(C) and 1919(b)(8)(C) of the Social
19 Security Act (as added by paragraphs (1)(B)
20 and (2)(B), respectively, of subsection (a));

21 (B) is sensitive to case mix and quality
22 outcomes; and

23 (C) indicates the percentile in which each
24 nursing facility falls compared with other nurs-
25 ing facilities in the State.

1 The Secretary shall not be required to comply with
 2 the requirements of subparagraph (B) to the extent
 3 that the development of a methodology to comply
 4 with such requirement would delay the implementa-
 5 tion of this section.

6 (2) FORM AND MANNER.—The nursing facility
 7 staffing measure described in paragraph (1) shall be
 8 displayed in the same form and manner as informa-
 9 tion that the Secretary displays to help the public
 10 compare the quality of care that nursing facilities
 11 provide.

12 (3) PERIODIC REVISIONS.—The Secretary may
 13 revise the nursing facility staffing measure described
 14 in paragraph (1) from time to time to improve the
 15 accuracy of such measure.

16 **Subtitle C—Hospice**

17 **SEC. 221. COVERAGE OF HOSPICE CONSULTATION SERV-** 18 **ICES.**

19 (a) COVERAGE OF HOSPICE CONSULTATION SERV-
 20 ICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amend-
 21 ed—

22 (1) by striking “and” at the end of paragraph
 23 (3);

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

1 (3) by inserting after paragraph (4) the fol-
 2 lowing new paragraph:

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

8 “(A) an evaluation of the individual’s need
 9 for pain and symptom management, including
 10 the need for hospice care;

11 “(B) counseling the individual with respect
 12 to end-of-life issues, the benefits of hospice
 13 care, and care options; and

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

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

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

24 (c) CONFORMING AMENDMENT.—Section
 25 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is

1 amended by inserting before the comma at the end the
 2 following: “and services described in section 1812(a)(5)”.

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

6 **SEC. 222. AUTHORIZING USE OF ARRANGEMENTS WITH**
 7 **OTHER HOSPICE PROGRAMS TO PROVIDE**
 8 **CORE HOSPICE SERVICES IN CERTAIN CIR-**
 9 **CUMSTANCES.**

10 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.
 11 1395x(dd)(5)) is amended by adding at the end the fol-
 12 lowing new subparagraph:

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

23 (b) CONFORMING PAYMENT PROVISION.—Section
 24 1814(i) (42 U.S.C. 1395f(i)), as amended by section

1 221(b), is amended by adding at the end the following new
2 paragraph:

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

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

11 **TITLE III—PROVISIONS**
12 **RELATING TO PART B**
13 **Subtitle A—Physicians’ Services**

14 **SEC. 301. REVISION OF UPDATES FOR PHYSICIANS’ SERV-**
15 **ICES.**

16 (a) REVISION.—

17 (1) UPDATE FOR 2003 THROUGH 2005.—

18 (A) IN GENERAL.—Section 1848(d) (42
19 U.S.C. 1395w–4(d)) is amended by adding at
20 the end the following new paragraphs:

21 “(5) UPDATE FOR 2003.—Notwithstanding
22 paragraph (4) and subject to the budget-neutrality
23 factor determined by the Secretary under subsection
24 (c)(2)(B)(ii), the update to the single conversion fac-

1 tor established in paragraph (1)(C) for 2003 is 2
2 percent.

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

7 “(A) USE OF 2002 DATA IN DETERMINING
8 ALLOWABLE COSTS.—

9 “(i) The reference in clause (ii)(I) of
10 such paragraph to April 1, 1996, is
11 deemed to be a reference to January 1,
12 2002.

13 “(ii) The allowed expenditures for
14 2002 is deemed to be equal to the actual
15 expenditures for physicians’ services fur-
16 nished during 2002, as estimated by the
17 Secretary.

18 “(B) 1 PERCENTAGE POINT INCREASE IN
19 GDP UNDER SGR.—The annual average percent-
20 age growth in real gross domestic product per
21 capita under subsection (f)(2)(C) for each of
22 2003, 2004, and 2005 is deemed to be in-
23 creased by 1 percentage point.”.

24 (B) CONFORMING AMENDMENT.—Section
25 1848(d)(4)(B) is amended, in the matter pre-

ceding clause (i), by inserting “and paragraph (6)” after “subparagraph (D)”.

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

(2) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

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

(i) by striking “projected” and inserting “annual average”; and

(ii) by striking “from the previous applicable period to the applicable period involved” and inserting “during the 10-year period ending with the applicable period involved”.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to computations of the sustainable growth rate for years beginning with 2002.

1 (3) ELIMINATION OF TRANSITIONAL ADJUST-
 2 MENT.—Section 1848(d)(4)(F) (42 U.S.C. 1395w-
 3 4(d)(4)(F)) is amended by striking “subparagraph
 4 (A)” and all that follows and inserting “subpara-
 5 graph (A), for each of 2001 and 2002, of -0.2 per-
 6 cent.”.

7 (b) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-
 8 CIANS’ SERVICES.—

9 (1) STUDY.—The Comptroller General of the
 10 United States shall conduct a study on access of
 11 medicare beneficiaries to physicians’ services under
 12 the medicare program. The study shall include—

13 (A) an assessment of the use by bene-
 14 ficiaries of such services through an analysis of
 15 claims submitted by physicians for such services
 16 under part B of the medicare program;

17 (B) an examination of changes in the use
 18 by beneficiaries of physicians’ services over
 19 time; and

20 (C) an examination of the extent to which
 21 physicians are not accepting new medicare
 22 beneficiaries as patients.

23 (2) REPORT.—Not later than 18 months after
 24 the date of the enactment of this Act, the Comp-
 25 troller General shall submit to Congress a report on

1 the study conducted under paragraph (1). The re-
 2 port shall include a determination whether—

3 (A) data from claims submitted by physi-
 4 cians under part B of the medicare program in-
 5 dicate potential access problems for medicare
 6 beneficiaries in certain geographic areas; and

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

10 **SEC. 302. THREE-YEAR EXTENSION OF TREATMENT OF CER-**
 11 **TAIN PHYSICIAN PATHOLOGY SERVICES**
 12 **UNDER MEDICARE.**

13 Section 542(c) of BIPA (114 Stat. 2763A–550) is
 14 amended by striking “2-year period” and inserting “5-
 15 year period”.

16 **Subtitle B—Other Services**

17 **SEC. 311. COMPETITIVE ACQUISITION OF CERTAIN ITEMS**
 18 **AND SERVICES.**

19 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.
 20 1395 et seq.) is amended by redesignating section 1866B
 21 as section 1866C and by inserting after section 1866A the
 22 following new section:

23 “COMPETITIVE ITEM AND SERVICE ACQUISITION
 24 PROGRAM

25 “SEC. 1866B. (a) PROGRAM AUTHORITY.—

1 “(1) IN GENERAL.—The Secretary shall imple-
2 ment programs and demonstration projects to pur-
3 chase, on behalf of individuals enrolled under part
4 B, certain competitively priced items and services in
5 competitive acquisition areas (in accordance with the
6 succeeding provisions of this section) for which pay-
7 ment is made under such part. Such areas may dif-
8 fer in the items and services provided.

9 “(2) RULES APPLICABLE TO PROGRAMS AND
10 DEMONSTRATION PROJECTS.—With respect to each
11 program and demonstration project implemented
12 under this section, the following rules shall apply:

13 “(A) The Secretary may reject unreason-
14 ably low bids.

15 “(B) If the Secretary determines that the
16 product quality or service quality of an entity
17 with a contract has deteriorated since the con-
18 tract was entered into, the Secretary may can-
19 cel the contract prior to the date on which the
20 contract is scheduled to end and award a con-
21 tract to a different entity for the remainder of
22 the term of the contract.

23 “(C) No device that is in a class of devices
24 described in section 513(a)(1)(C) of the Federal
25 Food Drug and Cosmetic Act (21 U.S.C.

1 360c(a)(1)(C)) may be furnished under such a
2 program or demonstration project.

3 “(3) PHASED-IN IMPLEMENTATION.—The pro-
4 grams implemented under paragraph (1) shall be
5 phased-in among competitive acquisition areas over
6 a period of not longer than 4 years in a manner so
7 that the competition under the programs occurs in—

8 “(A) at least $\frac{1}{4}$ of such areas in 2003;

9 “(B) at least $\frac{2}{4}$ of such areas in 2004;

10 and

11 “(C) at least $\frac{3}{4}$ of such areas in 2005.

12 “(b) IMPLEMENTATION OF PROGRAMS IN COMPETI-
13 TIVE ACQUISITION AREAS.—

14 “(1) TYPES OF PROGRAMS.—The Secretary
15 shall implement programs under which competitive
16 acquisition areas are established for contract award
17 purposes for the furnishing under part B of—

18 “(A) covered items (as defined in section
19 1834(a)(13)) and inhalation drugs used in con-
20 junction with durable medical equipment (other
21 than items used in infusion therapy); and

22 “(B) leg, arm, back, and neck braces de-
23 scribed in section 1861(s)(9), other than cus-
24 tom fabricated orthotics (as defined by the Sec-
25 retary).

1 “(2) PROGRAM REQUIREMENTS.—Each pro-
2 gram implemented under paragraph (1) shall—

3 “(A) include such categories of items and
4 services as the Secretary may prescribe; and

5 “(B) be conducted in such competitive ac-
6 quisition areas as the Secretary determines are
7 appropriate.

8 “(3) CRITERIA FOR ESTABLISHMENT OF COM-
9 PETITIVE ACQUISITION AREAS.—Each competitive
10 acquisition area established under a program imple-
11 mented under paragraph (1) shall—

12 “(A)(i) be, or shall be within, a metropoli-
13 tan statistical area (as defined by the Director
14 of the Office of Management and Budget and
15 the Secretary of Commerce) with a population
16 in excess of 500,000; or

17 “(ii) be an area that was designated as a
18 competitive acquisition area under section 1847
19 as of the date of the enactment of the Bene-
20 ficiary Access to Care and Medicare Equity Act
21 of 2002;

22 “(B) be chosen based on the availability
23 and accessibility of entities able to furnish
24 items and services, and the probable savings to
25 be realized by the use of competitive bidding in

1 the furnishing of items and services in such
 2 area; and

3 “(C) have multiple suppliers for each prod-
 4 uct category.

5 “(c) AWARDING OF CONTRACTS IN COMPETITIVE AC-
 6 QUISSION AREAS.—

7 “(1) IN GENERAL.—The Secretary shall con-
 8 duct a competition among entities supplying the
 9 items and services to be furnished under the pro-
 10 gram implemented under subsection (b)(1) for each
 11 competitive acquisition area established under sub-
 12 section (b)(3) for that program.

13 “(2) ADMINISTRATION BY CONTRACT.—

14 “(A) IN GENERAL.—The Secretary shall
 15 administer the programs under this section by
 16 entering into contracts with entities.

17 “(B) CONDITIONS FOR AWARDING CON-
 18 TRACT.—The Secretary may not award a con-
 19 tract to any entity under the competition con-
 20 ducted under paragraph (1) to furnish an item
 21 or service unless the Secretary finds that—

22 “(i) the entity meets quality and fi-
 23 nancial standards specified by the Sec-
 24 retary or developed by accreditation enti-

1 ties or organizations recognized by the Sec-
2 retary;

3 “(ii) beneficiary liability is limited to
4 the applicable percentage of the contract
5 award price;

6 “(iii) the entity has an agreement in
7 effect under section 1866 and has an ac-
8 tive National Supplier Clearinghouse iden-
9 tification number;

10 “(iv) the entity complies with all Fed-
11 eral and State licensure and regulatory re-
12 quirements;

13 “(v) the entity is in compliance with
14 all the provisions of title XI and this title,
15 such provisions of title XIX as the Sec-
16 retary determines are relevant to competi-
17 tive bidding, and any regulations relating
18 thereto;

19 “(vi) the entity is in compliance with
20 all billing guidelines relating to the pro-
21 gram under this title;

22 “(vii) the entity has not been sus-
23 pended within the 12 months preceding the
24 date on which a bid is submitted by any

DMERC antifraud unit for billing for items or services not furnished; and

“(viii) the total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

“(3) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted under paragraph (1) shall be subject to such terms and conditions as the Secretary may specify.

“(4) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

“(5) SMALL BUSINESS PROTECTIONS.—Notwithstanding any other provision of this section, the Secretary shall allow—

“(A) an entity to bid to become a supplier in a portion of the competitive acquisition area if the entity does not have the capacity to service an entire competitive acquisition area;

1 “(B) small suppliers to bid for only 1 or a
 2 few product categories instead of all the prod-
 3 ucts in a competitive acquisition area; and

4 “(C) small suppliers to join together to
 5 form networks for bidding purposes, as long as
 6 the combined market share of such suppliers
 7 does not exceed 25 percent.

8 “(d) EVALUATIONS AND ANNUAL REPORTS.—

9 “(1) EVALUATIONS.—The Secretary shall evalu-
 10 ate the impact of the implementation of the pro-
 11 grams implemented under subsection (b)(1) on—

12 “(A) payments made and savings realized
 13 under this title;

14 “(B) the access of beneficiaries to items
 15 and services furnished under such programs
 16 and demonstration projects;

17 “(C) the diversity of product selection
 18 under such programs and demonstration
 19 projects; and

20 “(D) the quality of items and services fur-
 21 nished under such programs and demonstration
 22 projects.

23 “(2) ANNUAL REPORTS.—Not less frequently
 24 than annually, the Secretary shall submit to the
 25 Committees on Ways and Means and Energy and

1 Commerce of the House of Representatives and the
2 Committee on Finance of the Senate a report on the
3 results of the evaluation conducted under paragraph
4 (1).

5 “(e) DIAGNOSTIC TESTS AND SURGICAL
6 DRESSINGS.—

7 “(1) IN GENERAL.—The Secretary shall imple-
8 ment demonstration projects under which competi-
9 tive acquisition areas are established for contract
10 award purposes for the furnishing under part B of—

11 “(A) diagnostic x-ray tests, clinical diag-
12 nostic laboratory tests, and other diagnostic
13 tests described in paragraph (3) of section
14 1861(s); and

15 “(B) surgical dressings, splints, casts, and
16 other devices described in paragraph (5) of such
17 section.

18 “(2) PROJECT REQUIREMENTS.—Each dem-
19 onstration project under paragraph (1) shall—

20 “(A) be conducted in not more than 3
21 competitive acquisition areas;

22 “(B) be operated over a 3-year period; and

23 “(C) otherwise be subject to the conditions
24 under subsections (b)(3) and (c) in the same

1 manner as such conditions apply to the pro-
2 grams established under subsection (a).

3 “(3) REPORTS.—

4 “(A) INITIAL REPORT.—Not later than
5 December 31, 2004, the Secretary shall submit
6 to the Committees on Ways and Means and En-
7 ergy and Commerce of the House of Represent-
8 atives and the Committee on Finance of the
9 Senate an initial report on the demonstration
10 projects conducted under this subsection.

11 “(B) PROGRESS AND FINAL REPORTS.—
12 The Secretary shall submit such progress and
13 final reports to the committees described in
14 subparagraph (A) after the date described in
15 such subparagraph as the Secretary determines
16 appropriate.

17 “(f) OTHER PART B ITEMS AND SERVICES.—

18 “(1) IN GENERAL.—The Secretary may imple-
19 ment not more than 5 demonstration projects under
20 which competitive acquisition areas are established
21 for contract award purposes for the furnishing under
22 part B of any item or service covered under such
23 part that the Secretary may specify other than—

24 “(A) any item or service described in sub-
25 paragraph (A) or (B) of subsection (e)(1); or

1 “(B) physicians’ services (as defined in
2 section 1861(r)(1)).

3 “(2) PROJECT REQUIREMENTS.—Each dem-
4 onstration project under paragraph (1) shall—

5 “(A) be conducted in not more than 3
6 competitive acquisition areas;

7 “(B) be operated over a 3-year period; and

8 “(C) otherwise be subject to the conditions
9 under subsections (b)(3) and (c) in the same
10 manner as such conditions apply to the pro-
11 grams established under subsection (a).

12 “(3) REPORTS.—

13 “(A) INITIAL REPORT.—Not later than
14 December 31, 2004, the Secretary shall submit
15 to the Committees on Ways and Means and En-
16 ergy and Commerce of the House of Represent-
17 atives and the Committee on Finance of the
18 Senate an initial report on the demonstration
19 projects conducted under this subsection.

20 “(B) PROGRESS AND FINAL REPORTS.—

21 The Secretary shall submit such progress and
22 final reports to the committees described in
23 subparagraph (A) after the date described in
24 such subparagraph as the Secretary determines
25 appropriate.

1 “(g) EXPANSION OF PROGRAMS AND DEMONSTRA-
2 TION PROJECTS.—The Secretary may expand a program
3 or demonstration project implemented under subsection
4 (b)(1) to additional competitive acquisition areas if the
5 Secretary determines, based on the evaluations conducted
6 under subsection (d)(1), that there is clear evidence that
7 any program or demonstration project—

8 “(1) results in a decrease in Federal expendi-
9 tures under this title; and

10 “(2) does not reduce program access, diversity
11 of product selection, and quality under this title.

12 “(h) DURATION OF PROGRAMS AND DEMONSTRA-
13 TION PROJECTS.—

14 “(1) DURABLE MEDICAL EQUIPMENT AND
15 ORTHOTICS.—The programs implemented under sub-
16 paragraph (A) or (B) of subsection (b)(1) shall ter-
17minate on such date as the Secretary may specify or
18may continue indefinitely (as determined by the Sec-
19retary).

20 “(2) DIAGNOSTIC TESTS AND SURGICAL
21 DRESSINGS.—

22 “(A) IN GENERAL.—Except as provided in
23 subparagraph (B), any demonstration project
24 implemented under subsection (e)(1) shall ter-
25minate not later than December 31, 2007.

1 “(B) EXCEPTION.—If the Secretary deter-
 2 mines that a demonstration project imple-
 3 mented under subsection (e)(1) meets the re-
 4 quirements of paragraphs (1) and (2) of sub-
 5 section (g), such project shall terminate on such
 6 date as the Secretary may specify or may con-
 7 tinue indefinitely (as determined by the Sec-
 8 retary).

9 “(3) OTHER PART B ITEMS AND SERVICES.—
 10 Any demonstration project implemented under sub-
 11 section (f)(1) shall terminate not later than Decem-
 12 ber 31, 2007.”.

13 (b) CONTINUATION OF ORIGINAL DEMONSTRATION
 14 PROJECTS.—Section 1847(e) (42 U.S.C. 1395w-3(e)) is
 15 amended to read as follows:

16 “(e) TERMINATION.—

17 “(1) IN GENERAL.—Notwithstanding any other
 18 provision of this section, except as provided in para-
 19 graph (2), all projects under this section shall termi-
 20 nate not later than December 31, 2002.

21 “(2) EXTENSION OF CERTAIN PROJECTS.—An
 22 project implemented under this section as of the
 23 date of enactment of the Beneficiary Access to Care
 24 and Medicare Equity Act of 2002 shall continue
 25 under the same terms and conditions applicable

1 under this section until such time as the competitive
 2 acquisition area under such a project is designated
 3 as a competitive acquisition area for purposes of sec-
 4 tion 1866B, except that no project may continue
 5 under this section after December 31, 2006.”.

6 (c) ITEMS AND SERVICES TO BE FURNISHED ONLY
 7 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)
 8 (42 U.S.C. 1395y(a)), as amended by section 3(a) of the
 9 Administrative Simplification Compliance Act (Public Law
 10 107–105; 115 Stat. 1006), is amended—

11 (1) by striking “or” at the end of paragraph
 12 (21);

13 (2) by striking the period at the end of para-
 14 graph (22) and inserting “; or”; and

15 (3) by inserting after paragraph (22) the fol-
 16 lowing new paragraph:

17 “(23) except in such cases of emergency or ur-
 18 gent need as the Secretary shall prescribe, where the
 19 expenses are for an item or service described in sec-
 20 tion 1866B(d) that is furnished in a competitive ac-
 21 quisition area (as established by the Secretary under
 22 section 1866B(b)) by an entity other than an entity
 23 with which the Secretary has entered into an agree-
 24 ment under section 1866B(c) for the furnishing of
 25 such an item or service in that area.”.

1 (d) CONFORMING AMENDMENTS RELATING TO GEN-
 2 ERAL PROVISIONS FOR ADMINISTRATION.—

3 (1) GENERAL ADMINISTRATIVE AUTHORITY.—

4 Section 1866C(a) (as redesignated by subsection
 5 (a)) is amended—

6 (A) in paragraph (1)—

7 (i) in the matter preceding subpara-
 8 graph (A), by striking “the program under
 9 section 1866A (in this section referred to
 10 as the ‘demonstration program’)” and in-
 11 serting “a program or demonstration
 12 project under section 1866A or 1866B”;

13 (ii) in subparagraph (A), by striking
 14 “and entitled to benefits under part A;
 15 and” and inserting a semicolon;

16 (iii) in subparagraph (B), by striking
 17 the period at the end and inserting “;
 18 and”; and

19 (iv) by adding at the end the following
 20 new subparagraph:

21 “(C) in the case of the demonstration pro-
 22 gram under section 1866A, is entitled to bene-
 23 fits under part A.”;

24 (B) in paragraph (3), by striking “Items
 25 and services shall” and inserting “Except as

provided in the authority for the programs and demonstration projects under section 1866B, items and services shall”;

(C) in paragraph (4), by striking “individuals or entities” and inserting “entities (or, in the case of the demonstration program under section 1866A, individuals or entities)”;

(D) in paragraph (5)—

(i) in the first sentence, by striking “the demonstration program” and inserting “the programs and demonstration projects under sections 1866A and 1866B”; and

(ii) in the second sentence, by striking “individuals or entities” and inserting “entities (or, in the case of the demonstration program under section 1866A, individuals or entities)”;

(E) in paragraph (6)—

(i) by striking “individual or entity” and inserting “entity (or, in the case of the demonstration program under section 1866A, an individual or entity)”;

(ii) by striking “the demonstration program” and inserting “the programs and

1 demonstration projects under sections
2 1866A and 1866B”;

3 (F) in paragraph (7), by striking “indi-
4 vidual or entity” each place it appears and in-
5 serting “entity (or, in the case of the dem-
6 onstration program under section 1866A, an in-
7 dividual or entity)”;

8 (G) in paragraph (8)—

9 (i) in subparagraph (A), by striking
10 “the demonstration program” and insert-
11 ing “the programs and demonstration
12 projects under sections 1866A and
13 1866B”; and

14 (ii) in subparagraph (B), by striking
15 “individual or entity” and inserting “entity
16 (or, in the case of the demonstration pro-
17 gram under section 1866A, an individual
18 or entity)”.

19 (2) CONTRACTS FOR PROGRAM ADMINISTRA-
20 TION.—Section 1866C(b) (as so redesignated) is
21 amended—

22 (A) in paragraph (1), by striking “the
23 demonstration program” and inserting “the
24 programs and demonstration projects under
25 sections 1866A and 1866B”;

(B) in paragraph (2), by striking “CONTRACTS.—The Secretary” and inserting the following: “CONTRACTS.—A contract under this subsection may, at the Secretary’s discretion, relate to the administration of either the program under section 1866A or a program or demonstration project under section 1866B, or both. The Secretary”; and

(C) in paragraph (7)—

(i) in subparagraph (D), by inserting “under section 1866A” before the period at the end;

(ii) by redesignating subparagraphs (E) through (H) as subparagraphs (G) through (J), respectively; and

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

“(E) LIST OF PROGRAM PARTICIPANTS.—

Maintain and regularly update a list of entities with agreements to provide health care items and services under the program under section 1866B, and ensure that such list, in electronic and hard copy formats, is readily available, as applicable, to—

1 “(i) individuals residing in the service
 2 area who are entitled to benefits under
 3 part A or enrolled in the program under
 4 part B;

5 “(ii) the entities responsible under
 6 sections 1816 and 1842 for administering
 7 payments for health care items and serv-
 8 ices furnished; and

9 “(iii) entities providing health care
 10 items and services in the service area.

11 “(F) BENEFICIARY ENROLLMENT.—Deter-
 12 mine eligibility of individuals to enroll under a
 13 program or demonstration project under section
 14 1866B and provide enrollment-related services
 15 (but only if the Secretary finds that the pro-
 16 gram administrator has no conflict of interest
 17 caused by a financial relationship with any enti-
 18 ty furnishing items or services for which pay-
 19 ment may be made under any such program, or
 20 any other conflict of interest with respect to
 21 such function).”.

22 (3) RULES APPLICABLE TO BOTH PROGRAM
 23 AGREEMENTS AND PROGRAM ADMINISTRATION CON-
 24 TRACTS.—Section 1866C(c) (as so redesignated) is
 25 amended—

(A) in paragraph (1), by striking “the demonstration program” and inserting “the programs and demonstration projects under sections 1866A and 1866B”;

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting “under section 1866A” after “the demonstration program”;

(ii) in subparagraph (A), by striking “the program” and inserting “such a program”; and

(iii) in subparagraph (B)(i), by inserting “under section 1866A” after “the demonstration program”; and

(C) in paragraph (3)—

(i) by striking “the demonstration program” and inserting “the programs and demonstration projects under sections 1866A and 1866B”; and

(ii) by striking “administer the program” and inserting “administer such a program or project”.

(4) LIMITATIONS ON JUDICIAL REVIEW.—Section 1866C(d) (as so redesignated) is amended—

1 (A) in the matter preceding paragraph (1),
 2 by striking “the demonstration program” and
 3 inserting “the programs and demonstration
 4 projects under sections 1866A and 1866B” in
 5 the matter preceding subparagraph (A);

6 (B) in paragraph (1), by striking “the pro-
 7 gram” and inserting “a program or demonstra-
 8 tion project under section 1866A or 1866B”;

9 (C) in paragraph (2), by striking “pro-
 10 gram” each place it appears and inserting “pro-
 11 gram or demonstration project”; and

12 (D) in paragraph (5)—

13 (i) in the matter preceding subpara-
 14 graph (A), by striking “to the program”
 15 and inserting “to a program or demonstra-
 16 tion project”;

17 (ii) in subparagraph (A), by striking
 18 “or” after the semicolon at the end; and

19 (iii) in subparagraph (B), by inserting
 20 “with respect to the demonstration pro-
 21 gram under section 1866A,” before “as to
 22 whether”.

