

108TH CONGRESS
1ST SESSION

S. 1926

To amend title XVIII of the Social Security Act to restore the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 21, 2003

Ms. STABENOW (for herself, Mr. GRAHAM of Florida, Mrs. CLINTON, Mrs. MURRAY, Mr. LEAHY, Mr. DASCHLE, Mr. PRYOR, Mr. LEVIN, Mr. SCHUMER, and Ms. CANTWELL) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to restore the medicare program, and for other purposes.

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

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

6 (a) SHORT TITLE.—This Act may be cited as the
7 “Support Our Health Care Providers Act of 2003”.

8 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
9 cept as otherwise specifically provided, whenever in divi-

1 sion A of this Act an amendment is expressed in terms
 2 of an amendment to or repeal of a section or other provi-
 3 sion, the reference shall be considered to be made to that
 4 section or other provision of the Social Security Act.

5 (c) BIPA; SECRETARY.—In this Act:

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

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

Sec. 102. Enhanced disproportionate share hospital (DSH) treatment for rural
 hospitals and urban hospitals with fewer than 100 beds.

Sec. 103. Adjustment to the medicare inpatient hospital prospective payment
 system wage index to revise the labor-related share of such
 index.

Sec. 104. More frequent update in weights used in hospital market basket.

Sec. 105. Improvements to critical access hospital program.

Sec. 106. Medicare inpatient hospital payment adjustment for low-volume hos-
 pitals.

Sec. 107. Treatment of missing cost reporting periods for sole community hos-
 pitals.

Sec. 108. Recognition of attending nurse practitioners as attending physicians
 to serve hospice patients.

Sec. 109. Rural hospice demonstration project.

Sec. 110. Exclusion of certain rural health clinic and federally qualified health
 center services from the prospective payment system for skilled
 nursing facilities.

Sec. 110A. Rural community hospital demonstration program.

Subtitle B—Provisions Relating to Part B Only

- Sec. 111. 2-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services.
- Sec. 112. Establishment of floor on work geographic adjustment.
- Sec. 113. Medicare incentive payment program improvements for physician scarcity.
- Sec. 114. Payment for rural and urban ambulance services.
- Sec. 115. Providing appropriate coverage of rural air ambulance services.
- Sec. 116. Treatment of certain clinical diagnostic laboratory tests furnished to hospital outpatients in certain rural areas.
- Sec. 117. Extension of telemedicine demonstration project.
- Sec. 118. Report on demonstration project permitting skilled nursing facilities to be originating telehealth sites; authority to implement.

Subtitle C—Provisions Relating to Parts A and B

- Sec. 121. 1-year increase for home health services furnished in a rural area.
- Sec. 122. Redistribution of unused resident positions.

Subtitle D—Other Provisions

- Sec. 131. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 132. Office of rural health policy improvements.
- Sec. 133. MedPac study on rural hospital payment adjustments.
- Sec. 134. Frontier extended stay clinic demonstration project.

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 201. Revision of acute care hospital payment updates.
- Sec. 202. Revision of the indirect medical education (IME) adjustment percentage.
- Sec. 203. Recognition of new medical technologies under inpatient hospital prospective payment system.
- Sec. 204. Increase in Federal rate for hospitals in Puerto Rico.
- Sec. 205. Wage index adjustment reclassification reform.
- Sec. 206. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
- Sec. 207. Clarifications to certain exceptions to medicare limits on physician referrals.
- Sec. 208. 1-time appeals process for hospital wage index classification.

Subtitle B—Other Provisions

- Sec. 211. Payment for covered skilled nursing facility services.
- Sec. 212. Coverage of hospice consultation services.
- Sec. 213. Study on portable diagnostic ultrasound services for beneficiaries in skilled nursing facilities.

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

- Sec. 301. Revision of updates for physicians' services.
- Sec. 302. Treatment of physicians' services furnished in Alaska.

- Sec. 303. Inclusion of podiatrists, dentists, and optometrists under private contracting authority.
- Sec. 304. GAO study on access to physicians' services.
- Sec. 305. Collaborative demonstration-based review of physician practice expense geographic adjustment data.
- Sec. 306. MedPac report on payment for physicians' services.

Subtitle B—Preventive Services

- Sec. 311. Coverage of an initial preventive physical examination.
- Sec. 312. Coverage of cardiovascular screening blood tests.
- Sec. 313. Coverage of diabetes screening tests.
- Sec. 314. Improved payment for certain mammography services.

Subtitle C—Other Provisions

- Sec. 321. Hospital outpatient department (HOPD) payment reform.
- Sec. 322. Limitation of application of functional equivalence standard.
- Sec. 323. Payment for renal dialysis services.
- Sec. 324. 2-year moratorium on therapy caps; provisions relating to reports.
- Sec. 325. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 326. Payment for services furnished in ambulatory surgical centers.
- Sec. 327. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
- Sec. 328. 5-year authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

- Sec. 341. Demonstration project for coverage of certain prescription drugs and biologicals.
- Sec. 342. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
- Sec. 343. MedPac study of coverage of surgical first assisting services of certified registered nurse first assistants.
- Sec. 344. MedPac study of payment for cardio-thoracic surgeons.
- Sec. 345. Studies relating to vision impairments.
- Sec. 346. Medicare health care quality demonstration programs.
- Sec. 347. MedPac study on direct access to physical therapy services.
- Sec. 348. Demonstration project for consumer-directed chronic outpatient services.
- Sec. 349. Medicare care management performance demonstration.
- Sec. 350. GAO study and report on the propagation of concierge care.
- Sec. 351. Demonstration of coverage of chiropractic services under medicare.

TITLE IV—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 401. Demonstration project to clarify the definition of homebound.
- Sec. 402. Demonstration project for medical adult day-care services.
- Sec. 403. Temporary suspension of oasis requirement for collection of data on non-medicare and non-medicaid patients.
- Sec. 404. MedPac study on medicare margins of home health agencies.
- Sec. 405. Coverage of religious nonmedical health care institution services furnished in the home.

Subtitle B—Graduate Medical Education

- Sec. 411. Exception to initial residency period for geriatric residency or fellowship programs.
- Sec. 412. Treatment of volunteer supervision.

Subtitle C—Chronic Care Improvement

- Sec. 421. Voluntary chronic care improvement under traditional fee-for-service.
- Sec. 422. Medicare advantage quality improvement programs.
- Sec. 423. Chronically ill medicare beneficiary research, data, demonstration strategy.

Subtitle D—Other Provisions

- Sec. 431. Improvements in national and local coverage determination process to respond to changes in technology.
- Sec. 432. Extension of treatment of certain physician pathology services under medicare.
- Sec. 433. Payment for pancreatic islet cell investigational transplants for medicare beneficiaries in clinical trials.
- Sec. 434. Restoration of medicare trust funds.
- Sec. 435. Modifications to Medicare Payment Advisory Commission (MedPac).
- Sec. 436. Technical amendments.

TITLE V—ADMINISTRATIVE IMPROVEMENTS, REGULATORY
REDUCTION, AND CONTRACTING REFORM

- Sec. 500. Administrative improvements within the Centers for Medicare & Medicaid Services (CMS).

Subtitle A—Regulatory Reform

- Sec. 501. Construction; definition of supplier.
- Sec. 502. Issuance of regulations.
- Sec. 503. Compliance with changes in regulations and policies.
- Sec. 504. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

- Sec. 511. Increased flexibility in medicare administration.
- Sec. 512. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

- Sec. 521. Provider education and technical assistance.
- Sec. 522. Small provider technical assistance demonstration program.
- Sec. 523. Medicare beneficiary ombudsman.
- Sec. 524. Beneficiary outreach demonstration program.
- Sec. 525. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
- Sec. 526. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

- Sec. 531. Transfer of responsibility for medicare appeals.
- Sec. 532. Process for expedited access to review.

- Sec. 533. Revisions to medicare appeals process.
- Sec. 534. Prepayment review.
- Sec. 535. Recovery of overpayments.
- Sec. 536. Provider enrollment process; right of appeal.
- Sec. 537. Process for correction of minor errors and omissions without pursuing appeals process.
- Sec. 538. Prior determination process for certain items and services; advance beneficiary notices.
- Sec. 539. Appeals by providers when there is no other party available.
- Sec. 540. Revisions to appeals timeframes and amounts.
- Sec. 540A. Mediation process for local coverage determinations.

Subtitle E—Miscellaneous Provisions

- Sec. 541. Policy development regarding evaluation and management (E & M) documentation guidelines.
- Sec. 542. Improvement in oversight of technology and coverage.
- Sec. 543. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 544. EMTALA improvements.
- Sec. 545. Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group.
- Sec. 546. Authorizing use of arrangements to provide core hospice services in certain circumstances.
- Sec. 547. Application of OSHA bloodborne pathogens standard to certain hospitals.
- Sec. 548. Bipa-related technical amendments and corrections.
- Sec. 549. Conforming authority to waive a program exclusion.
- Sec. 550. Treatment of certain dental claims.
- Sec. 551. Furnishing hospitals with information to compute DSH formula.
- Sec. 552. Revisions to reassignment provisions.
- Sec. 553. Other provisions.

TITLE VI—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

- Sec. 601. Medicaid disproportionate share hospital (DSH) payments.
- Sec. 602. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.
- Sec. 603. Extension of moratorium.

Subtitle B—Miscellaneous Provisions

- Sec. 611. Federal reimbursement of emergency health services furnished to undocumented aliens.
- Sec. 612. Commission on Systemic Interoperability.
- Sec. 613. Research on outcomes of health care items and services.
- Sec. 614. Health care that works for all Americans: Citizens Health Care Working Group.
- Sec. 615. Funding start-up administrative costs for medicare reform.
- Sec. 616. Health care infrastructure improvement program.

1 **TITLE I—RURAL PROVISIONS**
2 **Subtitle A—Provisions Relating to**
3 **Part A Only**

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

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

10 (1) by striking “(iv) For discharges” and in-
11 serting “(iv)(I) Subject to subclause (II), for dis-
12 charges”; and

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

15 “(II) For discharges occurring in a fiscal year
16 (beginning with fiscal year 2004), the Secretary
17 shall compute a standardized amount for hospitals
18 located in any area within the United States and
19 within each region equal to the standardized amount
20 computed for the previous fiscal year under this sub-
21 paragraph for hospitals located in a large urban area
22 (or, beginning with fiscal year 2005, for all hospitals
23 in the previous fiscal year) increased by the applica-
24 ble percentage increase under subsection (b)(3)(B)(i)
25 for the fiscal year involved.”.

1 (b) CONFORMING AMENDMENTS.—

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

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

7 (B) in the matter preceding clause (i), by
8 striking “, each of”;

9 (C) in clause (i)—

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

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

15 (D) in clause (ii)—

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

19 (ii) in subclause (II), by striking the
20 period at the end and inserting “; and”;
21 and

22 (E) by adding at the end the following new
23 clause:

1 “(iii) for a fiscal year beginning after fiscal
2 year 2003, for hospitals located in all areas, to
3 the product of—

4 “(I) the applicable standardized
5 amount (computed under subparagraph
6 (A)), reduced under subparagraph (B),
7 and adjusted or reduced under subpara-
8 graph (C) for the fiscal year; and

9 “(II) the weighting factor (determined
10 under paragraph (4)(B)) for that diag-
11 nosis-related group.”.

12 (2) TECHNICAL CONFORMING SUNSET.—Section
13 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

14 (A) in the matter preceding subparagraph
15 (A), by inserting “, for fiscal years before fiscal
16 year 1997,” before “a regional adjusted DRG
17 prospective payment rate”; and

18 (B) in subparagraph (D), in the matter
19 preceding clause (i), by inserting “, for fiscal
20 years before fiscal year 1997,” before “a re-
21 gional DRG prospective payment rate for each
22 region,”.

23 (3) ADDITIONAL TECHNICAL AMENDMENT.—
24 Section 1886(d)(3)(A)(iii) (42 U.S.C.

1 1395ww(d)(3)(A)(iii)) is amended by striking “in an
 2 other urban area” and inserting “in an urban area”.

3 (c) EQUALIZING URBAN AND RURAL STANDARDIZED
 4 PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT
 5 HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR HOS-
 6 PITALS IN PUERTO RICO.—

7 (1) IN GENERAL.—Section 1886(d)(9)(A) (42
 8 U.S.C. 1395ww(d)(9)(A)), as amended by section
 9 204, is amended—

10 (A) in clause (i), by striking “and” after
 11 the comma at the end; and

12 (B) by striking clause (ii) and inserting the
 13 following new clause:

14 “(ii) the applicable Federal percentage (speci-
 15 fied in subparagraph (E)) of—

16 “(I) for discharges beginning in a fiscal
 17 year beginning on or after October 1, 1997, and
 18 before October 1, 2003, the discharge-weighted
 19 average of—

20 “(aa) the national adjusted DRG pro-
 21 spective payment rate (determined under
 22 paragraph (3)(D)) for hospitals located in
 23 a large urban area,

24 “(bb) such rate for hospitals located
 25 in other urban areas, and

1 “(cc) such rate for hospitals located in
 2 a rural area,
 3 for such discharges, adjusted in the manner
 4 provided in paragraph (3)(E) for different area
 5 wage levels; and

6 “(II) for discharges in a fiscal year begin-
 7 ning on or after October 1, 2003, the national
 8 DRG prospective payment rate determined
 9 under paragraph (3)(D)(iii) for hospitals lo-
 10 cated in any area for such discharges, adjusted
 11 in the manner provided in paragraph (3)(E) for
 12 different area wage levels.

13 As used in this section, the term ‘subsection (d) Puerto
 14 Rico hospital’ means a hospital that is located in Puerto
 15 Rico and that would be a subsection (d) hospital (as de-
 16 fined in paragraph (1)(B)) if it were located in one of the
 17 50 States.”.

18 (2) APPLICATION OF PUERTO RICO STANDARD-
 19 IZED AMOUNT BASED ON LARGE URBAN AREAS.—
 20 Section 1886(d)(9)(C) (42 U.S.C. 1395ww(d)(9)(C))
 21 is amended—

22 (A) in clause (i)—

23 (i) by striking “(i) The Secretary”
 24 and inserting “(i)(I) For discharges in a

1 fiscal year after fiscal year 1988 and be-
2 fore fiscal year 2004, the Secretary”; and

3 (ii) by adding at the end the following
4 new subclause:

5 “(II) For discharges occurring in a fiscal year
6 (beginning with fiscal year 2004), the Secretary
7 shall compute an average standardized amount for
8 hospitals located in any area of Puerto Rico that is
9 equal to the average standardized amount computed
10 under subclause (I) for fiscal year 2003 for hospitals
11 in a large urban area (or, beginning with fiscal year
12 2005, for all hospitals in the previous fiscal year) in-
13 creased by the applicable percentage increase under
14 subsection (b)(3)(B) for the fiscal year involved.”;

15 (B) in clause (ii), by inserting “(or for fis-
16 cal year 2004 and thereafter, the average
17 standardized amount)” after “each of the aver-
18 age standardized amounts”; and

19 (C) in clause (iii)(I), by striking “for hos-
20 pitals located in an urban or rural area, respec-
21 tively”.

22 (d) IMPLEMENTATION.—

23 (1) IN GENERAL.—The amendments made by
24 subsections (a), (b), and (c)(1) of this section shall
25 have no effect on the authority of the Secretary,

1 under subsection (b)(2) of section 402 of Public Law
 2 108–89, to delay implementation of the extension of
 3 provisions equalizing urban and rural standardized
 4 inpatient hospital payments under subsection (a) of
 5 such section 402.

6 (2) APPLICATION OF PUERTO RICO STANDARD-
 7 IZED AMOUNT BASED ON LARGE URBAN AREAS.—
 8 The authority of the Secretary referred to in para-
 9 graph (1) shall apply with respect to the amend-
 10 ments made by subsection (c)(2) of this section in
 11 the same manner as that authority applies with re-
 12 spect to the extension of provisions equalizing urban
 13 and rural standardized inpatient hospital payments
 14 under subsection (a) of such section 402, except that
 15 any reference in subsection (b)(2)(A) of such section
 16 402 is deemed to be a reference to April 1, 2004.

17 **SEC. 102. ENHANCED DISPROPORTIONATE SHARE HOS-**
 18 **PITAL (DSH) TREATMENT FOR RURAL HOS-**
 19 **PITALS AND URBAN HOSPITALS WITH FEWER**
 20 **THAN 100 BEDS.**

21 (a) DOUBLING THE CAP.—Section 1886(d)(5)(F)
 22 (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at
 23 the end the following new clause:

24 “(xiv)(I) In the case of discharges occurring on or
 25 after April 1, 2004, subject to subclause (II), there shall

1 be substituted for the disproportionate share adjustment
2 percentage otherwise determined under clause (iv) (other
3 than subclause (I)) or under clause (viii), (x), (xi), (xii),
4 or (xiii), the disproportionate share adjustment percentage
5 determined under clause (vii) (relating to large, urban hos-
6 pitals).

7 “(II) Under subclause (I), the disproportionate share
8 adjustment percentage shall not exceed 12 percent for a
9 hospital that is not classified as a rural referral center
10 under subparagraph (C).”.

11 (b) CONFORMING AMENDMENTS.—Section 1886(d)
12 (42 U.S.C. 1395ww(d)) is amended—

13 (1) in paragraph (5)(F)—

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

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

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

24 (2) in paragraph (2)(C)(iv)—

1 (A) by striking “or” before “the enactment
2 of section 303”; and

3 (B) by inserting before the period at the
4 end the following: “, or the enactment of sec-
5 tion 402(a)(1) of the Medicare Provider Res-
6 toration Act of 2003”.

7 **SEC. 103. ADJUSTMENT TO THE MEDICARE INPATIENT HOS-**
8 **PITAL PROSPECTIVE PAYMENT SYSTEM**
9 **WAGE INDEX TO REVISE THE LABOR-RE-**
10 **LATED SHARE OF SUCH INDEX.**

11 (a) ADJUSTMENT.—

12 (1) IN GENERAL.—Section 1886(d)(3)(E) (42
13 U.S.C. 1395ww(d)(3)(E)) is amended—

14 (A) by striking “WAGE LEVELS.—The Sec-
15 retary” and inserting “WAGE LEVELS.—

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

18 (B) by adding at the end the following new
19 clause:

20 “(ii) ALTERNATIVE PROPORTION TO BE
21 ADJUSTED BEGINNING IN FISCAL YEAR 2005.—

22 For discharges occurring on or after October 1,
23 2004, the Secretary shall substitute ‘62 per-
24 cent’ for the proportion described in the first
25 sentence of clause (i), unless the application of

1 this clause would result in lower payments to a
2 hospital than would otherwise be made.”.

3 (2) WAIVING BUDGET NEUTRALITY.—Section
4 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as
5 amended by subsection (a), is amended by adding at
6 the end of clause (i) the following new sentence:
7 “The Secretary shall apply the previous sentence for
8 any period as if the amendments made by section
9 103(a)(1) of the Medicare Provider Restoration Act
10 of 2003 had not been enacted.”.

11 (b) APPLICATION TO PUERTO RICO HOSPITALS.—
12 Section 1886(d)(9)(C)(iv) (42 U.S.C.
13 1395ww(d)(9)(C)(iv)) is amended—

14 (1) by inserting “(I)” after “(iv)”;

15 (2) by striking “paragraph (3)(E)” and insert-
16 ing “paragraph (3)(E)(i)”; and

17 (3) by adding at the end the following new sub-
18 clause:

19 “(II) For discharges occurring on or after Octo-
20 ber 1, 2004, the Secretary shall substitute ‘62 per-
21 cent’ for the proportion described in the first sen-
22 tence of clause (i), unless the application of this sub-
23 clause would result in lower payments to a hospital
24 than would otherwise be made.”.

1 **SEC. 104. MORE FREQUENT UPDATE IN WEIGHTS USED IN**
2 **HOSPITAL MARKET BASKET.**

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

11 (b) INCORPORATION OF EXPLANATION IN RULE-
12 MAKING.—The Secretary shall include in the publication
13 of the final rule for payment for inpatient hospital services
14 under section 1886(d) of the Social Security Act (42
15 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation
16 of the reasons for, and options considered, in determining
17 frequency established under subsection (a).

18 **SEC. 105. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**
19 **PROGRAM.**

20 (a) INCREASE IN PAYMENT AMOUNTS.—

21 (1) IN GENERAL.—Sections 1814(l),
22 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l),
23 1395m(g)(1), and 1395tt(a)(3)) are each amended
24 by inserting “equal to 101 percent of” before “the
25 reasonable costs”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall apply to payments for serv-
3 ices furnished during cost reporting periods begin-
4 ning on or after January 1, 2004.

5 (b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY
6 ROOM ON-CALL PROVIDERS.—

7 (1) IN GENERAL.—Section 1834(g)(5) (42
8 U.S.C. 1395m(g)(5)) is amended—

9 (A) in the heading—

10 (i) by inserting “CERTAIN” before
11 “EMERGENCY”; and

12 (ii) by striking “PHYSICIANS” and in-
13 serting “PROVIDERS”;

14 (B) by striking “emergency room physi-
15 cians who are on-call (as defined by the Sec-
16 retary)” and inserting “physicians, physician
17 assistants, nurse practitioners, and clinical
18 nurse specialists who are on-call (as defined by
19 the Secretary) to provide emergency services”;
20 and

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

23 (2) EFFECTIVE DATE.—The amendments made
24 by paragraph (1) shall apply with respect to costs

1 incurred for services furnished on or after January
2 1, 2005.

3 (c) AUTHORIZATION OF PERIODIC INTERIM PAY-
4 MENT (PIP).—

5 (1) IN GENERAL.—Section 1815(e)(2) (42
6 U.S.C. 1395g(e)(2)) is amended—

7 (A) in the matter before subparagraph (A),
8 by inserting “, in the cases described in sub-
9 paragraphs (A) through (D)” after “1986”;

10 (B) by striking “and” at the end of sub-
11 paragraph (C);

12 (C) by adding “and” at the end of sub-
13 paragraph (D); and

14 (D) by inserting after subparagraph (D)
15 the following new subparagraph:

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

17 (2) DEVELOPMENT OF ALTERNATIVE TIMING
18 METHODS OF PERIODIC INTERIM PAYMENTS.—With
19 respect to periodic interim payments to critical ac-
20 cess hospitals for inpatient critical access hospital
21 services under section 1815(e)(2)(E) of the Social
22 Security Act, as added by paragraph (1), the Sec-
23 retary shall develop alternative methods for the tim-
24 ing of such payments.

1 (3) AUTHORIZATION OF PIP.—The amendments
2 made by paragraph (1) shall apply to payments
3 made on or after July 1, 2004.

4 (d) CONDITION FOR APPLICATION OF SPECIAL PRO-
5 FESSIONAL SERVICE PAYMENT ADJUSTMENT.—

6 (1) IN GENERAL.—Section 1834(g)(2) (42
7 U.S.C. 1395m(g)(2)) is amended by adding after
8 and below subparagraph (B) the following:
9 “The Secretary may not require, as a condition for
10 applying subparagraph (B) with respect to a critical
11 access hospital, that each physician or other practi-
12 tioner providing professional services in the hospital
13 must assign billing rights with respect to such serv-
14 ices, except that such subparagraph shall not apply
15 to those physicians and practitioners who have not
16 assigned such billing rights.”.

17 (2) EFFECTIVE DATE.—

18 (A) IN GENERAL.—Except as provided in
19 subparagraph (B), the amendment made by
20 paragraph (1) shall apply to cost reporting peri-
21 ods beginning on or after July 1, 2004.

22 (B) RULE OF APPLICATION.—In the case
23 of a critical access hospital that made an elec-
24 tion under section 1834(g)(2) of the Social Se-
25 curity Act (42 U.S.C. 1395m(g)(2)) before No-

1 vember 1, 2003, the amendment made by para-
2 graph (1) shall apply to cost reporting periods
3 beginning on or after July 1, 2001.