23 (5) APPLICATION LIMITED TO PARTS A AND
 24 B.—Section 1866C(e) (as so redesignated) is amend-

1 ed by striking “or of the demonstration program”
 2 and inserting “, section 1866A, or section 1866B”.

3 (6) OTHER CONFORMING AMENDMENTS.—

4 (A) Section 1866A(a)(2) (42 U.S.C.
 5 1395cc–1) is amended by striking “section
 6 1866B” and inserting “section 1866C”.

7 (B) The heading of section 1866C (as so
 8 redesignated) is amended to read as follows:

9 “GENERAL PROVISIONS FOR THE ADMINISTRATION OF
 10 CERTAIN PRIVATE SECTOR PURCHASING AND QUAL-
 11 ITY IMPROVEMENT PROGRAMS”.

12 (e) GAO STUDY AND REPORT.—

13 (1) STUDY.—The Comptroller General of the
 14 United States shall conduct a study on the coverage
 15 under the medicare program under title XVIII of the
 16 Social Security Act of new and innovative durable
 17 medical equipment, prosthetics, orthotics, supplies,
 18 and equipment and the coding of such items for pur-
 19 poses of payment under such program. Such study
 20 shall include an analysis of the review and approval
 21 process for the new and innovative items described
 22 in the preceding sentence, the coding process for
 23 such items, and beneficiary access to such items if
 24 such items are not covered under the medicare pro-
 25 gram.

1 (2) REPORT.—Not later than the date that is
 2 2 years after the date of the enactment of this Act,
 3 the Comptroller General shall submit a report on the
 4 study conducted under paragraph (1) to the Com-
 5 mittee on Ways and Means and the Committee on
 6 Energy and Commerce of the House of Representa-
 7 tives and the Committee on Finance of the Senate
 8 together with such recommendations for legislative
 9 and administrative action as the Comptroller Gen-
 10 eral determines appropriate.

11 **SEC. 312. TWO-YEAR EXTENSION OF MORATORIUM ON**
 12 **THERAPY CAPS; PROVISIONS RELATING TO**
 13 **REPORTS.**

14 (a) 2-YEAR EXTENSION OF MORATORIUM ON THER-
 15 APY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4))
 16 is amended by striking “and 2002” and inserting “2002,
 17 2003, and 2004”.

18 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON
 19 PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY
 20 SERVICES.—Not later than December 31, 2002, the Sec-
 21 retary shall submit to Congress the reports required under
 22 section 4541(d)(2) of the Balanced Budget Act of 1997
 23 (42 U.S.C. 1395l note) (relating to alternatives to a single
 24 annual dollar cap on outpatient therapy) and under sec-
 25 tion 221(d) of the Medicare, Medicaid, and SCHIP Bal-

1 anced Budget Refinement Act of 1999 (113 Stat. 1501A–
 2 352) (relating to utilization patterns for outpatient ther-
 3 apy).

4 (c) IDENTIFICATION OF CONDITIONS AND DISEASES
 5 JUSTIFYING WAIVER OF THERAPY CAP.—

6 (1) STUDY.—The Secretary, in consultation
 7 with clinicians, shall conduct a study to identify con-
 8 ditions or diseases that should be excluded from the
 9 therapy caps under section 1833(g)(4) of the Social
 10 Security Act (42 U.S.C. 1395l(g)(4)).

11 (2) REPORTS TO CONGRESS.—Not later than
 12 January 1, 2004, the Secretary shall submit a re-
 13 port to Congress on the study conducted under para-
 14 graph (1) together with recommendations for such
 15 legislation and administrative action as the Sec-
 16 retary determines appropriate.

17 **SEC. 313. ACCELERATION OF REDUCTION OF BENEFICIARY**
 18 **COPAYMENT FOR HOSPITAL OUTPATIENT DE-**
 19 **PARTMENT SERVICES.**

20 Section 1833(t)(8)(C)(ii) (42 U.S.C.
 21 1395l(t)(8)(C)(ii)) is amended—

22 (1) in subclause (V), by striking “and there-
 23 after” and inserting “through 2011”; and

24 (2) by adding at the end the following new sub-
 25 clause:

1 “(VI) For procedures performed
2 in 2012 and thereafter, 30 percent.”.

3 **SEC. 314. RENAL DIALYSIS SERVICES.**

4 (a) INCREASE IN RENAL DIALYSIS COMPOSITE RATE
5 FOR SERVICES FURNISHED IN 2003 AND 2004.—Notwith-
6 standing any other provision of law, with respect to pay-
7 ment under part B of title XVIII of the Social Security
8 Act for renal dialysis services furnished in 2003 and 2004,
9 the composite payment rate otherwise established under
10 section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7))
11 shall be increased by 1.2 percent.

12 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR
13 PEDIATRIC FACILITIES.—

14 (1) IN GENERAL.—Section 422(a)(2) of BIPA
15 (114 Stat. 2763A–516) is amended—

16 (A) in subparagraph (A), by striking “and
17 (C)” and inserting “, (C), and (D)”;

18 (B) in subparagraph (B), by striking “In
19 the case” and inserting “Subject to subpara-
20 graph (D), in the case”; and

21 (C) by adding at the end the following new
22 subparagraph:

23 “(D) INAPPLICABILITY TO PEDIATRIC FA-
24 CILITIES.—Subparagraphs (A) and (B) shall
25 not apply, as of October 1, 2002, to pediatric

1 facilities that do not have an exception rate de-
 2 scribed in subparagraph (C) in effect on such
 3 date. For purposes of this subparagraph, the
 4 term ‘pediatric facility’ means a renal facility at
 5 least 50 percent of whose patients are individ-
 6 uals under 18 years of age.”.

7 (2) CONFORMING AMENDMENT.—The fourth
 8 sentence of section 1881(b)(7) (42 U.S.C.
 9 1395rr(b)(7)) is amended by striking “The Sec-
 10 retary” and inserting “Subject to section 422(a)(2)
 11 of the Medicare, Medicaid, and SCHIP Benefits Im-
 12 provement and Protection Act of 2000, the Sec-
 13 retary”.

14 **SEC. 315. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**
 15 **RAPHY SERVICES.**

16 (a) EXCLUSION FROM OPD FEE SCHEDULE.—Sec-
 17 tion 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is
 18 amended by inserting before the period at the end the fol-
 19 lowing: “and does not include screening mammography (as
 20 defined in section 1861(jj)) and diagnostic mammog-
 21 raphy”.

22 (b) PAYMENT.—Section 1833(a)(2)(E)(i) (42 U.S.C.
 23 1395l(a)(2)(E)(i)) is amended by inserting “, and for serv-
 24 ices furnished on or after January 1, 2004, diagnostic
 25 mammography” after “screening mammography”.

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

4 **SEC. 316. WAIVER OF PART B LATE ENROLLMENT PENALTY**
 5 **FOR CERTAIN MILITARY RETIREES; SPECIAL**
 6 **ENROLLMENT PERIOD.**

7 (a) WAIVER OF PENALTY.—

8 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.
 9 1395r(b)) is amended by adding at the end the fol-
 10 lowing new sentence: “No increase in the premium
 11 shall be effected for a month in the case of an indi-
 12 vidual who is 65 years of age or older, who enrolls
 13 under this part during 2001, 2002, or 2003, and
 14 who demonstrates to the Secretary before December
 15 31, 2003, that the individual is a covered beneficiary
 16 (as defined in section 1072(5) of title 10, United
 17 States Code). The Secretary shall consult with the
 18 Secretary of Defense in identifying individuals de-
 19 scribed in the previous sentence.”.

20 (2) EFFECTIVE DATE.—The amendment made
 21 by paragraph (1) shall apply to premiums for
 22 months beginning with January 2003. The Secretary
 23 shall establish a method for providing rebates of pre-
 24 mium penalties paid for months on or after January
 25 2003 for which a penalty does not apply under such

1 amendment but for which a penalty was previously
2 collected.

3 (b) MEDICARE PART B SPECIAL ENROLLMENT PE-
4 RIOD.—

5 (1) IN GENERAL.—In the case of any individual
6 who, as of the date of the enactment of this Act, is
7 65 years of age or older, is eligible to enroll but is
8 not enrolled under part B of title XVIII of the So-
9 cial Security Act, and is a covered beneficiary (as
10 defined in section 1072(5) of title 10, United States
11 Code), the Secretary shall provide for a special en-
12 rollment period during which the individual may en-
13 roll under such part. Such period shall begin as soon
14 as possible after the date of the enactment of this
15 Act and shall end on December 31, 2003.

16 (2) COVERAGE PERIOD.—In the case of an indi-
17 vidual who enrolls during the special enrollment pe-
18 riod provided under paragraph (1), the coverage pe-
19 riod under part B of title XVIII of the Social Secu-
20 rity Act shall begin on the first day of the month
21 following the month in which the individual enrolls.

22 **SEC. 317. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**
23 **SCREENING.**

24 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
25 1395x(s)(2)) is amended—

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

3 (2) in subparagraph (V)(iii), by inserting “and”
4 at the end; and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 “(W) cholesterol and other blood lipid
8 screening tests (as defined in subsection
9 (ww));”.

10 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
11 1395x) is amended by adding at the end the following new
12 subsection:

13 “Cholesterol and Other Blood Lipid Screening Test

14 “(ww)(1) The term ‘cholesterol and other blood lipid
15 screening test’ means diagnostic testing of cholesterol and
16 other lipid levels of the blood for the purpose of early de-
17 tection of abnormal cholesterol and other lipid levels.

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

23 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.
24 1395y(a)(1)) is amended—

1 (1) by striking “and” at the end of subpara-
 2 graph (H);

3 (2) by striking the semicolon at the end of sub-
 4 paragraph (I) and inserting “, and”; and

5 (3) by adding at the end the following new sub-
 6 paragraph:

7 “(J) in the case of a cholesterol and other blood
 8 lipid screening test (as defined in section
 9 1861(w)(1)), which is performed more frequently
 10 than is covered under section 1861(w)(2).”.

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

14 **SEC. 318. TEMPORARY INCREASE FOR GROUND AMBU-**
 15 **LANCE SERVICES.**

16 Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

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

20 (2) by adding at the end the following new
 21 paragraph:

22 “(10) TEMPORARY INCREASE FOR GROUND AM-
 23 BULANCE SERVICES.—

24 “(A) IN GENERAL.—Notwithstanding any
 25 other provision of this subsection, in the case of

1 ground ambulance services furnished on or
2 after January 1, 2003, and before January 1,
3 2006 for which the transportation originates
4 in—

5 “(i) a rural area described in para-
6 graph (9) or in a rural census tract de-
7 scribed in such paragraph, the fee schedule
8 established under this section shall provide
9 that the rate for the service otherwise es-
10 tablished, after application of any increase
11 under such paragraph, shall be increased
12 by 5 percent; and

13 “(ii) an area not described in clause
14 (i), the fee schedule established under this
15 section shall provide that the rate for the
16 service otherwise established shall be in-
17 creased by 2 percent

18 “(B) APPLICATION OF INCREASED PAY-
19 MENTS AFTER 2005.—The increased payments
20 under subparagraph (A) shall not be taken into
21 account in calculating payments for services
22 furnished on or after the period specified in
23 such subparagraph.”.

1 **SEC. 319. ENSURING APPROPRIATE COVERAGE OF AIR AM-**
 2 **BULANCE SERVICES UNDER AMBULANCE FEE**
 3 **SCHEDULE.**

4 (a) COVERAGE.—Section 1834(l) (42 U.S.C.
 5 1395m(l)), as amended by section 318, is amended by
 6 adding at the end the following new paragraph:

7 “(11) ENSURING APPROPRIATE COVERAGE OF
 8 AIR AMBULANCE SERVICES.—

9 “(A) IN GENERAL.—The regulations de-
 10 scribed in section 1861(s)(7) shall ensure that
 11 air ambulance services (as defined in subpara-
 12 graph (C)) are reimbursed under this sub-
 13 section at the air ambulance rate if the air am-
 14 bulance service—

15 “(i) is medically necessary based on
 16 the health condition of the individual being
 17 transported at or immediately prior to the
 18 time of the transport; and

19 “(ii) complies with equipment and
 20 crew requirements established by the Sec-
 21 retary.

22 “(B) MEDICALLY NECESSARY.—An air
 23 ambulance service shall be considered to be
 24 medically necessary for purposes of subpara-
 25 graph (A)(i) if such service is requested—

1 “(i) by a physician or a hospital in ac-
2 cordance with the physician’s or hospital’s
3 responsibilities under section 1867 (com-
4 monly known as the Emergency Medical
5 Treatment and Active Labor Act);

6 “(ii) as a result of a protocol estab-
7 lished by a State or regional emergency
8 medical service (EMS) agency;

9 “(iii) by a physician, nurse practi-
10 tioner, physician assistant, registered
11 nurse, or emergency medical responder
12 who reasonably determines or certifies that
13 the patient’s condition is such that the
14 time needed to transport the individual by
15 land or the lack of an appropriate ground
16 ambulance, significantly increases the med-
17 ical risks for the individual; or

18 “(iv) by a Federal or State agency to
19 relocate patients following a natural dis-
20 aster, an act of war, or a terrorist attack.

21 “(C) AIR AMBULANCE SERVICES DE-
22 FINED.—For purposes of this paragraph, the
23 term ‘air ambulance service’ means fixed wing
24 and rotary wing air ambulance services.”.

1 (b) CONFORMING AMENDMENT.—Section 1861(s)(7)
 2 (42 U.S.C. 1395x(s)(7)) is amended by inserting “, sub-
 3 ject to section 1834(l)(11),” after “but”.

4 (c) EFFECTIVE DATE.—The amendments made by
 5 this section shall apply to services furnished on or after
 6 the date of the enactment of this Act.

7 **SEC. 320. ADJUSTMENTS TO LOCAL FEE SCHEDULES FOR**
 8 **CLINICAL LABORATORY TESTS FOR IM-**
 9 **PROVEMENT IN CERVICAL CANCER DETEC-**
 10 **TION.**

11 Section 1833(h)(2) (42 U.S.C. 1395l(h)(2)) is
 12 amended by adding at the end the following new subpara-
 13 graph:

14 “(C) Notwithstanding any other provision of law, in
 15 the case of a diagnostic test for the detection of cervical
 16 cancer utilizing automated thin layer preparation tech-
 17 niques for specimens collected in fluid medium, and for
 18 which a national limitation amount has been set pursuant
 19 to the parenthetical in paragraph (4)(B)(viii), furnished
 20 on or after July 1, 2003, and before June 30, 2005, the
 21 Secretary shall permit carriers and medicare administra-
 22 tive contractors, as the case may be, to raise their local
 23 fee schedule amount for purposes of determining payment
 24 for such tests under this section, up to, but not to exceed
 25 the national limitation amount previously established for

1 that test. Any such adjustment shall not affect such na-
 2 tional limitation amount.

3 **SEC. 321. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR**
 4 **ALL MEDICARE BENEFICIARIES.**

5 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.
 6 1395x(s)(2)(J)) is amended by striking “, to an individual
 7 who receives” and all that follows before the semicolon at
 8 the end and inserting “to an individual who has received
 9 an organ transplant”.

10 (b) EFFECTIVE DATE.—The amendments made by
 11 this section shall apply to drugs furnished on or after the
 12 date of the enactment of this Act.

13 **SEC. 322. MEDICARE COMPLEX CLINICAL CARE MANAGE-**
 14 **MENT PAYMENT DEMONSTRATION.**

15 (a) ESTABLISHMENT.—

16 (1) IN GENERAL.—The Secretary shall establish
 17 a demonstration program to make the medicare pro-
 18 gram more responsive to needs of eligible bene-
 19 ficiaries by promoting continuity of care, helping
 20 stabilize medical conditions, preventing or mini-
 21 mizing acute exacerbations of chronic conditions,
 22 and reducing adverse health outcomes, such as ad-
 23 verse drug interactions related to polypharmacy.

24 (2) SITES.—The Secretary shall designate 4
 25 sites at which to conduct the demonstration program

1 under this section, of which 3 shall be in an urban
2 area and 1 shall be in a rural area.

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

6 (b) PARTICIPANTS.—Any eligible beneficiary who re-
7 sides in an area designated by the Secretary as a dem-
8 onstration site under subsection (a)(2) may participate in
9 the demonstration program under this section if such ben-
10 eficiary identifies a principal care physician who agrees to
11 manage the complex clinical care of the eligible beneficiary
12 under the demonstration program.

13 (c) PRINCIPAL CARE PHYSICIAN RESPONSIBIL-
14 ITIES.—The Secretary shall enter into an agreement with
15 each principal care physician who agrees to manage the
16 complex clinical care of an eligible beneficiary under sub-
17 section (b) under which the principal care physician
18 shall—

19 (1) serve as the primary contact of the eligible
20 beneficiary in accessing items and services for which
21 payment may be made under the medicare program;

22 (2) maintain medical information related to
23 care provided by other health care providers who
24 provide health care items and services to the eligible
25 beneficiary, including clinical reports, medication

1 and treatments prescribed by other physicians, hos-
2 pital and hospital outpatient services, skilled nursing
3 home care, home health care, and medical equipment
4 services;

5 (3) monitor and advocate for the continuity of
6 care of the eligible beneficiary and the use of evi-
7 dence-based guidelines;

8 (4) promote self-care and family caregiver in-
9 volvement where appropriate;

10 (5) have appropriate staffing arrangements to
11 conduct patient self-management and other care co-
12 ordination activities as specified by the Secretary;
13 and

14 (6) meet such other complex care management
15 requirements as the Secretary may specify.

16 (d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

17 (1) PAYMENT.—Under an agreement entered
18 into under subsection (c), the Secretary shall pay to
19 each principal care physician, on behalf of each eligi-
20 ble beneficiary under the care of that physician, the
21 complex clinical care management fee developed by
22 the Secretary under paragraph (2).

23 (2) DEVELOPMENT OF FEE.—The Secretary
24 shall develop a complex care management fee under
25 this paragraph that is paid on a monthly basis and

1 which shall be payment in full for all the functions
2 performed by the principal care physician under the
3 demonstration program, including any functions per-
4 formed by other qualified practitioners acting on be-
5 half of the physician, appropriate staff under the su-
6 pervision of the physician, and any other person
7 under a contract with the physician, including any
8 person who conducts patient self-management and
9 caregiver education under subsection (c)(4).

10 (e) FUNDING.—

11 (1) IN GENERAL.—The Secretary shall provide
12 for the transfer from the Federal Supplementary In-
13 surance Trust Fund established under section 1841
14 of the Social Security Act (42 U.S.C. 1395t) of such
15 funds as are necessary for the costs of carrying out
16 the demonstration program under this section.

17 (2) BUDGET NEUTRALITY.—In conducting the
18 demonstration program under this section, the Sec-
19 retary shall ensure that the aggregate payments
20 made by the Secretary do not exceed the amount
21 which the Secretary would have paid if the dem-
22 onstration program under this section was not im-
23 plemented.

24 (f) WAIVER AUTHORITY.—The Secretary may waive
25 such requirements of titles XI and XVIII of the Social

1 Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.)) as
2 may be necessary for the purpose of carrying out the dem-
3 onstration program under this section.

4 (g) REPORT.—Not later than 6 months after the
5 completion of the demonstration program under this sec-
6 tion, the Secretary shall submit to Congress a report on
7 such program, together with recommendations for such
8 legislation and administrative action as the Secretary de-
9 termines to be appropriate.

10 (h) DEFINITIONS.—In this section:

11 (1) ACTIVITY OF DAILY LIVING.—The term “ac-
12 tivity of daily living” means eating, toiling, transfer-
13 ring, bathing, dressing, and continence.

14 (2) CHRONIC CONDITION.—The term “chronic
15 condition” means a biological, physical, or mental
16 condition that is likely to last a year or more, for
17 which there is no known cure, for which there is a
18 need for ongoing medical care, and which may affect
19 an individual’s ability to carry out activities of daily
20 living or instrumental activities of daily living, or
21 both.

22 (3) ELIGIBLE BENEFICIARY.—The term “eligi-
23 ble beneficiary” means any individual who—

24 (A) is enrolled for benefits under part B of
25 the medicare program;

1 (B) has at least 4 complex medical condi-
 2 tions; and

3 (C) has—

4 (i) an inability to self-manage their
 5 care; or

6 (ii) a functional limitation defined as
 7 an impairment in 1 or more activity of
 8 daily living or instrumental activity of daily
 9 living.

10 (4) INSTRUMENTAL ACTIVITY OF DAILY LIV-
 11 ING.—The term “instrumental activity of daily liv-
 12 ing” means meal preparation, shopping, house-
 13 keeping, laundry, money management, telephone
 14 use, and transportation use.

15 (5) MEDICARE PROGRAM.—The term “medicare
 16 program” means the health care program under title
 17 XVIII of the Social Security Act (42 U.S.C. 1395 et
 18 seq.).

19 (6) PRINCIPAL CARE PHYSICIAN.—The term
 20 “principal care physician” means the physician with
 21 primary responsibility for overall coordination of the
 22 care of an eligible beneficiary (as specified in a writ-
 23 ten plan of care) who may be a primary care physi-
 24 cian or a specialist.

1 **SEC. 323. STUDY AND REPORT ON NEW TECHNOLOGY PAY-**
2 **MENTS UNDER THE PROSPECTIVE PAYMENT**
3 **SYSTEM FOR HOSPITAL OUTPATIENT DE-**
4 **PARTMENT SERVICES.**

5 (a) STUDY.—

6 (1) IN GENERAL.—The Secretary shall conduct
7 a study of the methods by which new medical de-
8 vices, new drugs, biologicals, and other new tech-
9 nologies are recognized for payment under the hos-
10 pital outpatient department prospective payment
11 system established under section 1833(t) of the So-
12 cial Security Act (42 U.S.C. 1395l(t)) and on pos-
13 sible changes to those methods.

14 (2) Issues examined.—The study conducted
15 under paragraph (1) shall examine the following:

16 (A) The experience to date of the transi-
17 tional pass-through payment mechanism for ad-
18 ditional costs of innovative medical devices,
19 drugs, and biologicals (provided under section
20 1833(t)(6) of the Social Security Act (42
21 U.S.C. 1395l(t)(6))) and of the provision for
22 new technology ambulatory payment classifica-
23 tions provided through regulations. In par-
24 ticular, the study should examine the effect of
25 such payment mechanism on access of medicare
26 beneficiaries to orphan and single source drugs.

1 (B) The impact of transitional pass-
2 through payments of payment rates for proce-
3 dures not using new medical devices, drugs,
4 biologicals, and other new technologies.

5 (C) The impact of transitional pass-
6 through payments on various types of hospitals,
7 including teaching hospitals, rural hospitals,
8 and small urban hospitals.

9 (D) The extent to which additional pay-
10 ments are necessary to facilitate access to im-
11 proved treatments by medicare beneficiaries.

12 (3) OPTIONS CONSIDERED.—In conducting the
13 study under paragraph (1), the Secretary shall con-
14 sider the following options:

15 (A) Statutory, regulatory, or administra-
16 tive changes that may be desirable to assure ap-
17 propriate recognition of the costs to hospitals of
18 delivering such services. In considering such
19 changes, the Secretary shall take into account
20 the effect of such changes on the payment for
21 new technology services, on payment for serv-
22 ices that do not employ such technology serv-
23 ices, and on administrative resources of both
24 the Department of Health and Human Services

1 and hospitals that may be necessary to imple-
2 ment various changes in a reliable fashion.

3 (B) Appropriate methods for assuring that
4 decisions concerning the eligibility of new tech-
5 nologies for additional payment are made and
6 implemented expeditiously (including possible
7 methods for shortening the interval between ap-
8 proval of a technology by the Food and Drug
9 Administration and commencement of addi-
10 tional payment in instances when a new tech-
11 nology qualifies for such payment) and for as-
12 suring that additional payments are directed to
13 those services that add value for medicare bene-
14 ficiaries by comparison to other technologies for
15 which they may substitute.

16 (C) Methods of setting additional payment
17 rates that may reasonably reflect hospital costs
18 in furnishing new technology services, including
19 alternatives to pricing new drugs based on aver-
20 age wholesale price.

21 (D) Methods for appropriately reflecting
22 the costs of new technology services in payment
23 rates under the hospital outpatient department
24 prospective payment system after the period
25 during which additional payments are made.

1 (b) REPORT.—Not later than July 1, 2003, the Sec-
 2 retary shall submit a report on the study conducted under
 3 paragraph (1) to the Committee on Ways and Means and
 4 the Committee on Energy and Commerce of the House
 5 of Representatives and the Committee on Finance of the
 6 Senate together with such recommendations for legislative
 7 and administrative action as the Secretary determines ap-
 8 propriate.

9 **TITLE IV—PROVISION RELATING**
 10 **TO PARTS A AND B**
 11 **Subtitle A—Home Health Services**

12 **SEC. 401. ELIMINATION OF 15 PERCENT REDUCTION IN**
 13 **PAYMENT RATES UNDER THE PROSPECTIVE**
 14 **PAYMENT SYSTEM.**

15 (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.
 16 1395fff(b)(3)(A)) is amended to read as follows:

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

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

1 the system for fiscal year 2001 shall be
2 equal to the total amount that would have
3 been made if the system had not been in
4 effect and if section 1861(v)(1)(L)(ix) had
5 not been enacted.

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

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

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

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

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

8 (b) EFFECTIVE DATE.—The amendment made by
 9 subsection (a) shall take effect as if included in the
 10 amendments made by section 501 of BIPA (114 Stat.
 11 2763A–529).

12 **SEC. 402. UPDATE IN HOME HEALTH SERVICES.**

13 (a) CHANGE TO CALENDAR YEAR UPDATE.—

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

16 (A) in paragraph (3)(B)(i)—

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

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

23 (B) in paragraph (3)(B)(ii)—

24 (i) in subclause (II), by striking “fis-
 25 cal year” and inserting “year” and by re-

1 designating such subclause as subclause
2 (III); and

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

9 “(II) 2003”;

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

13 (D) in paragraph (3)(B)(iv)—

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

16 (ii) by inserting “or years” after “fis-
17 cal years”; and

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

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

1 (b) CHANGES IN UPDATES FOR 2003, 2004, AND
 2 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C.
 3 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B),
 4 is amended—

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

9 (2) by striking “or” at the end of subclause
 10 (II);

11 (3) by redesignating subclause (III) as sub-
 12 clause (V); and

13 (4) by inserting after subclause (II) the fol-
 14 lowing new subclause:

15 “(III) 2004, 1.1 percentage
 16 points;

17 “(IV) 2005, 2.7 percentage
 18 points; or”.