4 (e) REVISION OF BED LIMITATION FOR HOS-
5 PITALS.—

6 (1) IN GENERAL.—Section 1820(c)(2)(B)(iii)
7 (42 U.S.C. 1395i-4(e)(2)(B)(iii)) is amended by
8 striking “15 (or, in the case of a facility under an
9 agreement described in subsection (f), 25)” and in-
10 sserting “25”.

11 (2) CONFORMING AMENDMENT.—Section
12 1820(f) (42 U.S.C. 1395i-4(f)) is amended by strik-
13 ing “and the number of beds used at any time for
14 acute care inpatient services does not exceed 15
15 beds”.

16 (3) EFFECTIVE DATE.—The amendments made
17 by this subsection shall apply to designations made
18 before, on, or after January 1, 2004, but any elec-
19 tion made pursuant to regulations promulgated to
20 carry out such amendments shall only apply prospec-
21 tively.

22 (f) PROVISIONS RELATING TO FLEX GRANTS.—

23 (1) ADDITIONAL 4-YEAR PERIOD OF FUND-
24 ING.—Section 1820(j) (42 U.S.C. 1395i-4(j)) is
25 amended by inserting before the period at the end

1 the following: “, and for making grants to all States
2 under paragraphs (1) and (2) of subsection (g),
3 \$35,000,000 in each of fiscal years 2005 through
4 2008”.

5 (2) ADDITIONAL REQUIREMENTS AND ADMINIS-
6 TRATION.—Section 1820(g) (42 U.S.C. 1395i–4(g))
7 is amended by adding at the end the following new
8 paragraphs:

9 “(4) ADDITIONAL REQUIREMENTS WITH RE-
10 SPECT TO FLEX GRANTS.—With respect to grants
11 awarded under paragraph (1) or (2) from funds ap-
12 propriated for fiscal year 2005 and subsequent fiscal
13 years—

14 “(A) CONSULTATION WITH THE STATE
15 HOSPITAL ASSOCIATION AND RURAL HOSPITALS
16 ON THE MOST APPROPRIATE WAYS TO USE
17 GRANTS.—A State shall consult with the hos-
18 pital association of such State and rural hos-
19 pitals located in such State on the most appro-
20 priate ways to use the funds under such grant.

21 “(B) LIMITATION ON USE OF GRANT
22 FUNDS FOR ADMINISTRATIVE EXPENSES.—A
23 State may not expend more than the lesser of—

24 “(i) 15 percent of the amount of the
25 grant for administrative expenses; or

1 “(ii) the State’s federally negotiated
2 indirect rate for administering the grant.

3 “(5) USE OF FUNDS FOR FEDERAL ADMINIS-
4 TRATIVE EXPENSES.—Of the total amount appro-
5 priated for grants under paragraphs (1) and (2) for
6 a fiscal year (beginning with fiscal year 2005), up
7 to 5 percent of such amount shall be available to the
8 Health Resources and Services Administration for
9 purposes of administering such grants.”.

10 (g) AUTHORITY TO ESTABLISH PSYCHIATRIC AND
11 REHABILITATION DISTINCT PART UNITS.—

12 (1) IN GENERAL.—Section 1820(c)(2) (42
13 U.S.C. 1395i-4(c)(2)) is amended by adding at the
14 end the following:

15 “(E) AUTHORITY TO ESTABLISH PSY-
16 CHIATRIC AND REHABILITATION DISTINCT PART
17 UNITS.—

18 “(i) IN GENERAL.—Subject to the
19 succeeding provisions of this subparagraph,
20 a critical access hospital may establish—

21 “(I) a psychiatric unit of the hos-
22 pital that is a distinct part of the hos-
23 pital; and

1 “(II) a rehabilitation unit of the
2 hospital that is a distinct part of the
3 hospital,

4 if the distinct part meets the requirements
5 (including conditions of participation) that
6 would otherwise apply to the distinct part
7 if the distinct part were established by a
8 subsection (d) hospital in accordance with
9 the matter following clause (v) of section
10 1886(d)(1)(B), including any regulations
11 adopted by the Secretary under such sec-
12 tion.

13 “(ii) LIMITATION ON NUMBER OF
14 BEDS.—The total number of beds that
15 may be established under clause (i) for a
16 distinct part unit may not exceed 10.

17 “(iii) EXCLUSION OF BEDS FROM BED
18 COUNT.—In determining the number of
19 beds of a critical access hospital for pur-
20 poses of applying the bed limitations re-
21 ferred to in subparagraph (B)(iii) and sub-
22 section (f), the Secretary shall not take
23 into account any bed established under
24 clause (i).

1 “(iv) EFFECT OF FAILURE TO MEET
2 REQUIREMENTS.—If a psychiatric or reha-
3 bilitation unit established under clause (i)
4 does not meet the requirements described
5 in such clause with respect to a cost re-
6 porting period, no payment may be made
7 under this title to the hospital for services
8 furnished in such unit during such period.
9 Payment to the hospital for services fur-
10 nished in the unit may resume only after
11 the hospital has demonstrated to the Sec-
12 retary that the unit meets such require-
13 ments.”.

14 (2) PAYMENT ON A PROSPECTIVE PAYMENT
15 BASIS.—Section 1814(l) (42 U.S.C. 1395f(l)) is
16 amended—

17 (A) by striking “(l) The amount” and in-
18 serting “(l)(1) Except as provided in paragraph
19 (2), the amount”; and

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

22 “(2) In the case of a distinct part psychiatric or reha-
23 bilitation unit of a critical access hospital described in sec-
24 tion 1820(c)(2)(E), the amount of payment for inpatient
25 critical access hospital services of such unit shall be equal

1 to the amount of the payment that would otherwise be
2 made if such services were inpatient hospital services of
3 a distinct part psychiatric or rehabilitation unit, respec-
4 tively, described in the matter following clause (v) of sec-
5 tion 1886(d)(1)(B).”.

6 (3) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to cost reporting peri-
8 ods beginning on or after October 1, 2004.

9 (h) WAIVER AUTHORITY.—

10 (1) IN GENERAL.—Section 1820(c)(2)(B)(i)(II)
11 (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is amended by
12 inserting “before January 1, 2006,” after “is cer-
13 tified”.

14 (2) GRANDFATHERING WAIVER AUTHORITY FOR
15 CERTAIN FACILITIES.—Section 1820(h) (42 U.S.C.
16 1395i–4(h)) is amended—

17 (A) in the heading preceding paragraph
18 (1), by striking “OF CERTAIN FACILITIES” and
19 inserting “PROVISIONS”; and

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

22 “(3) STATE AUTHORITY TO WAIVE 35-MILE
23 RULE.—In the case of a facility that was designated
24 as a critical access hospital before January 1, 2006,
25 and was certified by the State as being a necessary

1 provider of health care services to residents in the
 2 area under subsection (c)(2)(B)(i)(II), as in effect
 3 before such date, the authority under such sub-
 4 section with respect to any redesignation of such fa-
 5 cility shall continue to apply notwithstanding the
 6 amendment made by section 105(h)(1) of the Medi-
 7 care Provider Restoration Act of 2003.”.

8 **SEC. 106. MEDICARE INPATIENT HOSPITAL PAYMENT AD-**
 9 **JUSTMENT FOR LOW-VOLUME HOSPITALS.**

10 (a) IN GENERAL.—Section 1886(d) (42 U.S.C.
 11 1395ww(d)) is amended by adding at the end the following
 12 new paragraph:

13 “(12) PAYMENT ADJUSTMENT FOR LOW-VOL-
 14 UME HOSPITALS.—

15 “(A) IN GENERAL.—In addition to any
 16 payments calculated under this section for a
 17 subsection (d) hospital, for discharges occurring
 18 during a fiscal year (beginning with fiscal year
 19 2005), the Secretary shall provide for an addi-
 20 tional payment amount to each low-volume hos-
 21 pital (as defined in subparagraph (C)(i)) for
 22 discharges occurring during that fiscal year
 23 that is equal to the applicable percentage in-
 24 crease (determined under subparagraph (B) for
 25 the hospital involved) in the amount paid to

1 such hospital under this section for such dis-
2 charges (determined without regard to this
3 paragraph).

4 “(B) APPLICABLE PERCENTAGE IN-
5 CREASE.—The Secretary shall determine an ap-
6 plicable percentage increase for purposes of
7 subparagraph (A) as follows:

8 “(i) The Secretary shall determine the
9 empirical relationship for subsection (d)
10 hospitals between the standardized cost-
11 per-case for such hospitals and the total
12 number of discharges of such hospitals and
13 the amount of the additional incremental
14 costs (if any) that are associated with such
15 number of discharges.

16 “(ii) The applicable percentage in-
17 crease shall be determined based upon
18 such relationship in a manner that reflects,
19 based upon the number of such discharges
20 for a subsection (d) hospital, such addi-
21 tional incremental costs.

22 “(iii) In no case shall the applicable
23 percentage increase exceed 25 percent.

24 “(C) DEFINITIONS.—

1 “(i) LOW-VOLUME HOSPITAL.—For
 2 purposes of this paragraph, the term ‘low-
 3 volume hospital’ means, for a fiscal year, a
 4 subsection (d) hospital (as defined in para-
 5 graph (1)(B)) that the Secretary deter-
 6 mines is located more than 25 road miles
 7 from another subsection (d) hospital and
 8 has less than 800 discharges during the
 9 fiscal year.

10 “(ii) DISCHARGE.—For purposes of
 11 subparagraph (B) and clause (i), the term
 12 ‘discharge’ means an inpatient acute care
 13 discharge of an individual regardless of
 14 whether the individual is entitled to bene-
 15 fits under part A.”.

16 (b) JUDICIAL REVIEW.—Section 1886(d)(7)(A) (42
 17 U.S.C. 1395ww(d)(7)(A)) is amended by inserting after
 18 “to subsection (e)(1)” the following: “or the determination
 19 of the applicable percentage increase under paragraph
 20 (12)(A)(ii)”.

21 **SEC. 107. TREATMENT OF MISSING COST REPORTING PERI-**
 22 **ODS FOR SOLE COMMUNITY HOSPITALS.**

23 (a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C.
 24 1395ww(b)(3)(I)) is amended by adding at the end the
 25 following new clause:

1 “(iii) In no case shall a hospital be denied treatment
 2 as a sole community hospital or payment (on the basis
 3 of a target rate as such as a hospital) because data are
 4 unavailable for any cost reporting period due to changes
 5 in ownership, changes in fiscal intermediaries, or other ex-
 6 traordinary circumstances, so long as data for at least one
 7 applicable base cost reporting period is available.”.

8 (b) EFFECTIVE DATE.—The amendment made by
 9 subsection (a) shall apply to cost reporting periods begin-
 10 ning on or after January 1, 2004.

11 **SEC. 108. RECOGNITION OF ATTENDING NURSE PRACTI-**
 12 **TIONERS AS ATTENDING PHYSICIANS TO**
 13 **SERVE HOSPICE PATIENTS.**

14 (a) IN GENERAL.—Section 1861(dd)(3)(B) (42
 15 U.S.C. 1395x(dd)(3)(B)) is amended by inserting “or
 16 nurse practitioner (as defined in subsection (aa)(5))” after
 17 “the physician (as defined in subsection (r)(1))”.

18 (b) CLARIFICATION OF HOSPICE ROLE OF NURSE
 19 PRACTITIONERS.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C.
 20 1395f(a)(7)(A)(i)(I)) is amended by inserting “(which for
 21 purposes of this subparagraph does not include a nurse
 22 practitioner)” after “attending physician (as defined in
 23 section 1861(dd)(3)(B))”.

1 **SEC. 109. RURAL HOSPICE DEMONSTRATION PROJECT.**

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

11 (b) SCOPE OF PROJECT.—The Secretary shall con-
12 duct the project under this section with respect to no more
13 than 3 hospice programs over a period of not longer than
14 5 years each.

15 (c) COMPLIANCE WITH CONDITIONS.—Under the
16 demonstration project—

17 (1) the hospice program shall comply with oth-
18 erwise applicable requirements, except that it shall
19 not be required to offer services outside of the home
20 or to meet the requirements of section
21 1861(dd)(2)(A)(iii) of the Social Security Act; and

22 (2) payments for hospice care shall be made at
23 the rates otherwise applicable to such care under
24 title XVIII of such Act.

25 The Secretary may require the program to comply with
26 such additional quality assurance standards for its provi-

1 sion of services in its facility as the Secretary deems ap-
 2 propriate.

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

8 **SEC. 110. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC**
 9 **AND FEDERALLY QUALIFIED HEALTH CEN-**
 10 **TER SERVICES FROM THE PROSPECTIVE PAY-**
 11 **MENT SYSTEM FOR SKILLED NURSING FA-**
 12 **CILITIES.**

13 (a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C.
 14 1395yy(e)(2)(A)) is amended—

15 (1) in clause (i)(II), by striking “clauses (ii)
 16 and (iii)” and inserting “clauses (ii), (iii), and (iv)”;
 17 and

18 (2) by adding at the end the following new
 19 clause:

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

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

4 “(II) Federally qualified health
5 center services (as defined in para-
6 graph (3) of such section);

7 that would be described in clause (ii) if
8 such services were furnished by an indi-
9 vidual not affiliated with a rural health
10 clinic or a Federally qualified health cen-
11 ter.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to services furnished on or after
14 January 1, 2005.

15 **SEC. 110A. RURAL COMMUNITY HOSPITAL DEMONSTRA-**
16 **TION PROGRAM.**

17 (a) ESTABLISHMENT OF RURAL COMMUNITY HOS-
18 PITAL (RCH) DEMONSTRATION PROGRAM.—

19 (1) IN GENERAL.—The Secretary shall establish
20 a demonstration program to test the feasibility and
21 advisability of the establishment of rural community
22 hospitals (as defined in subsection (f)(1)) to furnish
23 covered inpatient hospital services (as defined in
24 subsection (f)(2)) to medicare beneficiaries.

1 (2) DEMONSTRATION AREAS.—The program
2 shall be conducted in rural areas selected by the Sec-
3 retary in States with low population densities, as de-
4 termined by the Secretary.

5 (3) APPLICATION.—Each rural community hos-
6 pital that is located in a demonstration area selected
7 under paragraph (2) that desires to participate in
8 the demonstration program under this section shall
9 submit an application to the Secretary at such time,
10 in such manner, and containing such information as
11 the Secretary may require.

12 (4) SELECTION OF HOSPITALS.—The Secretary
13 shall select from among rural community hospitals
14 submitting applications under paragraph (3) not
15 more than 15 of such hospitals to participate in the
16 demonstration program under this section.

17 (5) DURATION.—The Secretary shall conduct
18 the demonstration program under this section for a
19 5-year period.

20 (6) IMPLEMENTATION.—The Secretary shall
21 implement the demonstration program not later than
22 January 1, 2005, but may not implement the pro-
23 gram before October 1, 2004.

24 (b) PAYMENT.—

1 (1) IN GENERAL.—The amount of payment
2 under the demonstration program for covered inpa-
3 tient hospital services furnished in a rural commu-
4 nity hospital, other than such services furnished in
5 a psychiatric or rehabilitation unit of the hospital
6 which is a distinct part, is—

7 (A) for discharges occurring in the first
8 cost reporting period beginning on or after the
9 implementation of the demonstration program,
10 the reasonable costs of providing such services;
11 and

12 (B) for discharges occurring in a subse-
13 quent cost reporting period under the dem-
14 onstration program, the lesser of—

15 (i) the reasonable costs of providing
16 such services in the cost reporting period
17 involved; or

18 (ii) the target amount (as defined in
19 paragraph (2), applicable to the cost re-
20 porting period involved.

21 (2) TARGET AMOUNT.—For purposes of para-
22 graph (1)(B)(ii), the term “target amount” means,
23 with respect to a rural community hospital for a
24 particular 12-month cost reporting period—

1 (A) in the case of the second such report-
2 ing period for which this subsection is in effect,
3 the reasonable costs of providing such covered
4 inpatient hospital services as determined under
5 paragraph (1)(A), and

6 (B) in the case of a later reporting period,
7 the target amount for the preceding 12-month
8 cost reporting period,
9 increased by the applicable percentage increase
10 (under clause (i) of section 1886(b)(3)(B) of the So-
11 cial Security Act (42 U.S.C. 1395ww(b)(3)(B))) in
12 the market basket percentage increase (as defined in
13 clause (iii) of such section) for that particular cost
14 reporting period.

15 (c) FUNDING.—

16 (1) IN GENERAL.—The Secretary shall provide
17 for the transfer from the Federal Hospital Insurance
18 Trust Fund under section 1817 of the Social Secu-
19 rity Act (42 U.S.C. 1395i) of such funds as are nec-
20 essary for the costs of carrying out the demonstra-
21 tion program under this section.

22 (2) BUDGET NEUTRALITY.—In conducting the
23 demonstration program under this section, the Sec-
24 retary shall ensure that the aggregate payments
25 made by the Secretary do not exceed the amount

1 which the Secretary would have paid if the dem-
2 onstration program under this section was not im-
3 plemented.

4 (d) WAIVER AUTHORITY.—The Secretary may waive
5 such requirements of title XVIII of the Social Security Act
6 (42 U.S.C. 1395 et seq.) as may be necessary for the pur-
7 pose of carrying out the demonstration program under
8 this section.

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

15 (f) DEFINITIONS.—In this section:

16 (1) RURAL COMMUNITY HOSPITAL DEFINED.—

17 (A) IN GENERAL.—The term “rural com-
18 munity hospital” means a hospital (as defined
19 in section 1861(e) of the Social Security Act
20 (42 U.S.C. 1395x(e))) that—

21 (i) is located in a rural area (as de-
22 fined in section 1886(d)(2)(D) of such Act
23 (42 U.S.C. 1395ww(d)(2)(D))) or treated
24 as being so located pursuant to section

1 1886(d)(8)(E) of such Act (42 U.S.C.
2 1395ww(d)(8)(E));

3 (ii) subject to paragraph (2), has
4 fewer than 51 acute care inpatient beds, as
5 reported in its most recent cost report;

6 (iii) makes available 24-hour emer-
7 gency care services; and

8 (iv) is not eligible for designation, or
9 has not been designated, as a critical ac-
10 cess hospital under section 1820.

11 (B) TREATMENT OF PSYCHIATRIC AND RE-
12 HABILITATION UNITS.—For purposes of para-
13 graph (1)(B), beds in a psychiatric or rehabili-
14 tation unit of the hospital which is a distinct
15 part of the hospital shall not be counted.

16 (2) COVERED INPATIENT HOSPITAL SERV-
17 ICES.—The term “covered inpatient hospital serv-
18 ices” means inpatient hospital services, and includes
19 extended care services furnished under an agreement
20 under section 1883 of the Social Security Act (42
21 U.S.C. 1395tt).

1 **Subtitle B—Provisions Relating to**
2 **Part B Only**

3 **SEC. 111. 2-YEAR EXTENSION OF HOLD HARMLESS PROVI-**
4 **SIONS FOR SMALL RURAL HOSPITALS AND**
5 **SOLE COMMUNITY HOSPITALS UNDER THE**
6 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**
7 **PITAL OUTPATIENT DEPARTMENT SERVICES.**

8 (a) HOLD HARMLESS PROVISIONS.—

9 (1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42
10 U.S.C. 1395l(t)(7)(D)(i)) is amended—

11 (A) in the heading, by striking “SMALL”
12 and inserting “CERTAIN”;

13 (B) by inserting “or a sole community hos-
14 pital (as defined in section 1886(d)(5)(D)(iii))
15 located in a rural area” after “100 beds”; and

16 (C) by striking “2004” and inserting
17 “2006”.

18 (2) EFFECTIVE DATE.—The amendment made
19 by paragraph (1)(B) shall apply with respect to cost
20 reporting periods beginning on and after January 1,
21 2004.

22 (b) STUDY; AUTHORIZATION OF ADJUSTMENT.—Sec-
23 tion 1833(t) (42 U.S.C. 1395l(t)) is amended—

24 (1) by redesignating paragraph (13) as para-
25 graph (16); and

1 (2) by inserting after paragraph (12) the fol-
2 lowing new paragraph:

3 “(13) AUTHORIZATION OF ADJUSTMENT FOR
4 RURAL HOSPITALS.—

5 “(A) STUDY.—The Secretary shall conduct
6 a study to determine if, under the system under
7 this subsection, costs incurred by hospitals lo-
8 cated in rural areas by ambulatory payment
9 classification groups (APCs) exceed those costs
10 incurred by hospitals located in urban areas.

11 “(B) AUTHORIZATION OF ADJUSTMENT.—
12 Insofar as the Secretary determines under sub-
13 paragraph (A) that costs incurred by hospitals
14 located in rural areas exceed those costs in-
15 curred by hospitals located in urban areas, the
16 Secretary shall provide for an appropriate ad-
17 justment under paragraph (2)(E) to reflect
18 those higher costs by January 1, 2006.”.

19 **SEC. 112. ESTABLISHMENT OF FLOOR ON WORK GEO-**
20 **GRAPHIC ADJUSTMENT.**

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

23 (1) in subparagraph (A), by striking “subpara-
24 graphs (B) and (C)” and inserting “subparagraphs
25 (B), (C), and (E)”; and

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

3 “(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC
4 INDEX.—After calculating the work geographic
5 index in subparagraph (A)(iii), for purposes of
6 payment for services furnished on or after Jan-
7 uary 1, 2004, and before January 1, 2007, the
8 Secretary shall increase the work geographic
9 index to 1.00 for any locality for which such
10 work geographic index is less than 1.00.”.

11 **SEC. 113. MEDICARE INCENTIVE PAYMENT PROGRAM IM-**
12 **PROVEMENTS FOR PHYSICIAN SCARCITY.**

13 (a) ADDITIONAL INCENTIVE PAYMENT FOR CERTAIN
14 PHYSICIAN SCARCITY AREAS.—Section 1833 (42 U.S.C.
15 1395l) is amended by adding at the end the following new
16 subsection:

17 “(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCAR-
18 CITY AREAS.—

19 “(1) IN GENERAL.—In the case of physicians’
20 services furnished on or after January 1, 2005, and
21 before January 1, 2008—

22 “(A) by a primary care physician in a pri-
23 mary care scarcity county (identified under
24 paragraph (4)); or

1 “(B) by a physician who is not a primary
2 care physician in a specialist care scarcity coun-
3 ty (as so identified),
4 in addition to the amount of payment that would
5 otherwise be made for such services under this part,
6 there also shall be paid an amount equal to 5 per-
7 cent of the payment amount for the service under
8 this part.

9 “(2) DETERMINATION OF RATIOS OF PHYSI-
10 CIANS TO MEDICARE BENEFICIARIES IN AREA.—
11 Based upon available data, the Secretary shall estab-
12 lish for each county or equivalent area in the United
13 States, the following:

14 “(A) NUMBER OF PHYSICIANS PRACTICING
15 IN THE AREA.—The number of physicians who
16 furnish physicians’ services in the active prac-
17 tice of medicine or osteopathy in that county or
18 area, other than physicians whose practice is
19 exclusively for the Federal Government, physi-
20 cians who are retired, or physicians who only
21 provide administrative services. Of such num-
22 ber, the number of such physicians who are—

23 “(i) primary care physicians; or

24 “(ii) physicians who are not primary
25 care physicians.

1 “(B) NUMBER OF MEDICARE BENE-
2 FICIARIES RESIDING IN THE AREA.—The num-
3 ber of individuals who are residing in the coun-
4 ty and are entitled to benefits under part A or
5 enrolled under this part, or both (in this sub-
6 section referred to as ‘individuals’).

7 “(C) DETERMINATION OF RATIOS.—

8 “(i) PRIMARY CARE RATIO.—The ratio
9 (in this paragraph referred to as the ‘pri-
10 mary care ratio’) of the number of primary
11 care physicians (determined under sub-
12 paragraph (A)(i)), to the number of indi-
13 viduals determined under subparagraph
14 (B).

15 “(ii) SPECIALIST CARE RATIO.—The
16 ratio (in this paragraph referred to as the
17 ‘specialist care ratio’) of the number of
18 other physicians (determined under sub-
19 paragraph (A)(ii)), to the number of indi-
20 viduals determined under subparagraph
21 (B).

22 “(3) RANKING OF COUNTIES.—The Secretary
23 shall rank each such county or area based separately
24 on its primary care ratio and its specialist care ratio.

25 “(4) IDENTIFICATION OF COUNTIES.—

1 “(A) IN GENERAL.—The Secretary shall
2 identify—

3 “(i) those counties and areas (in this
4 paragraph referred to as ‘primary care
5 scarcity counties’) with the lowest primary
6 care ratios that represent, if each such
7 county or area were weighted by the num-
8 ber of individuals determined under para-
9 graph (2)(B), an aggregate total of 20 per-
10 cent of the total of the individuals deter-
11 mined under such paragraph; and

12 “(ii) those counties and areas (in this
13 subsection referred to as ‘specialist care
14 scarcity counties’) with the lowest spe-
15 cialist care ratios that represent, if each
16 such county or area were weighted by the
17 number of individuals determined under
18 paragraph (2)(B), an aggregate total of 20
19 percent of the total of the individuals de-
20 termined under such paragraph.

21 “(B) PERIODIC REVISIONS.—The Sec-
22 retary shall periodically revise the counties or
23 areas identified in subparagraph (A) (but not
24 less often than once every three years) unless
25 the Secretary determines that there is no new

1 data available on the number of physicians
2 practicing in the county or area or the number
3 of individuals residing in the county or area, as
4 identified in paragraph (2).

5 “(C) IDENTIFICATION OF COUNTIES
6 WHERE SERVICE IS FURNISHED.—For purposes
7 of paying the additional amount specified in
8 paragraph (1), if the Secretary uses the 5-digit
9 postal ZIP Code where the service is furnished,
10 the dominant county of the postal ZIP Code (as
11 determined by the United States Postal Service,
12 or otherwise) shall be used to determine wheth-
13 er the postal ZIP Code is in a scarcity county
14 identified in subparagraph (A) or revised in
15 subparagraph (B).

16 “(D) JUDICIAL REVIEW.—There shall be
17 no administrative or judicial review under sec-
18 tion 1869, 1878, or otherwise, respecting—

19 “(i) the identification of a county or
20 area;

21 “(ii) the assignment of a specialty of
22 any physician under this paragraph;

23 “(iii) the assignment of a physician to
24 a county under paragraph (2); or

1 “(iv) the assignment of a postal ZIP
2 Code to a county or other area under this
3 subsection.

4 “(5) RURAL CENSUS TRACTS.—To the extent
5 feasible, the Secretary shall treat a rural census
6 tract of a metropolitan statistical area (as deter-
7 mined under the most recent modification of the
8 Goldsmith Modification, originally published in the
9 Federal Register on February 27, 1992 (57 Fed.
10 Reg. 6725)), as an equivalent area for purposes of
11 qualifying as a primary care scarcity county or spe-
12 cialist care scarcity county under this subsection.

13 “(6) PHYSICIAN DEFINED.—For purposes of
14 this paragraph, the term ‘physician’ means a physi-
15 cian described in section 1861(r)(1) and the term
16 ‘primary care physician’ means a physician who is
17 identified in the available data as a general practi-
18 tioner, family practice practitioner, general internist,
19 or obstetrician or gynecologist.

20 “(7) PUBLICATION OF LIST OF COUNTIES;
21 POSTING ON WEBSITE.—With respect to a year for
22 which a county or area is identified or revised under
23 paragraph (4), the Secretary shall identify such
24 counties or areas as part of the proposed and final
25 rule to implement the physician fee schedule under

1 section 1848 for the applicable year. The Secretary
2 shall post the list of counties identified or revised
3 under paragraph (4) on the Internet website of the
4 Centers for Medicare & Medicaid Services.”.

5 (b) IMPROVEMENT TO MEDICARE INCENTIVE PAY-
6 MENT PROGRAM.—

7 (1) IN GENERAL.—Section 1833(m) (42 U.S.C.
8 1395l(m)) is amended—

9 (A) by inserting “(1)” after “(m)”;

10 (B) in paragraph (1), as designated by
11 subparagraph (A)—

12 (i) by inserting “in a year” after “In
13 the case of physicians’ services furnished”;

14 and

15 (ii) by inserting “as identified by the
16 Secretary prior to the beginning of such
17 year” after “as a health professional short-
18 age area”; and

19 (C) by adding at the end the following new
20 paragraphs:

21 “(2) For each health professional shortage area iden-
22 tified in paragraph (1) that consists of an entire county,
23 the Secretary shall provide for the additional payment
24 under paragraph (1) without any requirement on the phy-
25 sician to identify the health professional shortage area in-

1 volved. The Secretary may implement the previous sen-
 2 tence using the method specified in subsection (u)(4)(C).

3 “(3) The Secretary shall post on the Internet website
 4 of the Centers for Medicare & Medicaid Services a list of
 5 the health professional shortage areas identified in para-
 6 graph (1) that consist of a partial county to facilitate the
 7 additional payment under paragraph (1) in such areas.

8 “(4) There shall be no administrative or judicial re-
 9 view under section 1869, section 1878, or otherwise, re-
 10 specting—

11 “(A) the identification of a county or area;

12 “(B) the assignment of a specialty of any physi-
 13 cian under this paragraph;

14 “(C) the assignment of a physician to a county
 15 under this subsection; or

16 “(D) the assignment of a postal zip code to a
 17 county or other area under this subsection.”.

18 (2) EFFECTIVE DATE.—The amendments made
 19 by paragraph (1) shall apply to physicians’ services
 20 furnished on or after January 1, 2005.

21 (c) GAO STUDY OF GEOGRAPHIC DIFFERENCES IN
 22 PAYMENTS FOR PHYSICIANS’ SERVICES.—

23 (1) STUDY.—The Comptroller General of the
 24 United States shall conduct a study of differences in
 25 payment amounts under the physician fee schedule

1 under section 1848 of the Social Security Act (42
2 U.S.C. 1395w-4) for physicians' services in different
3 geographic areas. Such study shall include—

4 (A) an assessment of the validity of the ge-
5 ographic adjustment factors used for each com-
6 ponent of the fee schedule;

7 (B) an evaluation of the measures used for
8 such adjustment, including the frequency of re-
9 visions;

10 (C) an evaluation of the methods used to
11 determine professional liability insurance costs
12 used in computing the malpractice component,
13 including a review of increases in professional
14 liability insurance premiums and variation in
15 such increases by State and physician specialty
16 and methods used to update the geographic cost
17 of practice index and relative weights for the
18 malpractice component; and

19 (D) an evaluation of the effect of the ad-
20 justment to the physician work geographic
21 index under section 1848(e)(1)(E) of the Social
22 Security Act, as added by section 112, on phy-
23 sician location and retention in areas affected
24 by such adjustment, taking into account—

- 1 (i) differences in recruitment costs
2 and retention rates for physicians, includ-
3 ing specialists, between large urban areas
4 and other areas; and
- 5 (ii) the mobility of physicians, includ-
6 ing specialists, over the last decade.

7 (2) REPORT.—Not later than 1 year after the
8 date of the enactment of this Act, the Comptroller
9 General shall submit to Congress a report on the
10 study conducted under paragraph (1). The report
11 shall include recommendations regarding the use of
12 more current data in computing geographic cost of
13 practice indices as well as the use of data directly
14 representative of physicians’ costs (rather than
15 proxy measures of such costs).

16 **SEC. 114. PAYMENT FOR RURAL AND URBAN AMBULANCE**
17 **SERVICES.**

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

21 (1) in paragraph (2)(E), by inserting “con-
22 sistent with paragraph (11)” after “in an efficient
23 and fair manner”; and

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

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

6 “(10) PHASE-IN PROVIDING FLOOR USING
7 BLEND OF FEE SCHEDULE AND REGIONAL FEE
8 SCHEDULES.—In carrying out the phase-in under
9 paragraph (2)(E) for each level of ground service
10 furnished in a year, the portion of the payment
11 amount that is based on the fee schedule shall be the
12 greater of the amount determined under such fee
13 schedule (without regard to this paragraph) or the
14 following blended rate of the fee schedule under
15 paragraph (1) and of a regional fee schedule for the
16 region involved:

17 “(A) For 2004 (for services furnished on
18 or after July 1, 2004), the blended rate shall be
19 based 20 percent on the fee schedule under
20 paragraph (1) and 80 percent on the regional
21 fee schedule.

22 “(B) For 2005, the blended rate shall be
23 based 40 percent on the fee schedule under
24 paragraph (1) and 60 percent on the regional
25 fee schedule.

1 “(C) For 2006, the blended rate shall be
2 based 60 percent on the fee schedule under
3 paragraph (1) and 40 percent on the regional
4 fee schedule.

5 “(D) For 2007, 2008, and 2009, the
6 blended rate shall be based 80 percent on the
7 fee schedule under paragraph (1) and 20 per-
8 cent on the regional fee schedule.

9 “(E) For 2010 and each succeeding year,
10 the blended rate shall be based 100 percent on
11 the fee schedule under paragraph (1).

12 For purposes of this paragraph, the Secretary shall
13 establish a regional fee schedule for each of the nine
14 census divisions (referred to in section 1886(d)(2))
15 using the methodology (used in establishing the fee
16 schedule under paragraph (1)) to calculate a re-
17 gional conversion factor and a regional mileage pay-
18 ment rate and using the same payment adjustments
19 and the same relative value units as used in the fee
20 schedule under such paragraph.”.

21 (b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG
22 TRIPS.—Section 1834(l), as amended by subsection (a),
23 is amended by adding at the end the following new para-
24 graph:

1 “(11) ADJUSTMENT IN PAYMENT FOR CERTAIN
2 LONG TRIPS.—In the case of ground ambulance
3 services furnished on or after July 1, 2004, and be-
4 fore January 1, 2009, regardless of where the trans-
5 portation originates, the fee schedule established
6 under this subsection shall provide that, with respect
7 to the payment rate for mileage for a trip above 50
8 miles the per mile rate otherwise established shall be
9 increased by $\frac{1}{4}$ of the payment per mile otherwise
10 applicable to miles in excess of 50 miles in such
11 trip.”.

12 (c) IMPROVEMENT IN PAYMENTS TO RETAIN EMER-
13 GENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL
14 AREAS.—

15 (1) IN GENERAL.—Section 1834(l) (42 U.S.C.
16 1395m(l)), as amended by subsections (a) and (b),
17 is amended by adding at the end the following new
18 paragraph:

19 “(12) ASSISTANCE FOR RURAL PROVIDERS
20 FURNISHING SERVICES IN LOW POPULATION DEN-
21 SITY AREAS.—

22 “(A) IN GENERAL.—In the case of ground
23 ambulance services furnished on or after July
24 1, 2004, and before January 1, 2010, for which
25 the transportation originates in a qualified

1 rural area (identified under subparagraph
2 (B)(iii)), the Secretary shall provide for a per-
3 cent increase in the base rate of the fee sched-
4 ule for a trip established under this subsection.
5 In establishing such percent increase, the Sec-
6 retary shall estimate the average cost per trip
7 for such services (not taking into account mile-
8 age) in the lowest quartile as compared to the
9 average cost per trip for such services (not tak-
10 ing into account mileage) in the highest quartile
11 of all rural county populations.

12 “(B) IDENTIFICATION OF QUALIFIED
13 RURAL AREAS.—

14 “(i) DETERMINATION OF POPULATION
15 DENSITY IN AREA.—Based upon data from
16 the United States decennial census for the
17 year 2000, the Secretary shall determine,
18 for each rural area, the population density
19 for that area.

20 “(ii) RANKING OF AREAS.—The Sec-
21 retary shall rank each such area based on
22 such population density.

23 “(iii) IDENTIFICATION OF QUALIFIED
24 RURAL AREAS.—The Secretary shall iden-
25 tify those areas (in subparagraph (A) re-

1 ferred to as ‘qualified rural areas’) with
2 the lowest population densities that rep-
3 resent, if each such area were weighted by
4 the population of such area (as used in
5 computing such population densities), an
6 aggregate total of 25 percent of the total
7 of the population of all such areas.

8 “(iv) RURAL AREA.—For purposes of
9 this paragraph, the term ‘rural area’ has
10 the meaning given such term in section
11 1886(d)(2)(D). If feasible, the Secretary
12 shall treat a rural census tract of a metro-
13 politan statistical area (as determined
14 under the most recent modification of the
15 Goldsmith Modification, originally pub-
16 lished in the Federal Register on February
17 27, 1992 (57 Fed. Reg. 6725) as a rural
18 area for purposes of this paragraph.

19 “(v) JUDICIAL REVIEW.—There shall
20 be no administrative or judicial review
21 under section 1869, 1878, or otherwise, re-
22 specting the identification of an area under
23 this subparagraph.”.

24 (2) USE OF DATA.—In order to promptly imple-
25 ment section 1834(l)(12) of the Social Security Act,

1 as added by paragraph (1), the Secretary may use
2 data furnished by the Comptroller General of the
3 United States.

4 (d) TEMPORARY INCREASE FOR GROUND AMBU-
5 LANCE SERVICES.—Section 1834(l) (42 U.S.C.
6 1395m(l)), as amended by subsections (a), (b), and (c),
7 is amended by adding at the end the following new para-
8 graph:

9 “(13) TEMPORARY INCREASE FOR GROUND AM-
10 BULANCE SERVICES.—

11 “(A) IN GENERAL.—After computing the
12 rates with respect to ground ambulance services
13 under the other applicable provisions of this
14 subsection, in the case of such services fur-
15 nished on or after July 1, 2004, and before
16 January 1, 2007, for which the transportation
17 originates in—

18 “(i) a rural area described in para-
19 graph (9) or in a rural census tract de-
20 scribed in such paragraph, the fee schedule
21 established under this section shall provide
22 that the rate for the service otherwise es-
23 tablished, after the application of any in-
24 crease under paragraphs (11) and (12),
25 shall be increased by 2 percent; and

1 “(ii) an area not described in clause
2 (i), the fee schedule established under this
3 subsection shall provide that the rate for
4 the service otherwise established, after the
5 application of any increase under para-
6 graph (11), shall be increased by 1 per-
7 cent.

8 “(B) APPLICATION OF INCREASED PAY-
9 MENTS AFTER 2006.—The increased payments
10 under subparagraph (A) shall not be taken into
11 account in calculating payments for services
12 furnished after the period specified in such sub-
13 paragraph.”.

14 (e) IMPLEMENTATION.—The Secretary may imple-
15 ment the amendments made by this section, and revise
16 the conversion factor applicable under section 1834(l) of
17 the Social Security Act (42 U.S.C. 1395m(l)) for purposes
18 of implementing such amendments, on an interim final
19 basis, or by program instruction.

20 (f) GAO REPORT ON COSTS AND ACCESS.—Not later
21 than December 31, 2005, the Comptroller General of the
22 United States shall submit to Congress an initial report
23 on how costs differ among the types of ambulance pro-
24 viders and on access, supply, and quality of ambulance
25 services in those regions and States that have a reduction

1 in payment under the medicare ambulance fee schedule
 2 (under section 1834(l) of the Social Security Act, as
 3 amended by this Act). Not later than December 31, 2007,
 4 the Comptroller General shall submit to Congress a final
 5 report on such access and supply.

6 (g) TECHNICAL AMENDMENTS.—(1) Section 221(c)
 7 of BIPA (114 Stat. 2763A–487) is amended by striking
 8 “subsection (b)(2)” and inserting “subsection (b)(3)”.

9 (2) Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is
 10 amended by moving subparagraph (U) 4 ems to the left.

11 **SEC. 115. PROVIDING APPROPRIATE COVERAGE OF RURAL**
 12 **AIR AMBULANCE SERVICES.**

13 (a) COVERAGE.—Section 1834(l) (42 U.S.C.
 14 1395m(l)), as amended by subsections (a), (b), (c), and
 15 (d) of section 114, is amended by adding at the end the
 16 following new paragraph:

17 “(14) PROVIDING APPROPRIATE COVERAGE OF
 18 RURAL AIR AMBULANCE SERVICES.—

19 “(A) IN GENERAL.—The regulations de-
 20 scribed in section 1861(s)(7) shall provide, to
 21 the extent that any ambulance services (wheth-
 22 er ground or air) may be covered under such
 23 section, that a rural air ambulance service (as
 24 defined in subparagraph (C)) is reimbursed

1 under this subsection at the air ambulance rate
2 if the air ambulance service—

3 “(i) is reasonable and necessary based
4 on the health condition of the individual
5 being transported at or immediately prior
6 to the time of the transport; and

7 “(ii) complies with equipment and
8 crew requirements established by the Sec-
9 retary.

10 “(B) SATISFACTION OF REQUIREMENT OF
11 MEDICALLY NECESSARY.—The requirement of
12 subparagraph (A)(i) is deemed to be met for a
13 rural air ambulance service if—

14 “(i) subject to subparagraph (D),
15 such service is requested by a physician or
16 other qualified medical personnel (as speci-
17 fied by the Secretary) who reasonably de-
18 termines or certifies that the individual’s
19 condition is such that the time needed to
20 transport the individual by land or the in-
21 stability of transportation by land poses a
22 threat to the individual’s survival or seri-
23 ously endangers the individual’s health; or

24 “(ii) such service is furnished pursu-
25 ant to a protocol that is established by a

1 State or regional emergency medical serv-
2 ice (EMS) agency and recognized or ap-
3 proved by the Secretary under which the
4 use of an air ambulance is recommended,
5 if such agency does not have an ownership
6 interest in the entity furnishing such serv-
7 ice.

8 “(C) RURAL AIR AMBULANCE SERVICE DE-
9 FINED.—For purposes of this paragraph, the
10 term ‘rural air ambulance service’ means fixed
11 wing and rotary wing air ambulance service in
12 which the point of pick up of the individual oc-
13 curs in a rural area (as defined in section
14 1886(d)(2)(D)) or in a rural census tract of a
15 metropolitan statistical area (as determined
16 under the most recent modification of the Gold-
17 smith Modification, originally published in the
18 Federal Register on February 27, 1992 (57
19 Fed. Reg. 6725)).

20 “(D) LIMITATION.—

21 “(i) IN GENERAL.—Subparagraph
22 (B)(i) shall not apply if there is a financial
23 or employment relationship between the
24 person requesting the rural air ambulance
25 service and the entity furnishing the ambu-

1 lance service, or an entity under common
2 ownership with the entity furnishing the
3 air ambulance service, or a financial rela-
4 tionship between an immediate family
5 member of such requester and such an en-
6 tity.

7 “(ii) EXCEPTION.—Where a hospital
8 and the entity furnishing rural air ambu-
9 lance services are under common owner-
10 ship, clause (i) shall not apply to remu-
11 neration (through employment or other re-
12 lationship) by the hospital of the requester
13 or immediate family member if the remu-
14 neration is for provider-based physician
15 services furnished in a hospital (as de-
16 scribed in section 1887) which are reim-
17 bursed under part A and the amount of
18 the remuneration is unrelated directly or
19 indirectly to the provision of rural air am-
20 bulance services.”.

21 (b) CONFORMING AMENDMENT.—Section 1861(s)(7)
22 (42 U.S.C. 1395x(s)(7)) is amended by inserting “, sub-
23 ject to section 1834(l)(14),” after “but”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this subsection shall apply to services furnished on or after
3 January 1, 2005.

4 **SEC. 116. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC**
5 **LABORATORY TESTS FURNISHED TO HOS-**
6 **PITAL OUTPATIENTS IN CERTAIN RURAL**
7 **AREAS.**

8 (a) IN GENERAL.—Notwithstanding subsections (a),
9 (b), and (h) of section 1833 of the Social Security Act
10 (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42
11 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic
12 laboratory test covered under part B of title XVIII of such
13 Act that is furnished during a cost reporting period de-
14 scribed in subsection (b) by a hospital with fewer than
15 50 beds that is located in a qualified rural area (identified
16 under paragraph (12)(B)(iii) of section 1834(l) of the So-
17 cial Security Act (42 U.S.C. 1395m(l)), as added by sec-
18 tion 114(c)) as part of outpatient services of the hospital,
19 the amount of payment for such test shall be 100 percent
20 of the reasonable costs of the hospital in furnishing such
21 test.

22 (b) APPLICATION.—A cost reporting period described
23 in this subsection is a cost reporting period beginning dur-
24 ing the 2-year period beginning on July 1, 2004.

1 (c) PROVISION AS PART OF OUTPATIENT HOSPITAL
 2 SERVICES.—For purposes of subsection (a), in deter-
 3 mining whether clinical diagnostic laboratory services are
 4 furnished as part of outpatient services of a hospital, the
 5 Secretary shall apply the same rules that are used to de-
 6 termine whether clinical diagnostic laboratory services are
 7 furnished as an outpatient critical access hospital service
 8 under section 1834(g)(4) of the Social Security Act (42
 9 U.S.C. 1395m(g)(4)).

10 **SEC. 117. EXTENSION OF TELEMEDICINE DEMONSTRATION**
 11 **PROJECT.**

12 Section 4207 of the Balanced Budget Act of 1997
 13 (Public Law 105–33) is amended—

14 (1) in subsection (a)(4), by striking “4-year”
 15 and inserting “8-year”; and

16 (2) in subsection (d)(3), by striking
 17 “\$30,000,000” and inserting “\$60,000,000”.

18 **SEC. 118. REPORT ON DEMONSTRATION PROJECT PERMIT-**
 19 **TING SKILLED NURSING FACILITIES TO BE**
 20 **ORIGINATING TELEHEALTH SITES; AUTHOR-**
 21 **ITY TO IMPLEMENT.**

22 (a) EVALUATION.—The Secretary, acting through the
 23 Administrator of the Health Resources and Services Ad-
 24 ministration in consultation with the Administrator of the
 25 Centers for Medicare & Medicaid Services, shall evaluate

1 demonstration projects conducted by the Secretary under
2 which skilled nursing facilities (as defined in section
3 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))
4 are treated as originating sites for telehealth services.

5 (b) REPORT.—Not later than January 1, 2005, the
6 Secretary shall submit to Congress a report on the evalua-
7 tion conducted under subsection (a). Such report shall in-
8 clude recommendations on mechanisms to ensure that per-
9 mitting a skilled nursing facility to serve as an originating
10 site for the use of telehealth services or any other service
11 delivered via a telecommunications system does not serve
12 as a substitute for in-person visits furnished by a physi-
13 cian, or for in-person visits furnished by a physician as-
14 sistant, nurse practitioner or clinical nurse specialist, as
15 is otherwise required by the Secretary.

16 (c) AUTHORITY TO EXPAND ORIGINATING TELE-
17 HEALTH SITES TO INCLUDE SKILLED NURSING FACILI-
18 TIES.—Insofar as the Secretary concludes in the report
19 required under subsection (b) that is advisable to permit
20 a skilled nursing facility to be an originating site for tele-
21 health services under section 1834(m) of the Social Secu-
22 rity Act (42 U.S.C. 1395m(m)), and that the Secretary
23 can establish the mechanisms to ensure such permission
24 does not serve as a substitute for in-person visits furnished
25 by a physician, or for in-person visits furnished by a physi-

1 cian assistant, nurse practitioner or clinical nurse spe-
 2 cialist, the Secretary may deem a skilled nursing facility
 3 to be an originating site under paragraph (4)(C)(ii) of
 4 such section beginning on January 1, 2006.

5 **Subtitle C—Provisions Relating to** 6 **Parts A and B**

7 **SEC. 121. 1-YEAR INCREASE FOR HOME HEALTH SERVICES** 8 **FURNISHED IN A RURAL AREA.**

9 (a) **IN GENERAL.**—With respect to episodes and vis-
 10 its ending on or after April 1, 2004, and before April 1,
 11 2005, in the case of home health services furnished in a
 12 rural area (as defined in section 1886(d)(2)(D) of the So-
 13 cial Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Sec-
 14 retary shall increase the payment amount otherwise made
 15 under section 1895 of such Act (42 U.S.C. 1395fff) for
 16 such services by 5 percent.