19 (c) PAYMENT ADJUSTMENT.—

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

23 (2) EFFECTIVE DATE.—The amendment made
 24 by paragraph (1) shall apply to years beginning with
 25 2003.

1 **Subtitle B—Other Provisions**

2 **SEC. 411. INFORMATION TECHNOLOGY DEMONSTRATION**
3 **PROJECT.**

4 (a) **IN GENERAL.**—The Secretary shall conduct a
5 demonstration project to demonstrate the use of third-
6 party software contractors in claims processing and qual-
7 ity improvement activities under parts A and B of title
8 XVIII of the Social Security Act. The Secretary shall
9 enter into up to 4 contracts with third-party software con-
10 tractors to carry out the purposes of the project.

11 (b) **DURATION.**—The demonstration project under
12 this section shall last for not longer than 2 years.

13 (c) **WAIVER.**—The Secretary may waive such provi-
14 sions of titles XI and XVIII of the Social Security Act
15 (42 U.S.C. 1301 et seq.; 1395) as may be necessary to
16 carry out the demonstration project under this section.

17 (d) **REPORT TO CONGRESS.**—Not later than 6
18 months after the completion of the demonstration project
19 under this section, the Secretary shall submit to Congress
20 a report on the project. Such report shall include informa-
21 tion on the cost-effectiveness of using third-party software
22 contractors for claims processing and quality improvement
23 activities under the medicare program and recommenda-
24 tions for such legislation and administrative actions as the
25 Secretary considers appropriate.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated such sums as are nec-
 3 essary to carry out this section.

4 **SEC. 412. MODIFICATIONS TO MEDICARE PAYMENT ADVI-**
 5 **SORY COMMISSION (MEDPAC).**

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

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

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

19 (c) ADDITIONAL REPORT.—

20 (1) DATA NEEDS AND SOURCES.—The Medicare
 21 Payment Advisory Commission shall conduct a
 22 study, and submit a report to Congress by not later
 23 than September 1, 2003, on the need for current
 24 data, and sources of current data available, to deter-

1 mine the solvency and financial circumstances of
2 hospitals and other medicare providers of services.

3 (2) REPORTS IN ADDITION TO ANNUAL RE-
4 PORT.—The report required under paragraph (1)
5 shall be in addition to the report required to be sub-
6 mitted by June 15, 2003, under section
7 1805(b)(1)(D) of the Social Security Act (42 U.S.C.
8 1395b–6(b)(1)(D)).

9 (d) REDUCTION IN NUMBER OF MEMBERS.—

10 (1) REDUCTION.—Section 1805(c)(1) (42
11 U.S.C. 1395b–6(c)(1)) is amended by striking “17”
12 and inserting “15”.

13 (2) APPLICATION.—In order to carry out the
14 amendment made by paragraph (1), in each of the
15 first 2 calendar years in which the terms of 2 or
16 more of the members of the Medicare Payment Advi-
17 sory Commission would expire (as provided in sec-
18 tion 1805(c)(3)(A) of the Social Security Act (42
19 U.S.C. 1395b–6(c)(3)(A)), the Comptroller General
20 of the United States shall not appoint an individual
21 to fill 1 of such vacancies.

1 **SEC. 413. RETAINING DIVERSITY OF LOCAL COVERAGE DE-**
 2 **TERMINATIONS.**

3 (a) IN GENERAL.—Section 1874A(b) of the Social
 4 Security Act, as added by section 621, is amended by add-
 5 ing at the end the following new paragraph:

6 “(6) RETAINING DIVERSITY OF LOCAL COV-
 7 ERAGE DETERMINATIONS.—A contract with a medi-
 8 care administrative contractor under this section to
 9 perform the function of developing local coverage de-
 10 terminations (as defined in section 1869(f)(2)(B))
 11 shall provide that the contractor shall—

12 “(A) designate at least 1 different indi-
 13 vidual to serve as medical director for every 2
 14 States for which such contract performs such
 15 function;

16 “(B) utilize such medical director in the
 17 performance of such function; and

18 “(C) appoint a contractor advisory com-
 19 mittee with respect to each such State to pro-
 20 vide a formal mechanism for physicians in the
 21 State to be informed of, and participate in, the
 22 development of a local coverage determination
 23 in an advisory capacity.”.

24 (b) CONFORMING AMENDMENT.—Section
 25 1874A(a)(4) of the Social Security Act, as added by sec-
 26 tion 621, is amended by inserting “including the function

1 of developing local coverage determinations, as defined in
 2 section 1869(f)(2)(B))” after “payment functions”.

3 (c) EFFECTIVE DATE.—The amendment made by
 4 subsection (a) shall take effect on October 1, 2004.

5 **TITLE V—MEDICARE+CHOICE** 6 **AND RELATED PROVISIONS**

7 **SEC. 501. REVISION IN MINIMUM PERCENTAGE INCREASE** 8 **FOR 2003 AND 2004.**

9 Section 1853(c)(1)(C) (42 U.S.C. 1395w–
 10 23(c)(1)(C)) is amended by striking clause (iv) and insert-
 11 ing the following:

12 “(iv) For 2002, 102 percent of the
 13 annual Medicare+Choice capitation rate
 14 under this paragraph for the area for
 15 2001.

16 “(v) For 2003, 104 percent of the an-
 17 nual Medicare+Choice capitation rate
 18 under this paragraph for the area for
 19 2002.

20 “(vi) For 2004, 103 percent of the
 21 annual Medicare+Choice capitation rate
 22 under this paragraph for the area for
 23 2003.

24 “(vii) For 2005 and each succeeding
 25 year, 102 percent of the annual

1 Medicare+Choice capitation rate under
 2 this paragraph for the area for the pre-
 3 vious year (determined as if the amend-
 4 ment made by section 501 of the Bene-
 5 ficiary Access to Care and Medicare Equity
 6 Act of 2002 had not been enacted).”.

7 **SEC. 502. CLARIFICATION OF AUTHORITY REGARDING DIS-**
 8 **APPROVAL OF UNREASONABLE BENEFICIARY**
 9 **COST-SHARING.**

10 (a) IN GENERAL.—Section 1854(a)(5) (42 U.S.C.
 11 1395w–24(a)(5)) is amended by adding at the end the fol-
 12 lowing new subparagraph:

13 “(C) CLARIFICATION OF AUTHORITY RE-
 14 GARDING DISAPPROVAL OF UNREASONABLE
 15 BENEFICIARY COST-SHARING.—Under the au-
 16 thority under subparagraph (A), the Secretary
 17 may disapprove the values submitted under
 18 paragraphs (2)(A)(iii) and (4)(A)(iii) if the Sec-
 19 retary determines that the deductibles, coinsur-
 20 ance, or copayments applicable under the plan
 21 discourage access to covered services or are
 22 likely to result in favorable selection of
 23 Medicare+Choice eligible individuals.”.

24 (b) STUDY AND REPORT.—

1 (1) STUDY.—The Secretary, in consultation
 2 with beneficiaries, consumer groups, employers, and
 3 Medicare+Choice organizations, shall conduct a
 4 study to determine the extent to which the cost-shar-
 5 ing structures under Medicare+Choice plans under
 6 part C of title XVIII of the Social Security Act dis-
 7 courage access to covered services or discriminate
 8 based on the health status of Medicare+Choice eligi-
 9 ble individuals (as defined in section 1851(a)(3) (42
 10 U.S.C. 1395w–21(a)(3))).

11 (2) REPORT.—Not later than December 31,
 12 2004, the Secretary shall submit a report to Con-
 13 gress on the study conducted under paragraph (1)
 14 together with recommendations for such legislation
 15 and administrative actions as the Secretary con-
 16 siders appropriate.

17 **SEC. 503. EXTENSION OF REASONABLE COST CONTRACTS.**

18 (a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C)
 19 (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking
 20 “2004” and inserting “2009”.

21 (b) APPLICATION OF CERTAIN MEDICARE+CHOICE
 22 REQUIREMENTS TO COST CONTRACTS EXTENDED OR RE-
 23 NEWED AFTER 2003.—Section 1876(h) (42 U.S.C.
 24 1395mm(h)(5)), as amended by subsection (a), is amend-
 25 ed—

1 (1) by redesignating paragraph (5) as para-
2 graph (6); and

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

5 “(5) Any reasonable cost reimbursement contract
6 with an eligible organization under this subsection that is
7 extended or renewed on or after the date of the enactment
8 of the Beneficiary Access to Care and Medicare Equity
9 Act of 2002 for plan years beginning on or after January
10 1, 2004, shall provide that the following provisions of the
11 Medicare+Choice program under part C shall apply to
12 such organization and such contract in a substantially
13 similar manner as such provisions apply to
14 Medicare+Choice organizations and Medicare+Choice
15 plans under such part:

16 “(A) Paragraph (1) of section 1852(e) (relating
17 to the requirement of having an ongoing quality as-
18 surance program) and paragraph (2)(B) of such sec-
19 tion (relating to the required elements for such a
20 program).

21 “(B) Section 1852(j)(4) (relating to limitations
22 on physician incentive plans).

23 “(C) Section 1854(c) (relating to the require-
24 ment of uniform premiums among individuals en-
25 rolled in the plan).

1 “(D) Section 1854(g) (relating to restrictions
2 on imposition of premium taxes with respect to pay-
3 ments to organizations).

4 “(E) Section 1856(b) (regarding compliance
5 with the standards established by regulation pursu-
6 ant to such section, including the provisions of para-
7 graph (3) of such section relating to relation to
8 State laws).

9 “(F) Section 1852(a)(3)(A) (regarding the au-
10 thority of organizations to include supplemental
11 health care benefits under the plan subject to the
12 approval of the Secretary).

13 “(G) The provisions of part C relating to
14 timelines for benefit filings, contract renewal, and
15 beneficiary notification.

16 “(H) Section 1854(a)(5)(C) (relating to pro-
17 posed cost-sharing under the contract being subject
18 to review by the Secretary).”.

19 **SEC. 504. EXTENSION OF SOCIAL HEALTH MAINTENANCE**
20 **ORGANIZATION (SHMO) DEMONSTRATION**
21 **PROJECT.**

22 (a) IN GENERAL.—Section 4018(b)(1) of the Omni-
23 bus Budget Reconciliation Act of 1987 is amended by
24 striking “the date that is 30 months after the date that
25 the Secretary submits to Congress the report described in

1 section 4014(c) of the Balanced Budget Act of 1997” and
 2 inserting “December 31, 2006”.

3 (b) SHMOs OFFERING MEDICARE+CHOICE
 4 PLANS.—Nothing in such section 4018 shall be construed
 5 as preventing a social health maintenance organization
 6 from offering a Medicare+Choice plan under part C of
 7 title XVIII of the Social Security Act.

8 **SEC. 505. SPECIALIZED MEDICARE+CHOICE PLANS FOR**
 9 **SPECIAL NEEDS BENEFICIARIES.**

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

16 (b) SPECIALIZED MEDICARE+CHOICE PLAN FOR
 17 SPECIAL NEEDS BENEFICIARIES DEFINED.—Section
 18 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding
 19 at the end the following new paragraph:

20 “(4) SPECIALIZED MEDICARE+CHOICE PLANS
 21 FOR SPECIAL NEEDS BENEFICIARIES.—

22 “(A) IN GENERAL.—The term ‘specialized
 23 Medicare+Choice plan for special needs bene-
 24 ficiaries’ means a Medicare+Choice plan that

1 exclusively serves special needs beneficiaries (as
2 defined in subparagraph (B)).

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

6 “(i) is institutionalized (as defined by
7 the Secretary);

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

10 “(iii) meets such requirements as the
11 Secretary may determine would benefit
12 from enrollment in such a specialized
13 Medicare+Choice plan described in sub-
14 paragraph (A) for individuals with severe
15 or disabling chronic conditions.”.

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

19 “(f) RESTRICTION ON ENROLLMENT FOR SPECIAL-
20 IZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS
21 BENEFICIARIES.—In the case of a specialized
22 Medicare+Choice plan (as defined in subsection (b)(4)),
23 notwithstanding any other provision of this part and in
24 accordance with regulations of the Secretary and for peri-
25 ods before January 1, 2007, the plan may restrict the en-

1 rollment of individuals under the plan to individuals who
2 are within one or more classes of special needs bene-
3 ficiaries.”.

4 (d) REPORT TO CONGRESS.—Not later than Decem-
5 ber 31, 2005, the Secretary shall submit to Congress a
6 report that assesses the impact of specialized
7 Medicare+Choice plans for special needs beneficiaries on
8 the cost and quality of services provided to enrollees. Such
9 report shall include an assessment of the costs and savings
10 to the medicare program as a result of amendments made
11 by subsections (a), (b), and (c).

12 (e) EFFECTIVE DATES.—

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

16 (2) DEADLINE FOR ISSUANCE OF REQUIRE-
17 MENTS FOR SPECIAL NEEDS BENEFICIARIES; TRAN-
18 SITION.—No later than 1 year after the date of the
19 enactment of this Act, the Secretary shall issue final
20 regulations to establish requirements for special
21 needs beneficiaries under section 1859(b)(4)(B)(iii)
22 of the Social Security Act, as added by subsection
23 (b).

1 **SEC. 506. EXTENSION OF NEW ENTRY BONUS.**

2 Section 1853(i) (42 U.S.C. 1395w-23(i)) is amend-
3 ed—

4 (1) in paragraph (1), by inserting “, or filed no-
5 tice with the Secretary as of October 3, 2002, that
6 they will not be offering such a plan as of January
7 1, 2002, or as of January 1, 2003” after “January
8 1, 2001” in the matter preceding subparagraph (A);
9 and

10 (2) in paragraph (2), by inserting “(or 4-year
11 period in the case of a Medicare+Choice plan that
12 is not a Medicare+Choice private fee-for-service plan
13 or a plan operating under demonstration project au-
14 thority)” after “2-year period”.

15 **SEC. 507. PAYMENT BY PACE PROVIDERS FOR MEDICARE**
16 **AND MEDICAID SERVICES FURNISHED BY**
17 **NONCONTRACT PROVIDERS.**

18 (a) MEDICARE SERVICES.—

19 (1) MEDICARE SERVICES FURNISHED BY PRO-
20 VIDERS OF SERVICES.—Section 1866(a)(1)(O) (42
21 U.S.C. 1395cc(a)(1)(O)) is amended—

22 (A) by striking “part C or” and inserting
23 “part C, with a PACE provider under section
24 1894 or 1934, or”;

25 (B) by striking “(i)”;

26 (C) by striking “and (ii)”;

(D) by striking “members of the organization” and inserting “members of the organization or PACE program eligible individuals enrolled with the PACE provider,”.

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

“(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

“(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section

1 applies to Medicare+Choice organizations, indi-
 2 viduals enrolled with such organizations, and
 3 physicians and other entities referred to in such
 4 section.

5 “(B) REFERENCE TO RELATED PROVISION
 6 FOR NONCONTRACT PROVIDERS OF SERVICES.—
 7 For the provision relating to limitations on bal-
 8 ance billing against PACE providers for serv-
 9 ices covered under this title furnished by non-
 10 contract providers of services, see section
 11 1866(a)(1)(O).

12 “(4) REFERENCE TO RELATED PROVISION
 13 FOR SERVICES COVERED UNDER TITLE XIX BUT
 14 NOT UNDER THIS TITLE.—For provisions relat-
 15 ing to limitations on payments to providers par-
 16 ticipating under the State plan under title XIX
 17 that do not have a contract with a PACE pro-
 18 vider establishing payment amounts for services
 19 covered under such plan (but not under this
 20 title) when such services are furnished to enroll-
 21 ees of that PACE provider, see section
 22 1902(a)(66).”.

23 (b) MEDICAID SERVICES.—

24 (1) REQUIREMENT UNDER STATE PLAN.—Sec-
 25 tion 1902(a) (42 U.S.C. 1396a(a) is amended—

1 (A) in paragraph (64), by striking “and”
 2 at the end;

3 (B) in paragraph (65), by striking the pe-
 4 riod at the end and inserting “; and”; and

5 (C) by inserting after paragraph (65) the
 6 following new paragraph:

7 “(66) provide, with respect to services cov-
 8 ered under the State plan (but not under title
 9 XVIII) that are furnished to a PACE program
 10 eligible individual enrolled with a PACE pro-
 11 vider by a provider participating under the
 12 State plan that does not have a contract with
 13 the PACE provider that establishes payment
 14 amounts for such services, that such partici-
 15 pating provider may not require the PACE pro-
 16 vider to pay the participating provider an
 17 amount greater than the amount that would
 18 otherwise be payable for the service to the par-
 19 ticipating provider under the State plan for the
 20 State where the PACE provider is located (in
 21 accordance with regulations issued by the Sec-
 22 retary).”.

23 (2) REFERENCE IN MEDICAID STATUTE.—Sec-
 24 tion 1934(b) (42 U.S.C. 1396u–4(b)) is amended by
 25 adding at the end the following new paragraphs:

1 “(3) TREATMENT OF MEDICARE SERVICES FUR-
2 NISHED BY NONCONTRACT PHYSICIANS AND OTHER
3 ENTITIES.—

4 “(A) APPLICATION OF MEDICARE+CHOICE
5 REQUIREMENT WITH RESPECT TO MEDICARE
6 SERVICES FURNISHED BY NONCONTRACT PHY-
7 SICIANS AND OTHER ENTITIES.—Section
8 1852(k)(1) (relating to limitations on balance
9 billing against Medicare+Choice organizations
10 for noncontract physicians and other entities
11 with respect to services covered under title
12 XVIII) shall apply to PACE providers, PACE
13 program eligible individuals enrolled with such
14 PACE providers, and physicians and other enti-
15 ties that do not have a contract establishing
16 payment amounts for services furnished to such
17 an individual in the same manner as such sec-
18 tion applies to Medicare+Choice organizations,
19 individuals enrolled with such organizations,
20 and physicians and other entities referred to in
21 such section.

22 “(B) REFERENCE TO RELATED PROVISION
23 FOR NONCONTRACT PROVIDERS OF SERVICES.—
24 For the provision relating to limitations on bal-
25 ance billing against PACE providers for serv-

1 ices covered under title XVIII furnished by non-
 2 contract providers of services, see section
 3 1866(a)(1)(O).

4 “(4) REFERENCE TO RELATED PROVISION
 5 FOR SERVICES COVERED UNDER THIS TITLE
 6 BUT NOT UNDER TITLE XVIII.—For provisions
 7 relating to limitations on payments to providers
 8 participating under the State plan under this
 9 title that do not have a contract with a PACE
 10 provider establishing payment amounts for serv-
 11 ices covered under such plan (but not under
 12 title XVIII) when such services are furnished to
 13 enrollees of that PACE provider, see section
 14 1902(a)(66).”.

15 (c) EFFECTIVE DATE.—The amendments made by
 16 this section shall apply to services furnished on or after
 17 January 1, 2003.

18 **SEC. 508. REFERENCE TO IMPLEMENTATION OF CERTAIN**
 19 **MEDICARE+CHOICE PROGRAM PROVISIONS**
 20 **IN 2003.**

21 For the provisions related to the implementation of
 22 certain Medicare+Choice program provisions in 2003, see
 23 section 807(c).

1 **TITLE VI—MEDICARE APPEALS,**
 2 **REGULATORY, AND CON-**
 3 **TRACTING IMPROVEMENTS**
 4 **Subtitle A—Regulatory Reform**

5 **SEC. 601. RULES FOR THE PUBLICATION OF A FINAL REGU-**
 6 **LATION BASED ON THE PREVIOUS PUBLICA-**
 7 **TION OF AN INTERIM FINAL REGULATION.**

8 (a) IN GENERAL.—Section 1871(a) (42 U.S.C.
 9 1395hh(a)) is amended by adding at the end the following
 10 new paragraph:

11 “(3)(A) With respect to the publication of a final reg-
 12 ulation based on the previous publication of an interim
 13 final regulation—

14 “(i) subject to subparagraph (ii), the Secretary
 15 shall publish the final regulation within the 12-
 16 month period that begins on the date of publication
 17 of the interim final regulation;

18 “(ii) if a final regulation is not published by the
 19 deadline established under this paragraph, the in-
 20 terim final regulation shall not continue in effect un-
 21 less the Secretary publishes a notice described in
 22 subparagraph (B) by such deadline; and

23 “(iii) the final regulation shall include responses
 24 to comments submitted in response to the interim
 25 final regulation.

1 “(B) If the Secretary determines before the deadline
2 otherwise established in this paragraph that there is good
3 cause, specified in a notice published before such deadline,
4 for delaying the deadline otherwise applicable under this
5 paragraph, the deadline otherwise established under this
6 paragraph shall be extended for such period (not to exceed
7 12 months) as the Secretary specifies in such notice.”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) shall take effect on the date of the enact-
10 ment of this Act and shall apply to interim final regula-
11 tions published on or after such date.

12 (c) STATUS OF PENDING INTERIM FINAL REG-
13 ULATIONS.—Not later than 6 months after the date
14 of the enactment of this Act, the Secretary shall
15 publish a notice in the Federal Register that pro-
16 vides the status of each interim final regulation that
17 was published on or before the date of the enact-
18 ment of this Act and for which no final regulation
19 has been published. Such notice shall include the
20 date by which the Secretary plans to publish the
21 final regulation that is based on the interim final
22 regulation.

1 **SEC. 602. COMPLIANCE WITH CHANGES IN REGULATIONS**
2 **AND POLICIES.**

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

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

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

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

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

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

22 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE
23 CHANGES AFTER NOTICE.—

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

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

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

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

22 (2) EFFECTIVE DATE.—The amendment made
23 by paragraph (1) shall apply to compliance actions
24 undertaken on or after the date of the enactment of
25 this Act.

1 **SEC. 603. REPORT ON LEGAL AND REGULATORY INCON-**
2 **SISTENCIES.**

3 Section 1871 (42 U.S.C. 1395hh), as amended by
4 section 602(a)(1), is amended by adding at the end the
5 following new subsection:

6 “(e)(1) Not later than 2 years after the date of the
7 enactment of this subsection, and every 2 years thereafter,
8 the Secretary shall submit to Congress a report with re-
9 spect to the administration of this title and areas of incon-
10 sistency or conflict among the various provisions under
11 law and regulation.

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

14 “(A) information from beneficiaries, providers
15 of services, physicians, practitioners, and other sup-
16 pliers with respect to such areas of inconsistency
17 and conflict; and

18 “(B) information from medicare contractors
19 that tracks the nature of all communications and
20 correspondence.

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

Subtitle B—Appeals Process Reform

SEC. 611. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2003, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

1 (B) COST PROJECTIONS AND FINANC-
2 ING.—Funding levels required for fiscal year
3 2004 and subsequent fiscal years to carry out
4 the functions transferred under the plan and
5 how such transfer should be financed.

6 (C) TRANSITION TIMETABLE.—A timetable
7 for the transition.

8 (D) REGULATIONS.—The establishment of
9 specific regulations to govern the appeals proc-
10 ess.

11 (E) CASE TRACKING.—The development of
12 a unified case tracking system that will facili-
13 tate the maintenance and transfer of case spe-
14 cific data across both the fee-for-service and
15 managed care components of the medicare pro-
16 gram.

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

23 (G) ACCESS TO ADMINISTRATIVE LAW
24 JUDGES.—The feasibility of—

1 (i) filing appeals with administrative
2 law judges electronically; and

3 (ii) conducting hearings using tele- or
4 video-conference technologies.

5 (H) INDEPENDENCE OF JUDGES.—The
6 steps that should be taken to ensure the inde-
7 pendence of judges performing the administra-
8 tive law judge functions that are transferred
9 under the plan from the Centers for Medicare
10 & Medicaid Services and its contractors.

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

18 (J) HIRING.—The steps that should be
19 taken to hire judges (and support staff) to per-
20 form the administrative law judge functions
21 that are transferred under the plan.

22 (K) PERFORMANCE STANDARDS.—The es-
23 tablishment of performance standards for
24 judges performing the administrative law judge
25 functions that are transferred under the plan

1 with respect to timelines for decisions in cases
2 under title XVIII.

3 (L) SHARED RESOURCES.—The feasibility
4 of the Secretary entering into such arrange-
5 ments with the Commissioner of Social Security
6 as may be appropriate with respect to trans-
7 ferred functions under the plan to share office
8 space, support staff, and other resources, with
9 appropriate reimbursement.

10 (M) TRAINING.—The training that should
11 be provided to judges performing the adminis-
12 trative law judge functions that are transferred
13 under the plan with respect to laws and regula-
14 tions under title XVIII.

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) and
21 this Act).

22 (b) GAO EVALUATION.—The Comptroller General of
23 the United States shall—

24 (1) evaluate the plan submitted under sub-
25 section (a); and

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

4 **SEC. 612. EXPEDITED ACCESS TO JUDICIAL REVIEW.**

5 (a) IN GENERAL.—Section 1869(b) (42 U.S.C.
 6 1395ff(b)) is amended—

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

10 (2) by adding at the end the following new
 11 paragraph:

12 “(2) EXPEDITED ACCESS TO JUDICIAL RE-
 13 VIEW.—

14 “(A) IN GENERAL.—The Secretary shall
 15 establish a process under which a provider of
 16 services or supplier that furnishes an item or
 17 service or a beneficiary who has filed an appeal
 18 under paragraph (1) (other than an appeal filed
 19 under paragraph (1)(F)(i)) may obtain access
 20 to judicial review when a review entity (de-
 21 scribed in subparagraph (D)), on its own mo-
 22 tion or at the request of the appellant, deter-
 23 mines that the Departmental Appeals Board
 24 does not have the authority to decide the ques-
 25 tion of law or regulation relevant to the matters

1 in controversy and that there is no material
2 issue of fact in dispute. The appellant may
3 make such request only once with respect to a
4 question of law or regulation for a specific mat-
5 ter in dispute in a case of an appeal.

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

25 “(C) ACCESS TO JUDICIAL REVIEW.—

1 “(i) IN GENERAL.—If the appropriate
2 review entity—

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

9 “(II) fails to make such deter-
10 mination within the period provided
11 under subparagraph (B);
12 then the appellant may bring a civil action
13 as described in this subparagraph.