17 (b) **WAIVING BUDGET NEUTRALITY.**—The Secretary
 18 shall not reduce the standard prospective payment amount
 19 (or amounts) under section 1895 of the Social Security
 20 Act (42 U.S.C. 1395fff) applicable to home health services
 21 furnished during a period to offset the increase in pay-
 22 ments resulting from the application of subsection (a).

23 (c) **NO EFFECT ON SUBSEQUENT PERIODS.**—The
 24 payment increase provided under subsection (a) for a pe-
 25 riod under such subsection—

1 (1) shall not apply to episodes and visits ending
2 after such period; and

3 (2) shall not be taken into account in calcu-
4 lating the payment amounts applicable for episodes
5 and visits occurring after such period.

6 **SEC. 122. REDISTRIBUTION OF UNUSED RESIDENT POSI-**
7 **TIONS.**

8 (a) IN GENERAL.—Section 1886(h) (42 U.S.C.
9 1395ww(h)(4)) is amended—

10 (1) in paragraph (4)(F)(i), by inserting “sub-
11 ject to paragraph (7),” after “October 1, 1997,”;

12 (2) in paragraph (4)(H)(i), by inserting “and
13 subject to paragraph (7),” after “subparagraphs (F)
14 and (G)”;

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

17 “(7) REDISTRIBUTION OF UNUSED RESIDENT
18 POSITIONS.—

19 “(A) REDUCTION IN LIMIT BASED ON UN-
20 USED POSITIONS.—

21 “(i) PROGRAMS SUBJECT TO REDUC-
22 TION.—

23 “(I) IN GENERAL.—Except as
24 provided in subclause (II), if a hos-
25 pital’s reference resident level (speci-

1 fied in clause (ii)) is less than the oth-
2 erwise applicable resident limit (as de-
3 fined in subparagraph (C)(ii)), effec-
4 tive for portions of cost reporting pe-
5 riods occurring on or after July 1,
6 2005, the otherwise applicable resi-
7 dent limit shall be reduced by 75 per-
8 cent of the difference between such
9 otherwise applicable resident limit and
10 such reference resident level.

11 “(II) EXCEPTION FOR SMALL
12 RURAL HOSPITALS.—This subpara-
13 graph shall not apply to a hospital lo-
14 cated in a rural area (as defined in
15 subsection (d)(2)(D)(ii)) with fewer
16 than 250 acute care inpatient beds.

17 “(ii) REFERENCE RESIDENT LEVEL.—

18 “(I) IN GENERAL.—Except as
19 otherwise provided in subclauses (II)
20 and (III), the reference resident level
21 specified in this clause for a hospital
22 is the resident level for the most re-
23 cent cost reporting period of the hos-
24 pital ending on or before September
25 30, 2002, for which a cost report has

1 been settled (or, if not, submitted
2 (subject to audit)), as determined by
3 the Secretary.

4 “(II) USE OF MOST RECENT AC-
5 COUNTING PERIOD TO RECOGNIZE EX-
6 PANSION OF EXISTING PROGRAMS.—If
7 a hospital submits a timely request to
8 increase its resident level due to an
9 expansion of an existing residency
10 training program that is not reflected
11 on the most recent settled cost report,
12 after audit and subject to the discre-
13 tion of the Secretary, the reference
14 resident level for such hospital is the
15 resident level for the cost reporting
16 period that includes July 1, 2003, as
17 determined by the Secretary.

18 “(III) EXPANSIONS UNDER
19 NEWLY APPROVED PROGRAMS.—Upon
20 the timely request of a hospital, the
21 Secretary shall adjust the reference
22 resident level specified under sub-
23 clause (I) or (II) to include the num-
24 ber of medical residents that were ap-
25 proved in an application for a medical

1 residency training program that was
2 approved by an appropriate accred-
3 iting organization (as determined by
4 the Secretary) before January 1,
5 2002, but which was not in operation
6 during the cost reporting period used
7 under subclause (I) or (II), as the
8 case may be, as determined by the
9 Secretary.

10 “(iii) AFFILIATION.—The provisions
11 of clause (i) shall be applied to hospitals
12 which are members of the same affiliated
13 group (as defined by the Secretary under
14 paragraph (4)(H)(ii)) as of July 1, 2003.

15 “(B) REDISTRIBUTION.—

16 “(i) IN GENERAL.—The Secretary is
17 authorized to increase the otherwise appli-
18 cable resident limit for each qualifying hos-
19 pital that submits a timely application
20 under this subparagraph by such number
21 as the Secretary may approve for portions
22 of cost reporting periods occurring on or
23 after July 1, 2005. The aggregate number
24 of increases in the otherwise applicable
25 resident limits under this subparagraph

1 may not exceed the Secretary's estimate of
2 the aggregate reduction in such limits at-
3 tributable to subparagraph (A).

4 “(ii) CONSIDERATIONS IN REDIS-
5 TRIBUTION.—In determining for which
6 hospitals the increase in the otherwise ap-
7 plicable resident limit is provided under
8 clause (i), the Secretary shall take into ac-
9 count the demonstrated likelihood of the
10 hospital filling the positions within the first
11 3 cost reporting periods beginning on or
12 after July 1, 2005, made available under
13 this subparagraph, as determined by the
14 Secretary.

15 “(iii) PRIORITY FOR RURAL AND
16 SMALL URBAN AREAS.—In determining for
17 which hospitals and residency training pro-
18 grams an increase in the otherwise applica-
19 ble resident limit is provided under clause
20 (i), the Secretary shall distribute the in-
21 crease to programs of hospitals located in
22 the following priority order:

23 “(I) First, to hospitals located in
24 rural areas (as defined in subsection
25 (d)(2)(D)(ii)).

1 “(II) Second, to hospitals located
2 in urban areas that are not large
3 urban areas (as defined for purposes
4 of subsection (d)).

5 “(III) Third, to other hospitals in
6 a State if the residency training pro-
7 gram involved is in a specialty for
8 which there are not other residency
9 training programs in the State.

10 Increases of residency limits within the
11 same priority category under this clause
12 shall be determined by the Secretary.

13 “(iv) LIMITATION.—In no case shall
14 more than 25 full-time equivalent addi-
15 tional residency positions be made available
16 under this subparagraph with respect to
17 any hospital.

18 “(v) APPLICATION OF LOCALITY AD-
19 JUSTED NATIONAL AVERAGE PER RESI-
20 DENT AMOUNT.—With respect to addi-
21 tional residency positions in a hospital at-
22 tributable to the increase provided under
23 this subparagraph, notwithstanding any
24 other provision of this subsection, the ap-
25 proved FTE resident amount is deemed to

1 be equal to the locality adjusted national
2 average per resident amount computed
3 under paragraph (4)(E) for that hospital.

4 “(vi) CONSTRUCTION.—Nothing in
5 this subparagraph shall be construed as
6 permitting the redistribution of reductions
7 in residency positions attributable to vol-
8 untary reduction programs under para-
9 graph (6), under a demonstration project
10 approved as of October 31, 2003, under
11 the authority of section 402 of Public Law
12 90–248, or as affecting the ability of a
13 hospital to establish new medical residency
14 training programs under paragraph
15 (4)(H).

16 “(C) RESIDENT LEVEL AND LIMIT DE-
17 FINED.—In this paragraph:

18 “(i) RESIDENT LEVEL.—The term
19 ‘resident level’ means, with respect to a
20 hospital, the total number of full-time
21 equivalent residents, before the application
22 of weighting factors (as determined under
23 paragraph (4)), in the fields of allopathic
24 and osteopathic medicine for the hospital.

1 “(ii) OTHERWISE APPLICABLE RESI-
2 DENT LIMIT.—The term ‘otherwise appli-
3 cable resident limit’ means, with respect to
4 a hospital, the limit otherwise applicable
5 under subparagraphs (F)(i) and (H) of
6 paragraph (4) on the resident level for the
7 hospital determined without regard to this
8 paragraph.

9 “(D) JUDICIAL REVIEW.—There shall be
10 no administrative or judicial review under sec-
11 tion 1869, 1878, or otherwise, with respect to
12 determinations made under this paragraph.”.

13 (b) CONFORMING PROVISIONS.—(1) Section
14 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amend-
15 ed—

16 (A) in the second sentence of clause (ii), by
17 striking “For discharges” and inserting “Subject to
18 clause (ix), for discharges”; and

19 (B) in clause (v), by adding at the end the fol-
20 lowing: “The provisions of subsection (h)(7) shall
21 apply with respect to the first sentence of this clause
22 in the same manner as it applies with respect to
23 subsection (h)(4)(F)(i).”; and

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

1 “(ix) For discharges occurring on or after July
2 1, 2005, insofar as an additional payment amount
3 under this subparagraph is attributable to resident
4 positions redistributed to a hospital under subsection
5 (h)(7)(B), in computing the indirect teaching adjust-
6 ment factor under clause (ii) the adjustment shall be
7 computed in a manner as if ‘c’ were equal to 0.66
8 with respect to such resident positions.”.

9 (2) Chapter 35 of title 44, United States Code, shall
10 not apply with respect to applications under section
11 1886(h)(7) of the Social Security Act, as added by sub-
12 section (a)(3).

13 (c) REPORT ON EXTENSION OF APPLICATIONS
14 UNDER REDISTRIBUTION PROGRAM.—Not later than July
15 1, 2005, the Secretary shall submit to Congress a report
16 containing recommendations regarding whether to extend
17 the deadline for applications for an increase in resident
18 limits under section 1886(h)(4)(I)(ii)(II) of the Social Se-
19 curity Act (as added by subsection (a)).

1 **Subtitle D—Other Provisions**

2 **SEC. 131. PROVIDING SAFE HARBOR FOR CERTAIN COL-**
3 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**
4 **CALLY UNDERSERVED POPULATIONS.**

5 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.
6 1320a–7(b)(3)), as amended by section 101(e)(2), is
7 amended—

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

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

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

14 “(H) any remuneration between a health
15 center entity described under clause (i) or (ii)
16 of section 1905(l)(2)(B) and any individual or
17 entity providing goods, items, services, dona-
18 tions, loans, or a combination thereof, to such
19 health center entity pursuant to a contract,
20 lease, grant, loan, or other agreement, if such
21 agreement contributes to the ability of the
22 health center entity to maintain or increase the
23 availability, or enhance the quality, of services
24 provided to a medically underserved population
25 served by the health center entity.”.

1 (b) RULEMAKING FOR EXCEPTION FOR HEALTH
2 CENTER ENTITY ARRANGEMENTS.—

3 (1) ESTABLISHMENT.—

4 (A) IN GENERAL.—The Secretary shall es-
5 tablish, on an expedited basis, standards relat-
6 ing to the exception described in section
7 1128B(b)(3)(H) of the Social Security Act, as
8 added by subsection (a), for health center entity
9 arrangements to the antikickback penalties.

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

15 (i) Whether the arrangement between
16 the health center entity and the other
17 party results in savings of Federal grant
18 funds or increased revenues to the health
19 center entity.

20 (ii) Whether the arrangement between
21 the health center entity and the other
22 party restricts or limits an individual's
23 freedom of choice.

24 (iii) Whether the arrangement be-
25 tween the health center entity and the

1 **SEC. 133. MEDPAC STUDY ON RURAL HOSPITAL PAYMENT**
2 **ADJUSTMENTS.**

3 (a) IN GENERAL.—The Medicare Payment Advisory
4 Commission shall conduct a study of the impact of sec-
5 tions 401 through 406, 411, 416, and 505. The Commis-
6 sion shall analyze the effect on total payments, growth in
7 costs, capital spending, and such other payment effects
8 under those sections.

9 (b) REPORTS.—

10 (1) INTERIM REPORT.—Not later than 18
11 months after the date of the enactment of this Act,
12 the Commission shall submit to Congress an interim
13 report on the matters studied under subsection (a)
14 with respect only to changes to the critical access
15 hospital provisions under section 105.

16 (2) FINAL REPORT.—Not later than 3 years
17 after the date of the enactment of this Act, the
18 Commission shall submit to Congress a final report
19 on all matters studied under subsection (a).

20 **SEC. 134. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION**
21 **PROJECT.**

22 (a) AUTHORITY TO CONDUCT DEMONSTRATION
23 PROJECT.—The Secretary shall waive such provisions of
24 the medicare program established under title XVIII of the
25 Social Security Act (42 U.S.C. 1395 et seq.) as are nec-
26 essary to conduct a demonstration project under which

1 frontier extended stay clinics described in subsection (b)
2 in isolated rural areas are treated as providers of items
3 and services under the medicare program.

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

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

10 (2) is designed to address the needs of—

11 (A) seriously or critically ill or injured pa-
12 tients who, due to adverse weather conditions or
13 other reasons, cannot be transferred quickly to
14 acute care referral centers; or

15 (B) patients who need monitoring and ob-
16 servation for a limited period of time.

17 (c) SPECIFICATION OF CODES.—The Secretary shall
18 determine the appropriate life-safety codes for such clinics
19 that treat patients for needs referred to in subsection
20 (b)(2).

21 (d) FUNDING.—

22 (1) IN GENERAL.—Subject to paragraph (2),
23 there are authorized to be appropriated, in appro-
24 priate part from the Federal Hospital Insurance
25 Trust Fund and the Federal Supplementary Medical

1 Insurance Trust Fund, such sums as are necessary
2 to conduct the demonstration project under this sec-
3 tion.

4 (2) BUDGET NEUTRAL IMPLEMENTATION.—In
5 conducting the demonstration project under this sec-
6 tion, the Secretary shall ensure that the aggregate
7 payments made by the Secretary under the medicare
8 program do not exceed the amount which the Sec-
9 retary would have paid under the medicare program
10 if the demonstration project under this section was
11 not implemented.

12 (e) 3-YEAR PERIOD.—The Secretary shall conduct
13 the demonstration under this section for a 3-year period.

14 (f) REPORT.—Not later than the date that is 1 year
15 after the date on which the demonstration project con-
16 cludes, the Secretary shall submit to Congress a report
17 on the demonstration project, together with such rec-
18 ommendations for legislation or administrative action as
19 the Secretary determines appropriate.

20 (g) DEFINITIONS.—In this section, the terms “hos-
21 pital” and “critical access hospital” have the meanings
22 given such terms in subsections (e) and (mm), respec-
23 tively, of section 1861 of the Social Security Act (42
24 U.S.C. 1395x).

1 **TITLE II—PROVISIONS**
2 **RELATING TO PART A**
3 **Subtitle A—Inpatient Hospital**
4 **Services**

5 **SEC. 201. REVISION OF ACUTE CARE HOSPITAL PAYMENT**
6 **UPDATES.**

7 (a) **IN GENERAL.**—Section 1886(b)(3)(B)(i) (42
8 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

9 (1) by striking “and” at the end of subclause
10 (XVIII);

11 (2) by striking subclause (XIX); and

12 (3) by inserting after subclause (XVIII) the fol-
13 lowing new subclauses:

14 “(XIX) for each of fiscal years 2004 through
15 2007, subject to clause (vii), the market basket per-
16 centage increase for hospitals in all areas; and

17 “(XX) for fiscal year 2008 and each subsequent
18 fiscal year, the market basket percentage increase
19 for hospitals in all areas.”.

20 (b) **SUBMISSION OF HOSPITAL QUALITY DATA.**—
21 Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is
22 amended by adding at the end the following new clause:

23 “(vii)(I) For purposes of clause (i)(XIX) for each of
24 fiscal years 2005 through 2007, in a case of a subsection
25 (d) hospital that does not submit data to the Secretary

1 in accordance with subclause (II) with respect to such a
 2 fiscal year, the applicable percentage increase under such
 3 clause for such fiscal year shall be reduced by 0.4 percent-
 4 age points. Such reduction shall apply only with respect
 5 to the fiscal year involved, and the Secretary shall not take
 6 into account such reduction in computing the applicable
 7 percentage increase under clause (i)(XIX) for a subse-
 8 quent fiscal year.

9 “(II) Each subsection (d) hospital shall submit to the
 10 Secretary quality data (for a set of 10 indicators estab-
 11 lished by the Secretary as of November 1, 2003) that re-
 12 late to the quality of care furnished by the hospital in in-
 13 patient settings in a form and manner, and at a time,
 14 specified by the Secretary for purposes of this clause, but
 15 with respect to fiscal year 2005, the Secretary shall pro-
 16 vide for a 30-day grace period for the submission of data
 17 by a hospital.”

18 (c) GAO STUDY AND REPORT ON APPROPRIATENESS
 19 OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYS-
 20 TEM FOR INPATIENT HOSPITAL SERVICES.—

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

24 (A) the appropriate level and distribution
 25 of payments in relation to costs under the pro-

1 spective payment system under section 1886 of
2 the Social Security Act (42 U.S.C. 1395ww) for
3 inpatient hospital services furnished by sub-
4 section (d) hospitals (as defined in subsection
5 (d)(1)(B) of such section); and

6 (B) whether there is a need to adjust such
7 payments under such system to reflect legiti-
8 mate differences in costs across different geo-
9 graphic areas, kinds of hospitals, and types of
10 cases.

11 (2) REPORT.—Not later than 24 months after
12 the date of the enactment of this Act, the Comp-
13 troller General of the United States shall submit to
14 Congress a report on the study conducted under
15 paragraph (1) together with such recommendations
16 for legislative and administrative action as the
17 Comptroller General determines appropriate.

18 **SEC. 202. REVISION OF THE INDIRECT MEDICAL EDU-**
19 **CATION (IME) ADJUSTMENT PERCENTAGE.**

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

22 (1) in subclause (VI), by striking “and” after
23 the semicolon at the end;

24 (2) in subclause (VII)—

1 (A) by inserting “and before April 1,
2 2004,” after “on or after October 1, 2002,”;
3 and

4 (B) by striking the period at the end and
5 inserting a semicolon; and

6 (3) by adding at the end the following new sub-
7 clauses:

8 “(VIII) on or after April 1, 2004, and be-
9 fore October 1, 2004, ‘c’ is equal to 1.47;

10 “(IX) during fiscal year 2005, ‘c’ is equal
11 to 1.42;

12 “(X) during fiscal year 2006, ‘c’ is equal
13 to 1.37;

14 “(XI) during fiscal year 2007, ‘c’ is equal
15 to 1.32; and

16 “(XII) on or after October 1, 2007, ‘c’ is
17 equal to 1.35.”.

18 (b) CONFORMING AMENDMENT RELATING TO DE-
19 TERMINATION OF STANDARDIZED AMOUNT.—Section
20 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is
21 amended—

22 (1) by striking “1999 or” and inserting
23 “1999,”; and

24 (2) by inserting “, or the Medicare Provider
25 Restoration Act of 2003” after “2000”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to discharges occurring on or after
 3 April 1, 2004.

4 **SEC. 203. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**
 5 **UNDER INPATIENT HOSPITAL PROSPECTIVE**
 6 **PAYMENT SYSTEM.**

7 (a) IMPROVING TIMELINESS OF DATA COLLEC-
 8 TION.—Section 1886(d)(5)(K) (42 U.S.C.
 9 1395ww(d)(5)(K)) is amended by adding at the end the
 10 following new clause:

11 “(vii) Under the mechanism under this subpara-
 12 graph, the Secretary shall provide for the addition of new
 13 diagnosis and procedure codes in April 1 of each year, but
 14 the addition of such codes shall not require the Secretary
 15 to adjust the payment (or diagnosis-related group classi-
 16 fication) under this subsection until the fiscal year that
 17 begins after such date.”.

18 (b) ELIGIBILITY STANDARD FOR TECHNOLOGY
 19 OUTLIERS.—

20 (1) ADJUSTMENT OF THRESHOLD.—Section
 21 1886(d)(5)(K)(ii)(I) (42 U.S.C.
 22 1395ww(d)(5)(K)(ii)(I)) is amended by inserting
 23 “(applying a threshold specified by the Secretary
 24 that is the lesser of 75 percent of the standardized
 25 amount (increased to reflect the difference between

1 cost and charges) or 75 percent of one standard de-
2 viation for the diagnosis-related group involved)”
3 after “is inadequate”.

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

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

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

12 “(viii) The mechanism established pursuant to clause
13 (i) shall be adjusted to provide, before publication of a
14 proposed rule, for public input regarding whether a new
15 service or technology represents an advance in medical
16 technology that substantially improves the diagnosis or
17 treatment of individuals entitled to benefits under part A
18 as follows:

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

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

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

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

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

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

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

3 (d) ESTABLISHMENT OF NEW FUNDING FOR HOS-
4 PITAL INPATIENT TECHNOLOGY.—

5 (1) IN GENERAL.—Section
6 1886(d)(5)(K)(ii)(III) (42 U.S.C.
7 1395ww(d)(5)(K)(ii)(III)) is amended by striking
8 “subject to paragraph (4)(C)(iii),”.

9 (2) NOT BUDGET NEUTRAL.—There shall be no
10 reduction or other adjustment in payments under
11 section 1886 of the Social Security Act because an
12 additional payment is provided under subsection
13 (d)(5)(K)(ii)(III) of such section.

14 (e) EFFECTIVE DATE.—

15 (1) IN GENERAL.—The Secretary shall imple-
16 ment the amendments made by this section so that
17 they apply to classification for fiscal years beginning
18 with fiscal year 2005.

19 (2) RECONSIDERATIONS OF APPLICATIONS FOR
20 FISCAL YEAR 2004 THAT ARE DENIED.—In the case
21 of an application for a classification of a medical
22 service or technology as a new medical service or
23 technology under section 1886(d)(5)(K) of the Social
24 Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was
25 filed for fiscal year 2004 and that is denied—

1 (A) the Secretary shall automatically re-
2 consider the application as an application for
3 fiscal year 2005 under the amendments made
4 by this section; and

5 (B) the maximum time period otherwise
6 permitted for such classification of the service
7 or technology shall be extended by 12 months.

8 **SEC. 204. INCREASE IN FEDERAL RATE FOR HOSPITALS IN**
9 **PUERTO RICO.**

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

12 (1) in subparagraph (A)—

13 (A) in clause (i), by striking “for dis-
14 charges beginning on or after October 1, 1997,
15 50 percent (and for discharges between October
16 1, 1987, and September 30, 1997, 75 percent)”
17 and inserting “the applicable Puerto Rico per-
18 centage (specified in subparagraph (E))”; and

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

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

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

5 “(i) on or after October 1, 1987, and before Oc-
6 tober 1, 1997, the applicable Puerto Rico percentage
7 is 75 percent and the applicable Federal percentage
8 is 25 percent;

9 “(ii) on or after October 1, 1997, and before
10 April 1, 2004, the applicable Puerto Rico percentage
11 is 50 percent and the applicable Federal percentage
12 is 50 percent;

13 “(iii) on or after April 1, 2004, and before Oc-
14 tober 1, 2004, the applicable Puerto Rico percentage
15 is 37.5 percent and the applicable Federal percent-
16 age is 62.5 percent; and

17 “(iv) on or after October 1, 2004, the applica-
18 ble Puerto Rico percentage is 25 percent and the ap-
19 plicable Federal percentage is 75 percent.”.

20 **SEC. 205. WAGE INDEX ADJUSTMENT RECLASSIFICATION**
21 **REFORM.**

22 (a) IN GENERAL.—Section 1886(d) (42 U.S.C.
23 1395ww(d)), as amended by section 106, is amended by
24 adding at the end the following new paragraph:

1 “(13)(A) In order to recognize commuting patterns
2 among geographic areas, the Secretary shall establish a
3 process through application or otherwise for an increase
4 of the wage index applied under paragraph (3)(E) for sub-
5 section (d) hospitals located in a qualifying county de-
6 scribed in subparagraph (B) in the amount computed
7 under subparagraph (D) based on out-migration of hos-
8 pital employees who reside in that county to any higher
9 wage index area.