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

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

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

24 “(iii) VENUE.—Such action shall be
25 brought in the district court of the United

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

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

1 imbursement due providers of services,
 2 physicians, practitioners, and other sup-
 3 pliers under this Act.

4 “(D) REVIEW ENTITY DEFINED.—For pur-
 5 poses of this subsection, a ‘review entity’ is a
 6 panel of no more than 3 members from the De-
 7 partmental Appeals Board, selected for the pur-
 8 pose of making determinations under this para-
 9 graph.”.

10 (b) APPLICATION TO PROVIDER AGREEMENT DETER-
 11 MINATIONS.—Section 1866(h)(1) (42 U.S.C.
 12 1395cc(h)(1)) is amended—

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

14 (2) by adding at the end the following new sub-
 15 paragraph:

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

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

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

8 (d) EFFECTIVE DATE.—The amendments made by
 9 this section shall apply to appeals filed on or after October
 10 1, 2003.

11 **SEC. 613. EXPEDITED REVIEW OF CERTAIN PROVIDER**
 12 **AGREEMENT DETERMINATIONS.**

13 (a) TERMINATION AND CERTAIN OTHER IMMEDIATE
 14 REMEDIES.—

15 (1) IN GENERAL.—The Secretary shall develop
 16 and implement a process to expedite proceedings
 17 under sections 1866(h) of the Social Security Act
 18 (42 U.S.C. 1395cc(h)) in which—

19 (A) the remedy of termination of participa-
 20 tion has been imposed;

21 (B) a sanction described in clause (i) or
 22 (iii) of section 1819(h)(2)(B) of such Act (42
 23 U.S.C. 1395i–3(h)(2)(B)) has been imposed,
 24 but only if such sanction has been imposed on
 25 an immediate basis; or

1 (C) the Secretary has required a skilled
2 nursing facility to suspend operations of a
3 nurse aide training program.

4 (2) PRIORITY FOR CASES OF TERMINATION.—

5 Under the process described in paragraph (1), pri-
6 ority shall be provided in cases of termination de-
7 scribed in subparagraph (A) of such paragraph.

8 (b) INCREASED FINANCIAL SUPPORT.—In addition
9 to any amounts otherwise appropriated, to reduce by 50
10 percent the average time for administrative determina-
11 tions on appeals under section 1866(h) of the Social Secu-
12 rity Act (42 U.S.C. 1395cc(h)), there are authorized to
13 be appropriated (in appropriate part from the Federal
14 Hospital Insurance Trust Fund and the Federal Supple-
15 mentary Medical Insurance Trust Fund) to the Secretary
16 such sums for fiscal year 2003 and each subsequent fiscal
17 year as may be necessary to increase the number of ad-
18 ministrative law judges (and their staffs) at the Depart-
19 mental Appeals Board of the Department of Health and
20 Human Services and to educate such judges and staff on
21 long-term care issues.

22 **SEC. 614. REVISIONS TO MEDICARE APPEALS PROCESS.**

23 (a) TIMEFRAMES FOR THE COMPLETION OF THE
24 RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as

1 amended by section 612(a)(2), is amended by adding at
2 the end the following new paragraph:

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

4 “(A) DEADLINE.—Subject to subpara-
5 graph (B), the deadline to complete the record
6 in a hearing before an administrative law judge
7 or a review by the Departmental Appeals Board
8 is 90 days after the date the request for the re-
9 view or hearing is filed.

10 “(B) EXTENSIONS FOR GOOD CAUSE.—

11 The person filing a request under subparagraph
12 (A) may request an extension of such deadline
13 for good cause. The administrative law judge,
14 in the case of a hearing, and the Departmental
15 Appeals Board, in the case of a review, may ex-
16 tend such deadline based upon a finding of
17 good cause to a date specified by the judge or
18 Board, as the case may be.

19 “(C) DELAY IN DECISION DEADLINES

20 UNTIL COMPLETION OF RECORD.—Notwith-
21 standing any other provision of this section, the
22 deadlines otherwise established under sub-
23 section (d) for the making of determinations in
24 hearings or review under this section are 90

1 days after the date on which the record is com-
 2 plete.

3 “(D) COMPLETE RECORD DESCRIBED.—

4 For purposes of this paragraph, a record is
 5 complete when the administrative law judge, in
 6 the case of a hearing, or the Departmental Ap-
 7 peals Board, in the case of a review, has re-
 8 ceived—

9 “(i) written or testimonial evidence, or
 10 both, submitted by the person filing the re-
 11 quest,

12 “(ii) written or oral argument, or
 13 both,

14 “(iii) the decision of, and the record
 15 for, the prior level of appeal, and

16 “(iv) such other evidence as such
 17 judge or Board, as the case may be, deter-
 18 mines is required to make a determination
 19 on the request.”.

20 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section
 21 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amend-
 22 ed by inserting “(including the medical records of the indi-
 23 vidual involved)” after “clinical experience”.

24 (c) NOTICE REQUIREMENTS FOR MEDICARE AP-
 25 PEALS.—

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

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

13 “(A) the reasons for the determination, in-
14 cluding, as appropriate—

15 “(i) upon request in the case of an
16 initial determination, the provision of the
17 policy, manual, or regulation that resulted
18 in the denial; and

19 “(ii) in the case of a redetermination,
20 a summary of the clinical or scientific evi-
21 dence used in making the determination
22 (as appropriate);

23 “(B) the procedures for obtaining addi-
24 tional information concerning the determination
25 or redetermination; and

1 “(C) notification of the right to seek a re-
 2 determination or otherwise appeal the deter-
 3 mination and instructions on how to initiate
 4 such a redetermination or appeal under this
 5 section.”.

6 (2) RECONSIDERATIONS.—Section
 7 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is
 8 amended to read as follows:

9 “(E) EXPLANATION OF DECISION.—Any
 10 decision with respect to a reconsideration of a
 11 qualified independent contractor shall be in
 12 writing in a manner to be understood by the
 13 beneficiary and shall include—

14 “(i) to the extent appropriate, a de-
 15 tailed explanation of the decision as well as
 16 a discussion of the pertinent facts and ap-
 17 plicable regulations applied in making such
 18 decision;

19 “(ii) a notification of the right to ap-
 20 peal such determination and instructions
 21 on how to initiate such appeal under this
 22 section; and

23 “(iii) in the case of a determination of
 24 whether an item or service is reasonable
 25 and necessary for the diagnosis or treat-

1 ment of illness or injury (under section
2 1862(a)(1)(A)) an explanation of the med-
3 ical or scientific rationale for the deci-
4 sion.”.

5 (3) APPEALS.—Section 1869(d) (42 U.S.C.
6 1395ff(d)) is amended—

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

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

11 “(4) NOTICE.—Notice of the decision of an ad-
12 ministrative law judge shall be in writing in a man-
13 ner to be understood by the beneficiary and shall in-
14 clude—

15 “(A) the specific reasons for the deter-
16 mination (including, to the extent appropriate,
17 a summary of the clinical or scientific evidence
18 used in making the determination);

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

21 “(C) notification of the right to appeal the
22 decision and instructions on how to initiate
23 such an appeal under this section.”.

24 (4) PREPARATION OF RECORD FOR APPEAL.—
25 Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is

1 amended by striking “such information as is re-
 2 quired for an appeal” and inserting “the record for
 3 the appeal”.

4 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

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

8 (A) in paragraph (2)—

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

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

17 “(A) GENERAL REQUIREMENTS.—

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

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

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

12 “(B) INDEPENDENCE REQUIREMENTS.—

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

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

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

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

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

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

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

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

1 (A) by amending subsection (c)(3)(D) to
 2 read as follows:

3 “(D) QUALIFICATIONS FOR REVIEWERS.—
 4 The requirements of subsection (g) shall be met
 5 (relating to qualifications of reviewing profes-
 6 sionals).”; and

7 (B) by adding at the end the following new
 8 subsection:

9 “(g) QUALIFICATIONS OF REVIEWERS.—

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

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

15 “(B) compensation provided by the con-
 16 tractor to each such reviewer is consistent with
 17 paragraph (3); and

18 “(C) in the case of a review by a panel de-
 19 scribed in subsection (c)(3)(B) composed of
 20 physicians or other health care professionals
 21 (each in this subsection referred to as a ‘review-
 22 ing professional’), each reviewing professional
 23 meets the qualifications described in paragraph
 24 (4).

25 “(2) INDEPENDENCE.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), each individual conducting a review
3 in a case shall—

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

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

9 “(iii) not otherwise have a conflict of
10 interest with such a party (as determined
11 under regulations).

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

14 “(i) prohibit an individual, solely on
15 the basis of affiliation with a fiscal inter-
16 mediary, carrier, or other contractor, from
17 serving as a reviewing professional if—

18 “(I) a nonaffiliated individual is
19 not reasonably available;

20 “(II) the affiliated individual is
21 not involved in the provision of items
22 or services in the case under review;

23 “(III) the fact of such an affili-
24 ation is disclosed to the Secretary and
25 the beneficiary (or authorized rep-

1 resentative) and neither party objects;
2 and

3 “(IV) the affiliated individual is
4 not an employee of the intermediary,
5 carrier, or contractor and does not
6 provide services exclusively or pri-
7 marily to or on behalf of such inter-
8 mediary, carrier, or contractor;

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

17 “(iii) prohibit receipt of compensation
18 by a reviewing professional from a con-
19 tractor if the compensation is provided
20 consistent with paragraph (3).

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

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

4 “(A) is appropriately credentialed or li-
5 censed in 1 or more States to deliver health
6 care services; and

7 “(B) has medical expertise in the field of
8 practice that is appropriate for the items or
9 services at issue.

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

14 “(A) The Secretary, the medicare adminis-
15 trative contractor involved, or any fiduciary, of-
16 ficer, director, or employee of the Department
17 of Health and Human Services, or of such con-
18 tractor.

19 “(B) The individual (or authorized rep-
20 resentative).

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

23 “(D) The institution at which the items or
24 services (or treatment) involved in the case are
25 provided.

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

4 “(F) Any other party determined under
5 any regulations to have a substantial interest in
6 the case involved.”.

7 (3) NUMBER OF QUALIFIED INDEPENDENT
8 CONTRACTORS.—Section 1869(c)(4) (42 U.S.C.
9 1395ff(c)(4)) is amended by striking “12” and in-
10 serting “4”.

11 (e) IMPLEMENTATION OF CERTAIN BIPA RE-
12 FORMS.—

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

16 “(d) EFFECTIVE DATE.—

17 “(1) IN GENERAL.—Except as specified in
18 paragraph (2), the amendments made by this section
19 shall apply with respect to initial determinations
20 made on or after December 1, 2003.

21 “(2) EXPEDITED PROCEEDINGS AND RECONSID-
22 ERATION REQUIREMENTS.—For the following provi-
23 sions, the amendments made by subsection (a) shall
24 apply with respect to initial determinations made on
25 or after October 1, 2002:

1 “(A) Subsection (b)(1)(F)(i) of section
2 1869 of the Social Security Act.

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

5 “(C) Subsection (c)(3)(C)(iv) of such sec-
6 tion to the extent that it applies to expedited
7 reconsiderations under subsection (c)(3)(C)(iii)
8 of such section.

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

17 (2) CONFORMING AMENDMENT.—Section
18 521(c) of BIPA (114 Stat. 2763A–543) and section
19 1869(c)(3)(C)(iii)(III) of the Social Security Act (42
20 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section
21 521 of BIPA, are repealed.

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

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

8 **SEC. 615. HEARING RIGHTS RELATED TO DECISIONS BY**
 9 **THE SECRETARY TO DENY OR NOT RENEW A**
 10 **MEDICARE ENROLLMENT AGREEMENT; CON-**
 11 **SULTATION BEFORE CHANGING PROVIDER**
 12 **ENROLLMENT FORMS.**

13 (a) HEARING RIGHTS.—

14 (1) IN GENERAL.—Section 1866 (42 U.S.C.
 15 1395cc) is amended by adding at the end the fol-
 16 lowing new subsection:

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

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

23 “(2) providers of services, physicians, practi-
 24 tioners, and suppliers whose application to enroll
 25 (or, if applicable, to renew enrollment) are denied

1 are provided a mechanism to appeal such denial and
 2 a deadline for consideration of such appeals.”.

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

8 (b) CONSULTATION BEFORE CHANGING PROVIDER
 9 ENROLLMENT FORMS.—Section 1871 (42 U.S.C.
 10 1395hh), as amended by sections 602 and 603, is amend-
 11 ed by adding at the end the following new subsection:

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

18 **SEC. 616. APPEALS BY PROVIDERS WHEN THERE IS NO**
 19 **OTHER PARTY AVAILABLE.**

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

23 “(h) Notwithstanding subsection (f) or any other pro-
 24 vision of law, the Secretary shall permit a provider of serv-
 25 ices, physician, practitioner, or other supplier to appeal

1 any determination of the Secretary under this title relating
 2 to services rendered under this title to an individual who
 3 subsequently dies if there is no other party available to
 4 appeal such determination.”.

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

9 **SEC. 617. PROVIDER ACCESS TO REVIEW OF LOCAL COV-**
 10 **ERAGE DETERMINATIONS.**

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

14 “(5) AGGRIEVED PARTY DEFINED.—In this sec-
 15 tion, the term ‘aggrieved party’ means—

16 “(A) with respect to a national coverage
 17 determination, an individual entitled to benefits
 18 under part A, or enrolled under part B, or both,
 19 who is in need of the items or services that are
 20 the subject of the coverage determination; and

21 “(B) with respect to a local coverage deter-
 22 mination—

23 “(i) an individual who is entitled to
 24 benefits under part A, or enrolled under

1 part B, or both, who is adversely affected
 2 by such a determination; or

3 “(ii) a provider of services, physician,
 4 practitioner, or supplier that is adversely
 5 affected by such a determination.”.

6 (b) CLARIFICATION OF LOCAL COVERAGE DETER-
 7 MINATION DEFINITION.—Section 1869(f)(2)(B) (42
 8 U.S.C. 1395ff(f)(2)(B)) is amended by inserting “, includ-
 9 ing, where appropriate, the specific requirements and clin-
 10 ical indications relating to the medical necessity of an item
 11 or service” before the period at the end.

12 (c) REQUEST FOR LOCAL COVERAGE DETERMINA-
 13 TIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff),
 14 as amended by section 614(d)(2)(B), is amended by add-
 15 ing at the end the following new subsection:

16 “(h) REQUEST FOR LOCAL COVERAGE DETERMINA-
 17 TIONS BY PROVIDERS.—

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

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

11 “(3) REQUEST REQUIREMENTS.—Under the
12 process established under paragraph (1), by not
13 later than 30 days after the date on which a pro-
14 vider local coverage determination request is filed
15 under paragraph (1), the Secretary shall determine
16 whether such request establishes that—

17 “(A) there have been at least 5 reversals of
18 redeterminations made by a fiscal intermediary
19 or carrier after a hearing before an administra-
20 tive law judge on claims submitted by the pro-
21 vider in at least 2 different cases before an ad-
22 ministrative law judge;

23 “(B) each reversal described in subpara-
24 graph (A) involves substantially similar mate-
25 rial facts;

1 “(C) each reversal described in subpara-
2 graph (A) involves the same medical necessity
3 issue; and

4 “(D) at least 50 percent of the total num-
5 ber of claims submitted by such provider within
6 the past year involving the substantially similar
7 material facts described in subparagraph (B)
8 and the same medical necessity issue described
9 in subparagraph (C) have been denied and have
10 been reversed by an administrative law judge.

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

12 “(A) APPROVAL OF REQUEST.—If the Sec-
13 retary determines that subparagraphs (A)
14 through (D) of paragraph (3) have been satis-
15 fied, the Secretary shall require the fiscal inter-
16 mediary, carrier, or program safeguard con-
17 tractor identified in the provider local coverage
18 determination request, to make or revise a local
19 coverage determination with respect to the item
20 or service that is the subject of the request not
21 later than the date that is 210 days after the
22 date on which the Secretary makes the deter-
23 mination. Such fiscal intermediary, carrier, or
24 program safeguard contractor shall retain the
25 discretion to determine whether or not, and/or

1 the circumstances under which, to cover the
 2 item or service for which a local coverage deter-
 3 mination is requested. Nothing in this sub-
 4 section shall be construed to require a fiscal
 5 intermediary, carrier or program safeguard con-
 6 tractor to develop a local coverage determina-
 7 tion that is inconsistent with any national cov-
 8 erage determination, or any coverage provision
 9 in this title or in regulation, manual, or inter-
 10 pretive guidance of the Secretary.

11 “(B) REJECTION OF REQUEST.—If the
 12 Secretary determines that subparagraphs (A)
 13 through (D) of paragraph (3) have not been
 14 satisfied, the Secretary shall reject the provider
 15 local coverage determination request and shall
 16 notify the provider of services, physician, practi-
 17 tioner, or supplier that filed the request of the
 18 reason for such rejection and no further pro-
 19 ceedings in relation to such request shall be
 20 conducted.”.

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

23 (1) STUDY.—The Secretary of Health and
 24 Human Services (in this section referred to as the
 25 “Secretary”) shall conduct a study on the feasibility

1 and advisability of requiring fiscal intermediaries
2 and carriers to monitor and track—

3 (A) the subject matter and status of claims
4 denied by the fiscal intermediary or carrier (as
5 applicable) that are appealed under section
6 1869 of the Social Security Act (42 U.S.C.
7 1395ff), as added by section 522 of BIPA (114
8 Stat. 2763A–543) and amended by this Act;
9 and

10 (B) any final determination made with re-
11 spect to such claims.

12 (2) REPORT.—Not later than the date that is
13 1 year after the date of the enactment of this Act,
14 the Secretary shall submit to Congress a report on
15 the study conducted under paragraph (1) together
16 with such recommendations for legislation and ad-
17 ministrative action as the Commission determines
18 appropriate.

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

23 (f) EFFECTIVE DATES.—

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

4 (A) any review of any local coverage deter-
 5 mination filed on or after October 1, 2002;

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

8 (C) any local coverage determination made
 9 on or after such date.

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

17 **Subtitle C—Contracting Reform**

18 **SEC. 621. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-** 19 **TRATION.**

20 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE
 21 ADMINISTRATION.—

22 (1) IN GENERAL.—Title XVIII is amended by
 23 inserting after section 1874 the following new sec-
 24 tion:

1 “CONTRACTS WITH MEDICARE ADMINISTRATIVE
2 CONTRACTORS

3 “SEC. 1874A. (a) AUTHORITY.—

4 “(1) AUTHORITY TO ENTER INTO CON-
5 TRACTS.—The Secretary may enter into contracts
6 with any eligible entity to serve as a medicare ad-
7 ministrative contractor with respect to the perform-
8 ance of any or all of the functions described in para-
9 graph (4) or parts of those functions (or, to the ex-
10 tent provided in a contract, to secure performance
11 thereof by other entities).

12 “(2) ELIGIBILITY OF ENTITIES.—An entity is
13 eligible to enter into a contract with respect to the
14 performance of a particular function described in
15 paragraph (4) only if—

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

18 “(B) the entity complies with such conflict
19 of interest standards as are generally applicable
20 to Federal acquisition and procurement;

21 “(C) the entity has sufficient assets to fi-
22 nancially support the performance of such func-
23 tion; and

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

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

3 “(A) IN GENERAL.—The term ‘medicare
4 administrative contractor’ means an agency, or-
5 ganization, or other person with a contract
6 under this section.

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

23 “(4) FUNCTIONS DESCRIBED.—The functions
24 referred to in paragraphs (1) and (2) are payment

1 functions, provider services functions, and bene-
2 ficiary services functions as follows:

3 “(A) DETERMINATION OF PAYMENT
4 AMOUNTS.—Determining (subject to the provi-
5 sions of section 1878 and to such review by the
6 Secretary as may be provided for by the con-
7 tracts) the amount of the payments required
8 pursuant to this title to be made to providers
9 of services, physicians, practitioners, facilities,
10 suppliers, and individuals.

11 “(B) MAKING PAYMENTS.—Making pay-
12 ments described in subparagraph (A) (including
13 receipt, disbursement, and accounting for funds
14 in making such payments).

15 “(C) BENEFICIARY EDUCATION AND AS-
16 SISTANCE.—Serving as a center for, and com-
17 municating to individuals entitled to benefits
18 under part A or enrolled under part B, or both,
19 with respect to education and outreach for
20 those individuals, and assistance with specific
21 issues, concerns, or problems of those individ-
22 uals.

23 “(D) PROVIDER CONSULTATIVE SERV-
24 ICES.—Providing consultative services to insti-
25 tutions, agencies, and other persons to enable

1 them to establish and maintain fiscal records
2 necessary for purposes of this title and other-
3 wise to qualify as providers of services, physi-
4 cians, practitioners, facilities, or suppliers.

5 “(E) COMMUNICATION WITH PRO-
6 VIDERS.—Serving as a center for, and commu-
7 nicating to providers of services, physicians,
8 practitioners, facilities, and suppliers, any infor-
9 mation or instructions furnished to the medi-
10 care administrative contractor by the Secretary,
11 and serving as a channel of communication
12 from such providers, physicians, practitioners,
13 facilities, and suppliers to the Secretary.

14 “(F) PROVIDER EDUCATION AND TECH-
15 NICAL ASSISTANCE.—Performing the functions
16 described in subsections (e) and (f), relating to
17 education, training, and technical assistance to
18 providers of services, physicians, practitioners,
19 facilities, and suppliers.

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

25 “(5) RELATIONSHIP TO MIP CONTRACTS.—

1 “(A) NONDUPLICATION OF ACTIVITIES.—

2 In entering into contracts under this section,
 3 the Secretary shall assure that activities of
 4 medicare administrative contractors do not du-
 5 plicate activities carried out under contracts en-
 6 tered into under the Medicare Integrity Pro-
 7 gram under section 1893. The previous sen-
 8 tence shall not apply with respect to the activity
 9 described in section 1893(b)(5) (relating to
 10 prior authorization of certain items of durable
 11 medical equipment under section 1834(a)(15)).

12 “(B) CONSTRUCTION.—An entity shall not
 13 be treated as a medicare administrative con-
 14 tractor merely by reason of having entered into
 15 a contract with the Secretary under section
 16 1893.

17 “(6) APPLICATION OF FEDERAL ACQUISITION
 18 REGULATION.—Except to the extent inconsistent
 19 with a specific requirement of this title, the Federal
 20 Acquisition Regulation applies to contracts under
 21 this title.

22 “(b) CONTRACTING REQUIREMENTS.—

23 “(1) USE OF COMPETITIVE PROCEDURES.—

24 “(A) IN GENERAL.—Except as provided in
 25 laws with general applicability to Federal acqui-

1 sition and procurement, the Federal Acquisition
2 Regulation, or in subparagraph (B), the Sec-
3 retary shall use competitive procedures when
4 entering into contracts with medicare adminis-
5 trative contractors under this section.

6 “(B) RENEWAL OF CONTRACTS.—The Sec-
7 retary may renew a contract with a medicare
8 administrative contractor under this section
9 from term to term without regard to section 5
10 of title 41, United States Code, or any other
11 provision of law requiring competition, if the
12 medicare administrative contractor has met or
13 exceeded the performance requirements applica-
14 ble with respect to the contract and contractor,
15 except that the Secretary shall provide for the
16 application of competitive procedures under
17 such a contract not less frequently than once
18 every 6 years.

19 “(C) TRANSFER OF FUNCTIONS.—The
20 Secretary may transfer functions among medi-
21 care administrative contractors without regard
22 to any provision of law requiring competition.
23 The Secretary shall ensure that performance
24 quality is considered in such transfers. The Sec-
25 retary shall provide notice (whether in the Fed-

1 eral Register or otherwise) of any such transfer
 2 (including a description of the functions so
 3 transferred and contact information for the
 4 contractors involved) to providers of services,
 5 physicians, practitioners, facilities, and sup-
 6 pliers affected by the transfer.

7 “(D) INCENTIVES FOR QUALITY.—The
 8 Secretary may provide incentives for medicare
 9 administrative contractors to provide quality
 10 service and to promote efficiency.

11 “(2) COMPLIANCE WITH REQUIREMENTS.—No
 12 contract under this section shall be entered into with
 13 any medicare administrative contractor unless the
 14 Secretary finds that such medicare administrative
 15 contractor will perform its obligations under the con-
 16 tract efficiently and effectively and will meet such
 17 requirements as to financial responsibility, legal au-
 18 thority, and other matters as the Secretary finds
 19 pertinent.

20 “(3) PERFORMANCE REQUIREMENTS.—

21 “(A) DEVELOPMENT OF SPECIFIC PER-
 22 FORMANCE REQUIREMENTS.—The Secretary
 23 shall develop contract performance require-
 24 ments to carry out the specific requirements ap-
 25 plicable under this title to a function described

1 in subsection (a)(4) and shall develop standards
2 for measuring the extent to which a contractor
3 has met such requirements. In developing such
4 performance requirements and standards for
5 measurement, the Secretary shall consult with
6 providers of services, organizations representa-
7 tive of beneficiaries under this title, and organi-
8 zations and agencies performing functions nec-
9 essary to carry out the purposes of this section
10 with respect to such performance requirements.
11 The Secretary shall make such performance re-
12 quirements and measurement standards avail-
13 able to the public.

14 “(B) CONSIDERATIONS.—The Secretary
15 shall include, as one of the standards, provider
16 and beneficiary satisfaction levels.

17 “(C) INCLUSION IN CONTRACTS.—All con-
18 tractor performance requirements shall be set
19 forth in the contract between the Secretary and
20 the appropriate medicare administrative con-
21 tractor. Such performance requirements—

22 “(i) shall reflect the performance re-
23 quirements published under subparagraph
24 (A), but may include additional perform-
25 ance requirements;

1 “(ii) shall be used for evaluating con-
2 tractor performance under the contract;
3 and

4 “(iii) shall be consistent with the writ-
5 ten statement of work provided under the
6 contract.

7 “(4) INFORMATION REQUIREMENTS.—The Sec-
8 retary shall not enter into a contract with a medi-
9 care administrative contractor under this section un-
10 less the contractor agrees—

11 “(A) to furnish to the Secretary such time-
12 ly information and reports as the Secretary may
13 find necessary in performing his functions
14 under this title; and

15 “(B) to maintain such records and afford
16 such access thereto as the Secretary finds nec-
17 essary to assure the correctness and verification
18 of the information and reports under subpara-
19 graph (A) and otherwise to carry out the pur-
20 poses of this title.

21 “(5) SURETY BOND.—A contract with a medi-
22 care administrative contractor under this section
23 may require the medicare administrative contractor,
24 and any of its officers or employees certifying pay-
25 ments or disbursing funds pursuant to the contract,

1 or otherwise participating in carrying out the con-
2 tract, to give surety bond to the United States in
3 such amount as the Secretary may deem appro-
4 priate.

5 “(c) TERMS AND CONDITIONS.—

6 “(1) IN GENERAL.—Subject to subsection
7 (a)(6), a contract with any medicare administrative
8 contractor under this section may contain such
9 terms and conditions as the Secretary finds nec-
10 essary or appropriate and may provide for advances
11 of funds to the medicare administrative contractor
12 for the making of payments by it under subsection
13 (a)(4)(B).

14 “(2) PROHIBITION ON MANDATES FOR CERTAIN
15 DATA COLLECTION.—The Secretary may not require,
16 as a condition of entering into, or renewing, a con-
17 tract under this section, that the medicare adminis-
18 trative contractor match data obtained other than in
19 its activities under this title with data used in the
20 administration of this title for purposes of identi-
21 fying situations in which the provisions of section
22 1862(b) may apply.

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

1 “(1) CERTIFYING OFFICER.—No individual des-
2 ignated pursuant to a contract under this section as
3 a certifying officer shall, in the absence of the reck-
4 less disregard of the individual’s obligations or the
5 intent by that individual to defraud the United
6 States, be liable with respect to any payments cer-
7 tified by the individual under this section.

8 “(2) DISBURSING OFFICER.—No disbursing of-
9 ficer shall, in the absence of the reckless disregard
10 of the officer’s obligations or the intent by that offi-
11 cer to defraud the United States, be liable with re-
12 spect to any payment by such officer under this sec-
13 tion if it was based upon an authorization (which
14 meets the applicable requirements for such internal
15 controls established by the Comptroller General) of
16 a certifying officer designated as provided in para-
17 graph (1) of this subsection.

18 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE
19 CONTRACTOR.—No medicare administrative con-
20 tractor shall be liable to the United States for a pay-
21 ment by a certifying or disbursing officer unless, in
22 connection with such a payment, the medicare ad-
23 ministrative contractor acted with reckless disregard
24 of its obligations under its medicare administrative
25 contract or with intent to defraud the United States.

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

7 “(5) INDEMNIFICATION BY SECRETARY.—

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

22 “(B) CONDITIONS.—The Secretary may
23 not provide indemnification under subparagraph
24 (A) insofar as the liability for such costs arises
25 directly from conduct that is determined by the

1 Secretary to be criminal in nature, fraudulent,
2 or grossly negligent.

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

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

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

22 “(i) to change any common law immu-
23 nity that may be available to a medicare
24 administrative contractor or person de-
25 scribed in subparagraph (A); or

1 “(ii) to permit the payment of costs
2 not otherwise allowable, reasonable, or allo-
3 cable under the Federal Acquisition Regu-
4 lations.”.

5 (2) CONSIDERATION OF INCORPORATION OF
6 CURRENT LAW STANDARDS.—In developing contract
7 performance requirements under section 1874A(b)
8 of the Social Security Act (as added by paragraph
9 (1)) the Secretary shall consider inclusion of the per-
10 formance standards described in sections 1816(f)(2)
11 of such Act (relating to timely processing of recon-
12 siderations and applications for exemptions) and sec-
13 tion 1842(b)(2)(B) of such Act (relating to timely
14 review of determinations and fair hearing requests),
15 as such sections were in effect before the date of the
16 enactment of this Act.

17 (b) CONFORMING AMENDMENTS TO SECTION 1816
18 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816
19 (42 U.S.C. 1395h) is amended as follows:

20 (1) The heading is amended to read as follows:
21 “PROVISIONS RELATING TO THE ADMINISTRATION OF
22 PART A”.

23 (2) Subsection (a) is amended to read as fol-
24 lows:

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:

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

2 “PROVISIONS RELATING TO THE ADMINISTRATION OF
3 PART B”.

4 (2) Subsection (a) is amended to read as fol-
5 lows:

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

9 (3) Subsection (b) is amended—

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)—

20 (i) in the matter before subparagraph
21 (A), by striking “Each such contract shall
22 provide that the carrier” and inserting
23 “The Secretary”;

24 (ii) by striking “will” the first place it
25 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,”;

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”;

1 (E) in paragraph (5), by striking “contract
 2 under this section which provides for the dis-
 3bursement of funds, as described in subsection
 4(a)(1)(B), shall require the carrier” and “car-
 5rier responses” and inserting “contract under
 6section 1874A that provides for making pay-
 7ments under this part shall require the medi-
 8care administrative contractor” and “contractor
 9responses”, respectively; and

10 (F) by striking paragraph (6).

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

12 (6) Subsection (g) is amended by striking “car-
 13rier or carriers” and inserting “medicare administra-
 14tive contractor or contractors”.

15 (7) Subsection (h) is amended—

16 (A) in paragraph (2)—

17 (i) by striking “Each carrier having
 18an agreement with the Secretary under
 19subsection (a)” and inserting “The Sec-
 20retary”; and

21 (ii) by striking “Each such carrier”
 22and inserting “The Secretary”;

23 (B) in paragraph (3)(A)—

24 (i) by striking “a carrier having an
 25agreement 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) IN GENERAL.—Except as otherwise
 9 provided in this subsection, the amendments
 10 made by this section shall take effect on Octo-
 11 ber 1, 2004, and the Secretary is authorized to
 12 take such steps before such date as may be nec-
 13 essary to implement such amendments on a
 14 timely basis.

15 (B) CONSTRUCTION FOR CURRENT CON-
 16 TRACTS.—Such amendments shall not apply to
 17 contracts in effect before the date specified
 18 under subparagraph (A) that continue to retain
 19 the terms and conditions in effect on such date
 20 (except as otherwise provided under this title,
 21 other than under this section) until such date
 22 as the contract is let out for competitive bid-
 23 ding under such amendments.

24 (C) DEADLINE FOR COMPETITIVE BID-
 25 DING.—The Secretary shall provide for the let-

ting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2010.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO AGREEMENTS NEW AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

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

1 (3) AUTHORIZING CONTINUATION OF MIP AC-
 2 TIVITIES UNDER CURRENT CONTRACTS AND AGREE-
 3 MENTS AND UNDER TRANSITION CONTRACTS.—The
 4 provisions contained in the exception in section
 5 1893(d)(2) of the Social Security Act (42 U.S.C.
 6 1395ddd(d)(2)) shall continue to apply notwith-
 7 standing the amendments made by this section, and
 8 any reference in such provisions to an agreement or
 9 contract shall be deemed to include agreements and
 10 contracts entered into pursuant to paragraph (2)(A).

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

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

25 (g) REPORTS ON IMPLEMENTATION.—

1 (1) PROPOSAL FOR IMPLEMENTATION.—At
2 least 1 year before the date specified in subsection
3 (d)(1)(A), the Secretary shall submit a report to
4 Congress and the Comptroller General of the United
5 States that describes a plan for an appropriate tran-
6 sition. The Comptroller General shall conduct an
7 evaluation of such plan and shall submit to Con-
8 gress, not later than 6 months after the date the re-
9 port is received, a report on such evaluation and
10 shall include in such report such recommendations
11 as the Comptroller General deems appropriate.

12 (2) STATUS OF IMPLEMENTATION.—The Sec-
13 retary shall submit a report to Congress not later
14 than October 1, 2007, that describes the status of
15 implementation of such amendments and that in-
16 cludes a description of the following:

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

19 (B) The distribution of functions among
20 contracts and contractors.

21 (C) A timeline for complete transition to
22 full competition.

23 (D) A detailed description of how the Sec-
24 retary has modified oversight and management

1 of medicare contractors to adapt to full com-
2 petition.

3 **Subtitle D—Education and**
4 **Outreach Improvements**

5 **SEC. 631. PROVIDER EDUCATION AND TECHNICAL ASSIST-**
6 **ANCE.**

7 (a) COORDINATION OF EDUCATION FUNDING.—

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

11 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

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

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

22 (3) REPORT.—Not later than October 1, 2003,
23 the Secretary shall submit to Congress a report that
24 includes a description and evaluation of the steps
25 taken to coordinate the funding of provider edu-

1 cation under section 1889(a) of the Social Security
2 Act, as added by paragraph (1).

3 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-
4 FORMANCE.—

5 (1) IN GENERAL.—Section 1874A, as added by
6 section 621(a)(1), is amended by adding at the end
7 the following new subsection:

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

10 “(1) METHODOLOGY TO MEASURE CONTRACTOR
11 ERROR RATES.—In order to give medicare contrac-
12 tors (as defined in paragraph (3)) an incentive to
13 implement effective education and outreach pro-
14 grams for providers of services, physicians, practi-
15 tioners, and suppliers, the Secretary shall develop
16 and implement by October 1, 2003, a methodology
17 to measure the specific claims payment error rates
18 of such contractors in the processing or reviewing of
19 medicare claims.

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

24 “(3) MEDICARE CONTRACTOR DEFINED.—For
25 purposes of this subsection, the term ‘medicare con-

1 tractor’ includes a medicare administrative con-
 2 tractor, a fiscal intermediary with a contract under
 3 section 1816, and a carrier with a contract under
 4 section 1842.’’.

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

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

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

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

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

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

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

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

7 “(i) IN GENERAL.—In addition to the
8 amount appropriated under subparagraph
9 (B), the amount appropriated under sub-
10 paragraph (A) for a fiscal year (beginning
11 with fiscal year 2003) is increased by
12 \$35,000,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 **SEC. 632. ACCESS TO AND PROMPT RESPONSES FROM**
2 **MEDICARE CONTRACTORS.**

3 (a) IN GENERAL.—Section 1874A, as added by sec-
4 tion 621(a)(1) and as amended by section 631(b)(1), is
5 amended by adding at the end the following new sub-
6 section:

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

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

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

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

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

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

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

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

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

16 “(B) DEVELOPMENT OF STANDARDS.—

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

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

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

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

24 (b) EFFECTIVE DATE.—The amendment made by
 25 subsection (a) shall take effect October 1, 2003.

1 **SEC. 633. RELIANCE ON GUIDANCE.**

2 (a) IN GENERAL.—Section 1871(d), as added by sec-
3 tion 602(a), is amended by adding at the end the following
4 new paragraph:

5 “(2) If—

6 “(A) a provider of services, physician, practi-
7 tioner, or other supplier follows written guidance
8 provided—

9 “(i) by the Secretary; or

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

18 “(B) the Secretary determines that—

19 “(i) the provider of services, physician,
20 practitioner, or supplier has accurately pre-
21 sented the circumstances relating to such items,
22 services, and claim to the Secretary or the con-
23 tractor in the written guidance; and

24 “(ii) there is no indication of fraud or
25 abuse committed by the provider of services,

1 physician, practitioner, or supplier against the
 2 program under this title; and

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

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

18 **SEC. 634. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**
 19 **BENEFICIARY OMBUDSMAN.**

20 (a) MEDICARE PROVIDER OMBUDSMAN.—Section
 21 1868 (42 U.S.C. 1395ee) is amended—

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

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

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

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

6 (5) by adding at the end the following new sub-
7 section:

8 “(b) MEDICARE PROVIDER OMBUDSMAN.—By not
9 later than 1 year after the date of the enactment of the
10 Beneficiary Access to Care and Medicare Equity Act of
11 2002, the Secretary shall appoint a Medicare Provider
12 Ombudsman. The Ombudsman shall—

13 “(1) provide assistance, on a confidential basis,
14 to providers of services and suppliers with respect to
15 complaints, grievances, and requests for information
16 concerning the programs under this title (including
17 provisions of title XI insofar as they relate to this
18 title and are not administered by the Office of the
19 Inspector General of the Department of Health and
20 Human Services) and in the resolution of unclear or
21 conflicting guidance given by the Secretary and
22 medicare contractors to such providers of services
23 and suppliers regarding such programs and provi-
24 sions and requirements under this title and such
25 provisions; and

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

4 “(A) recommendations to respond to recur-
5 ring patterns of confusion in this title and such
6 provisions (including recommendations regard-
7 ing suspending imposition of sanctions where
8 there is widespread confusion in program ad-
9 ministration), and

10 “(B) recommendations to provide for an
11 appropriate and consistent response (including
12 not providing for audits) in cases of self-identi-
13 fied overpayments by providers of services and
14 suppliers.”.

15 (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title
16 XVIII is amended by inserting after section 1806 the fol-
17 lowing new section:

18 “MEDICARE BENEFICIARY OMBUDSMAN

19 “SEC. 1807. (a) IN GENERAL.—By not later than 1
20 year after the date of the enactment of the Beneficiary
21 Access to Care and Medicare Equity Act of 2002, the Sec-
22 retary shall appoint within the Department of Health and
23 Human Services a Medicare Beneficiary Ombudsman who
24 shall have expertise and experience in the fields of health
25 care and advocacy.

1 “(b) DUTIES.—The Medicare Beneficiary Ombuds-
2 man shall—

3 “(1) receive complaints, grievances, and re-
4 quests for information submitted by a medicare ben-
5 eficiary, with respect to any aspect of the medicare
6 program;

7 “(2) provide assistance with respect to com-
8 plaints, grievances, and requests referred to in para-
9 graph (1), including—

10 “(A) assistance in collecting relevant infor-
11 mation for such beneficiaries, to seek an appeal
12 of a decision or determination made by a fiscal
13 intermediary, carrier, Medicare+Choice organi-
14 zation, or the Secretary; and

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

18 “(3) submit annual reports to Congress and the
19 Secretary that describe the activities of the Office
20 and that include such recommendations for improve-
21 ment in the administration of this title as the Om-
22 budsman determines appropriate.”.

23 “(c) FUNDING.—There are authorized to be appro-
24 priated to the Secretary (in appropriate part from the
25 Federal Hospital Insurance Trust Fund and the Federal

1 Supplementary Medical Insurance Trust Fund) to carry
 2 out the provisions of subsection (b) of section 1868 of the
 3 Social Security Act (relating to the Medicare Provider
 4 Ombudsman), as added by subsection (a)(5) and section
 5 1807 of such Act (relating to the Medicare Beneficiary
 6 Ombudsman), as added by subsection (b), such sums as
 7 are necessary for fiscal year 2002 and each succeeding fis-
 8 cal year.

9 (d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-
 10 MEDICARE).—Section 1804(b) (42 U.S.C. 1395b-2(b))
 11 is amended by adding at the end the following: “By not
 12 later than 1 year after the date of the enactment of the
 13 Beneficiary Access to Care and Medicare Equity Act of
 14 2002, the Secretary shall provide, through the toll-free
 15 number 1-800-MEDICARE, for a means by which indi-
 16 viduals seeking information about, or assistance with, such
 17 programs who phone such toll-free number are transferred
 18 (without charge) to appropriate entities for the provision
 19 of such information or assistance. Such toll-free number
 20 shall be the toll-free number listed for general information
 21 and assistance in the annual notice under subsection (a)
 22 instead of the listing of numbers of individual contrac-
 23 tors.”.

1 **SEC. 635. BENEFICIARY OUTREACH DEMONSTRATION PRO-**
2 **GRAM.**

3 (a) IN GENERAL.—The Secretary shall establish a
4 demonstration program (in this section referred to as the
5 “demonstration program”) under which medicare special-
6 ists employed by the Department of Health and Human
7 Services provide advice and assistance to medicare bene-
8 ficiaries at the location of existing local offices of the So-
9 cial Security Administration.

10 (b) LOCATIONS.—

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

17 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—
18 The Secretary shall provide for the selection of at
19 least 2 rural areas to participate in the demonstra-
20 tion program. In conducting the demonstration pro-
21 gram in such rural areas, the Secretary shall provide
22 for medicare specialists to travel among local offices
23 in a rural area on a scheduled basis.

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

26 (d) EVALUATION AND REPORT.—

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

4 (A) utilization of, and beneficiary satisfac-
 5 tion with, the assistance provided under the
 6 program; and

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

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

15 **Subtitle E—Review, Recovery, and** 16 **Enforcement Reform**

17 **SEC. 641. PREPAYMENT REVIEW.**

18 (a) IN GENERAL.—Section 1874A, as added by sec-
 19 tion 621(a)(1) and as amended by sections 631(b)(1) and
 20 632(a), is amended by adding at the end the following new
 21 subsection:

22 “(g) CONDUCT OF PREPAYMENT REVIEW.—

23 “(1) STANDARDIZATION OF RANDOM PREPAY-
 24 MENT REVIEW.—A medicare administrative con-
 25 tractor shall conduct random prepayment review

1 only in accordance with a standard protocol for ran-
2 dom prepayment audits developed by the Secretary.

3 “(2) LIMITATIONS ON INITIATION OF NON-
4 RANDOM PREPAYMENT REVIEW.—A medicare admin-
5 istrative contractor may not initiate nonrandom pre-
6 payment review of a provider of services, physician,
7 practitioner, or supplier based on the initial identi-
8 fication by that provider of services, physician, prac-
9 titioner, or supplier of an improper billing practice
10 unless there is a likelihood of sustained or high level
11 of payment error (as defined by the Secretary).

12 “(3) TERMINATION OF NONRANDOM PREPAY-
13 MENT REVIEW.—The Secretary shall establish proto-
14 cols or standards relating to the termination, includ-
15 ing termination dates, of nonrandom prepayment re-
16 view. Such regulations may vary such a termination
17 date based upon the differences in the circumstances
18 triggering prepayment review.

19 “(4) CONSTRUCTION.—Nothing in this sub-
20 section shall be construed as preventing the denial of
21 payments for claims actually reviewed under a ran-
22 dom prepayment review. In the case of a provider of
23 services, physician, practitioner, or supplier with re-
24 spect to which amounts were previously overpaid,
25 nothing in this subsection shall be construed as lim-

1 iting the ability of a medicare administrative con-
 2 tractor to request the periodic production of records
 3 or supporting documentation for a limited sample of
 4 submitted claims to ensure that the previous prac-
 5 tice is not continuing.

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

11 (b) EFFECTIVE DATE.—

12 (1) IN GENERAL.—Except as provided in this
 13 subsection, the amendment made by subsection (a)
 14 shall take effect on the date of the enactment of this
 15 Act.

16 (2) DEADLINE FOR PROMULGATION OF CER-
 17 TAIN REGULATIONS.—The Secretary shall first issue
 18 regulations under section 1874A(g) of the Social Se-
 19 curity Act, as added by subsection (a), by not later
 20 than 1 year after the date of the enactment of this
 21 Act.

22 (3) APPLICATION OF STANDARD PROTOCOLS
 23 FOR RANDOM PREPAYMENT REVIEW.—Section
 24 1874A(g)(1) of the Social Security Act, as added by
 25 subsection (a), shall apply to random prepayment re-

1 views conducted on or after such date (not later
 2 than 1 year after the date of the enactment of this
 3 Act) as the Secretary shall specify. The Secretary
 4 shall develop and publish the standard protocol
 5 under such section by not later than 1 year after the
 6 date of the enactment of this Act.

7 **SEC. 642. RECOVERY OF OVERPAYMENTS.**

8 (a) IN GENERAL.—Section 1874A, as added by sec-
 9 tion 621(a)(1) and as amended by sections 631(b)(1),
 10 632(a), and 641(a), is amended by adding at the end the
 11 following new subsection:

12 “(h) RECOVERY OF OVERPAYMENTS.—

13 “(1) USE OF REPAYMENT PLANS.—

14 “(A) IN GENERAL.—If the repayment,
 15 within the period otherwise permitted by a pro-
 16 vider of services, physician, practitioner, or
 17 other supplier, of an overpayment under this
 18 title meets the standards developed under sub-
 19 paragraph (B), subject to subparagraph (C),
 20 and the provider, physician, practitioner, or
 21 supplier requests the Secretary to enter into a
 22 repayment plan with respect to such overpay-
 23 ment, the Secretary shall enter into a plan with
 24 the provider, physician, practitioner, or supplier
 25 for the offset or repayment (at the election of

1 the provider, physician, practitioner, or sup-
2 plier) of such overpayment over a period of at
3 least 1 year, but not longer than 3 years. Inter-
4 est shall accrue on the balance through the pe-
5 riod of repayment. The repayment plan shall
6 meet terms and conditions determined to be ap-
7 propriate by the Secretary.

8 “(B) DEVELOPMENT OF STANDARDS.—
9 The Secretary shall develop standards for the
10 recovery of overpayments. Such standards
11 shall—

12 “(i) include a requirement that the
13 Secretary take into account (and weigh in
14 favor of the use of a repayment plan) the
15 reliance (as described in section
16 1871(d)(2)) by a provider of services, phy-
17 sician, practitioner, and supplier on guid-
18 ance when determining whether a repay-
19 ment plan should be offered; and

20 “(ii) provide for consideration of the
21 financial hardship imposed on a provider of
22 services, physician, practitioner, or supplier
23 in considering such a repayment plan.

24 In developing standards with regard to financial
25 hardship with respect to a provider of services,

1 physician, practitioner, or supplier, the Sec-
2 retary shall take into account the amount of the
3 proposed recovery as a proportion of payments
4 made to that provider, physician, practitioner,
5 or supplier.

6 “(C) EXCEPTIONS.—Subparagraph (A)
7 shall not apply if—

8 “(i) the Secretary has reason to sus-
9 pect that the provider of services, physi-
10 cian, practitioner, or supplier may file for
11 bankruptcy or otherwise cease to do busi-
12 ness or discontinue participation in the
13 program under this title; or

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

16 “(D) IMMEDIATE COLLECTION IF VIOLA-
17 TION OF REPAYMENT PLAN.—If a provider of
18 services, physician, practitioner, or supplier fails
19 to make a payment in accordance with a repay-
20 ment plan under this paragraph, the Secretary
21 may immediately seek to offset or otherwise re-
22 cover the total balance outstanding (including
23 applicable interest) under the repayment plan.

24 “(E) RELATION TO NO FAULT PROVI-
25 SION.—Nothing in this paragraph shall be con-

1 strued as affecting the application of section
2 1870(c) (relating to no adjustment in the cases
3 of certain overpayments).

4 “(2) LIMITATION ON RECOUPMENT.—

5 “(A) NO RECOUPMENT UNTIL RECONSID-
6 ERATION EXERCISED.—In the case of a pro-
7 vider of services, physician, practitioner, or sup-
8 plier that is determined to have received an
9 overpayment under this title and that seeks a
10 reconsideration of such determination by a
11 qualified independent contractor under section
12 1869(c), the Secretary may not take any action
13 (or authorize any other person, including any
14 medicare contractor, as defined in subpara-
15 graph (C)) to recoup the overpayment until the
16 date the decision on the reconsideration has
17 been rendered.

18 “(B) PAYMENT OF INTEREST.—

19 “(i) RETURN OF RECOUPED AMOUNT
20 WITH INTEREST IN CASE OF REVERSAL.—

21 Insofar as such determination on appeal
22 against the provider of services, physician,
23 practitioner, or supplier is later reversed,
24 the Secretary shall provide for repayment
25 of the amount recouped plus interest for

1 the period in which the amount was re-
2 couped.

3 “(ii) INTEREST IN CASE OF AFFIRMA-
4 TION.—Insofar as the determination on
5 such appeal is against the provider of serv-
6 ices, physician, practitioner, or supplier, in-
7 terest on the overpayment shall accrue on
8 and after the date of the original notice of
9 overpayment.

10 “(iii) RATE OF INTEREST.—The rate
11 of interest under this subparagraph shall
12 be the rate otherwise applicable under this
13 title in the case of overpayments.

14 “(C) MEDICARE CONTRACTOR DEFINED.—
15 For purposes of this subsection, the term ‘medi-
16 care contractor’ has the meaning given such
17 term in section 1889(e).

18 “(3) PAYMENT AUDITS.—

19 “(A) WRITTEN NOTICE FOR POST-PAY-
20 MENT AUDITS.—Subject to subparagraph (C), if
21 a medicare contractor decides to conduct a
22 post-payment audit of a provider of services,
23 physician, practitioner, or supplier under this
24 title, the contractor shall provide the provider of
25 services, physician, practitioner, or supplier

1 with written notice (which may be in electronic
2 form) of the intent to conduct such an audit.

3 “(B) EXPLANATION OF FINDINGS FOR ALL
4 AUDITS.—Subject to subparagraph (C), if a
5 medicare contractor audits a provider of serv-
6 ices, physician, practitioner, or supplier under
7 this title, the contractor shall—

8 “(i) give the provider of services, phy-
9 sician, practitioner, or supplier a full re-
10 view and explanation of the findings of the
11 audit in a manner that is understandable
12 to the provider of services, physician, prac-
13 titioner, or supplier and permits the devel-
14 opment of an appropriate corrective action
15 plan;

16 “(ii) inform the provider of services,
17 physician, practitioner, or supplier of the
18 appeal rights under this title as well as
19 consent settlement options (which are at
20 the discretion of the Secretary); and

21 “(iii) give the provider of services,
22 physician, practitioner, or supplier an op-
23 portunity to provide additional information
24 to the contractor.

1 “(C) EXCEPTION.—Subparagraphs (A)
 2 and (B) shall not apply if the provision of no-
 3 tice or findings would compromise pending law
 4 enforcement activities, whether civil or criminal,
 5 or reveal findings of law enforcement-related
 6 audits.

7 “(4) NOTICE OF OVER-UTILIZATION OF
 8 CODES.—The Secretary shall establish, in consulta-
 9 tion with organizations representing the classes of
 10 providers of services, physicians, practitioners, and
 11 suppliers, a process under which the Secretary pro-
 12 vides for notice to classes of providers of services,
 13 physicians, practitioners, and suppliers served by a
 14 medicare contractor in cases in which the contractor
 15 has identified that particular billing codes may be
 16 overutilized by that class of providers of services,
 17 physicians, practitioners, or suppliers under the pro-
 18 grams under this title (or provisions of title XI inso-
 19 far as they relate to such programs).

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

25 “(6) CONSENT SETTLEMENT REFORMS.—

1 “(A) IN GENERAL.—The Secretary may
2 use a consent settlement (as defined in sub-
3 paragraph (D)) to settle a projected overpay-
4 ment.