10 “(B) The Secretary shall establish criteria for a
11 qualifying county under this subparagraph based on the
12 out-migration referred to in subparagraph (A) and dif-
13 ferences in the area wage indices. Under such criteria the
14 Secretary shall, utilizing such data as the Secretary deter-
15 mines to be appropriate, establish—

16 “(i) a threshold percentage, established by the
17 Secretary, of the weighted average of the area wage
18 index or indices for the higher wage index areas in-
19 volved;

20 “(ii) a threshold (of not less than 10 percent)
21 for minimum out-migration to a higher wage index
22 area or areas; and

23 “(iii) a requirement that the average hourly
24 wage of the hospitals in the qualifying county equals
25 or exceeds the average hourly wage of all the hos-

1 pitals in the area in which the qualifying county is
2 located.

3 “(C) For purposes of this paragraph, the term ‘high-
4 er wage index area’ means, with respect to a county, an
5 area with a wage index that exceeds that of the county.

6 “(D) The increase in the wage index under subpara-
7 graph (A) for a qualifying county shall be equal to the
8 percentage of the hospital employees residing in the quali-
9 fying county who are employed in any higher wage index
10 area multiplied by the sum of the products, for each higher
11 wage index area of—

12 “(i) the difference between—

13 “(I) the wage index for such higher wage
14 index area, and

15 “(II) the wage index of the qualifying
16 county; and

17 “(ii) the number of hospital employees residing
18 in the qualifying county who are employed in such
19 higher wage index area divided by the total number
20 of hospital employees residing in the qualifying
21 county who are employed in any higher wage index
22 area.

23 “(E) The process under this paragraph may be based
24 upon the process used by the Medicare Geographic Classi-
25 fication Review Board under paragraph (10). As the Sec-

1 retary determines to be appropriate to carry out such
2 process, the Secretary may require hospitals (including
3 subsection (d) hospitals and other hospitals) and critical
4 access hospitals, as required under section 1866(a)(1)(T),
5 to submit data regarding the location of residence, or the
6 Secretary may use data from other sources.

7 “(F) A wage index increase under this paragraph
8 shall be effective for a period of 3 fiscal years, except that
9 the Secretary shall establish procedures under which a
10 subsection (d) hospital may elect to waive the application
11 of such wage index increase.

12 “(G) A hospital in a county that has a wage index
13 increase under this paragraph for a period and that has
14 not waived the application of such an increase under sub-
15 paragraph (F) is not eligible for reclassification under
16 paragraph (8) or (10) during that period.

17 “(H) Any increase in a wage index under this para-
18 graph for a county shall not be taken into account for
19 purposes of—

20 “(i) computing the wage index for portions of
21 the wage index area (not including the county) in
22 which the county is located; or

23 “(ii) applying any budget neutrality adjustment
24 with respect to such index under paragraph (8)(D).

1 “(I) The thresholds described in subparagraph (B),
2 data on hospital employees used under this paragraph,
3 and any determination of the Secretary under the process
4 described in subparagraph (E) shall be final and shall not
5 be subject to judicial review.”.

6 (b) CONFORMING AMENDMENTS.—Section
7 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

8 (1) in subparagraph (R), by striking “and” at
9 the end;

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

12 (3) by inserting after subparagraph (S) the fol-
13 lowing new subparagraph:

14 “(T) in the case of hospitals and critical access
15 hospitals, to furnish to the Secretary such data as
16 the Secretary determines appropriate pursuant to
17 subparagraph (E) of section 1886(d)(12) to carry
18 out such section.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall first apply to the wage index for dis-
21 charges occurring on or after October 1, 2004. In initially
22 implementing such amendments, the Secretary may mod-
23 ify the deadlines otherwise applicable under clauses (ii)
24 and (iii)(I) of section 1886(d)(10)(C) of the Social Secu-
25 rity Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of,

1 and actions on, applications relating to changes in hospital
2 geographic reclassification.

3 **SEC. 206. LIMITATION ON CHARGES FOR INPATIENT HOS-**
4 **PITAL CONTRACT HEALTH SERVICES PRO-**
5 **VIDED TO INDIANS BY MEDICARE PARTICI-**
6 **PATING HOSPITALS.**

7 (a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C.
8 1395cc(a)(1)), as amended by section 205(b), is amend-
9 ed—

10 (1) in subparagraph (S), by striking “and” at
11 the end;

12 (2) in subparagraph (T), by striking the period
13 and inserting “, and”; and

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

16 “(U) in the case of hospitals which furnish
17 inpatient hospital services for which payment
18 may be made under this title, to be a partici-
19 pating provider of medical care both—

20 “(i) under the contract health services
21 program funded by the Indian Health
22 Service and operated by the Indian Health
23 Service, an Indian tribe, or tribal organiza-
24 tion (as those terms are defined in section
25 4 of the Indian Health Care Improvement

1 Act), with respect to items and services
2 that are covered under such program and
3 furnished to an individual eligible for such
4 items and services under such program;
5 and

6 “(ii) under any program funded by
7 the Indian Health Service and operated by
8 an urban Indian organization with respect
9 to the purchase of items and services for
10 an eligible urban Indian (as those terms
11 are defined in such section 4),

12 in accordance with regulations promulgated by
13 the Secretary regarding admission practices,
14 payment methodology, and rates of payment
15 (including the acceptance of no more than such
16 payment rate as payment in full for such items
17 and services.”.

18 (b) EFFECTIVE DATE.—The amendments made by
19 this section shall apply as of a date specified by the Sec-
20 retary of Health and Human Services (but in no case later
21 than 1 year after the date of enactment of this Act) to
22 medicare participation agreements in effect (or entered
23 into) on or after such date.

1 (c) PROMULGATION OF REGULATIONS.—The Sec-
 2 retary shall promulgate regulations to carry out the
 3 amendments made by subsection (a).

4 **SEC. 207. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO**
 5 **MEDICARE LIMITS ON PHYSICIAN REFER-**
 6 **RALS.**

7 (a) LIMITS ON PHYSICIAN REFERRALS.—

8 (1) OWNERSHIP AND INVESTMENT INTERESTS
 9 IN WHOLE HOSPITALS.—

10 (A) IN GENERAL.—Section 1877(d)(3) (42
 11 U.S.C. 1395nn(d)(3)) is amended—

12 (i) by striking “, and” at the end of
 13 subparagraph (A) and inserting a semi-
 14 colon; and

15 (ii) by redesignating subparagraph
 16 (B) as subparagraph (C) and inserting
 17 after subparagraph (A) the following new
 18 subparagraph:

19 “(B) effective for the 18-month period be-
 20 ginning on the date of the enactment of the
 21 Medicare Provider Restoration Act of 2003, the
 22 hospital is not a specialty hospital (as defined
 23 in subsection (h)(7)); and”.

1 (B) DEFINITION.—Section 1877(h) (42
2 U.S.C. 1395nn(h)) is amended by adding at the
3 end the following:

4 “(7) SPECIALTY HOSPITAL.—

5 “(A) IN GENERAL.—For purposes of this
6 section, except as provided in subparagraph
7 (B), the term ‘specialty hospital’ means a sub-
8 section (d) hospital (as defined in section
9 1886(d)(1)(B)) that is primarily or exclusively
10 engaged in the care and treatment of one of the
11 following categories:

12 “(i) Patients with a cardiac condition.

13 “(ii) Patients with an orthopedic con-
14 dition.

15 “(iii) Patients receiving a surgical
16 procedure.

17 “(iv) Any other specialized category of
18 services that the Secretary designates as
19 inconsistent with the purpose of permitting
20 physician ownership and investment inter-
21 ests in a hospital under this section.

22 “(B) EXCEPTION.—For purposes of this
23 section, the term ‘specialty hospital’ does not
24 include any hospital—

25 “(i) determined by the Secretary—

1 “(I) to be in operation before No-
2 vember 18, 2003; or

3 “(II) under development as of
4 such date;

5 “(ii) for which the number of physi-
6 cian investors at any time on or after such
7 date is no greater than the number of such
8 investors as of such date;

9 “(iii) for which the type of categories
10 described in subparagraph (A) at any time
11 on or after such date is no different than
12 the type of such categories as of such date;

13 “(iv) for which any increase in the
14 number of beds occurs only in the facilities
15 on the main campus of the hospital and
16 does not exceed 50 percent of the number
17 of beds in the hospital as of November 18,
18 2003, or 5 beds, whichever is greater; and

19 “(v) that meets such other require-
20 ments as the Secretary may specify.”.

21 (2) OWNERSHIP AND INVESTMENT INTERESTS
22 IN A RURAL PROVIDER.—Section 1877(d)(2) (42
23 U.S.C. 1395nn(d)(2)) is amended to read as follows:

1 “(2) RURAL PROVIDERS.—In the case of des-
2 ignated health services furnished in a rural area (as
3 defined in section 1886(d)(2)(D)) by an entity, if—

4 “(A) substantially all of the designated
5 health services furnished by the entity are fur-
6 nished to individuals residing in such a rural
7 area; and

8 “(B) effective for the 18-month period be-
9 ginning on the date of the enactment of the
10 Medicare Provider Restoration Act of 2003, the
11 entity is not a specialty hospital (as defined in
12 subsection (h)(7)).”.

13 (b) APPLICATION OF EXCEPTION FOR HOSPITALS
14 UNDER DEVELOPMENT.—For purposes of section
15 1877(h)(7)(B)(i)(II) of the Social Security Act, as added
16 by subsection (a)(1)(B), in determining whether a hospital
17 is under development as of November 18, 2003, the Sec-
18 retary shall consider—

19 (1) whether architectural plans have been com-
20 pleted, funding has been received, zoning require-
21 ments have been met, and necessary approvals from
22 appropriate State agencies have been received; and

23 (2) any other evidence the Secretary determines
24 would indicate whether a hospital is under develop-
25 ment as of such date.

1 (c) STUDIES.—

2 (1) MEDPAC STUDY.—The Medicare Payment
3 Advisory Commission, in consultation with the
4 Comptroller General of the United States, shall con-
5 duct a study to determine—

6 (A) any differences in the costs of health
7 care services furnished to patients by physician-
8 owned specialty hospitals and the costs of such
9 services furnished by local full-service commu-
10 nity hospitals within specific diagnosis-related
11 groups;

12 (B) the extent to which specialty hospitals,
13 relative to local full-service community hos-
14 pitals, treat patients in certain diagnosis-related
15 groups within a category, such as cardiology,
16 and an analysis of the selection;

17 (C) the financial impact of physician-
18 owned specialty hospitals on local full-service
19 community hospitals;

20 (D) how the current diagnosis-related
21 group system should be updated to better re-
22 flect the cost of delivering care in a hospital
23 setting; and

1 (E) the proportions of payments received,
2 by type of payer, between the specialty hospitals
3 and local full-service community hospitals.

4 (2) HHS STUDY.—The Secretary shall conduct
5 a study of a representative sample of specialty hos-
6 pitals—

7 (A) to determine the percentage of patients
8 admitted to physician-owned specialty hospitals
9 who are referred by physicians with an owner-
10 ship interest;

11 (B) to determine the referral patterns of
12 physician owners, including the percentage of
13 patients they referred to physician-owned spe-
14 cialty hospitals and the percentage of patients
15 they referred to local full-service community
16 hospitals for the same condition;

17 (C) to compare the quality of care fur-
18 nished in physician-owned specialty hospitals
19 and in local full-service community hospitals for
20 similar conditions and patient satisfaction with
21 such care; and

22 (D) to assess the differences in uncompen-
23 sated care, as defined by the Secretary, between
24 the specialty hospital and local full-service com-

1 community hospitals, and the relative value of any
2 tax exemption available to such hospitals.

3 (3) REPORTS.—Not later than 15 months after
4 the date of the enactment of this Act, the Commis-
5 sion and the Secretary, respectively, shall each sub-
6 mit to Congress a report on the studies conducted
7 under paragraphs (1) and (2), respectively, and shall
8 include any recommendations for legislation or ad-
9 ministrative changes.

10 **SEC. 208. 1-TIME APPEALS PROCESS FOR HOSPITAL WAGE**

11 **INDEX CLASSIFICATION.**

12 (a) ESTABLISHMENT OF PROCESS.—

13 (1) IN GENERAL.—The Secretary shall establish
14 not later than January 1, 2004, by instruction or
15 otherwise a process under which a hospital may ap-
16 peal the wage index classification otherwise applica-
17 ble to the hospital and select another area within the
18 State (or, at the discretion of the Secretary, within
19 a contiguous State) to which to be reclassified.

20 (2) PROCESS REQUIREMENTS.—The process es-
21 tablished under paragraph (1) shall be consistent
22 with the following:

23 (A) Such an appeal may be filed as soon
24 as possible after the date of the enactment of

1 this Act but shall be filed by not later than
2 February 15, 2004.

3 (B) Such an appeal shall be heard by the
4 Medicare Geographic Reclassification Review
5 Board.

6 (C) There shall be no further administra-
7 tive or judicial review of a decision of such
8 Board.

9 (3) RECLASSIFICATION UPON SUCCESSFUL AP-
10 PEAL.—If the Medicare Geographic Reclassification
11 Review Board determines that the hospital is a
12 qualifying hospital (as defined in subsection (c)), the
13 hospital shall be reclassified to the area selected
14 under paragraph (1). Such reclassification shall
15 apply with respect to discharges occurring during
16 the 3-year period beginning with April 1, 2004.

17 (4) INAPPLICABILITY OF CERTAIN PROVI-
18 SIONS.—Except as the Secretary may provide, the
19 provisions of paragraphs (8) and (10) of section
20 1886(d) of the Social Security Act (42 U.S.C.
21 1395ww(d)) shall not apply to an appeal under this
22 section.

23 (b) APPLICATION OF RECLASSIFICATION.—In the
24 case of an appeal decided in favor of a qualifying hospital
25 under subsection (a), the wage index reclassification shall

1 not affect the wage index computation for any area or for
2 any other hospital and shall not be effected in a budget
3 neutral manner. The provisions of this section shall not
4 affect payment for discharges occurring after the end of
5 the 3-year-period referred to in subsection (a).

6 (c) QUALIFYING HOSPITAL DEFINED.—For purposes
7 of this section, the term “qualifying hospital” means a
8 subsection (d) hospital (as defined in section
9 1886(d)(1)(B) of the Social Security Act, 42 U.S.C.
10 1395ww(d)(1)(B)) that—

11 (1) does not qualify for a change in wage index
12 classification under paragraph (8) or (10) of section
13 1886(d) of the Social Security Act (42 U.S.C.
14 1395ww(d)) on the basis of requirements relating to
15 distance or commuting; and

16 (2) meets such other criteria, such as quality,
17 as the Secretary may specify by instruction or other-
18 wise.

19 The Secretary may modify the wage comparison guidelines
20 promulgated under section 1886(d)(10)(D) of such Act
21 (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this sec-
22 tion.

23 (d) WAGE INDEX CLASSIFICATION.—For purposes of
24 this section, the term “wage index classification” means
25 the geographic area in which it is classified for purposes

1 of determining for a fiscal year the factor used to adjust
 2 the DRG prospective payment rate under section 1886(d)
 3 of the Social Security Act (42 U.S.C. 1395ww(d)) for area
 4 differences in hospital wage levels that applies to such hos-
 5 pital under paragraph (3)(E) of such section.

6 (e) LIMITATION ON EXPENDITURES.—The aggregate
 7 amount of additional expenditures resulting from the ap-
 8 plication of this section shall not exceed \$900,000,000.

9 (f) TRANSITIONAL EXTENSION.—Any reclassification
 10 of a county or other area made by Act of Congress for
 11 purposes of making payments under section 1886(d) of
 12 the Social Security Act (42 U.S.C. 1395ww(d)) that ex-
 13 pired on September 30, 2003, shall be deemed to be in
 14 effect during the period beginning on January 1, 2004,
 15 and ending on September 30, 2004.

16 **Subtitle B—Other Provisions**

17 **SEC. 211. PAYMENT FOR COVERED SKILLED NURSING FA-** 18 **CILITY SERVICES.**

19 (a) ADJUSTMENT TO RUGS FOR AIDS RESI-
 20 DENTS.—Paragraph (12) of section 1888(e) (42 U.S.C.
 21 1395yy(e)) is amended to read as follows:

22 “(12) ADJUSTMENT FOR RESIDENTS WITH
 23 AIDS.—

24 “(A) IN GENERAL.—Subject to subpara-
 25 graph (B), in the case of a resident of a skilled

1 nursing facility who is afflicted with acquired
2 immune deficiency syndrome (AIDS), the per
3 diem amount of payment otherwise applicable
4 (determined without regard to any increase
5 under section 101 of the Medicare, Medicaid,
6 and SCHIP Balanced Budget Refinement Act
7 of 1999, or under section 314(a) of Medicare,
8 Medicaid, and SCHIP Benefits Improvement
9 and Protection Act of 2000), shall be increased
10 by 128 percent to reflect increased costs associ-
11 ated with such residents.

12 “(B) SUNSET.—Subparagraph (A) shall
13 not apply on and after such date as the Sec-
14 retary certifies that there is an appropriate ad-
15 justment in the case mix under paragraph
16 (4)(G)(i) to compensate for the increased costs
17 associated with residents described in such sub-
18 paragraph.”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 paragraph (1) shall apply to services furnished on or after
21 October 1, 2004.

1 **SEC. 212. COVERAGE OF HOSPICE CONSULTATION SERV-**
2 **ICES.**

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

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

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

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

12 “(5) for individuals who are terminally ill, have
13 not made an election under subsection (d)(1), and
14 have not previously received services under this
15 paragraph, services that are furnished by a physi-
16 cian (as defined in section 1861(r)(1)) who is either
17 the medical director or an employee of a hospice pro-
18 gram and that—

19 “(A) consist of—

20 “(i) an evaluation of the individual’s
21 need for pain and symptom management,
22 including the individual’s need for hospice
23 care; and

24 “(ii) counseling the individual with re-
25 spect to hospice care and other care op-
26 tions; and

1 “(B) may include advising the individual
2 regarding advanced care planning.”.

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

6 “(4) The amount paid to a hospice program with re-
7 spect to the services under section 1812(a)(5) for which
8 payment may be made under this part shall be equal to
9 an amount established for an office or other outpatient
10 visit for evaluation and management associated with pre-
11 senting problems of moderate severity and requiring med-
12 ical decisionmaking of low complexity under the fee sched-
13 ule established under section 1848(b), other than the por-
14 tion of such amount attributable to the practice expense
15 component.”.

16 (c) CONFORMING AMENDMENT.—Section
17 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is
18 amended by inserting before the comma at the end the
19 following: “and services described in section 1812(a)(5)”.

20 (d) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to services provided by a hospice
22 program on or after January 1, 2005.

1 **SEC. 213. STUDY ON PORTABLE DIAGNOSTIC ULTRASOUND**
2 **SERVICES FOR BENEFICIARIES IN SKILLED**
3 **NURSING FACILITIES.**

4 (a) STUDY.—The Comptroller General of the United
5 States shall conduct a study of portable diagnostic
6 ultrasound services furnished to medicare beneficiaries in
7 skilled nursing facilities. Such study shall consider the fol-
8 lowing:

9 (1) TYPES OF EQUIPMENT; TRAINING.—The
10 types of portable diagnostic ultrasound services fur-
11 nished to such beneficiaries, the types of portable
12 ultrasound equipment used to furnish such services,
13 and the technical skills, or training, or both, re-
14 quired for technicians to furnish such services.

15 (2) CLINICAL APPROPRIATENESS.—The clinical
16 appropriateness of transporting portable diagnostic
17 ultrasound diagnostic and technicians to patients in
18 skilled nursing facilities as opposed to transporting
19 such patients to a hospital or other facility that fur-
20 nishes diagnostic ultrasound services.

21 (3) FINANCIAL IMPACT.—The financial impact
22 if Medicare were make a separate payment for port-
23 able ultrasound diagnostic services, including the im-
24 pact of separate payments—

25 (A) for transportation and technician serv-
26 ices for residents during a resident in a part A

1 stay, that would otherwise be paid for under the
 2 prospective payment system for covered skilled
 3 nursing facility services (under section 1888(e)
 4 of the Social Security Act (42 U.S.C.
 5 1395yy(e)); and

6 (B) for such services for residents in a
 7 skilled nursing facility after a part A stay.

8 (4) CREDENTIALING REQUIREMENTS.—Whether
 9 the Secretary should establish credentialing or other
 10 requirements for technicians that furnish diagnostic
 11 ultrasound services to medicare beneficiaries.

12 (b) REPORT.—Not later than 2 years after the date
 13 of the enactment of this Act, the Comptroller General shall
 14 submit to Congress a report on the study conducted under
 15 subsection (a), and shall include any recommendations for
 16 legislation or administrative change as the Comptroller
 17 General determines appropriate.

18 **TITLE III—PROVISIONS**
 19 **RELATING TO PART B**
 20 **Subtitle A—Provisions Relating to**
 21 **Physicians’ Services**

22 **SEC. 301. REVISION OF UPDATES FOR PHYSICIANS’ SERV-**
 23 **ICES.**

24 (a) UPDATE FOR 2004 AND 2005.—

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

4 “(5) UPDATE FOR 2004 AND 2005.—The update
5 to the single conversion factor established in para-
6 graph (1)(C) for each of 2004 and 2005 shall be not
7 less than 1.5 percent.”.

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

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

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

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

22 (A) by striking “projected” and inserting
23 “annual average”; and

24 (B) by striking “from the previous applica-
25 ble period to the applicable period involved”

1 and inserting “during the 10-year period ending
2 with the applicable period involved”.

3 (2) EFFECTIVE DATE.—The amendments made
4 by paragraph (1) shall apply to computations of the
5 sustainable growth rate for years beginning with
6 2003.

7 **SEC. 302. TREATMENT OF PHYSICIANS’ SERVICES FUR-**
8 **NISHED IN ALASKA.**

9 Section 1848(e)(1) (42 U.S.C. 1395w-4(e)(1)), as
10 amended by section 121, is amended—

11 (1) in subparagraph (A), by striking “subpara-
12 graphs (B), (C), (E), and (F)” and inserting “sub-
13 paragraphs (B), (C), (E), (F) and (G)”; and

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

16 “(G) FLOOR FOR PRACTICE EXPENSE,
17 MALPRACTICE, AND WORK GEOGRAPHIC INDI-
18 CES FOR SERVICES FURNISHED IN ALASKA.—

19 For purposes of payment for services furnished
20 in Alaska on or after January 1, 2004, and be-
21 fore January 1, 2006, after calculating the
22 practice expense, malpractice, and work geo-
23 graphic indices in clauses (i), (ii), and (iii) of
24 subparagraph (A) and in subparagraph (B), the
25 Secretary shall increase any such index to 1.67

1 if such index would otherwise be less than
2 1.67.”.

3 **SEC. 303. INCLUSION OF PODIATRISTS, DENTISTS, AND OP-**
4 **TOMETRISTS UNDER PRIVATE CONTRACTING**
5 **AUTHORITY.**

6 Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is
7 amended by striking “section 1861(r)(1)” and inserting
8 “paragraphs (1), (2), (3), and (4) of section 1861(r)”.

9 **SEC. 304. GAO STUDY ON ACCESS TO PHYSICIANS’ SERV-**
10 **ICES.**

11 (a) STUDY.—The Comptroller General of the United
12 States shall conduct a study on access of medicare bene-
13 ficiaries to physicians’ services under the medicare pro-
14 gram. The study shall include—

15 (1) an assessment of the use by beneficiaries of
16 such services through an analysis of claims sub-
17 mitted by physicians for such services under part B
18 of the medicare program;

19 (2) an examination of changes in the use by
20 beneficiaries of physicians’ services over time; and

21 (3) an examination of the extent to which phy-
22 sicians are not accepting new medicare beneficiaries
23 as patients.

24 (b) REPORT.—Not later than 18 months after the
25 date of the enactment of this Act, the Comptroller General

1 shall submit to Congress a report on the study conducted
 2 under subsection (a). The report shall include a deter-
 3 mination whether—

4 (1) data from claims submitted by physicians
 5 under part B of the medicare program indicate po-
 6 tential access problems for medicare beneficiaries in
 7 certain geographic areas; and

8 (2) access by medicare beneficiaries to physi-
 9 cians' services may have improved, remained con-
 10 stant, or deteriorated over time.

11 **SEC. 305. COLLABORATIVE DEMONSTRATION-BASED RE-**
 12 **VIEW OF PHYSICIAN PRACTICE EXPENSE GE-**
 13 **OGRAPHIC ADJUSTMENT DATA.**

14 (a) IN GENERAL.—Not later than January 1, 2005,
 15 the Secretary shall, in collaboration with State and other
 16 appropriate organizations representing physicians, and
 17 other appropriate persons, review and consider alternative
 18 data sources than those currently used in establishing the
 19 geographic index for the practice expense component
 20 under the medicare physician fee schedule under section
 21 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C.
 22 1395w-4(e)(1)(A)(i)).

23 (b) SITES.—The Secretary shall select two physician
 24 payment localities in which to carry out subsection (a).
 25 One locality shall include rural areas and at least one lo-

1 cality shall be a statewide locality that includes both urban
2 and rural areas.

3 (c) REPORT AND RECOMMENDATIONS.—

4 (1) REPORT.—Not later than January 1, 2006,
5 the Secretary shall submit to Congress a report on
6 the review and consideration conducted under sub-
7 section (a). Such report shall include information on
8 the alternative developed data sources considered by
9 the Secretary under subsection (a), including the ac-
10 curacy and validity of the data as measures of the
11 elements of the geographic index for practice ex-
12 penses under the medicare physician fee schedule as
13 well as the feasibility of using such alternative data
14 nationwide in lieu of current proxy data used in such
15 index, and the estimated impacts of using such al-
16 ternative data.

17 (2) RECOMMENDATIONS.—The report sub-
18 mitted under paragraph (1) shall contain rec-
19 ommendations on which data sources reviewed and
20 considered under subsection (a) are appropriate for
21 use in calculating the geographic index for practice
22 expenses under the medicare physician fee schedule.

1 **SEC. 306. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS'**
2 **SERVICES.**

3 (a) PRACTICE EXPENSE COMPONENT.—Not later
4 than 1 year after the date of the enactment of this Act,
5 the Medicare Payment Advisory Commission shall submit
6 to Congress a report on the effect of refinements to the
7 practice expense component of payments for physicians'
8 services, after the transition to a full resource-based pay-
9 ment system in 2002, under section 1848 of the Social
10 Security Act (42 U.S.C. 1395w-4). Such report shall ex-
11 amine the following matters by physician specialty:

12 (1) The effect of such refinements on payment
13 for physicians' services.

14 (2) The interaction of the practice expense com-
15 ponent with other components of and adjustments to
16 payment for physicians' services under such section.

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

19 (4) The effect of such refinements on access to
20 care by medicare beneficiaries to physicians' serv-
21 ices.

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

24 (b) VOLUME OF PHYSICIANS' SERVICES.—Not later
25 than 1 year after the date of the enactment of this Act,
26 the Medicare Payment Advisory Commission shall submit

1 to Congress a report on the extent to which increases in
2 the volume of physicians' services under part B of the
3 medicare program are a result of care that improves the
4 health and well-being of medicare beneficiaries. The study
5 shall include the following:

6 (1) An analysis of recent and historic growth in
7 the components that the Secretary includes under
8 the sustainable growth rate (under section 1848(f)
9 of the Social Security Act (42 U.S.C. 1395w-4(f))).

10 (2) An examination of the relative growth of
11 volume in physicians' services between medicare
12 beneficiaries and other populations.

13 (3) An analysis of the degree to which new
14 technology, including coverage determinations of the
15 Centers for Medicare & Medicaid Services, has af-
16 fected the volume of physicians' services.

17 (4) An examination of the impact on volume of
18 demographic changes.

19 (5) An examination of shifts in the site of serv-
20 ice or services that influence the number and inten-
21 sity of services furnished in physicians' offices and
22 the extent to which changes in reimbursement rates
23 to other providers have effected these changes.

24 (6) An evaluation of the extent to which the
25 Centers for Medicare & Medicaid Services takes into

1 account the impact of law and regulations on the
2 sustainable growth rate.

3 **Subtitle B—Preventive Services**

4 **SEC. 311. COVERAGE OF AN INITIAL PREVENTIVE PHYS-** 5 **ICAL EXAMINATION.**

6 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
7 1395x(s)(2)) is amended—

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

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

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

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

16 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
17 1395x) is amended by adding at the end the following new
18 subsection:

19 “Initial Preventive Physical Examination

20 “(ww)(1) The term ‘initial preventive physical exam-
21 ination’ means physicians’ services consisting of a physical
22 examination (including measurement of height, weight,
23 and blood pressure, and an electrocardiogram) with the
24 goal of health promotion and disease detection and in-
25 cludes education, counseling, and referral with respect to

1 screening and other preventive services described in para-
2 graph (2), but does not include clinical laboratory tests.

3 “(2) The screening and other preventive services de-
4 scribed in this paragraph include the following:

5 “(A) Pneumococcal, influenza, and hepatitis B
6 vaccine and administration under subsection (s)(10).

7 “(B) Screening mammography as defined in
8 subsection (jj).

9 “(C) Screening pap smear and screening pelvic
10 exam as defined in subsection (nn).

11 “(D) Prostate cancer screening tests as defined
12 in subsection (oo).

13 “(E) Colorectal cancer screening tests as de-
14 fined in subsection (pp).

15 “(F) Diabetes outpatient self-management
16 training services as defined in subsection (qq)(1).

17 “(G) Bone mass measurement as defined in
18 subsection (rr).

19 “(H) Screening for glaucoma as defined in sub-
20 section (uu).

21 “(I) Medical nutrition therapy services as de-
22 fined in subsection (vv).

23 “(J) Cardiovascular screening blood tests as de-
24 fined in subsection (xx)(1).

1 “(K) Diabetes screening tests as defined in sub-
2 section (yy).”.

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

6 (d) OTHER CONFORMING AMENDMENTS.—(1) Sec-
7 tion 1862(a) (42 U.S.C. 1395y(a)), as amended by section
8 303(i)(3)(B), is amended—

9 (A) in paragraph (1)—

10 (i) by striking “and” at the end of sub-
11 paragraph (I);

12 (ii) by striking the semicolon at the end of
13 subparagraph (J) and inserting “, and”; and

14 (iii) by adding at the end the following new
15 subparagraph:

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

20 (B) in paragraph (7), by striking “or (H)” and
21 inserting “(H), or (K)”.

22 (2) Clauses (i) and (ii) of section 1861(s)(2)(K) (42
23 U.S.C. 1395x(s)(2)(K)) are each amended by inserting
24 “and services described in subsection (ww)(1)” after
25 “services which would be physicians’ services”.

1 (e) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to services furnished on or after
 3 January 1, 2005, but only for individuals whose coverage
 4 period under part B begins on or after such date.

5 **SEC. 312. COVERAGE OF CARDIOVASCULAR SCREENING**
 6 **BLOOD TESTS.**

7 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
 8 1395x(s)(2)), as amended by section 311(a), is amended—

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

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

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

15 “(X) cardiovascular screening blood tests (as
 16 defined in subsection (xx)(1));”.

17 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
 18 1395x) is amended by adding at the end the following new
 19 subsection:

20 “Cardiovascular Screening Blood Test

21 “(xx)(1) The term ‘cardiovascular screening blood
 22 test’ means a blood test for the early detection of cardio-
 23 vascular disease (or abnormalities associated with an ele-
 24 vated risk of cardiovascular disease) that tests for the fol-
 25 lowing:

1 “(A) Cholesterol levels and other lipid or
2 triglyceride levels.

3 “(B) Such other indications associated with the
4 presence of, or an elevated risk for, cardiovascular
5 disease as the Secretary may approve for all individ-
6 uals (or for some individuals determined by the Sec-
7 retary to be at risk for cardiovascular disease), in-
8 cluding indications measured by noninvasive testing.
9 The Secretary may not approve an indication under sub-
10 paragraph (B) for any individual unless a blood test for
11 such is recommended by the United States Preventive
12 Services Task Force.

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

18 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.
19 1395y(a)(1)), as amended by section 311(d), is amend-
20 ed—

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

23 (2) by striking the semicolon at the end of sub-
24 paragraph (L) and inserting “, and”; and

1 (3) by adding at the end the following new sub-
2 paragraph:

3 “(M) in the case of cardiovascular screening
4 blood tests (as defined in section 1861(xx)(1)),
5 which are performed more frequently than is covered
6 under section 1861(xx)(2);”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to tests furnished on or after Janu-
9 ary 1, 2005.

10 **SEC. 313. COVERAGE OF DIABETES SCREENING TESTS.**

11 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
12 1395x(s)(2)), as amended by section 312(a), is amended—

13 (1) in subparagraph (W), by striking “and” at
14 the end;

15 (2) in subparagraph (X), by adding “and” at
16 the end; and

17 (3) by adding at the end the following new sub-
18 paragraph:

19 “(Y) diabetes screening tests (as defined in sub-
20 section (yy));”.

21 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
22 1395x), as amended by section 312(b), is amended by add-
23 ing at the end the following new subsection:

1 “Diabetes Screening Tests

2 “(yy)(1) The term ‘diabetes screening tests’ means
3 testing furnished to an individual at risk for diabetes (as
4 defined in paragraph (2)) for the purpose of early detec-
5 tion of diabetes, including—

6 “(A) a fasting plasma glucose test; and

7 “(B) such other tests, and modifications to
8 tests, as the Secretary determines appropriate, in
9 consultation with appropriate organizations.

10 “(2) For purposes of paragraph (1), the term ‘indi-
11 vidual at risk for diabetes’ means an individual who has
12 any of the following risk factors for diabetes:

13 “(A) Hypertension.

14 “(B) Dyslipidemia.

15 “(C) Obesity, defined as a body mass index
16 greater than or equal to 30 kg/m².

17 “(D) Previous identification of an elevated im-
18 paired fasting glucose.

19 “(E) Previous identification of impaired glucose
20 tolerance.

21 “(F) A risk factor consisting of at least 2 of the
22 following characteristics:

23 “(i) Overweight, defined as a body mass
24 index greater than 25, but less than 30, kg/m².

25 “(ii) A family history of diabetes.

1 “(iii) A history of gestational diabetes
2 mellitus or delivery of a baby weighing greater
3 than 9 pounds.

4 “(iv) 65 years of age or older.

5 “(3) The Secretary shall establish standards, in con-
6 sultation with appropriate organizations, regarding the
7 frequency of diabetes screening tests, except that such fre-
8 quency may not be more often than twice within the 12-
9 month period following the date of the most recent diabe-
10 tes screening test of that individual.”.

11 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.
12 1395y(a)(1)), as amended by section 312(e), is amend-
13 ed—

14 (1) by striking “and” at the end of subpara-
15 graph (L);

16 (2) by striking the semicolon at the end of sub-
17 paragraph (M) and inserting “, and”; and

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

20 “(N) in the case of a diabetes screening test (as
21 defined in section 1861(yy)(1)), which is performed
22 more frequently than is covered under section
23 1861(yy)(3);”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to tests furnished on or after Janu-
3 ary 1, 2005.

4 **SEC. 314. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**
5 **RAPHY SERVICES.**

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

12 (b) CONFORMING AMENDMENT.—Section
13 1833(a)(2)(E)(i) (42 U.S.C. 1395l(a)(2)(E)(i)) is amend-
14 ed by inserting “and, for services furnished on or after
15 January 1, 2005, diagnostic mammography” after
16 “screening mammography”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply—

19 (1) in the case of screening mammography, to
20 services furnished on or after the date of the enact-
21 ment of this Act; and

22 (2) in the case of diagnostic mammography, to
23 services furnished on or after January 1, 2005.

1 **Subtitle C—Other Provisions**

2 **SEC. 321. HOSPITAL OUTPATIENT DEPARTMENT (HOPD)**

3 **PAYMENT REFORM.**

4 (a) **PAYMENT FOR DRUGS.—**

5 (1) **SPECIAL RULES FOR CERTAIN DRUGS AND**
 6 **BIOLOGICALS.—**Section 1833(t) (42 U.S.C.
 7 1395l(t)), as amended by section 111(b), is amended
 8 by inserting after paragraph (13) the following new
 9 paragraphs:

10 “(14) **DRUG APC PAYMENT RATES.—**

11 “(A) **IN GENERAL.—**The amount of pay-
 12 ment under this subsection for a specified cov-
 13 ered outpatient drug (defined in subparagraph
 14 (B)) that is furnished as part of a covered OPD
 15 service (or group of services)—

16 “(i) in 2004, in the case of—

17 “(I) a sole source drug shall in
 18 no case be less than 88 percent, or ex-
 19 ceed 95 percent, of the reference aver-
 20 age wholesale price for the drug;

21 “(II) an innovator multiple
 22 source drug shall in no case exceed 68
 23 percent of the reference average
 24 wholesale price for the drug; or

1 “(III) a noninnovator multiple
2 source drug shall in no case exceed 46
3 percent of the reference average
4 wholesale price for the drug;

5 “(ii) in 2005, in the case of—

6 “(I) a sole source drug shall in
7 no case be less than 83 percent, or ex-
8 ceed 95 percent, of the reference aver-
9 age wholesale price for the drug;

10 “(II) an innovator multiple
11 source drug shall in no case exceed 68
12 percent of the reference average
13 wholesale price for the drug; or

14 “(III) a noninnovator multiple
15 source drug shall in no case exceed 46
16 percent of the reference average
17 wholesale price for the drug; or

18 “(iii) in a subsequent year, shall be
19 equal, subject to subparagraph (E)—

20 “(I) to the average acquisition
21 cost for the drug for that year (which,
22 at the option of the Secretary, may
23 vary by hospital group (as defined by
24 the Secretary based on volume of cov-
25 ered OPD services or other relevant

1 characteristics)), as determined by the
 2 Secretary taking into account the hos-
 3 pital acquisition cost survey data
 4 under subparagraph (D); or

5 “(II) if hospital acquisition cost
 6 data are not available, the average
 7 price for the drug in the year estab-
 8 lished under section 1842(o), section
 9 1847A, or section 1847B, as the case
 10 may be, as calculated and adjusted by
 11 the Secretary as necessary for pur-
 12 poses of this paragraph.

13 “(B) SPECIFIED COVERED OUTPATIENT
 14 DRUG DEFINED.—

15 “(i) IN GENERAL.—In this paragraph,
 16 the term ‘specified covered outpatient
 17 drug’ means, subject to clause (ii), a cov-
 18 ered outpatient drug (as defined in section
 19 1927(k)(2)) for which a separate ambula-
 20 tory payment classification group (APC)
 21 has been established and that is—

22 “(I) a radiopharmaceutical; or

23 “(II) a drug or biological for
 24 which payment was made under para-
 25 graph (6) (relating to pass-through

1 payments) on or before December 31,
2 2002.

3 “(ii) EXCEPTION.—Such term does
4 not include—

5 “(I) a drug or biological for
6 which payment is first made on or
7 after January 1, 2003, under para-
8 graph (6);

9 “(II) a drug or biological for
10 which a temporary HCPCS code has
11 not been assigned; or

12 “(III) during 2004 and 2005, an
13 orphan drug (as designated by the
14 Secretary).

15 “(C) PAYMENT FOR DESIGNATED ORPHAN
16 DRUGS DURING 2004 AND 2005.—The amount of
17 payment under this subsection for an orphan
18 drug designated by the Secretary under sub-
19 paragraph (B)(ii)(III) that is furnished as part
20 of a covered OPD service (or group of services)
21 during 2004 and 2005 shall equal such amount
22 as the Secretary may specify.

23 “(D) ACQUISITION COST SURVEY FOR HOS-
24 PITAL OUTPATIENT DRUGS.—

1 “(i) ANNUAL GAO SURVEYS IN 2004
2 AND 2005.—

3 “(I) IN GENERAL.—The Comp-
4 troller General of the United States
5 shall conduct a survey in each of 2004
6 and 2005 to determine the hospital
7 acquisition cost for each specified cov-
8 ered outpatient drug. Not later than
9 April 1, 2005, the Comptroller Gen-
10 eral shall furnish data from such sur-
11 veys to the Secretary for use in set-
12 ting the payment rates under sub-
13 paragraph (A) for 2006.

14 “(II) RECOMMENDATIONS.—
15 Upon the completion of such surveys,
16 the Comptroller General shall rec-
17 ommend to the Secretary the fre-
18 quency and methodology of subse-
19 quent surveys to be conducted by the
20 Secretary under clause (ii).

21 “(ii) SUBSEQUENT SECRETARIAL SUR-
22 VEYS.—The Secretary, taking into account
23 such recommendations, shall conduct peri-
24 odic subsequent surveys to determine the
25 hospital acquisition cost for each specified

1 covered outpatient drug for use in setting
2 the payment rates under subparagraph
3 (A).

4 “(iii) SURVEY REQUIREMENTS.—The
5 surveys conducted under clauses (i) and
6 (ii) shall have a large sample of hospitals
7 that is sufficient to generate a statistically
8 significant estimate of the average hospital
9 acquisition cost for each specified covered
10 outpatient drug. With respect to the sur-
11 veys conducted under clause (i), the Comp-
12 troller General shall report to Congress on
13 the justification for the size of the sample
14 used in order to assure the validity of such
15 estimates.

16 “(iv) DIFFERENTIATION IN COST.—In
17 conducting surveys under clause (i), the
18 Comptroller General shall determine and
19 report to Congress if there is (and the ex-
20 tent of any) variation in hospital acquisi-
21 tion costs for drugs among hospitals based
22 on the volume of covered OPD services
23 performed by such hospitals or other rel-
24 evant characteristics of such hospitals (as
25 defined by the Comptroller General).

1 “(v) COMMENT ON PROPOSED
2 RATES.—Not later than 30 days after the
3 date the Secretary promulgated proposed
4 rules setting forth the payment rates under
5 subparagraph (A) for 2006, the Comp-
6 troller General shall evaluate such pro-
7 posed rates and submit to Congress a re-
8 port regarding the appropriateness of such
9 rates based on the surveys the Comptroller
10 General has conducted under clause (i).

11 “(E) ADJUSTMENT IN PAYMENT RATES
12 FOR OVERHEAD COSTS.—

13 “(i) MEDPAC REPORT ON DRUG APC
14 DESIGN.—The Medicare Payment Advisory
15 Commission shall submit to the Secretary,
16 not later than July 1, 2005, a report on
17 adjustment of payment for ambulatory
18 payment classifications for specified cov-
19 ered outpatient drugs to take into account
20 overhead and related expenses, such as
21 pharmacy services and handling costs.
22 Such report shall include—

23 “(I) a description and analysis of
24 the data available with regard to such
25 expenses;

1 “(II) a recommendation as to
2 whether such a payment adjustment
3 should be made; and

4 “(III) if such adjustment should
5 be made, a recommendation regarding
6 the methodology for making such an
7 adjustment.

8 “(ii) ADJUSTMENT AUTHORIZED.—
9 The Secretary may adjust the weights for
10 ambulatory payment classifications for
11 specified covered outpatient drugs to take
12 into account the recommendations con-
13 tained in the report submitted under
14 clause (i).

15 “(F) CLASSES OF DRUGS.—For purposes
16 of this paragraph:

17 “(i) SOLE SOURCE DRUGS.—The term
18 ‘sole source drug’ means—

19 “(I) a biological product (as de-
20 fined under section 1861(t)(1)); or

21 “(II) a single source drug (as de-
22 fined in section 1927(k)(7)(A)(iv)).

23 “(ii) INNOVATOR MULTIPLE SOURCE
24 DRUGS.—The term ‘innovator multiple

1 source drug' has the meaning given such
2 term in section 1927(k)(7)(A)(ii).

3 “(iii) NONINNOVATOR MULTIPLE
4 SOURCE DRUGS.—The term ‘noninnovator
5 multiple source drug’ has the meaning
6 given such term in section
7 1927(k)(7)(A)(iii).

8 “(G) REFERENCE AVERAGE WHOLESALE
9 PRICE.—The term ‘reference average wholesale
10 price’ means, with respect to a specified covered
11 outpatient drug, the average wholesale price for
12 the drug as determined under section 1842(o)
13 as of May 1, 2003.

14 “(H) INAPPLICABILITY OF EXPENDITURES
15 IN DETERMINING CONVERSION, WEIGHTING,
16 AND OTHER ADJUSTMENT FACTORS.—Addi-
17 tional expenditures resulting from this para-
18 graph shall not be taken into account in estab-
19 lishing the conversion, weighting, and other ad-
20 justment factors for 2004 and 2005 under
21 paragraph (9), but shall be taken into account
22 for subsequent years.

23 “(15) PAYMENT FOR NEW DRUGS AND
24 BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With
25 respect to payment under this part for an outpatient

1 drug or biological that is covered under this part
2 and is furnished as part of covered OPD services for
3 which a HCPCS code has not been assigned, the
4 amount provided for payment for such drug or bio-
5 logical under this part shall be equal to 95 percent
6 of the average wholesale price for the drug or bio-
7 logical.”.

8 (2) REDUCTION IN THRESHOLD FOR SEPARATE
9 APCS FOR DRUGS.—Section 1833(t)(16), as redesign-
10 nated section 111(b), is amended by adding at the
11 end the following new subparagraph:

12 “(B) THRESHOLD FOR ESTABLISHMENT
13 OF SEPARATE APCS FOR DRUGS.—The Sec-
14 retary shall reduce the threshold for the estab-
15 lishment of separate ambulatory payment clas-
16 sification groups (APCs) with respect to drugs
17 or biologicals to \$50 per administration for
18 drugs and biologicals furnished in 2005 and
19 2006.”.

20 (3) EXCLUSION OF SEPARATE DRUG APCS FROM
21 OUTLIER PAYMENTS.—Section 1833(t)(5) is amend-
22 ed by adding at the end the following new subpara-
23 graph:

24 “(E) EXCLUSION OF SEPARATE DRUG AND
25 BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—

1 No additional payment shall be made under
2 subparagraph (A) in the case of ambulatory
3 payment classification groups established sepa-
4 rately for drugs or biologicals.”.

5 (4) PAYMENT FOR PASS THROUGH DRUGS.—

6 Section 1833(t)(6)(D)(i) (42 U.S.C.
7 13951(t)(6)(D)(i)) is amended by inserting after
8 “under section 1842(o)” the following: “(or if the
9 drug or biological is covered under a competitive ac-
10 quisition contract under section 1847B, an amount
11 determined by the Secretary equal to the average
12 price for the drug or biological for all competitive
13 acquisition areas and year established under such
14 section as calculated and adjusted by the Secretary
15 for purposes of this paragraph)”.

16 (5) CONFORMING AMENDMENT TO BUDGET

17 NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B)

18 (42 U.S.C. 13951(t)(9)(B)) is amended by adding at

19 the end the following: “In determining adjustments

20 under the preceding sentence for 2004 and 2005,

21 the Secretary shall not take into account under this

22 subparagraph or paragraph (2)(E) any expenditures

23 that would not have been made but for the applica-

24 tion of paragraph (14).”.

1 (6) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to items and services
3 furnished on or after January 1, 2004.

4 (b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

5 (1) IN GENERAL.—Section 1833(t)(16), as re-
6 designated by section 111(b) and as amended by
7 subsection (a)(2), is amended by adding at the end
8 the following new subparagraph:

9 “(C) PAYMENT FOR DEVICES OF
10 BRACHYTHERAPY AT CHARGES ADJUSTED TO
11 COST.—Notwithstanding the preceding provi-
12 sions of this subsection, for a device of
13 brachytherapy consisting of a seed or seeds (or
14 radioactive source) furnished on or after Janu-
15 ary 1, 2004, and before January 1, 2007, the
16 payment basis for the device under this sub-
17 section shall be equal to the hospital’s charges
18 for each device furnished, adjusted to cost.
19 Charges for such devices shall not be included
20 in determining any outlier payment under this
21 subsection.”.