5 “(B) OPPORTUNITY TO SUBMIT ADDI-
6 TIONAL INFORMATION BEFORE CONSENT SET-
7 TLEMENT OFFER.—Before offering a provider
8 of services, physician, practitioner, or supplier a
9 consent settlement, the Secretary shall—

10 “(i) communicate to the provider of
11 services, physician, practitioner, or supplier
12 in a nonthreatening manner that, based on
13 a review of the medical records requested
14 by the Secretary, a preliminary evaluation
15 of those records indicates that there would
16 be an overpayment; and

17 “(ii) provide for a 45-day period dur-
18 ing which the provider of services, physi-
19 cian, practitioner, or supplier may furnish
20 additional information concerning the med-
21 ical records for the claims that had been
22 reviewed.

23 “(C) CONSENT SETTLEMENT OFFER.—The
24 Secretary shall review any additional informa-
25 tion furnished by the provider of services, physi-

1 cian, practitioner, or supplier under subpara-
2 graph (B)(ii). Taking into consideration such
3 information, the Secretary shall determine if
4 there still appears to be an overpayment. If so,
5 the Secretary—

6 “(i) shall provide notice of such deter-
7 mination to the provider of services, physi-
8 cian, practitioner, or supplier, including an
9 explanation of the reason for such deter-
10 mination; and

11 “(ii) in order to resolve the overpay-
12 ment, may offer the provider of services,
13 physician, practitioner, or supplier—

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

16 “(II) a consent settlement.

17 The opportunity provided under clause (ii)(I)
18 does not waive any appeal rights with respect to
19 the alleged overpayment involved.

20 “(D) CONSENT SETTLEMENT DEFINED.—

21 For purposes of this paragraph, the term ‘con-
22 sent settlement’ means an agreement between
23 the Secretary and a provider of services, physi-
24 cian, practitioner, or supplier whereby both par-
25 ties agree to settle a projected overpayment

1 based on less than a statistically valid sample of
2 claims and the provider of services, physician,
3 practitioner, or supplier agrees not to appeal
4 the claims involved.”.

5 (b) EFFECTIVE DATES AND DEADLINES.—

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

8 (A) develop standards for the recovery of
9 overpayments under section 1874A(h)(1)(B) of
10 the Social Security Act, as added by subsection
11 (a);

12 (B) establish the process for notice of over-
13 utilization of billing codes under section
14 1874A(h)(4) of the Social Security Act, as
15 added by subsection (a); and

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

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

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

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

8 **SEC. 643. PROCESS FOR CORRECTION OF MINOR ERRORS**
9 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**
10 **SUING APPEALS PROCESS.**

11 (a) IN GENERAL.—The Secretary shall develop, in
12 consultation with appropriate medicare contractors (as de-
13 fined in section 1889(e) of the Social Security Act, as
14 added by section 631(d)(1)) and representatives of pro-
15 viders of services, physicians, practitioners, facilities, and
16 suppliers, a process whereby, in the case of minor errors
17 or omissions (as defined by the Secretary) that are de-
18 tected in the submission of claims under the programs
19 under title XVIII of such Act, a provider of services, phy-
20 sician, practitioner, facility, or supplier is given an oppor-
21 tunity to correct such an error or omission without the
22 need to initiate an appeal. Such process shall include the
23 ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 644. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: “Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.”.

TITLE VII—MEDICAID AND SCHIP

SEC. 701. MEDICAID DSH ALLOTMENTS.

(a) CONTINUATION OF BIPA RULE FOR DETERMINATION OF ALLOTMENTS FOR FISCAL YEARS 2003 THROUGH 2005.—

(1) IN GENERAL.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)) is amended—

1 (A) in the paragraph heading, by striking
2 “AND 2002” and inserting “THROUGH 2005”;

3 (B) in subparagraph (A)—

4 (i) in clause (i), by striking “and” at
5 the end;

6 (ii) in clause (ii), by striking the pe-
7 riod and inserting a semicolon; and

8 (iii) by adding at the end the fol-
9 lowing:

10 “(iii) fiscal year 2003, shall be the
11 DSH allotment determined under clause
12 (ii) increased, subject to subparagraph (B)
13 and paragraph (5), by the percentage
14 change in the Consumer Price Index for all
15 urban consumers (all items; U.S. city aver-
16 age) for fiscal year 2002;

17 “(iv) fiscal year 2004, shall be the
18 DSH allotment determined under clause
19 (iii) increased, subject to subparagraph (B)
20 and paragraph (5), by the percentage
21 change in the Consumer Price Index for all
22 urban consumers (all items; U.S. city aver-
23 age) for fiscal year 2003; and

24 “(v) fiscal year 2005, shall be the
25 DSH allotment determined under clause

(iv) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for fiscal year 2004.”; and

(C) in subparagraph (C)—

(i) in the subparagraph heading, by striking “2002” and inserting “2005”; and

(ii) by striking “2003” and inserting “2006”.

(2) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)), as amended by paragraph (1), is amended—

(A) in subparagraph (A), by inserting “and except as provided in subparagraph (C)” after “paragraph (2)”;

(B) by redesignating subparagraph (C) as subparagraph (D);

(C) in subparagraph (D) (as so redesignated), by inserting “or (C)” after “(A)”;

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

“(C) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Notwithstanding subparagraph

1 (A), the DSH allotment for the District of Co-
2 lumbia for—

3 “(i) fiscal year 2003, shall be deter-
4 mined by substituting “49” for “32” in
5 the item in the table contained in para-
6 graph (2) with respect to the DSH allot-
7 ment for FY 00 (fiscal year 2000) for the
8 District of Columbia, and then increasing
9 such allotment, subject to subparagraph
10 (B) and paragraph (5), by the percentage
11 change in the Consumer Price Index for all
12 urban consumers (all items; U.S. city aver-
13 age) for each of fiscal years 2000, 2001,
14 and 2002;

15 “(ii) fiscal year 2004, shall be the
16 DSH allotment determined under clause
17 (i) increased, subject to subparagraph (B)
18 and paragraph (5), by the percentage
19 change in the Consumer Price Index for all
20 urban consumers (all items; U.S. city aver-
21 age) for fiscal year 2003; and

22 “(iii) fiscal year 2005, shall be the
23 DSH allotment determined under clause
24 (ii) increased, subject to subparagraph (B)
25 and paragraph (5), by the percentage

1 change in the Consumer Price Index for all
2 urban consumers (all items; U.S. city aver-
3 age) for fiscal year 2004.”.

4 (3) CONFORMING AMENDMENTS.—Section
5 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

6 (A) in the paragraph heading, by striking
7 “2003” and inserting “2006”; and

8 (B) by striking subparagraph (A) and in-
9 serting the following:

10 “(A) IN GENERAL.—The DSH allotment
11 for any State—

12 “(i) for fiscal year 2006, is equal to
13 the DSH allotment determined for the
14 State for fiscal year 2002 under the table
15 set forth in paragraph (2), increased, sub-
16 ject to subparagraph (B) and paragraph
17 (5), by the percentage change in the Con-
18 sumer Price Index for all urban consumers
19 (all items; U.S. city average), for each of
20 fiscal years 2002 through 2005; and

21 “(ii) for fiscal year 2007 and each
22 succeeding fiscal year, is equal to the DSH
23 allotment determined for the State for the
24 preceding fiscal year under this paragraph,
25 increased, subject to subparagraph (B) and

1 paragraph (5), by the percentage change in
 2 the Consumer Price Index for all urban
 3 consumers (all items; U.S. city average),
 4 for the previous fiscal year.”.

5 (4) EFFECTIVE DATE.—The amendments made
 6 by this subsection shall take effect as if included in
 7 the enactment of section 701 of BIPA (114 Stat.
 8 2763A–569).

9 (b) CONTINGENT ALLOTMENT.—

10 (1) IN GENERAL.—Section 1923(f) (42 U.S.C.
 11 1396r–4(f)) is amended—

12 (A) by redesignating paragraph (6) as
 13 paragraph (7); and

14 (B) by inserting after paragraph (5) the
 15 following:

16 “(6) CONTINGENT ALLOTMENT ADJUSTMENT
 17 FOR CERTAIN STATES.—In the case of a State that,
 18 as of the date of enactment of this subsection, has
 19 a DSH allotment equal to 0, and that has a State-
 20 wide waiver approved under section 1115 with re-
 21 spect to the requirements of this title (as in effect
 22 on such date of enactment) that is revoked or termi-
 23 nated after such date of enactment, the Secretary
 24 shall—

1 “(A) permit the State for which the waiver
 2 was revoked or terminated to submit an amend-
 3 ment to its State plan that would describe the
 4 methodology to be used by the State (after the
 5 effective date of such revocation or termination)
 6 to identify and make payments to dispropor-
 7 tionate share hospitals on the basis of their pro-
 8 portion of patients served by such hospitals that
 9 are low-income patients with special needs; and

10 “(B) provide for purposes of this sub-
 11 section for computation of an appropriate DSH
 12 allotment for the State that provides for the
 13 maximum amount (permitted consistent with
 14 paragraph (3)(B)(ii)) that does not result in
 15 greater expenditures under this title than would
 16 have been made if such waiver had not been re-
 17 voked or terminated.”.

18 (2) EFFECTIVE DATE.—The amendment made
 19 by this subsection shall take effect as if enacted on
 20 October 1, 2002.

21 **SEC. 702. TEMPORARY INCREASE IN FLOOR FOR TREAT-**
 22 **MENT AS AN EXTREMELY LOW DSH STATE.**

23 (a) TEMPORARY INCREASE.—Section 1923(f)(5) (42
 24 U.S.C. 1396r-4(f)(5)) is amended—

1 (1) by striking “In the case of” and inserting
2 the following:

3 “(A) IN GENERAL.—In the case of”; and

4 (2) by adding at the end the following:

5 “(B) TEMPORARY INCREASE IN FLOOR.—

6 During the period that begins on October 1,
7 2002, and ends on September 30, 2005, sub-
8 paragraph (A) shall be applied—

9 “(i) by substituting ‘fiscal year 2003’
10 for ‘fiscal year 2001’;

11 “(ii) by substituting ‘Centers for
12 Medicare & Medicaid Services’ for ‘Health
13 Care Financing Administration’;

14 “(iii) by substituting ‘August 31,
15 2002’ for ‘August 31, 2000’;

16 “(iv) by substituting ‘3 percent’ for ‘1
17 percent’ each place it appears;

18 “(v) by substituting ‘fiscal year 2001’
19 for ‘fiscal year 1999’; and

20 “(vi) by substituting for the second
21 sentence the following: “With respect to
22 each of fiscal years 2004 and 2005, such
23 increased allotment is subject to an in-
24 crease for inflation as provided in para-
25 graph (4).”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall take effect as if included in the enact-
 3 ment of section 701 of BIPA (114 Stat. 2763A–569).

4 **SEC. 703. EXTENSION OF MEDICARE COST-SHARING FOR**
 5 **PART B PREMIUM FOR CERTAIN ADDITIONAL**
 6 **LOW-INCOME MEDICARE BENEFICIARIES.**

7 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42
 8 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as fol-
 9 lows:

10 “(iv) subject to sections 1933 and
 11 1905(p)(4), for making medical assistance
 12 available (but only for premiums payable with
 13 respect to months during the period beginning
 14 with January 1998, and ending with December
 15 2007) for medicare cost-sharing described in
 16 section 1905(p)(3)(A)(ii) for individuals who
 17 would be qualified medicare beneficiaries de-
 18 scribed in section 1905(p)(1) but for the fact
 19 that their income exceeds the income level es-
 20 tablished by the State under section 1905(p)(2)
 21 and is at least 120 percent, but less than 135
 22 percent, of the official poverty line (referred to
 23 in such section) for a family of the size involved
 24 and who are not otherwise eligible for medical
 25 assistance under the State plan;”.

1 (b) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—

2 Section 1933(c) (42 U.S.C. 1396u–3(c)) is amended—

3 (1) in paragraph (1)(E), by striking “fiscal year
4 2002” and inserting “each of fiscal years 2002
5 through 2007”; and

6 (2) in paragraph (2)(A), by striking “the sum
7 of” and all that follows through
8 “1902(a)(10)(E)(iv)(II) in the State; to” and insert-
9 ing “twice the total number of individuals described
10 in section 1902(a)(10)(E)(iv) in the State; to”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall take effect as if enacted on October 1,
13 2002.

14 **SEC. 704. CLARIFICATION OF INCLUSION OF INPATIENT**
15 **DRUG PRICES CHARGED TO CERTAIN PUBLIC**
16 **HOSPITALS IN THE BEST PRICE EXEMPTIONS**
17 **FOR THE MEDICAID DRUG REBATE PRO-**
18 **GRAM.**

19 (a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42
20 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting
21 before the semicolon the following: “(including inpatient
22 prices charged to hospitals described in section
23 340B(a)(4)(L) of the Public Health Service Act)”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 subsection (a) shall take effect as if enacted on October
 3 1, 2002.

4 **SEC. 705. SCHIP ALLOTMENTS.**

5 (a) CHANGES TO RULES FOR REDISTRIBUTION AND
 6 EXTENDED AVAILABILITY OF FISCAL YEAR 2000 AND
 7 SUBSEQUENT FISCAL YEAR ALLOTMENTS.—Section
 8 2104(g) (42 U.S.C. 1397dd(g)) is amended—

9 (1) in the subsection heading—

10 (A) by striking “AND” after “1998” and
 11 inserting a comma; and

12 (B) by inserting “, 2000, AND SUBSE-
 13 QUENT FISCAL YEAR” after “1999”;

14 (2) in paragraph (1)—

15 (A) in subparagraph (A)—

16 (i) in the matter preceding clause

17 (i)—

18 (I) by inserting “or for fiscal
 19 year 2000 by the end of fiscal year
 20 2002, or allotments for fiscal year
 21 2001 and subsequent fiscal years by
 22 the end of the last fiscal year for
 23 which such allotments are available
 24 under subsection (e), subject to para-
 25 graph (2)(C),” after “2001,”; and

1 (II) by striking “1998 or 1999”
2 and inserting “1998, 1999, 2000, or
3 subsequent fiscal year”;

4 (ii) in clause (i)—

5 (I) in subclause (I), by striking
6 “or” at the end;

7 (II) in subclause (II), by striking
8 the period and inserting a semicolon;
9 and

10 (III) by adding at the end the
11 following:

12 “(III) subject to paragraph
13 (2)(C), the fiscal year 2000 allotment,
14 the amount by which the State’s ex-
15 penditures under this title in fiscal
16 years 2000, 2001, and 2002 exceed
17 the State’s allotment for fiscal year
18 2000 under subsection (b);

19 “(IV) subject to paragraph
20 (2)(C), the fiscal year 2001 allotment,
21 the amount by which the State’s ex-
22 penditures under this title in fiscal
23 years 2001, 2002, and 2003 exceed
24 the State’s allotment for fiscal year
25 2001 under subsection (b); or

- 1 “(V) subject to paragraph (2)(C),
- 2 the allotment for any subsequent fis-
- 3 cal year, the amount by which the
- 4 State’s expenditures under this title in
- 5 the period such allotment is available
- 6 under subsection (e) exceeds the
- 7 State’s allotment for that fiscal year
- 8 under subsection (b).”; and
- 9 (iii) in clause (ii), by striking “1998
- 10 or 1999 allotment” and inserting “1998,
- 11 1999, 2000, or subsequent fiscal year al-
- 12 lotment”; and
- 13 (B) in subparagraph (B)—
- 14 (i) in the matter preceding clause (i),
- 15 by striking “with respect to fiscal year
- 16 1998 or 1999”;
- 17 (ii) in clause (ii)—
- 18 (I) by inserting “with respect to
- 19 fiscal year 1998 or 1999,” after “sub-
- 20 section (e),”; and
- 21 (II) by striking “2002; and” and
- 22 inserting “2003;”;
- 23 (iii) by redesignating clause (iii) as
- 24 clause (iv); and

1 (iv) by inserting after clause (ii), the
 2 following:

3 “(iii) notwithstanding subsection (e),
 4 with respect to fiscal year 2000 or any
 5 subsequent fiscal year, shall remain avail-
 6 able for expenditure by the State through
 7 the end of the fiscal year in which the
 8 State is allotted a redistribution under this
 9 paragraph; and”;

10 (3) in paragraph (2)—

11 (A) in the paragraph heading, by striking
 12 “1998 AND 1999” and inserting “1998, 1999, 2000,
 13 AND SUBSEQUENT FISCAL YEAR”;

14 (B) in subparagraph (A)—

15 (i) in clause (i), by striking “2002”
 16 and inserting “2003”;

17 (ii) in clause (ii), by striking “2002”
 18 and inserting “2003”; and

19 (iii) by adding at the end the fol-
 20 lowing:

21 “(iii) FISCAL YEAR 2000 ALLOT-
 22 MENT.—Of the amounts allotted to a State
 23 pursuant to this section for fiscal year
 24 2000 that were not expended by the State
 25 by the end of fiscal year 2002, the amount

1 specified in subparagraph (B) for fiscal
2 year 2000 for such State shall remain
3 available for expenditure by the State
4 through the end of fiscal year 2003.

5 “(iv) FISCAL YEAR 2001 ALLOT-
6 MENT.—Of the amounts allotted to a State
7 pursuant to this section for fiscal year
8 2001 that were not expended by the State
9 by the end of fiscal year 2003, the amount
10 specified in subparagraph (B) for fiscal
11 year 2001 for such State shall remain
12 available for expenditure by the State
13 through the end of fiscal year 2004.

14 “(v) SUBSEQUENT FISCAL YEAR AL-
15 LOTMENTS.—Of the amounts allotted to a
16 State pursuant to this section for any fis-
17 cal year after 2001, that were not ex-
18 pended by the State by the end of the last
19 fiscal year such amounts are available
20 under subsection (e), the amount specified
21 in subparagraph (B) for that fiscal year
22 for such State shall remain available for
23 expenditure by the State through the end
24 of the fiscal year following the last fiscal

1 year such amounts are available under
2 subsection (e).”;

3 (C) in subparagraph (B), by striking
4 “The” and inserting “Subject to subparagraph
5 (C), the”;

6 (D) by redesignating subparagraph (C) as
7 subparagraph (D); and

8 (E) by inserting after subparagraph (B),
9 the following:

10 “(C) FLOOR FOR ALLOTMENT FOR FISCAL
11 YEAR 2000 OR ANY SUBSEQUENT FISCAL
12 YEAR.—

13 “(i) IN GENERAL.—With respect to
14 the allotments for each of fiscal years 2000
15 through 2003, if the total amounts that
16 would otherwise be redistributed under
17 paragraph (1) exceed 60 percent of the
18 total amount available for redistribution
19 under subsection (f) for the fiscal year, the
20 amount remaining available for expendi-
21 ture by the State under subparagraph (A)
22 for such fiscal years shall be—

23 “(I) the amount equal to—

24 “(aa) the applicable percent
25 (as determined under clause (ii))

1 of the total amount available for
 2 redistribution under subsection
 3 (f) from the allotments for the
 4 applicable fiscal year; multiplied
 5 by

6 “(II) the ratio of the amount of
 7 such State’s unexpended allotment for
 8 that fiscal year to the total amount
 9 available for redistribution under sub-
 10 section (f) from the allotments for the
 11 fiscal year.

12 “(ii) APPLICABLE PERCENT.—For
 13 purposes of clause (i)(I)(aa), the applicable
 14 percent is—

15 “(I) 40 percent, with respect to
 16 the allotments for each of fiscal years
 17 2000 and 2001;

18 “(II) 30 percent, with respect to
 19 the allotment for fiscal year 2002; and

20 “(III) 20 percent, with respect to
 21 the allotment for fiscal year 2003.”;

22 and

23 (4) in paragraph (3), by adding at the end the
 24 following: “For purposes of calculating the amounts
 25 described in paragraphs (1) and (2) relating to the

1 allotment for any fiscal year after 1999, the Sec-
 2 retary shall use the amount reported by the States
 3 not later than November 30 of the applicable cal-
 4 endar year on HCFA Form 64 or HCFA Form 21,
 5 as approved by the Secretary.”.

6 (b) ESTABLISHMENT OF CASELOAD STABILIZATION
 7 POOL AND ADDITIONAL REDISTRIBUTION OF ALLOT-
 8 MENTS.—Section 2104 (42 U.S.C. 1397dd) is amended by
 9 adding at the end the following:

10 “(h) REDISTRIBUTION OF CASELOAD STABILIZATION
 11 POOL AMOUNTS.—

12 “(1) ADDITIONAL REDISTRIBUTION TO STA-
 13 BILIZE CASELOADS.—

14 “(A) IN GENERAL.—With respect to fiscal
 15 year 2004 and each fiscal year thereafter, the
 16 Secretary shall redistribute to an eligible State
 17 (as defined in subparagraph (B)) the amount
 18 available for redistribution to the State (as de-
 19 termined under subparagraph (C)) from the
 20 caseload stabilization pool established under
 21 paragraph (3).

22 “(B) DEFINITION OF ELIGIBLE STATE.—
 23 For purposes of subparagraph (A), an eligible
 24 State is a State whose total expenditures under
 25 this title through the end of the previous fiscal

year exceed the total allotments made available to the State under subsection (b) or (c) (not including amounts made available under subsection (f)) through the previous fiscal year.

“(C) AMOUNT OF ADDITIONAL REDISTRIBUTION.—For purposes of subparagraph (A), the amount available for redistribution to a State under subparagraph (A) is equal to—

“(i) the ratio of the State’s allotment for the previous fiscal year under subsection (b) or (c) to the total allotments made available under such subsections to eligible States as defined under subparagraph (A) for the previous fiscal year; multiplied by

“(ii) the total amounts available in the caseload stabilization pool established under paragraph (3).

“(2) PERIOD OF AVAILABILITY.—Amounts redistributed under this subsection shall remain available for expenditure by the State through the end of the fiscal year in which the State receives any such amounts.

“(3) CASELOAD STABILIZATION POOL.—For purposes of making a redistribution under para-

1 graph (1), the Secretary shall establish a caseload
 2 stabilization pool that includes the following
 3 amounts:

4 “(A) Any amount made available to a
 5 State under subsection (g) but not expended
 6 within the periods required under paragraph
 7 (1)(B)(ii), (1)(B)(iii), or (2)(A) of that sub-
 8 section.

9 “(B) Any amount made available to a
 10 State under this subsection but not expended
 11 within the period required under paragraph
 12 (2).”.

13 (c) AUTHORITY FOR QUALIFYING STATES TO USE
 14 PORTION OF SCHIP FUNDS FOR MEDICAID EXPENDI-
 15 TURES.—Section 2105 (42 U.S.C. 1397ee) is amended by
 16 adding at the end the following:

17 “(g) AUTHORITY FOR QUALIFYING STATES TO USE
 18 CERTAIN FUNDS FOR MEDICAID EXPENDITURES.—

19 “(1) STATE OPTION.—

20 “(A) IN GENERAL.—Notwithstanding any
 21 other provision of law, with respect to fiscal
 22 year 2003 and each fiscal year thereafter, a
 23 qualifying State (as defined in paragraph (2))
 24 may elect to use not more than 20 percent of
 25 the amount allotted to the State under sub-

1 section (b) or (c) of section 2104 for the fiscal
 2 year (instead of for expenditures under this
 3 title) for payments for such fiscal year under
 4 title XIX in accordance with subparagraph (B).

5 “(B) PAYMENTS TO STATES.—

6 “(i) IN GENERAL.—In the case of a
 7 qualifying State that has elected the option
 8 described in subparagraph (A), subject to
 9 the total amount of funds described with
 10 respect to the State in subparagraph (A),
 11 the Secretary shall pay the State an
 12 amount each quarter equal to the addi-
 13 tional amount that would have been paid
 14 to the State under title XIX for expendi-
 15 tures of the State for the fiscal year de-
 16 scribed in clause (ii) if the enhanced
 17 FMAP (as determined under subsection
 18 (b)) had been substituted for the Federal
 19 medical assistance percentage (as defined
 20 in section 1905(b)) of such expenditures.

21 “(ii) EXPENDITURES DESCRIBED.—

22 For purposes of clause (i), the expendi-
 23 tures described in this clause are expendi-
 24 tures for such fiscal years for providing
 25 medical assistance under title XIX to indi-

1 viduals who have not attained age 19 and
 2 whose family income exceeds 150 percent
 3 of the poverty line.

4 “(2) QUALIFYING STATE.—In this subsection,
 5 the term ‘qualifying State’ means a State that—

6 “(A) as of March 31, 1997, has an income
 7 eligibility standard with respect to any 1 or
 8 more categories of children (other than infants)
 9 who are eligible for medical assistance under
 10 section 1902(a)(10)(A) that is at least 185 per-
 11 cent of the poverty line; and

12 “(B) satisfies the requirements described
 13 in paragraph (3).

14 “(3) REQUIREMENTS.—The requirements de-
 15 scribed in this paragraph are the following:

16 “(A) SCHIP INCOME ELIGIBILITY.—The
 17 State has a State child health plan that (wheth-
 18 er implemented under title XIX or this title)—

19 “(i) as of January 1, 2001, has an in-
 20 come eligibility standard that is at least
 21 200 percent of the poverty line;

22 “(ii) subject to subparagraph (B),
 23 does not limit the acceptance of applica-
 24 tions for children; and

1 “(iii) provides benefits to all children
2 in the State who apply for and meet eligi-
3 bility standards on a statewide basis.

4 “(B) NO WAITING LIST IMPOSED.—With
5 respect to children whose family income is at or
6 below 200 percent of the poverty line, the State
7 does not impose any numerical limitation, wait-
8 ing list, or similar limitation on the eligibility of
9 such children for child health assistance under
10 such State plan.

11 “(C) ADDITIONAL REQUIREMENTS.—The
12 State has implemented at least 4 of the fol-
13 lowing policies and procedures (relating to cov-
14 erage of children under title XIX and this title):

15 “(i) UNIFORM, SIMPLIFIED APPLICA-
16 TION FORM.—With respect to children who
17 are eligible for medical assistance under
18 section 1902(a)(10)(A), the State uses the
19 same uniform, simplified application form
20 (including, if applicable, permitting appli-
21 cation other than in person) for purposes
22 of establishing eligibility for benefits under
23 title XIX and this title.

24 “(ii) ELIMINATION OF ASSET TEST.—
25 The State does not apply any asset test for

1 eligibility under section 1902(l) or this title
2 with respect to children.

3 “(iii) ADOPTION OF 12-MONTH CON-
4 TINUOUS ENROLLMENT.—The State pro-
5 vides that eligibility shall not be regularly
6 redetermined more often than once every
7 year under this title or for children de-
8 scribed in section 1902(a)(10)(A).

9 “(iv) SAME VERIFICATION AND REDE-
10 TERMINATION POLICIES; AUTOMATIC REAS-
11 SESSMENT OF ELIGIBILITY.—With respect
12 to children who are eligible for medical as-
13 sistance under section 1902(a)(10)(A), the
14 State provides for initial eligibility deter-
15 minations and redeterminations of eligi-
16 bility using the same verification policies
17 (including with respect to face-to-face
18 interviews), forms, and frequency as the
19 State uses for such purposes under this
20 title, and, as part of such redetermina-
21 tions, provides for the automatic reassess-
22 ment of the eligibility of such children for
23 assistance under title XIX and this title.

24 “(v) OUTSTATIONING ENROLLMENT
25 STAFF.—The State provides for the receipt

1 and initial processing of applications for
 2 benefits under this title and for children
 3 under title XIX at facilities defined as dis-
 4 proportionate share hospitals under section
 5 1923(a)(1)(A) and Federally-qualified
 6 health centers described in section
 7 1905(l)(2)(B) consistent with section
 8 1902(a)(55).”.

9 (d) GAO STUDY AND REPORT REGARDING EXPENDI-
 10 TURE OF SCHIP ALLOTMENTS.—

11 (1) STUDY.—The Comptroller General of the
 12 United States shall conduct a study regarding the
 13 expenditure of State allotments under the State chil-
 14 dren’s health insurance program under title XXI of
 15 the Social Security Act (42 U.S.C. 1397aa et seq.)
 16 to determine, with respect to States that have not
 17 expended all of their allotment under that program
 18 for fiscal year 1998, 1999, or 2000, the reasons why
 19 the States have not expended such allotments and to
 20 identify any impediments in title XXI of such Act or
 21 under regulations implemented to carry out such
 22 title to the full expenditure of such allotments. As
 23 part of the study, the Comptroller General—

24 (A) shall evaluate—

1 (i) the methods used to redistribute
 2 unexpended allotments under title XXI of
 3 such Act as of the date of enactment of
 4 this Act;

5 (ii) the caseload stabilization pool es-
 6 tablished under section 2104(h) of the So-
 7 cial Security Act (as added by subsection
 8 (b)); and

9 (iii) the adequacy of the funding and
 10 resources for the State children's health in-
 11 surance program under title XXI of such
 12 Act; and

13 (B) shall identify the potential benefits and
 14 problems with respect to the matters evaluated
 15 under subparagraph (A).

16 (2) REPORTS.—

17 (A) INTERIM REPORT.—Not later than Oc-
 18 tober 1, 2004, the Comptroller General of the
 19 United States shall submit an interim report to
 20 Congress on the study conducted under para-
 21 graph (1).

22 (B) FINAL REPORT.—Not later than Octo-
 23 ber 1, 2005, the Comptroller General of the
 24 United States shall submit a final report to
 25 Congress on the study conducted under para-

1 graph (1), along with such recommendations for
 2 legislative action as the Comptroller General de-
 3 termines appropriate.

4 (e) EFFECTIVE DATE.—This section and the amend-
 5 ments made by this section shall take effect as if enacted
 6 on October 1, 2002.

7 **SEC. 706. IMPROVEMENT OF THE PROCESS FOR THE DE-**
 8 **VELOPMENT AND IMPLEMENTATION OF MED-**
 9 **ICAID AND SCHIP WAIVERS.**

10 (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)
 11 is amended by inserting after subsection (c) the following:

12 “(d) In the case of any experimental, pilot, or dem-
 13 onstration project undertaken under subsection (a) to as-
 14 sist in promoting the objectives of title XIX or XXI in
 15 a State that would result in a nontrivial impact on eligi-
 16 bility, enrollment, benefits, cost-sharing, or financing with
 17 respect to a State program under title XIX or XXI (in
 18 this subsection referred to as a ‘medicaid waiver’ and a
 19 ‘SCHIP waiver’, respectively,) the following shall apply:

20 “(1) The Secretary may not approve a proposal
 21 for a medicaid waiver, SCHIP waiver, or an amend-
 22 ment to a previously approved medicaid waiver or
 23 SCHIP waiver unless the State requesting approval
 24 certifies that the following process was used to de-
 25 velop the proposal:

1 “(A) Prior to publication of the notice re-
2 quired under subparagraph (B), the State—

3 “(i) provided notice (which may have
4 been accomplished by electronic mail) of
5 the State’s intent to develop the proposal
6 to the medical care advisory committee es-
7 tablished for the State for purposes of
8 complying with section 1902(a)(4) and any
9 individual or organization that requests
10 such notice; and

11 “(ii) convened at least 1 meeting of
12 such medical care advisory committee at
13 which the proposal and any modifications
14 of the proposal were considered and dis-
15 cussed.

16 “(B) At least 60 days prior to the date
17 that the State submits the proposal to the Sec-
18 retary, the State published for written comment
19 (in accordance with the State’s procedure for
20 issuing regulations) a notice of the proposal
21 that contains at least the following:

22 “(i) Information regarding how the
23 public may submit comments to the State
24 on the proposal.

1 “(ii) A statement of the State’s pro-
2 jections regarding the likely effect and im-
3 pact of the proposal on any individuals
4 who are eligible for, or receiving, medical
5 assistance, child health assistance, or other
6 health benefits coverage under a State pro-
7 gram under title XIX or XXI and the
8 State’s assumptions on which such projec-
9 tions are based.

10 “(iii) A statement of the State’s pro-
11 jections regarding the likely effect and im-
12 pact of the proposal on any providers or
13 suppliers of items or services for which
14 payment may be made under title XIX or
15 XXI and the State’s assumptions on which
16 such projections are based.

17 “(C) Concurrent with the publication of
18 the notice required under subparagraph (B),
19 the State—

20 “(i) posted the proposal (and any
21 modifications of the proposal) on the
22 State’s Internet website; and

23 “(ii) provided the notice (which may
24 have been accomplished by electronic mail)
25 to the medical care advisory committee re-

1 ferred to in subparagraph (A)(i) and to
2 any individual or organization that re-
3 quested such notice.

4 “(D) Not later than 30 days after publica-
5 tion of the notice required under subparagraph
6 (B), the State convened at least 1 open meeting
7 of the medical care advisory committee referred
8 to in subparagraph (A)(i), at which the pro-
9 posal and any modifications of the proposal
10 were the primary items considered and dis-
11 cussed.

12 “(E) After publication of the notice re-
13 quired under subparagraph (B), the State—

14 “(i) held at least 2 public hearings on
15 the proposal and any modifications of the
16 proposal; and

17 “(ii) held the last such public hearing
18 at least 15 days before the State submitted
19 the proposal to the Secretary.

20 “(F) The State has a record of all public
21 comments submitted in response to the notice
22 required under subparagraph (B) or at any
23 hearings or meetings required under this para-
24 graph regarding the proposal.

1 “(2) A State shall include with any proposal
2 submitted to the Secretary for a medicaid waiver,
3 SCHIP waiver, or an amendment to a previously ap-
4 proved medicaid waiver or SCHIP waiver the fol-
5 lowing:

6 “(A) A detailed description of the public
7 notice and input process used to develop the
8 proposal in accordance with the requirements of
9 paragraph (1).

10 “(B) Copies of all notices required under
11 paragraph (1).

12 “(C) The dates of all meetings and hear-
13 ings required under paragraph (1).

14 “(D) A summary of the public comments
15 received in response to the notices required
16 under paragraph (1) or at any hearings or
17 meetings required under that paragraph regard-
18 ing the proposal and the State’s response to the
19 comments.

20 “(E) A certification that the State com-
21 plied with any applicable notification require-
22 ments with respect to Indian tribes during the
23 development of the proposal in accordance with
24 paragraph (1).

1 “(3) The Secretary shall return to a State with-
2 out action any proposal for a medicaid waiver,
3 SCHIP waiver, or an amendment to a previously ap-
4 proved medicaid waiver or SCHIP waiver that fails
5 to satisfy the requirements of paragraphs (1) and
6 (2).

7 “(4) With respect to all proposals for medicaid
8 waivers, SCHIP waivers, or amendments to a pre-
9 viously approved medicaid waiver or SCHIP waiver
10 received by the Secretary the following shall apply:

11 “(A) Each month the Secretary shall pub-
12 lish a notice in the Federal Register identifying
13 all of the proposals for such waivers or amend-
14 ments that were received by the Secretary dur-
15 ing the preceding month.

16 “(B) The notice required under subpara-
17 graph (A) shall provide information regarding
18 the method by which comments on the pro-
19 posals will be received from the public.

20 “(C) Not later than 7 days after receipt of
21 a proposal for a medicaid waiver, SCHIP waiv-
22 er, or an amendment to a previously approved
23 medicaid waiver or SCHIP waiver, the Sec-
24 retary shall—

1 “(i) provide notice (which may be ac-
2 complished by electronic mail) to any indi-
3 vidual or organization that has requested
4 such notification;

5 “(ii) publish on the Internet website
6 of the Centers for Medicare & Medicaid
7 Services a copy of the proposal, including
8 any appendices or modifications of the pro-
9 posal; and

10 “(iii) ensure that the information
11 posted on the website is updated to accu-
12 rately reflect the proposal.

13 “(D) The Secretary shall provide for a pe-
14 riod of not less than 30 days from the later of
15 the date of publication of the notice required
16 under subparagraph (A) that first identifies re-
17 ceipt of the proposal or the date on which an
18 Internet website containing the information re-
19 quired under subparagraph (C)(ii) with respect
20 to the proposal is first published, in which writ-
21 ten comments on the proposal may be sub-
22 mitted from all interested parties.

23 “(E) After the completion of the public
24 comment period required under subparagraph
25 (D), if the Secretary intends to approve the

1 proposal, as originally submitted or revised, the
2 Secretary shall—

3 “(i) publish and post on the Internet
4 website for the Centers for Medicare &
5 Medicaid Services the proposed terms and
6 conditions for such approval and updated
7 versions of the statements required to be
8 published by the State under clauses (ii)
9 and (iii) of paragraph (1)(B);

10 “(ii) provide at least a 15-day period
11 for the submission of written comments on
12 such proposed terms and conditions and
13 such statements; and

14 “(iii) retain, and make available upon
15 request, all comments received concerning
16 the proposal, the terms and conditions for
17 approval of the proposal, or such state-
18 ments.

19 “(F) In no event may the Secretary ap-
20 prove or deny a proposal for a medicaid waiver,
21 SCHIP waiver, or an amendment to a pre-
22 viously approved medicaid waiver or SCHIP
23 waiver until the Secretary—

1 “(i) reviews and considers all com-
2 ments submitted in response to the notices
3 required under this paragraph; and

4 “(ii) considers the nature and impact
5 of the proposal; and

6 “(iii) determines that the proposal—

7 “(I) is based on a reasonable hy-
8 pothesis which the proposal is de-
9 signed to test in a methodologically
10 sound manner; and

11 “(II) will be evaluated on a year-
12 ly basis utilizing a sound methodology
13 to determine whether the proposal has
14 resulted in a change in access to
15 health care or in health outcomes for
16 any beneficiaries of medical assist-
17 ance, child health assistance, or other
18 health benefits coverage whose assist-
19 ance or coverage would be altered as
20 a result of the proposal.

21 “(G) Not later than 3 days after the ap-
22 proval of any proposal for a medicaid waiver,
23 SCHIP waiver, or amendment to a previously
24 approved medicaid waiver or SCHIP waiver, the
25 Secretary shall post on the Internet website for

1 the Centers for Medicare & Medicaid Services
2 the following:

3 “(i) The text of the approved med-
4 icaid waiver, SCHIP waiver, or amendment
5 to a previously approved medicaid waiver
6 or SCHIP waiver.

7 “(ii) A list identifying each provision
8 of title XIX or XXI, and each regulation
9 relating to either such title, for which com-
10 pliance is waived under the approved waiv-
11 er or amendment or for which costs that
12 would otherwise not be permitted under
13 the provision will be allowed.

14 “(iii) The terms and conditions for
15 approval of the waiver or amendment.

16 “(v) The approval letter.

17 “(vi) The protocol for the waiver or
18 amendment.

19 “(vii) The evaluation design for the
20 waiver or amendment.

21 “(viii) The results of the evaluation of
22 the waiver or amendment.

23 Any item required to be posted under this sub-
24 paragraph that is not available within 3 days of
25 the approval of the waiver or amendment shall

1 be posted as soon as the item becomes avail-
 2 able.

3 “(H) Each month the Secretary shall pub-
 4 lish a notice in the Federal Register that identi-
 5 fies any proposals for medicaid waivers, SCHIP
 6 waivers, or amendments to a previously ap-
 7 proved medicaid waiver or SCHIP waiver that
 8 were approved, denied, or returned to the State
 9 without action during the preceding month.

10 “(5) Any provision under title XIX or XXI, or
 11 under any regulation in effect that relates to either
 12 such title, that is not explicitly waived by the Sec-
 13 retary when the medicaid waiver, SCHIP waiver, or
 14 amendment is approved and identified in the list re-
 15 quired under paragraph (4)(G)(ii), is not waived and
 16 a State shall continue to comply with any such re-
 17 quirement.”.

18 (b) CLARIFICATION OF LIMITATIONS OF WAIVER AU-
 19 THORITY.—

20 (1) SECTION 1115 WAIVERS.—Paragraphs (1)
 21 and (2) of section 1115(a) (42 U.S.C. 1315(a)) are
 22 each amended by inserting “and only to the extent
 23 that waiving such requirements is likely to assist in
 24 promoting the objectives of the title in which such
 25 section is located,” after “as the case may be,”.

1 (2) EPSDT.—Section 1902(e) (42 U.S.C.
2 1396a(e)) is amended by adding at the end the fol-
3 lowing:

4 “(13) Notwithstanding section 1115(a), with respect
5 to any waiver, experimental, pilot, or demonstration
6 project that involves the use of funds made available under
7 this title, or an amendment to such a project that has been
8 approved as of the date of enactment of this paragraph,
9 the Secretary may not waive compliance with the require-
10 ments of subsection (a)(43) (relating to early and periodic
11 screening, diagnostic, and treatment services as described
12 in section 1905(r)).”.

13 (3) USE OF SCHIP FUNDS.—

14 (A) IN GENERAL.—Section 2107 (42
15 U.S.C. 1397gg) is amended by adding at the
16 end the following:

17 “(f) LIMITATION OF WAIVER AUTHORITY.—Notwith-
18 standing subsection (e)(2)(A) and section 1115(a), the
19 Secretary may not approve a waiver, experimental, pilot,
20 or demonstration project, or an amendment to such a
21 project that has been approved as of the date of enactment
22 of this subsection, that would allow funds made available
23 under this title to be used to provide child health assist-
24 ance or other health benefits coverage to childless adults.
25 For purposes of the preceding sentence, a caretaker rel-

1 ative (as such term is defined for purposes of carrying out
2 section 1931) shall not be considered a childless adult.”.

3 (B) CONFORMING AMENDMENT.—Section
4 2105(c)(1) (42 U.S.C. 1397ee(c)(1)) is amend-
5 ed by inserting before the period the following:
6 “and may not include coverage of childless
7 adults. For purposes of the preceding sentence,
8 a caretaker relative (as such term is defined for
9 purposes of carrying out section 1931) shall not
10 be considered a childless adult.”.

11 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion or the amendments made by this section shall be con-
13 strued to—

14 (1) authorize the waiver of any provision of title
15 XIX or XXI of the Social Security Act (42 U.S.C.
16 1396 et seq., 1397aa et seq.) that is not otherwise
17 authorized to be waived under such titles or under
18 title XI of such Act (42 U.S.C. 1301 et seq.) as of
19 the date of enactment of this Act; or

20 (2) imply congressional approval of any waiver,
21 experimental, pilot, or demonstration project affect-
22 ing the medicaid program under title XIX of the So-
23 cial Security Act or the State children’s health in-
24 surance program under title XXI of such Act that
25 has been approved as of such date of enactment.

1 (d) EFFECTIVE DATE.—This section and the amend-
2 ments made by this section take effect on the date of en-
3 actment of this Act and apply to proposals to conduct a
4 waiver, experimental, pilot, or demonstration project af-
5 fecting the medicaid program under title XIX of the Social
6 Security Act or the State children’s health insurance pro-
7 gram under title XXI of such Act, and to any proposals
8 to amend such projects, that are approved or extended on
9 or after such date of enactment.

10 **SEC. 707. TEMPORARY STATE FISCAL RELIEF.**

11 (a) TEMPORARY INCREASE OF MEDICAID FMAP.—

12 (1) PERMITTING MAINTENANCE OF FISCAL
13 YEAR 2002 FMAP FOR FISCAL YEAR 2003.—Notwith-
14 standing any other provision of law, but subject to
15 paragraphs (4) and (6), if the FMAP determined
16 without regard to this subsection for a State for fis-
17 cal year 2003 is less than the FMAP as so deter-
18 mined for fiscal year 2002, the FMAP for the State
19 for fiscal year 2002 shall be substituted for the
20 State’s FMAP for fiscal year 2003, before the appli-
21 cation of this subsection.

22 (2) GENERAL 1.3 PERCENTAGE POINTS IN-
23 CREASE FOR FISCAL YEAR 2003.—Notwithstanding
24 any other provision of law, but subject to paragraphs
25 (4), (5), and (6), for each State for fiscal year 2003,

1 the FMAP (taking into account the application of
2 paragraph (1)) shall be increased by 1.3 percentage
3 points.

4 (3) INCREASE IN CAP ON MEDICAID PAYMENTS
5 TO TERRITORIES.—

6 (A) IN GENERAL.—Notwithstanding any
7 other provision of law, but subject to paragraph
8 (5) and subparagraph (B), with respect to fiscal
9 year 2003, the amounts otherwise determined
10 for Puerto Rico, the Virgin Islands, Guam, the
11 Northern Mariana Islands, and American
12 Samoa under subsections (f) and (g) of section
13 1108 of the Social Security Act (42 U.S.C.
14 1308) shall each be increased by an amount
15 equal to 2.6 percent of such amounts.

16 (B) NO APPLICATION AFTER FISCAL YEAR
17 2003.—The amounts determined for Puerto
18 Rico, the Virgin Islands, Guam, the Northern
19 Mariana Islands, and American Samoa under
20 subsections (f) and (g) of section 1108 of the
21 Social Security Act (42 U.S.C. 1308) for fiscal
22 year 2004 and each fiscal year thereafter shall
23 be determined without regard to the increase
24 under subparagraph (A) in such amounts for
25 fiscal year 2003.

1 (4) SCOPE OF APPLICATION.—The increases in
2 the FMAP for a State under this subsection shall
3 apply only for purposes of title XIX of the Social Se-
4 curity Act and shall not apply with respect to—

5 (A) disproportionate share hospital pay-
6 ments described in section 1923 of such Act
7 (42 U.S.C. 1396r-4); or

8 (B) payments under title IV or XXI of
9 such Act (42 U.S.C. 601 et seq. and 1397aa et
10 seq.).

11 (5) STATE ELIGIBILITY.—

12 (A) IN GENERAL.—Subject to subpara-
13 graph (B), a State is eligible for an increase in
14 its FMAP under paragraph (2) or an increase
15 in a cap amount under paragraph (3) only if
16 the eligibility under its State plan under title
17 XIX of the Social Security Act (including any
18 waiver under such title or under section 1115
19 of such Act (42 U.S.C. 1315)) is no more re-
20 strictive than the eligibility under such plan (or
21 waiver) as in effect on January 1, 2002.

22 (B) STATE REINSTATEMENT OF ELIGI-
23 BILITY PERMITTED.—A State that has re-
24 stricted eligibility under its State plan under
25 title XIX of the Social Security Act (including

1 any waiver under such title or under section
2 1115 of such Act (42 U.S.C. 1315)) after Jan-
3 uary 1, 2002, but prior to the date of enact-
4 ment of this Act is eligible for an increase in its
5 FMAP under paragraph (2) or an increase in
6 a cap amount under paragraph (3) in the first
7 calendar quarter (and subsequent calendar
8 quarters) in which the State has reinstated eli-
9 gibility that is no more restrictive than the eli-
10 gibility under such plan (or waiver) as in effect
11 on January 1, 2002.

12 (C) RULE OF CONSTRUCTION.—Nothing in
13 subparagraph (A) or (B) shall be construed as
14 affecting a State’s flexibility with respect to
15 benefits offered under the State medicaid pro-
16 gram under title XIX of the Social Security Act
17 (42 U.S.C. 1396 et seq.) (including any waiver
18 under such title or under section 1115 of such
19 Act (42 U.S.C. 1315)).

20 (6) LIMITATION.—Notwithstanding paragraphs
21 (1) and (2), the FMAP determined for a State
22 under this section for fiscal year 2003 may not ex-
23 ceed 100 percent.

24 (7) DEFINITIONS.—In this subsection:

1 (A) FMAP.—The term “FMAP” means
 2 the Federal medical assistance percentage, as
 3 defined in section 1905(b) of the Social Secu-
 4 rity Act (42 U.S.C. 1396d(b)).

5 (B) STATE.—The term “State” has the
 6 meaning given such term for purposes of title
 7 XIX of the Social Security Act (42 U.S.C. 1396
 8 et seq.).

9 (8) REPEAL.—Effective as of October 1, 2003,
 10 this subsection is repealed.

11 (b) ADDITIONAL TEMPORARY STATE FISCAL RE-
 12 LIEF.—

13 (1) IN GENERAL.—Title XX of the Social Secu-
 14 rity Act (42 U.S.C. 1397–1397f) is amended by
 15 adding at the end the following:

16 **“SEC. 2008. ADDITIONAL TEMPORARY GRANTS FOR STATE**
 17 **FISCAL RELIEF.**

18 “(a) IN GENERAL.—For the purpose of providing
 19 State fiscal relief allotments to States under this section,
 20 there are hereby appropriated, out of any funds in the
 21 Treasury not otherwise appropriated, \$1,000,000,000.
 22 Such funds shall be available for obligation by the State
 23 through June 30, 2003, and for expenditure by the State
 24 through September 30, 2003. This section constitutes
 25 budget authority in advance of appropriations Acts and

1 represents the obligation of the Federal Government to
 2 provide for the payment to States of amounts provided
 3 under this section.

4 “(b) ALLOTMENT.—Funds appropriated under sub-
 5 section (a) shall be allotted by the Secretary among the
 6 States in accordance with the following table:

“State	Allotment (in dollars)
Alabama	\$11,154,135
Alaska	\$2,840,803
Amer. Samoa	\$29,438
Arizona	\$16,220,383
Arkansas	\$9,163,338
California	\$100,833,576
Colorado	\$9,331,095
Connecticut	\$13,994,165
Delaware	\$2,767,146
District of Columbia	\$4,059,080
Florida	\$44,008,674
Georgia	\$21,937,652
Guam	\$45,247
Hawaii	\$3,373,790
Idaho	\$3,471,124
Illinois	\$34,733,333
Indiana	\$17,207,622
Iowa	\$8,513,126
Kansas	\$6,919,819
Kentucky	\$14,548,137
Louisiana	\$17,118,506
Maine	\$5,979,575
Maryland	\$14,684,167
Massachusetts	\$34,248,540
Michigan	\$29,836,794
Minnesota	\$19,370,869
Mississippi	\$12,153,821
Missouri	\$20,314,882
Montana	\$2,838,819
Nebraska	\$5,613,219
Nevada	\$3,808,574
New Hampshire	\$3,550,440
New Jersey	\$29,327,902
New Mexico	\$7,255,647
New York	\$157,469,433
North Carolina	\$26,223,106
North Dakota	\$1,874,707
N. Mariana Islands	\$16,630
Ohio	\$39,106,122
Oklahoma	\$10,452,381
Oregon	\$11,647,633
Pennsylvania	\$53,862,604
Puerto Rico	\$1,308,459
Rhode Island	\$5,492,778
South Carolina	\$12,652,401
South Dakota	\$1,994,912
Tennessee	\$27,222,837
Texas	\$54,043,284
Utah	\$4,254,036
Vermont	\$2,655,179
Virgin Islands	\$42,210
Virginia	\$14,289,158
Washington	\$20,884,225
West Virginia	\$6,542,196
Wisconsin	\$15,441,057
Wyoming	\$1,271,214
Total	\$1,000,000,000

1 “(c) USE OF FUNDS.—Funds appropriated under
 2 this section may be used by a State for services directed
 3 at the goals set forth in section 2001, subject to the re-
 4 quirements of this title.

5 “(d) PAYMENT TO STATES.—Not later than 30 days
 6 after amounts are appropriated under subsection (a), in
 7 addition to any payment made under section 2002 or
 8 2007, the Secretary shall make a lump sum payment to
 9 a State of the total amount of the allotment for the State
 10 as specified in subsection (b).

11 “(e) DEFINITION.—For purposes of this section, the
 12 term ‘State’ means the 50 States, the District of Colum-
 13 bia, and the territories contained in the list under sub-
 14 section (b).”.

15 (2) REPEAL.—Effective as of January 1, 2004,
 16 section 2008 of the Social Security Act, as added by
 17 paragraph (1), is repealed.

18 **TITLE VIII—OTHER PROVISIONS**

19 **SEC. 801. INCREASE IN APPROPRIATIONS FOR SPECIAL DI-** 20 **ABETES PROGRAMS FOR TYPE I DIABETES** 21 **AND INDIANS.**

22 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-
 23 BETES.—Section 330B(b)(2) of the Public Health Service
 24 Act (42 U.S.C. 254c–2(b)(2)) is amended—

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

3 (2) in subparagraph (B), by striking the period
4 at the end and inserting “; and”; and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 “(C) \$150,000,000 for each of fiscal years
8 2004, 2005, and 2006.”.

9 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
10 Section 330C(c)(2) of the Public Health Service Act (42
11 U.S.C. 254c-3(c)(2)) is amended—

12 (1) in subparagraph (A), by striking “and” at
13 the end;

14 (2) in subparagraph (B), by striking the period
15 at the end and inserting “; and”; and

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

18 “(C) \$150,000,000 for each of fiscal years
19 2004, 2005, and 2006.”.