22 (2) SPECIFICATION OF GROUPS FOR
23 BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42
24 U.S.C. 1395l(t)(2)) is amended—

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

3 (B) in subparagraph (G), by striking the
4 period at the end and inserting “; and”; and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(H) with respect to devices of
8 brachytherapy consisting of a seed or seeds (or
9 radioactive source), the Secretary shall create
10 additional groups of covered OPD services that
11 classify such devices separately from the other
12 services (or group of services) paid for under
13 this subsection in a manner reflecting the num-
14 ber, isotope, and radioactive intensity of such
15 devices furnished, including separate groups for
16 palladium-103 and iodine-125 devices.”.

17 (3) GAO REPORT.—The Comptroller General of
18 the United States shall conduct a study to determine
19 appropriate payment amounts under section
20 1833(t)(16)(C) of the Social Security Act, as added
21 by paragraph (1), for devices of brachytherapy. Not
22 later than January 1, 2005, the Comptroller General
23 shall submit to Congress and the Secretary a report
24 on the study conducted under this paragraph, and

1 shall include specific recommendations for appro-
2 priate payments for such devices.

3 **SEC. 322. LIMITATION OF APPLICATION OF FUNCTIONAL**
4 **EQUIVALENCE STANDARD.**

5 Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amend-
6 ed by adding at the end the following new subparagraph:

7 “(F) LIMITATION OF APPLICATION OF
8 FUNCTIONAL EQUIVALENCE STANDARD.—

9 “(i) IN GENERAL.—The Secretary
10 may not publish regulations that apply a
11 functional equivalence standard to a drug
12 or biological under this paragraph.

13 “(ii) APPLICATION.—Clause (i) shall
14 apply to the application of a functional
15 equivalence standard to a drug or biologi-
16 cal on or after the date of enactment of
17 the Medicare Provider Restoration Act of
18 2003 unless—

19 “(I) such application was being
20 made to such drug or biological prior
21 to such date of enactment; and

22 “(II) the Secretary applies such
23 standard to such drug or biological
24 only for the purpose of determining
25 eligibility of such drug or biological

1 for additional payments under this
2 paragraph and not for the purpose of
3 any other payments under this title.

4 “(iii) RULE OF CONSTRUCTION.—
5 Nothing in this subparagraph shall be con-
6 strued to effect the Secretary’s authority
7 to deem a particular drug to be identical to
8 another drug if the 2 products are phar-
9 maceutically equivalent and bioequivalent,
10 as determined by the Commissioner of
11 Food and Drugs.”.

12 **SEC. 323. PAYMENT FOR RENAL DIALYSIS SERVICES.**

13 (a) INCREASE IN RENAL DIALYSIS COMPOSITE RATE
14 FOR SERVICES FURNISHED.—The last sentence of section
15 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended—

16 (1) by striking “and” before “for such services”
17 the second place it appears;

18 (2) by inserting “and before January 1, 2005,”
19 after “January 1, 2001,”; and

20 (3) by inserting before the period at the end the
21 following: “, and for such services furnished on or
22 after January 1, 2005, by 1.6 percent above such
23 composite rate payment amounts for such services
24 furnished on December 31, 2004”.

1 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR
2 PEDIATRIC FACILITIES.—

3 (1) IN GENERAL.—Section 422(a)(2) of BIPA
4 is amended—

5 (A) in subparagraph (A), by striking “and
6 (C)” and inserting “, (C), and (D)”;

7 (B) in subparagraph (B), by striking “In
8 the case” and inserting “Subject to subpara-
9 graph (D), in the case”; and

10 (C) by adding at the end the following new
11 subparagraph:

12 “(D) INAPPLICABILITY TO PEDIATRIC FA-
13 CILITIES.—Subparagraphs (A) and (B) shall
14 not apply, as of October 1, 2002, to pediatric
15 facilities that do not have an exception rate de-
16 scribed in subparagraph (C) in effect on such
17 date. For purposes of this subparagraph, the
18 term ‘pediatric facility’ means a renal facility at
19 least 50 percent of whose patients are individ-
20 uals under 18 years of age.”.

21 (2) CONFORMING AMENDMENT.—The fourth
22 sentence of section 1881(b)(7) (42 U.S.C.
23 1395rr(b)(7)) is amended by striking “The Sec-
24 retary” and inserting “Subject to section 422(a)(2)
25 of the Medicare, Medicaid, and SCHIP Benefits Im-

1 provement and Protection Act of 2000, the Sec-
2 retary”.

3 (c) INSPECTOR GENERAL STUDIES ON ESRD
4 DRUGS.—

5 (1) IN GENERAL.—The Inspector General of
6 the Department of Health and Human Services shall
7 conduct two studies with respect to drugs and
8 biologicals (including erythropoietin) furnished to
9 end-stage renal disease patients under the medicare
10 program which are separately billed by end stage
11 renal disease facilities.

12 (2) STUDIES ON ESRD DRUGS.—

13 (A) EXISTING DRUGS.—The first study
14 under paragraph (1) shall be conducted with re-
15 spect to such drugs and biologicals for which a
16 billing code exists prior to January 1, 2004.

17 (B) NEW DRUGS.—The second study
18 under paragraph (1) shall be conducted with re-
19 spect to such drugs and biologicals for which a
20 billing code does not exist prior to January 1,
21 2004.

22 (3) MATTERS STUDIED.—Under each study
23 conducted under paragraph (1), the Inspector Gen-
24 eral shall—

1 (A) determine the difference between the
2 amount of payment made to end stage renal
3 disease facilities under title XVIII of the Social
4 Security Act for such drugs and biologicals and
5 the acquisition costs of such facilities for such
6 drugs and biologicals and which are separately
7 billed by end stage renal disease facilities, and

8 (B) estimate the rates of growth of ex-
9 penditures for such drugs and biologicals billed
10 by such facilities.

11 (4) REPORTS.—

12 (A) EXISTING ESRD DRUGS.—Not later
13 than April 1, 2004, the Inspector General shall
14 report to the Secretary on the study described
15 in paragraph (2)(A).

16 (B) NEW ESRD DRUGS.—Not later than
17 April 1, 2006, the Inspector General shall re-
18 port to the Secretary on the study described in
19 paragraph (2)(B).

20 (d) BASIC CASE-MIX ADJUSTED COMPOSITE RATE
21 FOR RENAL DIALYSIS FACILITY SERVICES.—(1) Section
22 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at
23 the end the following new paragraphs:

24 “(12)(A) In lieu of payment under paragraph (7) be-
25 ginning with services furnished on January 1, 2005, the

1 Secretary shall establish a basic case-mix adjusted pro-
2 spective payment system for dialysis services furnished by
3 providers of services and renal dialysis facilities in a year
4 to individuals in a facility and to such individuals at home.
5 The case-mix under such system shall be for a limited
6 number of patient characteristics.

7 “(B) The system described in subparagraph (A) shall
8 include—

9 “(i) the services comprising the composite rate
10 established under paragraph (7); and

11 “(ii) the difference between payment amounts
12 under this title for separately billed drugs and
13 biologicals (including erythropoietin) and acquisition
14 costs of such drugs and biologicals, as determined by
15 the Inspector General reports to the Secretary as re-
16 quired by section 323(c) of the Medicare Provider
17 Restoration Act of 2003—

18 “(I) beginning with 2005, for such drugs
19 and biologicals for which a billing code exists
20 prior to January 1, 2004; and

21 “(II) beginning with 2007, for such drugs
22 and biologicals for which a billing code does not
23 exist prior to January 1, 2004,
24 adjusted to 2005, or 2007, respectively, as deter-
25 mined to be appropriate by the Secretary.

1 “(C)(i) In applying subparagraph (B)(ii) for 2005,
2 such payment amounts under this title shall be determined
3 using the methodology specified in paragraph (13)(A)(i).

4 “(ii) For 2006, the Secretary shall provide for
5 an adjustment to the payments under clause (i) to
6 reflect the difference between the payment amounts
7 using the methodology under paragraph (13)(A)(i)
8 and the payment amount determined using the
9 methodology applied by the Secretary under para-
10 graph (13)(A)(iii) of such paragraph, as estimated
11 by the Secretary.

12 “(D) The Secretary shall adjust the payment rates
13 under such system by a geographic index as the Secretary
14 determines to be appropriate. If the Secretary applies a
15 geographic index under this paragraph that differs from
16 the index applied under paragraph (7) the Secretary shall
17 phase-in the application of the index under this paragraph
18 over a multiyear period.

19 “(E)(i) Such system shall be designed to result in the
20 same aggregate amount of expenditures for such services,
21 as estimated by the Secretary, as would have been made
22 for 2005 if this paragraph did not apply.

23 “(ii) The adjustment made under subparagraph
24 (B)(ii)(II) shall be done in a manner to result in the same
25 aggregate amount of expenditures after such adjustment

1 as would otherwise have been made for such services for
2 2006 or 2007, respectively, as estimated by the Secretary,
3 if this paragraph did not apply.

4 “(F) Beginning with 2006, the Secretary shall annu-
5 ally increase the basic case-mix adjusted payment amounts
6 established under this paragraph, by an amount deter-
7 mined by—

8 “(i) applying the estimated growth in expendi-
9 tures for drugs and biologicals (including erythro-
10 poietin) that are separately billable to the component
11 of the basic case-mix adjusted system described in
12 subparagraph (B)(ii); and

13 “(ii) converting the amount determined in
14 clause (i) to an increase applicable to the basic case-
15 mix adjusted payment amounts established under
16 subparagraph (B).

17 Nothing in this paragraph shall be construed as providing
18 for an update to the composite rate component of the basic
19 case-mix adjusted system under subparagraph (B).

20 “(G) There shall be no administrative or judicial re-
21 view under section 1869, section 1878, or otherwise, of
22 the case-mix system, relative weights, payment amounts,
23 the geographic adjustment factor, or the update for the
24 system established under this paragraph, or the deter-
25 mination of the difference between medicare payment

1 amounts and acquisition costs for separately billed drugs
2 and biologicals (including erythropoietin) under this para-
3 graph and paragraph (13).

4 “(13)(A) The payment amounts under this title for
5 separately billed drugs and biologicals furnished in a year,
6 beginning with 2004, are as follows:

7 “(i) For such drugs and biologicals (other than
8 erythropoietin) furnished in 2004, the amount deter-
9 mined under section 1842(o)(1)(A)(v) for the drug
10 or biological.

11 “(ii) For such drugs and biologicals (including
12 erythropoietin) furnished in 2005, the acquisition
13 cost of the drug or biological, as determined by the
14 Inspector General reports to the Secretary as re-
15 quired by section 323(c) of the Medicare Provider
16 Restoration Act of 2003. Insofar as the Inspector
17 General has not determined the acquisition cost with
18 respect to a drug or biological, the Secretary shall
19 determine the payment amount for such drug or bio-
20 logical.

21 “(iii) For such drugs and biologicals (including
22 erythropoietin) furnished in 2006 and subsequent
23 years, such acquisition cost or the amount deter-
24 mined under section 1847A for the drug or biologi-
25 cal, as the Secretary may specify.

1 “(B)(i) Drugs and biologicals (including erythro-
2 poietin) which were separately billed under this subsection
3 on the day before the date of the enactment of the Medi-
4 care Provider Restoration Act of 2003 shall continue to
5 be separately billed on and after such date.

6 “(ii) Nothing in this paragraph, section 1842(o), sec-
7 tion 1847A, or section 1847B shall be construed as requir-
8 ing or authorizing the bundling of payment for drugs and
9 biologicals into the basic case-mix adjusted payment sys-
10 tem under this paragraph.”.

11 (2) Paragraph (7) of such section is amended in the
12 first sentence by striking “The Secretary” and inserting
13 “Subject to paragraph (12), the Secretary”.

14 (3) Paragraph (11)(B) of such section is amended by
15 inserting “subject to paragraphs (12) and (13)” before
16 “payment for such item”.

17 (e) DEMONSTRATION OF BUNDLED CASE-MIX AD-
18 JUSTED PAYMENT SYSTEM FOR ESRD SERVICES.—

19 (1) IN GENERAL.—The Secretary shall establish
20 a demonstration project of the use of a fully case-
21 mix adjusted payment system for end stage renal
22 disease services under section 1881 of the Social Se-
23 curity Act (42 U.S.C. 1395rr) for patient character-
24 istics identified in the report under subsection (f)
25 that bundles into such payment rates amounts for—

1 (A) drugs and biologicals (including eryth-
2 ropoietin) furnished to end-stage renal disease
3 patients under the medicare program which are
4 separately billed by end stage renal disease fa-
5 cilities (as of the date of the enactment of this
6 Act); and

7 (B) clinical laboratory tests related to such
8 drugs and biologicals.

9 (2) FACILITIES INCLUDED IN THE DEMONSTRA-
10 TION.—In conducting the demonstration under this
11 subsection, the Secretary shall ensure the partici-
12 pation of a sufficient number of providers of dialysis
13 services and renal dialysis facilities, but in no case
14 to exceed 500. In selecting such providers and facili-
15 ties, the Secretary shall ensure that the following
16 types of providers are included in the demonstration:

17 (A) Urban providers and facilities.

18 (B) Rural providers and facilities.

19 (C) Not-for-profit providers and facilities.

20 (D) For-profit providers and facilities.

21 (E) Independent providers and facilities.

22 (F) Specialty providers and facilities, in-
23 cluding pediatric providers and facilities and
24 small providers and facilities.

1 (3) TEMPORARY ADD-ON PAYMENT FOR DIALY-
2 SIS SERVICES FURNISHED UNDER THE DEMONSTRA-
3 TION.—

4 (A) IN GENERAL.—During the period of
5 the demonstration project, the Secretary shall
6 increase payment rates that would otherwise
7 apply under section 1881(b) of such Act (42
8 U.S.C. 1395rr(b)) by 1.6 percent for dialysis
9 services furnished in facilities in the demonstra-
10 tion site.

11 (B) RULES OF CONSTRUCTION.—Nothing
12 in this subsection shall be construed as—

13 (i) as an annual update under section
14 1881(b) of the Social Security Act (42
15 U.S.C. 1395rr(b));

16 (ii) as increasing the baseline for pay-
17 ments under such section; or

18 (iii) requiring the budget neutral im-
19 plementation of the demonstration project
20 under this subsection.

21 (4) 3-YEAR PERIOD.—The Secretary shall con-
22 duct the demonstration under this subsection for the
23 3-year period beginning on January 1, 2006.

24 (5) USE OF ADVISORY BOARD.—

1 (A) IN GENERAL.—In carrying out the
2 demonstration under this subsection, the Sec-
3 retary shall establish an advisory board com-
4 prised of representatives described in subpara-
5 graph (B) to provide advice and recommenda-
6 tions with respect to the establishment and op-
7 eration of such demonstration.

8 (B) REPRESENTATIVES.—Representatives
9 referred to in subparagraph (A) include rep-
10 resentatives of the following:

11 (i) Patient organizations.

12 (ii) Individuals with expertise in end-
13 stage renal dialysis services, such as clini-
14 cians, economists, and researchers.

15 (iii) The Medicare Payment Advisory
16 Commission, established under section
17 1805 of the Social Security Act (42 U.S.C.
18 1395b–6).

19 (iv) The National Institutes of
20 Health.

21 (v) Network organizations under sec-
22 tion 1881(c) of the Social Security Act (42
23 U.S.C. 1395rr(c)).

24 (vi) Medicare contractors to monitor
25 quality of care.

1 (vii) Providers of services and renal
2 dialysis facilities furnishing end-stage renal
3 disease services.

4 (C) TERMINATION OF ADVISORY PANEL.—
5 The advisory panel shall terminate on Decem-
6 ber 31, 2008.

7 (6) AUTHORIZATION OF APPROPRIATIONS.—
8 There are authorized to be appropriated, in appro-
9 priate part from the Federal Hospital Insurance
10 Trust Fund and the Federal Supplementary Medical
11 Insurance Trust Fund, \$5,000,000 in fiscal year
12 2006 to conduct the demonstration under this sub-
13 section.

14 (f) REPORT ON A BUNDLED PROSPECTIVE PAYMENT
15 SYSTEM FOR END STAGE RENAL DISEASE SERVICES.—

16 (1) REPORT.—

17 (A) IN GENERAL.—Not later than October
18 1, 2005, the Secretary shall submit to Congress
19 a report detailing the elements and features for
20 the design and implementation of a bundled
21 prospective payment system for services fur-
22 nished by end stage renal disease facilities in-
23 cluding, to the maximum extent feasible, bun-
24 dling of drugs, clinical laboratory tests, and
25 other items that are separately billed by such

1 facilities. The report shall include a description
2 of the methodology to be used for the establish-
3 ment of payment rates, including components of
4 the new system described in paragraph (2).

5 (B) RECOMMENDATIONS.—The Secretary
6 shall include in such report recommendations
7 on elements, features, and methodology for a
8 bundled prospective payment system or other
9 issues related to such system as the Secretary
10 determines to be appropriate.

11 (2) ELEMENTS AND FEATURES OF A BUNDLED
12 PROSPECTIVE PAYMENT SYSTEM.—The report re-
13 quired under paragraph (1) shall include the fol-
14 lowing elements and features of a bundled prospec-
15 tive payment system:

16 (A) BUNDLE OF ITEMS AND SERVICES.—A
17 description of the bundle of items and services
18 to be included under the prospective payment
19 system.

20 (B) CASE MIX.—A description of the case-
21 mix adjustment to account for the relative re-
22 source use of different types of patients.

23 (C) WAGE INDEX.—A description of an ad-
24 justment to account for geographic differences
25 in wages.

1 (D) RURAL AREAS.—The appropriateness
2 of establishing a specific payment adjustment to
3 account for additional costs incurred by rural
4 facilities.

5 (E) OTHER ADJUSTMENTS.—Such other
6 adjustments as may be necessary to reflect the
7 variation in costs incurred by facilities in caring
8 for patients with end stage renal disease.

9 (F) UPDATE FRAMEWORK.—A method-
10 ology for appropriate updates under the pro-
11 spective payment system.

12 (G) ADDITIONAL RECOMMENDATIONS.—
13 Such other matters as the Secretary determines
14 to be appropriate.

15 **SEC. 324. 2-YEAR MORATORIUM ON THERAPY CAPS; PROVI-**
16 **SIONS RELATING TO REPORTS.**

17 (a) ADDITIONAL MORATORIUM ON THERAPY CAPS.—

18 (1) 2004 AND 2005.—Section 1833(g)(4) (42
19 U.S.C. 1395l(g)(4)) is amended by striking “and
20 2002” and inserting “2002, 2004, and 2005”.

21 (2) REMAINDER OF 2003.—For the period be-
22 ginning on the date of the enactment of this Act and
23 ending of December 31, 2003, the Secretary shall
24 not apply the provisions of paragraphs (1), (2), and
25 (3) of section 1833(g) to expenses incurred with re-

1 spect to services described in such paragraphs dur-
2 ing such period. Nothing in the preceding sentence
3 shall be construed as affecting the application of
4 such paragraphs by the Secretary before the date of
5 the enactment of this Act.

6 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON
7 PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY
8 SERVICES.—Not later than March 31, 2004, the Secretary
9 shall submit to Congress the reports required under sec-
10 tion 4541(d)(2) of the Balanced Budget Act of 1997
11 (Public Law 105–33; 111 Stat. 457) (relating to alter-
12 natives to a single annual dollar cap on outpatient ther-
13 apy) and under section 221(d) of the Medicare, Medicaid,
14 and SCHIP Balanced Budget Refinement Act of 1999
15 (Appendix F, 113 Stat. 1501A–352), as enacted into law
16 by section 1000(a)(6) of Public Law 106–113 (relating
17 to utilization patterns for outpatient therapy).

18 (c) GAO REPORT IDENTIFYING CONDITIONS AND
19 DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

20 (1) STUDY.—The Comptroller General of the
21 United States shall identify conditions or diseases
22 that may justify waiving the application of the ther-
23 apy caps under section 1833(g) of the Social Secu-
24 rity Act (42 U.S.C. 1395l(g)) with respect to such
25 conditions or diseases.

1 (2) REPORT TO CONGRESS.—Not later than Oc-
2 tober 1, 2004, the Comptroller General shall submit
3 to Congress a report on the conditions and diseases
4 identified under paragraph (1), and shall include a
5 recommendation of criteria, with respect to such
6 conditions and disease, under which a waiver of the
7 therapy caps would apply.

8 **SEC. 325. WAIVER OF PART B LATE ENROLLMENT PENALTY**
9 **FOR CERTAIN MILITARY RETIREES; SPECIAL**
10 **ENROLLMENT PERIOD.**

11 (a) WAIVER OF PENALTY.—

12 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.
13 1395r(b)) is amended by adding at the end the fol-
14 lowing new sentence: “No increase in the premium
15 shall be effected for a month in the case of an indi-
16 vidual who enrolls under this part during 2001,
17 2002, 2003, or 2004 and who demonstrates to the
18 Secretary before December 31, 2004, that the indi-
19 vidual is a covered beneficiary (as defined in section
20 1072(5) of title 10, United States Code). The Sec-
21 retary of Health and Human Services shall consult
22 with the Secretary of Defense in identifying individ-
23 uals described in the previous sentence.”.

24 (2) EFFECTIVE DATE.—The amendment made
25 by paragraph (1) shall apply to premiums for

1 months beginning with January 2004. The Secretary
2 shall establish a method for providing rebates of pre-
3 mium penalties paid for months on or after January
4 2004 for which a penalty does not apply under such
5 amendment but for which a penalty was previously
6 collected.

7 (b) MEDICARE PART B SPECIAL ENROLLMENT PE-
8 RIOD.—

9 (1) IN GENERAL.—In the case of any individual
10 who, as of the date of the enactment of this Act, is
11 eligible to enroll but is not enrolled under part B of
12 title XVIII of the Social Security Act and is a cov-
13 ered beneficiary (as defined in section 1072(5) of
14 title 10, United States Code), the Secretary of
15 Health and Human Services shall provide for a spe-
16 cial enrollment period during which the individual
17 may enroll under such part. Such period shall begin
18 as soon as possible after the date of the enactment
19 of this Act and shall end on December 31, 2004.

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

1 **SEC. 326. PAYMENT FOR SERVICES FURNISHED IN AMBULA-**
2 **TORY SURGICAL CENTERS.**

3 (a) REDUCTIONS IN PAYMENT UPDATES.—Section
4 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended to
5 read as follows:

6 “(C)(i) Notwithstanding the second sentence of each
7 of subparagraphs (A) and (B), except as otherwise speci-
8 fied in clauses (ii), (iii), and (iv), if the Secretary has not
9 updated amounts established under such subparagraphs
10 or under subparagraph (D), with respect to facility serv-
11 ices furnished during a fiscal year (beginning with fiscal
12 year 1986 or a calendar year (beginning with 2006)), such
13 amounts shall be increased by the percentage increase in
14 the Consumer Price Index for all urban consumers (U.S.
15 city average) as estimated by the Secretary for the 12-
16 month period ending with the midpoint of the year in-
17 volved.

18 “(ii) In each of the fiscal years 1998 through 2002,
19 the increase under this subparagraph shall be reduced
20 (but not below zero) by 2.0 percentage points.

21 “(iii) In fiscal year 2004, beginning with April 1,
22 2004, the increase under this subparagraph shall be the
23 Consumer Price Index for all urban consumers (U.S. city
24 average) as estimated by the Secretary for the 12-month
25 period ending with March 31, 2003, minus 3.0 percentage
26 points.

1 “(iv) In fiscal year 2005, the last quarter of calendar
2 year 2005, and each of calendar years 2006 through 2009,
3 the increase under this subparagraph shall be 0 percent.”.

4 (b) REPEAL OF SURVEY REQUIREMENT AND IMPLE-
5 MENTATION OF NEW SYSTEM.—Section 1833(i)(2) (42
6 U.S.C. 1395l(i)(2)) is amended—

7 (1) in subparagraph (A)—

8 (A) in the matter preceding clause (i), by
9 striking “The” and inserting “For services fur-
10 nished prior to the implementation of the sys-
11 tem described in subparagraph (D), the”; and

12 (B) in clause (i), by striking “taken not
13 later than January 1, 1995, and every 5 years
14 thereafter,”; and

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

17 “(D)(i) Taking into account the recommendations in
18 the report under section 326(d) of Medicare Provider Res-
19 toration Act of 2003, the Secretary shall implement a re-
20 vised payment system for payment of surgical services fur-
21 nished in ambulatory surgical centers.