20 (c) EXTENSION OF FINAL REPORT ON GRANT PRO-
21 GRAMS.—Section 4923(b)(2) of the Balanced Budget Act
22 of 1997 (Public Law 105-33; 111 Stat. 251), as amended
23 by section 931(c) of BIPA (114 Stat. 2763A-585), is
24 amended by striking “2003” and inserting “2005”.

1 **SEC. 802. DISREGARD OF CERTAIN PAYMENTS UNDER THE**
2 **EMERGENCY SUPPLEMENTAL ACT, 2000 IN**
3 **THE ADMINISTRATION OF FEDERAL PRO-**
4 **GRAMS AND FEDERALLY ASSISTED PRO-**
5 **GRAMS.**

6 (a) IN GENERAL.—Chapter 2 of title II of the Emer-
7 gency Supplemental Act, 2000 (Public Law 106–246; 114
8 Stat. 547) is amended by adding at the end the following
9 new section:

10 “SEC. 2205. CERTAIN PAYMENTS DISREGARDED IN
11 THE ADMINISTRATION OF FEDERAL PROGRAMS AND
12 FEDERALLY ASSISTED PROGRAMS.—Any payment under
13 this chapter with respect to west coast groundfish fishery
14 shall not be taken into account as income or resources for
15 purposes of determining the eligibility of such individual
16 or any other individual for benefits or assistance, or the
17 amount or extent of benefits or assistance, under any Fed-
18 eral program or under any State or local program financed
19 in whole or in part with Federal funds.”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 this section shall take effect as if included in the enact-
22 ment of the Emergency Supplemental Act, 2000.

23 **SEC. 803. SAFETY NET ORGANIZATIONS AND PATIENT ADVI-**
24 **SORY COMMISSION.**

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

1 “PART D—SAFETY NET ORGANIZATIONS AND PATIENT
2 ADVISORY COMMISSION

3 “SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY
4 COMMISSION

5 “SEC. 1181. (a) ESTABLISHMENT.—There is hereby
6 established the Safety Net Organizations and Patient Ad-
7 visory Commission (in this section referred to as the ‘Com-
8 mission’).

9 “(b) REVIEW OF HEALTH CARE SAFETY NET PRO-
10 GRAMS AND REPORTING REQUIREMENTS.—

11 “(1) REVIEW.—The Commission shall conduct
12 an ongoing review of the health care safety net pro-
13 grams (as described in paragraph (3)(C)) by—

14 “(A) monitoring each health care safety
15 net program to document and analyze the ef-
16 fects of changes in these programs on the core
17 health care safety net;

18 “(B) evaluating the impact of the Emer-
19 gency Medical Treatment and Labor Act, the
20 Health Insurance Portability and Accountability
21 Act of 1996, the Balanced Budget Act of 1997,
22 the Medicare, Medicaid, and SCHIP Balanced
23 Budget Refinement Act of 1999, the Medicare,
24 Medicaid, and SCHIP Benefits Protection and
25 Improvement Act of 2000, the Beneficiary Ac-

1 cess to Care and Medicare Equity Act of 2002,
2 and other forces on the capacity of the core
3 health care safety net to continue their roles in
4 the core health care safety net system to care
5 for uninsured individuals, medicaid bene-
6 ficiaries, and other vulnerable populations;

7 “(C) monitoring existing data sets to as-
8 sess the status of the core health care safety
9 net and health outcomes for vulnerable popu-
10 lations;

11 “(D) wherever possible, linking and inte-
12 grating existing data systems to enhance the
13 ability of the core health care safety net to
14 track changes in the status of the core health
15 care safety net and health outcomes for vulner-
16 able populations;

17 “(E) supporting the development of new
18 data systems where existing data are insuffi-
19 cient or inadequate;

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

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

1 “(H) providing accurate and timely infor-
2 mation to Federal, State, and local policy-
3 makers on the indicators that may lead to the
4 failure of the core health care safety net and an
5 estimate of the projected consequences of such
6 failures and the impact of such a failure on the
7 community;

8 “(I) monitoring and providing oversight for
9 the transition of individuals receiving supple-
10 mental security income benefits, medical assist-
11 ance under title XIX, or child health assistance
12 under title XXI who enroll with a managed care
13 entity (as defined in section 1932(a)(1)(B)), in-
14 cluding the review of—

15 “(i) the degree to which health plans
16 have the capacity (including case manage-
17 ment and management information system
18 infrastructure) to provide quality managed
19 care services to such an individual;

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

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

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

4 “(2) REPORTS.—

5 “(A) ANNUAL REPORTS.—Not later than
6 June 1 of each year (beginning with 2004), the
7 Commission shall, based on the review con-
8 ducted under paragraph (1), submit to the ap-
9 propriate committees of Congress a report on—

10 “(i) the health care needs of the unin-
11 sured; and

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

15 “(B) AGENDA AND ADDITIONAL RE-
16 VIEWS.—

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

24 “(ii) ADDITIONAL REVIEWS.—The
25 Commission shall conduct additional re-

1 views and submit additional reports to the
2 appropriate committees of Congress on
3 topics relating to the health care safety net
4 programs under the following cir-
5 cumstances:

6 “(I) If requested by the Chair-
7 persons or Ranking Minority Members
8 of such committees.

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

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

17 “(3) DEFINITIONS.—In this section:

18 “(A) APPROPRIATE COMMITTEES OF CON-
19 GRESS.—The term ‘appropriate committees of
20 Congress’ means the Committees on Ways and
21 Means and Energy and Commerce of the House
22 of Representatives and the Committees on Fi-
23 nance and Health, Education, Labor, and Pen-
24 sions of the Senate.

“(B) CORE HEALTH CARE SAFETY NET.—

The term ‘core health care safety net’ means any health care provider that—

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

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

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

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

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

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

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

7 “(iv) FQHC PROGRAMS.—Each feder-
8 ally funded program under which a health
9 center (as defined in section 330(1) of the
10 Public Health Service Act), a Federally
11 qualified health center (as defined in sec-
12 tion 1861(aa)(4)), or a Federally-qualified
13 health center (as defined in section
14 1905(l)(2)(B)) receives funds.

15 “(v) RHC PROGRAMS.—Each feder-
16 ally funded program under which a rural
17 health clinic (as defined in section
18 1861(aa)(4) or 1905(l)(1)) receives funds.

19 “(vi) DSH PAYMENT PROGRAMS.—
20 Each federally funded program under
21 which a disproportionate share hospital re-
22 ceives funds.

23 “(vii) EMERGENCY MEDICAL TREAT-
24 MENT AND ACTIVE LABOR ACT.—All care
25 provided under section 1867 for the unin-

1 sured, underinsured, beneficiaries under
2 title XIX, and other vulnerable individuals.

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

7 “(D) VULNERABLE POPULATIONS.—The
8 term ‘vulnerable populations’ includes unin-
9 sured and underinsured individuals, low-income
10 individuals, farm workers, homeless individuals,
11 individuals with disabilities, individuals with
12 HIV or AIDS, and such other individuals as the
13 Commission may designate.

14 “(c) MEMBERSHIP.—

15 “(1) NUMBER AND APPOINTMENT.—The Com-
16 mission shall be composed of 13 members appointed
17 by the Comptroller General of the United States (in
18 this section referred to as the ‘Comptroller Gen-
19 eral’), in consultation with the appropriate commit-
20 tees of Congress.

21 “(2) QUALIFICATIONS.—

22 “(A) IN GENERAL.—The membership of
23 the Commission shall include individuals with
24 national recognition for their expertise in health
25 finance and economics, health care safety net

1 research and program management, actuarial
2 science, health facility management, health
3 plans and integrated delivery systems, reim-
4 bursement of health facilities, allopathic and os-
5 teopathic medicine (including emergency medi-
6 cine), and other providers of health services,
7 and other related fields, who provide a mix of
8 different professionals, broad geographic rep-
9 resentation, and a balance between urban and
10 rural representatives.

11 “(B) INCLUSION.—The membership of the
12 Commission shall include health professionals,
13 employers, third-party payers, individuals
14 skilled in the conduct and interpretation of bio-
15 medical, health services, and health economics
16 research and expertise in outcomes and effec-
17 tiveness research and technology assessment.
18 Such membership shall also include recipients
19 of care from core health care safety net and in-
20 dividuals who provide and manage the delivery
21 of care by the core health care safety net.

22 “(C) MAJORITY NONPROVIDERS.—Individ-
23 uals who are directly involved in the provision,
24 or management of the delivery, of items and
25 services covered under the health care safety

1 net programs shall not constitute a majority of
 2 the membership of the Commission.

3 “(D) ETHICAL DISCLOSURE.—The Comp-
 4 troller General shall establish a system for pub-
 5 lic disclosure by members of the Commission of
 6 financial and other potential conflicts of interest
 7 relating to such members.

8 “(3) TERMS.—

9 “(A) IN GENERAL.—The terms of mem-
 10 bers of the Commission shall be for 3 years ex-
 11 cept that of the members first appointed, the
 12 Comptroller General shall designate—

13 “(i) four to serve a term of 1 year;

14 “(ii) four to serve a term of 2 years;

15 and

16 “(iii) five to serve a term of 3 years.

17 “(B) VACANCIES.—

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

22 “(ii) APPOINTMENT.—Any member
 23 appointed to fill a vacancy occurring before
 24 the expiration of the term for which the
 25 member’s predecessor was appointed shall

1 be appointed only for the remainder of that
2 term.

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

6 “(4) COMPENSATION.—

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

10 “(i) shall be entitled to compensation
11 at the per diem equivalent of the rate pro-
12 vided for level IV of the Executive Sched-
13 ule under section 5315 of title 5, United
14 States Code; and

15 “(ii) while so serving away from home
16 and the member’s regular place of busi-
17 ness, may be allowed travel expenses, as
18 authorized by the Commission.

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

1 “(5) CHAIR; VICE CHAIR.—The Comptroller
2 General shall designate a member of the Commis-
3 sion, at the time of appointment of the member as
4 Chair and a member as Vice Chair for that term of
5 appointment, except that in the case of vacancy of
6 the Chair or Vice Chair, the Comptroller General
7 may designate another member for the remainder of
8 that member’s term.

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

12 “(d) DIRECTOR AND STAFF; EXPERTS AND CON-
13 SULTANTS.—Subject to such review as the Comptroller
14 General determines necessary to ensure the efficient ad-
15 ministration of the Commission, the Commission may—

16 “(1) employ and fix the compensation of an Ex-
17 ecutive Director (subject to the approval of the
18 Comptroller General) and such other personnel as
19 may be necessary to carry out the duties of the
20 Commission under this section (without regard to
21 the provisions of title 5, United States Code, gov-
22 erning appointments in the competitive service);

23 “(2) seek such assistance and support as may
24 be required in the performance of the duties of the

1 Commission under this section from appropriate
2 Federal departments and agencies;

3 “(3) enter into contracts or make other ar-
4 rangements, as may be necessary for the conduct of
5 the work of the Commission (without regard to sec-
6 tion 3709 of the Revised Statutes (41 U.S.C. 5));

7 “(4) make advance, progress, and other pay-
8 ments which relate to the work of the Commission;

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

11 “(6) prescribe such rules and regulations as it
12 deems necessary with respect to the internal organi-
13 zation and operation of the Commission.

14 “(e) POWERS.—

15 “(1) OBTAINING OFFICIAL DATA.—

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

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

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

4 “(A) use existing information, both pub-
5 lished and unpublished, where possible, collected
6 and assessed either by the staff of the Commis-
7 sion or under other arrangements made in ac-
8 cordance with this section;

9 “(B) carry out, or award grants or con-
10 tracts for, original research and experimen-
11 tation, where existing information is inad-
12 equate; and

13 “(C) adopt procedures allowing any inter-
14 ested party to submit information for the Com-
15 mission’s use in making reports and rec-
16 ommendations.

17 “(3) ACCESS OF GAO TO INFORMATION.—The
18 Comptroller General shall have unrestricted access
19 to all deliberations, records, and nonproprietary data
20 that pertains to the work of the Commission, imme-
21 diately upon request. The expense of providing such
22 information shall be borne by the General Account-
23 ing Office.

1 “(4) PERIODIC AUDIT.—The Commission shall
2 be subject to periodic audit by the Comptroller Gen-
3 eral.

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

7 “(g) AUTHORIZATION OF APPROPRIATIONS.—

8 “(1) REQUEST FOR APPROPRIATIONS.—The
9 Commission shall submit requests for appropriations
10 in the same manner as the Comptroller General sub-
11 mits requests for appropriations, but amounts ap-
12 propriated for the Commission shall be separate
13 from amounts appropriated for the Comptroller Gen-
14 eral.

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

18 (b) EFFECTIVE DATE.—The Comptroller General of
19 the United States shall appoint the initial members of the
20 Safety Net Organizations and Patient Advisory Commis-
21 sion established under subsection (a) not later than June
22 1, 2003.

1 **SEC. 804. PUBLICATION ON FINAL WRITTEN GUIDANCE**
2 **CONCERNING PROHIBITIONS AGAINST DIS-**
3 **CRIMINATION BY NATIONAL ORIGIN WITH**
4 **RESPECT TO HEALTH CARE SERVICES.**

5 Not later than January 1, 2003, the Secretary shall
6 issue final written guidance concerning the application of
7 the prohibition in title VI of the Civil Rights Act of 1964
8 (42 U.S.C. 2000d et seq.) against national origin discrimi-
9 nation as it affects persons with limited English pro-
10 ficiency with respect to access to health care services
11 under the medicare program under title XVIII of the So-
12 cial Security Act, the medicaid program under title XIX
13 of such Act, and the SCHIP program under title XXI of
14 such Act.

15 **SEC. 805. FEDERAL REIMBURSEMENT OF EMERGENCY**
16 **HEALTH SERVICES FURNISHED TO UNDOCU-**
17 **MENTED ALIENS.**

18 Section 4723 of the Balanced Budget Act of 1997
19 (8 U.S.C. 1611 note) is amended to read as follows:

20 **“SEC. 4723. FEDERAL REIMBURSEMENT OF EMERGENCY**
21 **HEALTH SERVICES FURNISHED TO UNDOCU-**
22 **MENTED ALIENS.**

23 “(a) TOTAL AMOUNT AVAILABLE FOR ALLOT-
24 MENT.—There is appropriated, out of any funds in the
25 Treasury not otherwise appropriated, \$48,000,000 for
26 each of fiscal years 2003 and 2004, for the purpose of

1 making allotments under this section to States described
2 in paragraph (1) or (2) of subsection (b).

3 “(b) STATE ALLOTMENTS.—

4 “(1) BASED ON HIGHEST NUMBER OF UNDOCU-
5 MENTED ALIENS.—

6 “(A) DETERMINATION OF ALLOTMENTS.—

7 “(i) IN GENERAL.—Out of the amount
8 appropriated under subsection (a) for a fis-
9 cal year, the Secretary shall use
10 \$32,000,000 of such amount to compute
11 an allotment for each such fiscal year for
12 each of the 17 States with the highest
13 number of undocumented aliens.

14 “(ii) FORMULA.—The amount of such
15 allotment for each such State for a fiscal
16 year shall bear the same ratio to the total
17 amount available for allotments under this
18 paragraph for the fiscal year as the ratio
19 of the number of undocumented aliens in
20 the State in the fiscal year bears to the
21 total of such numbers for all such States
22 for such fiscal year.

23 “(iii) AVAILABILITY OF FUNDS.—The
24 amount of an allotment provided to a State
25 under this paragraph for a fiscal year that

1 is not paid out under subsection (c) shall
2 be available for payment during the subse-
3 quent fiscal year.

4 “(B) DATA.—For purposes of subpara-
5 graph (A), the number of undocumented aliens
6 in a State shall be determined based on esti-
7 mates of the resident undocumented alien popu-
8 lation residing in each State prepared by the
9 Statistics Division of the Immigration and Nat-
10 uralization Service as of October 1992 (or as of
11 such later date if such date is at least 1 year
12 before the beginning of the fiscal year involved).

13 “(2) BASED ON NUMBER OF UNDOCUMENTED
14 ALIEN APPREHENSION STATES.—

15 “(A) IN GENERAL.—Out of the amount
16 appropriated under subsection (a) for a fiscal
17 year, the Secretary shall use \$16,000,000 of
18 such amount to compute an allotment for each
19 such fiscal year for each of the 6 States with
20 the highest number of undocumented alien ap-
21 prehensions for such fiscal year.

22 “(B) DETERMINATION OF ALLOTMENTS.—
23 The amount of such allotment for each such
24 State for a fiscal year shall bear the same ratio
25 to the total amount available for allotments

1 under this paragraph for the fiscal year as the
2 ratio of the number of undocumented alien ap-
3 prehensions in the State in the fiscal year bears
4 to the total of such numbers for all such States
5 for such fiscal year.

6 “(C) DATA.—For purposes of this para-
7 graph, the highest number of undocumented
8 alien apprehensions for a fiscal year shall be
9 based on the 4 most recent quarterly apprehen-
10 sion rates for undocumented aliens in such
11 States, as reported by the Immigration and
12 Naturalization Service.

13 “(D) AVAILABILITY OF FUNDS.—The
14 amount of an allotment provided to a State
15 under this paragraph for a fiscal year that is
16 not paid out under subsection (c) shall be avail-
17 able for payment during the subsequent fiscal
18 year.

19 “(3) RULE OF CONSTRUCTION.—Nothing in
20 this section shall be construed as prohibiting a State
21 that is described in both of paragraphs (1) and (2)
22 from receiving an allotment under both such para-
23 graphs for a fiscal year.

24 “(c) USE OF FUNDS.—The Secretary shall pay, from
25 the allotments made for a State under paragraphs (1) and,

1 if applicable, (2) of subsection (b) for a fiscal year, to each
2 State and directly to local governments, hospitals, or other
3 providers located in the State (including providers of serv-
4 ices received through an Indian Health Service facility
5 whether operated by the Indian Health Service or by an
6 Indian tribe or tribal organization (as defined in section
7 4 of the Indian Health Care Improvement Act)) that pro-
8 vide uncompensated emergency health services furnished
9 to undocumented aliens during that fiscal year, such
10 amounts (subject to the total amount available from such
11 allotments) as the State, local governments, hospitals, or
12 providers demonstrate were incurred for the provision of
13 such services during that fiscal year.

14 “(d) DEFINITIONS.—In this section:

15 “(1) HOSPITAL.—The term ‘hospital’ has the
16 meaning given such term in section 1861(e) of the
17 Social Security Act (42 U.S.C. 1395x(e)).

18 “(2) PROVIDER.—The term ‘provider’ includes
19 a physician, any other health care professional li-
20 censed under State law, and any other entity that
21 furnishes emergency health services, including ambu-
22 lance services.

23 “(3) SECRETARY.—The term ‘Secretary’ means
24 the Secretary of Health and Human Services.

1 “(4) STATE.—The term ‘State’ means the 50
2 States and the District of Columbia.

3 “(e) ENTITLEMENT.—This section constitutes budget
4 authority in advance of appropriations Acts and rep-
5 resents the obligation of the Federal Government to pro-
6 vide for the payment of amounts provided under this sec-
7 tion.”.

8 **SEC. 806. EXTENSION OF MEDICARE MUNICIPAL HEALTH**
9 **SERVICES DEMONSTRATION PROJECTS.**

10 Section 9215(a) of the Consolidated Omnibus Budget
11 Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as
12 amended by section 6135 of the Omnibus Budget Rec-
13 onciliation Act of 1989, section 13557 of the Omnibus
14 Budget Reconciliation Act of 1993, section 4017 of the
15 Balance Budget Act of 1997 (111 Stat. 345, section 534
16 of the Medicare, Medicaid, and SCHIP Balanced Budget
17 Refinement Act of 1999 (113 Stat. 1501A–390), and sec-
18 tion 633 of BIPA (114 Stat. 2763A–568), is amended by
19 striking “December 31, 2004” and inserting “December
20 31, 2005”.

21 **SEC. 807. DELAYED IMPLEMENTATION OF CERTAIN PROVI-**
22 **SIONS.**

23 (a) AUTHORITY TO DELAY IMPLEMENTATION OF
24 CERTAIN FEE-FOR-SERVICE PAYMENT CHANGES.—

1 (1) IN GENERAL.—If the Secretary determines
2 that it is not administratively feasible to implement
3 a covered payment change on the date otherwise ap-
4 plicable, notwithstanding any other provision of this
5 Act and in order to comply with Congressional in-
6 tent, the Secretary may delay the implementation of
7 such change in accordance with subsection (b).

8 (2) COVERED PAYMENT CHANGE DEFINED.—
9 For purposes of this section, the term “covered pay-
10 ment change” means a provision contained in titles
11 I through IV of this Act that—

12 (A) changes the amount of payment made
13 for an item or service furnished under the medi-
14 care program; and

15 (B) has an effective date during the period
16 beginning on October 1, 2002, and ending on
17 March 31, 2003.

18 (b) RULES FOR DELAYED IMPLEMENTATION.—

19 (1) PERIOD OF DELAY.—In the case of a cov-
20 ered payment change in which medicare payment
21 rates change on a—

22 (A) fiscal year basis (or a cost reporting
23 period basis that relates to a fiscal year), the
24 Secretary may delay the implementation of the
25 change until such time as the Secretary deter-

1 mines to be appropriate, but in no case later
2 than April 1, 2003; or

3 (B) calendar year basis (or a cost report-
4 ing period basis that relates to a calendar year),
5 the Secretary may delay the implementation of
6 the change until such time as the Secretary de-
7 termines to be appropriate, but in no case later
8 than July 1, 2003.

9 (2) TEMPORARY ADJUSTMENT FOR REMAINDER
10 OF FISCAL YEAR OR CALENDAR YEAR 2003 TO EF-
11 FECT FULL RATE CHANGE.—If the Secretary delays
12 implementation of a covered payment change under
13 paragraph (1), the Secretary shall make such adjust-
14 ment to the amount of payments affected by such
15 change, for the portion of fiscal year 2003 (or, in
16 the case of a delay under paragraph (1)(B), calendar
17 year 2003) after the date of the delayed implementa-
18 tion, in such manner as the Secretary estimates will
19 ensure that the total payments so affected (for a
20 type of service) with respect to such fiscal or cal-
21 endar year, respectively, is the same as would have
22 been made if this section had not been enacted.

23 (3) NO EFFECT ON PAYMENTS FOR SUBSE-
24 QUENT PAYMENT PERIODS.—The application of
25 paragraphs (1) and (2) shall not affect payment

1 rates and shall not be taken into account in calcu-
 2 lating payment amounts for services furnished for
 3 periods after September 30, 2003 (or, in the case of
 4 a delay under paragraph (1)(B), December 31,
 5 2003).

6 (c) IMPLEMENTATION OF MEDICARE+CHOICE PRO-
 7 VISIONS.—

8 (1) TRANSITION TO REVISED
 9 MEDICARE+CHOICE PAYMENT RATES.—In order to
 10 comply with Congressional intent, the provisions of
 11 section 604 of BIPA (114 Stat. 2763A–555) shall
 12 apply to the provisions of title V of this Act for
 13 2003 in the same manner as the provisions of such
 14 section applied to the provisions of BIPA for 2001.

15 (2) SPECIAL RULE FOR MEDICARE+CHOICE
 16 PAYMENT RATES IN 2003.—

17 (A) JANUARY AND FEBRUARY.—Notwith-
 18 standing the amendments made by sections 501
 19 and 506, for purposes of making payments
 20 under section 1853 of the Social Security Act
 21 (42 U.S.C. 1395w–23) for January and Feb-
 22 ruary 2003, the annual Medicare+Choice capi-
 23 tation rate for a Medicare+Choice payment
 24 area shall be calculated, the new entry bonus
 25 amount under section 1853(i) under such Act

1 (42 U.S.C. 1395w–23(i)) shall be determined,
2 and the excess amount under section
3 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–
4 24(f)(1)(B)) shall be determined, as if such
5 amendments had not been enacted.

6 (B) MARCH THROUGH DECEMBER.—Not-
7 withstanding the amendments made by sections
8 501 and 506, for purposes of making payments
9 under section 1853 of the Social Security Act
10 (42 U.S.C. 1395w–23) for March through Feb-
11 ruary 2003, the annual Medicare+Choice capi-
12 tation rate for a Medicare+Choice payment
13 area shall be calculated, the new entry bonus
14 amount under section 1853(i) under such Act
15 (42 U.S.C. 1395w–23(i)) shall be determined,
16 and the excess amount under section
17 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–
18 24(f)(1)(B)) shall be determined, in such man-
19 ner as the Secretary estimates will ensure that
20 the total of such payments with respect to 2003
21 is the same as the amounts that would have
22 been if subparagraph (A) had not been enacted.

23 (C) CONSTRUCTION.—Subparagraph (A)
24 shall not be taken into account in computing

1 such capitation rate for 2004 and subsequent
2 years.

3 (3) PLANS REQUIRED TO PROVIDE NOTICE OF
4 CHANGES IN PLAN BENEFITS.—If a
5 Medicare+Choice organization offering a
6 Medicare+Choice plan revises its submission of the
7 information described in section 1854(a)(1)(B) of
8 the Social Security Act (42 U.S.C. 1395w–
9 23(a)(1)(B)) for a plan pursuant to the application
10 of paragraph (1), and such revision results in re-
11 duced beneficiary premiums, reduced beneficiary
12 cost-sharing, or enhanced benefits under the plan,
13 then by not later than the date that is 3 weeks after
14 the Secretary approves such submission, the
15 Medicare+Choice organization offering the plan
16 shall provide each beneficiary enrolled in the plan
17 with written notice of such changes.

18 (d) ADMINISTRATION OF PROVISIONS.—

19 (1) NO RULEMAKING OR NOTICE REQUIRED.—
20 The Secretary may carry out the authority under
21 this section by program memorandum or otherwise
22 and is not required to prescribe regulations or to
23 provide notice in the Federal Register in order to
24 carry out such authority.

1 (2) LIMITATION ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869 or 1878 of the Social Security Act, or other-
4 wise of any determination made by the Secretary
5 under this section or the application of the payment
6 rates determined under this section.

Calendar No. 627

107TH CONGRESS
2^D SESSION

S. 3018

A BILL

To amend title XVIII of the Social Security Act to enhance beneficiary access to quality health care services under the medicare program, and for other purposes.

OCTOBER 2, 2002

Read the second time and placed on the calendar