22 “(ii) In the year the system described in clause (i)
23 is implemented, such system shall be designed to result
24 in the same aggregate amount of expenditures for such

1 services as would be made if this subparagraph did not
2 apply, as estimated by the Secretary.

3 “(iii) The Secretary shall implement the system de-
4 scribed in clause (i) for periods in a manner so that it
5 is first effective beginning on or after January 1, 2006,
6 and not later than January 1, 2008.

7 “(iv) There shall be no administrative or judicial re-
8 view under section 1869, 1878, or otherwise, of the classi-
9 fication system, the relative weights, payment amounts,
10 and the geographic adjustment factor, if any, under this
11 subparagraph.”.

12 (c) CONFORMING AMENDMENT.—Section 1833(a)(1)
13 (42 U.S.C. 1395l(a)(1)) is amended by adding the fol-
14 lowing new subparagraph:

15 “(G) with respect to facility services fur-
16 nished in connection with a surgical procedure
17 specified pursuant to subsection (i)(1)(A) and
18 furnished to an individual in an ambulatory
19 surgical center described in such subsection, for
20 services furnished beginning with the implemen-
21 tation date of a revised payment system for
22 such services in such facilities specified in sub-
23 section (i)(2)(D), the amounts paid shall be 80
24 percent of the lesser of the actual charge for

1 the services or the amount determined by the
2 Secretary under such revised payment system,”.

3 (d) GAO STUDY OF AMBULATORY SURGICAL CEN-
4 TER PAYMENTS.—

5 (1) STUDY.—

6 (A) IN GENERAL.—The Comptroller Gen-
7 eral of the United States shall conduct a study
8 that compares the relative costs of procedures
9 furnished in ambulatory surgical centers to the
10 relative costs of procedures furnished in hos-
11 pital outpatient departments under section
12 1833(t) of the Social Security Act (42 U.S.C.
13 1395l(t)). The study shall also examine how ac-
14 curately ambulatory payment categories reflect
15 procedures furnished in ambulatory surgical
16 centers.

17 (B) CONSIDERATION OF ASC DATA.—In
18 conducting the study under paragraph (1), the
19 Comptroller General shall consider data sub-
20 mitted by ambulatory surgical centers regarding
21 the matters described in clauses (i) through (iii)
22 of paragraph (2)(B).

23 (2) REPORT AND RECOMMENDATIONS.—

24 (A) REPORT.—Not later than January 1,
25 2005, the Comptroller General shall submit to

1 Congress a report on the study conducted under
2 paragraph (1).

3 (B) RECOMMENDATIONS.—The report sub-
4 mitted under subparagraph (A) shall include
5 recommendations on the following matters:

6 (i) The appropriateness of using the
7 groups of covered services and relative
8 weights established under the outpatient
9 prospective payment system as the basis of
10 payment for ambulatory surgical centers.

11 (ii) If the relative weights under such
12 hospital outpatient prospective payment
13 system are appropriate for such purpose—

14 (I) whether the payment rates for
15 ambulatory surgical centers should be
16 based on a uniform percentage of the
17 payment rates or weights under such
18 outpatient system; or

19 (II) whether the payment rates
20 for ambulatory surgical centers should
21 vary, or the weights should be revised,
22 based on specific procedures or types
23 of services (such as ophthalmology
24 and pain management services).

1 (iii) Whether a geographic adjustment
2 should be used for payment of services fur-
3 nished in ambulatory surgical centers, and
4 if so, the labor and nonlabor shares of
5 such payment.

6 **SEC. 327. PAYMENT FOR CERTAIN SHOES AND INSERTS**
7 **UNDER THE FEE SCHEDULE FOR ORTHOTICS**
8 **AND PROSTHETICS.**

9 (a) IN GENERAL.—Section 1833(o) (42 U.S.C.
10 1395l(o)) is amended—

11 (1) in paragraph (1)(B), by striking “no more
12 than the limits established under paragraph (2)”
13 and inserting “no more than the amount of payment
14 applicable under paragraph (2)”; and

15 (2) in paragraph (2), to read as follows:

16 “(2)(A) Except as provided by the Secretary under
17 subparagraphs (B) and (C), the amount of payment under
18 this paragraph for custom molded shoes, extra-depth
19 shoes, and inserts shall be the amount determined for such
20 items by the Secretary under section 1834(h).

21 “(B) The Secretary may establish payment amounts
22 for shoes and inserts that are lower than the amount es-
23 tablished under section 1834(h) if the Secretary finds that
24 shoes and inserts of an appropriate quality are readily

1 available at or below the amount established under such
2 section.

3 “(C) In accordance with procedures established by
4 the Secretary, an individual entitled to benefits with re-
5 spect to shoes described in section 1861(s)(12) may sub-
6 stitute modification of such shoes instead of obtaining one
7 (or more, as specified by the Secretary) pair of inserts
8 (other than the original pair of inserts with respect to such
9 shoes). In such case, the Secretary shall substitute, for
10 the payment amount established under section 1834(h),
11 a payment amount that the Secretary estimates will assure
12 that there is no net increase in expenditures under this
13 subsection as a result of this subparagraph.”.

14 (b) CONFORMING AMENDMENTS.—(1) Section
15 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by
16 inserting “(and includes shoes described in section
17 1861(s)(12))” after “in section 1861(s)(9)”.

18 (2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is
19 amended by striking subparagraph (C).

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to items furnished on or after Jan-
22 uary 1, 2005.

1 **SEC. 329. 5-YEAR AUTHORIZATION OF REIMBURSEMENT**
2 **FOR ALL MEDICARE PART B SERVICES FUR-**
3 **NISHED BY CERTAIN INDIAN HOSPITALS AND**
4 **CLINICS.**

5 Section 1880(e)(1)(A) (42 U.S.C. 1395qq(e)(1)(A))
6 is amended by inserting “(and for items and services fur-
7 nished during the 5-year period beginning on January 1,
8 2005, all items and services for which payment may be
9 made under part B)” after “for services described in para-
10 graph (2)”.

11 **Subtitle D—Additional Demonstra-**
12 **tions, Studies, and Other Provi-**
13 **sions**

14 **SEC. 341. DEMONSTRATION PROJECT FOR COVERAGE OF**
15 **CERTAIN PRESCRIPTION DRUGS AND**
16 **BIOLOGICALS.**

17 (a) DEMONSTRATION PROJECT.—The Secretary shall
18 conduct a demonstration project under part B of title
19 XVIII of the Social Security Act under which payment is
20 made for drugs or biologicals that are prescribed as re-
21 placements for drugs and biologicals described in section
22 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C.
23 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which pay-
24 ment is made under such part. Such project shall provide
25 for cost-sharing applicable with respect to such drugs or
26 biologicals.

1 (b) DEMONSTRATION PROJECT SITES.—The project
2 established under this section shall be conducted in sites
3 selected by the Secretary.

4 (c) DURATION.—The Secretary shall conduct the
5 demonstration project for the 2-year period beginning on
6 the date that is 90 days after the date of the enactment
7 of this Act, but in no case may the project extend beyond
8 December 31, 2005.

9 (d) LIMITATION.—Under the demonstration project
10 over the duration of the project, the Secretary may not
11 provide—

12 (1) coverage for more than 50,000 patients;

13 and

14 (2) more than \$500,000,000 in funding.

15 (e) REPORT.—Not later than July 1, 2006, the Sec-
16 retary shall submit to Congress a report on the project.
17 The report shall include an evaluation of patient access
18 to care and patient outcomes under the project, as well
19 as an analysis of the cost effectiveness of the project, in-
20 cluding an evaluation of the costs savings (if any) to the
21 medicare program attributable to reduced physicians'
22 services and hospital outpatient departments services for
23 administration of the biological.

1 **SEC. 342. EXTENSION OF COVERAGE OF INTRAVENOUS IM-**
 2 **MUNE GLOBULIN (IVIG) FOR THE TREAT-**
 3 **MENT OF PRIMARY IMMUNE DEFICIENCY DIS-**
 4 **EASES IN THE HOME.**

5 (a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x),
 6 as amended by sections 611(a) and 612(a) is amended—

7 (1) in subsection (s)(2)—

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

10 (B) by adding “and” at the end of sub-
 11 paragraph (Y); and

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

14 “(Z) intravenous immune globulin for the
 15 treatment of primary immune deficiency dis-
 16 eases in the home (as defined in subsection
 17 (zz));” and

18 (2) by adding at the end the following new sub-
 19 section:

20 “Intravenous Immune Globulin

21 “(zz) The term ‘intravenous immune globulin’ means
 22 an approved pooled plasma derivative for the treatment
 23 in the patient’s home of a patient with a diagnosed pri-
 24 mary immune deficiency disease, but not including items
 25 or services related to the administration of the derivative,

1 if a physician determines administration of the derivative
2 in the patient's home is medically appropriate.”.

3 (b) PAYMENT AS A DRUG OR BIOLOGICAL.—Section
4 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by
5 inserting “(including intravenous immune globulin (as de-
6 fined in section 1861(zz)))” after “with respect to drugs
7 and biologicals”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to items furnished administered
10 on or after January 1, 2004.

11 **SEC. 343. MEDPAC STUDY OF COVERAGE OF SURGICAL**
12 **FIRST ASSISTING SERVICES OF CERTIFIED**
13 **REGISTERED NURSE FIRST ASSISTANTS.**

14 (a) STUDY.—The Medicare Payment Advisory Com-
15 mission (in this section referred to as the “Commission”)
16 shall conduct a study on the feasibility and advisability
17 of providing for payment under part B of title XVIII of
18 the Social Security Act for surgical first assisting services
19 furnished by a certified registered nurse first assistant to
20 medicare beneficiaries.

21 (b) REPORT.—Not later than January 1, 2005, the
22 Commission shall submit to Congress a report on the
23 study conducted under subsection (a) together with rec-
24 ommendations for such legislation or administrative action
25 as the Commission determines to be appropriate.

1 (c) DEFINITIONS.—In this section:

2 (1) SURGICAL FIRST ASSISTING SERVICES.—

3 The term “surgical first assisting services” means
4 services consisting of first assisting a physician with
5 surgery and related preoperative, intraoperative, and
6 postoperative care (as determined by the Secretary)
7 furnished by a certified registered nurse first assist-
8 ant (as defined in paragraph (2)) which the certified
9 registered nurse first assistant is legally authorized
10 to perform by the State in which the services are
11 performed.

12 (2) CERTIFIED REGISTERED NURSE FIRST AS-
13 SISTANT.—The term “certified registered nurse first
14 assistant” means an individual who—

15 (A) is a registered nurse and is licensed to
16 practice nursing in the State in which the surgical
17 first assisting services are performed;

18 (B) has completed a minimum of 2,000 hours
19 of first assisting a physician with surgery and re-
20 lated preoperative, intraoperative, and postoperative
21 care; and

22 (C) is certified as a registered nurse first assist-
23 ant by an organization recognized by the Secretary.

1 **SEC. 344. MEDPAC STUDY OF PAYMENT FOR CARDIO-THO-**
2 **RACIC SURGEONS.**

3 (a) STUDY.—The Medicare Payment Advisory Com-
4 mission (in this section referred to as the “Commission”)
5 shall conduct a study on the practice expense relative val-
6 ues established by the Secretary of Health and Human
7 Services under the medicare physician fee schedule under
8 section 1848 of the Social Security Act (42 U.S.C.
9 1395w–4) for physicians in the specialties of thoracic and
10 cardiac surgery to determine whether such values ade-
11 quately take into account the attendant costs that such
12 physicians incur in providing clinical staff for patient care
13 in hospitals.

14 (b) REPORT.—Not later than January 1, 2005, the
15 Commission shall submit to Congress a report on the
16 study conducted under subsection (a) together with rec-
17 ommendations for such legislation or administrative action
18 as the Commission determines to be appropriate.

19 **SEC. 345. STUDIES RELATING TO VISION IMPAIRMENTS.**

20 (a) COVERAGE OF OUTPATIENT VISION SERVICES
21 FURNISHED BY VISION REHABILITATION PROFESSIONALS
22 UNDER PART B.—

23 (1) STUDY.—The Secretary shall conduct a
24 study to determine the feasibility and advisability of
25 providing for payment for vision rehabilitation serv-
26 ices furnished by vision rehabilitation professionals.

1 (2) REPORT.—Not later than January 1, 2005,
2 the Secretary shall submit to Congress a report on
3 the study conducted under paragraph (1) together
4 with recommendations for such legislation or admin-
5 istrative action as the Secretary determines to be ap-
6 propriate.

7 (3) VISION REHABILITATION PROFESSIONAL
8 DEFINED.—In this subsection, the term “vision re-
9 habilitation professional” means an orientation and
10 mobility specialist, a rehabilitation teacher, or a low
11 vision therapist.

12 (b) REPORT ON APPROPRIATENESS OF A DEM-
13 ONSTRATION PROJECT TO TEST FEASIBILITY OF USING
14 PPO NETWORKS TO REDUCE COSTS OF ACQUIRING EYE-
15 GLASSES FOR MEDICARE BENEFICIARIES AFTER CATA-
16 RACT SURGERY.—Not later than 1 year after the date of
17 the enactment of this Act, the Secretary shall submit to
18 Congress a report on the feasibility of establishing a two-
19 year demonstration project under which the Secretary en-
20 ters into arrangements with vision care preferred provider
21 organization networks to furnish and pay for conventional
22 eyeglasses subsequent to each cataract surgery with inser-
23 tion of an intraocular lens on behalf of Medicare bene-
24 ficiaries. In such report, the Secretary shall include an es-
25 timate of potential cost savings to the Medicare program

1 through the use of such networks, taking into consider-
 2 ation quality of service and beneficiary access to services
 3 offered by vision care preferred provider organization net-
 4 works.

5 **SEC. 346. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.**
 6

7 Title XVIII (42 U.S.C. 1395 et seq.) is amended by
 8 inserting after section 1866B the following new section:

9 **“SEC. 1866C. HEALTH CARE QUALITY DEMONSTRATION PROGRAM.**
 10

11 **“SEC. (a) DEFINITIONS.—**In this section:

12 **“(1) BENEFICIARY.—**The term ‘beneficiary’
 13 means an individual who is entitled to benefits under
 14 part A and enrolled under part B, including any in-
 15 dividual who is enrolled in a Medicare Advantage
 16 plan under part C.

17 **“(2) HEALTH CARE GROUP.—**

18 **“(A) IN GENERAL.—**The term ‘health care
 19 group’ means—

20 **“(i)** a group of physicians that is or-
 21 ganized at least in part for the purpose of
 22 providing physician’s services under this
 23 title;

24 **“(ii)** an integrated health care delivery
 25 system that delivers care through coordi-

1 nated hospitals, clinics, home health agen-
2 cies, ambulatory surgery centers, skilled
3 nursing facilities, rehabilitation facilities
4 and clinics, and employed, independent, or
5 contracted physicians; or

6 “(iii) an organization representing re-
7 gional coalitions of groups or systems de-
8 scribed in clause (i) or (ii).

9 “(B) INCLUSION.—As the Secretary deter-
10 mines appropriate, a health care group may in-
11 clude a hospital or any other individual or enti-
12 ty furnishing items or services for which pay-
13 ment may be made under this title that is affili-
14 ated with the health care group under an ar-
15 rangement structured so that such hospital, in-
16 dividual, or entity participates in a demonstra-
17 tion project under this section.

18 “(3) PHYSICIAN.—Except as otherwise provided
19 for by the Secretary, the term ‘physician’ means any
20 individual who furnishes services that may be paid
21 for as physicians’ services under this title.

22 “(b) DEMONSTRATION PROJECTS.—The Secretary
23 shall establish a 5-year demonstration program under
24 which the Secretary shall approve demonstration projects

1 that examine health delivery factors that encourage the
2 delivery of improved quality in patient care, including—

3 “(1) the provision of incentives to improve the
4 safety of care provided to beneficiaries;

5 “(2) the appropriate use of best practice guide-
6 lines by providers and services by beneficiaries;

7 “(3) reduced scientific uncertainty in the deliv-
8 ery of care through the examination of variations in
9 the utilization and allocation of services, and out-
10 comes measurement and research;

11 “(4) encourage shared decision making between
12 providers and patients;

13 “(5) the provision of incentives for improving
14 the quality and safety of care and achieving the effi-
15 cient allocation of resources;

16 “(6) the appropriate use of culturally and eth-
17 nically sensitive health care delivery; and

18 “(7) the financial effects on the health care
19 marketplace of altering the incentives for care deliv-
20 ery and changing the allocation of resources.

21 “(c) ADMINISTRATION BY CONTRACT.—

22 “(1) IN GENERAL.—Except as otherwise pro-
23 vided in this section, the Secretary may administer
24 the demonstration program established under this
25 section in a manner that is similar to the manner in

1 which the demonstration program established under
2 section 1866A is administered in accordance with
3 section 1866B.

4 “(2) ALTERNATIVE PAYMENT SYSTEMS.—A
5 health care group that receives assistance under this
6 section may, with respect to the demonstration
7 project to be carried out with such assistance, in-
8 clude proposals for the use of alternative payment
9 systems for items and services provided to bene-
10 ficiaries by the group that are designed to—

11 “(A) encourage the delivery of high quality
12 care while accomplishing the objectives de-
13 scribed in subsection (b); and

14 “(B) streamline documentation and report-
15 ing requirements otherwise required under this
16 title.

17 “(3) BENEFITS.—A health care group that re-
18 ceives assistance under this section may, with re-
19 spect to the demonstration project to be carried out
20 with such assistance, include modifications to the
21 package of benefits available under the original
22 medicare fee-for-service program under parts A and
23 B or the package of benefits available through a
24 Medicare Advantage plan under part C. The criteria
25 employed under the demonstration program under

1 this section to evaluate outcomes and determine best
2 practice guidelines and incentives shall not be used
3 as a basis for the denial of medicare benefits under
4 the demonstration program to patients against their
5 wishes (or if the patient is incompetent, against the
6 wishes of the patient’s surrogate) on the basis of the
7 patient’s age or expected length of life or of the pa-
8 tient’s present or predicted disability, degree of med-
9 ical dependency, or quality of life.

10 “(d) ELIGIBILITY CRITERIA.—To be eligible to re-
11 ceive assistance under this section, an entity shall—

12 “(1) be a health care group;

13 “(2) meet quality standards established by the
14 Secretary, including—

15 “(A) the implementation of continuous
16 quality improvement mechanisms that are
17 aimed at integrating community-based support
18 services, primary care, and referral care;

19 “(B) the implementation of activities to in-
20 crease the delivery of effective care to bene-
21 ficiaries;

22 “(C) encouraging patient participation in
23 preference-based decisions;

1 “(D) the implementation of activities to
2 encourage the coordination and integration of
3 medical service delivery; and

4 “(E) the implementation of activities to
5 measure and document the financial impact on
6 the health care marketplace of altering the in-
7 centives of health care delivery and changing
8 the allocation of resources; and

9 “(3) meet such other requirements as the Sec-
10 retary may establish.

11 “(e) WAIVER AUTHORITY.—The Secretary may waive
12 such requirements of titles XI and XVIII as may be nec-
13 essary to carry out the purposes of the demonstration pro-
14 gram established under this section.

15 “(f) BUDGET NEUTRALITY.—With respect to the 5-
16 year period of the demonstration program under sub-
17 section (b), the aggregate expenditures under this title for
18 such period shall not exceed the aggregate expenditures
19 that would have been expended under this title if the pro-
20 gram established under this section had not been imple-
21 mented.

22 “(g) NOTICE REQUIREMENTS.—In the case of an in-
23 dividual that receives health care items or services under
24 a demonstration program carried out under this section,
25 the Secretary shall ensure that such individual is notified

1 of any waivers of coverage or payment rules that are appli-
2 cable to such individual under this title as a result of the
3 participation of the individual in such program.

4 “(h) PARTICIPATION AND SUPPORT BY FEDERAL
5 AGENCIES.—In carrying out the demonstration program
6 under this section, the Secretary may direct—

7 “(1) the Director of the National Institutes of
8 Health to expand the efforts of the Institutes to
9 evaluate current medical technologies and improve
10 the foundation for evidence-based practice;

11 “(2) the Administrator of the Agency for
12 Healthcare Research and Quality to, where possible
13 and appropriate, use the program under this section
14 as a laboratory for the study of quality improvement
15 strategies and to evaluate, monitor, and disseminate
16 information relevant to such program; and

17 “(3) the Administrator of the Centers for Medi-
18 care & Medicaid Services and the Administrator of
19 the Center for Medicare Choices to support linkages
20 of relevant medicare data to registry information
21 from participating health care groups for the bene-
22 ficiary populations served by the participating
23 groups, for analysis supporting the purposes of the
24 demonstration program, consistent with the applica-

1 ble provisions of the Health Insurance Portability
2 and Accountability Act of 1996.”.

3 **SEC. 347. MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL**
4 **THERAPY SERVICES.**

5 (a) STUDY.—The Medicare Payment Advisory Com-
6 mission (in this section referred to as the “Commission”)
7 shall conduct a study on the feasibility and advisability
8 of allowing medicare fee-for-service beneficiaries direct ac-
9 cess to outpatient physical therapy services and physical
10 therapy services furnished as comprehensive rehabilitation
11 facility services.

12 (b) REPORT.—Not later than January 1, 2005, the
13 Commission shall submit to Congress a report on the
14 study conducted under subsection (a) together with rec-
15 ommendations for such legislation or administrative action
16 as the Commission determines to be appropriate.

17 (c) DIRECT ACCESS DEFINED.—The term “direct ac-
18 cess” means, with respect to outpatient physical therapy
19 services and physical therapy services furnished as com-
20 prehensive outpatient rehabilitation facility services, cov-
21 erage of and payment for such services in accordance with
22 the provisions of title XVIII of the Social Security Act,
23 except that sections 1835(a)(2), 1861(p), and 1861(cc) of
24 such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and
25 1395x(cc), respectively) shall be applied—

- 1 (1) without regard to any requirement that—
- 2 (A) an individual be under the care of (or
- 3 referred by) a physician; or
- 4 (B) services be provided under the super-
- 5 vision of a physician; and
- 6 (2) by allowing a physician or a qualified phys-
- 7 ical therapist to satisfy any requirement for—
- 8 (A) certification and recertification; and
- 9 (B) establishment and periodic review of a
- 10 plan of care.

11 **SEC. 348. DEMONSTRATION PROJECT FOR CONSUMER-DI-**

12 **RECTED CHRONIC OUTPATIENT SERVICES.**

13 (a) ESTABLISHMENT.—

14 (1) IN GENERAL.—Subject to the succeeding

15 provisions of this section, the Secretary shall estab-

16 lish demonstration projects (in this section referred

17 to as “demonstration projects”) under which the

18 Secretary shall evaluate methods that improve the

19 quality of care provided to individuals with chronic

20 conditions and that reduce expenditures that would

21 otherwise be made under the medicare program on

22 behalf of such individuals for such chronic condi-

23 tions, such methods to include permitting those

24 beneficiaries to direct their own health care needs

25 and services.

1 (2) INDIVIDUALS WITH CHRONIC CONDITIONS
2 DEFINED.—In this section, the term “individuals
3 with chronic conditions” means an individual enti-
4 tled to benefits under part A of title XVIII of the
5 Social Security Act, and enrolled under part B of
6 such title, but who is not enrolled under part C of
7 such title who is diagnosed as having one or more
8 chronic conditions (as defined by the Secretary),
9 such as diabetes.

10 (b) DESIGN OF PROJECTS.—

11 (1) EVALUATION BEFORE IMPLEMENTATION OF
12 PROJECT.—

13 (A) IN GENERAL.—In establishing the
14 demonstration projects under this section, the
15 Secretary shall evaluate best practices employed
16 by group health plans and practices under State
17 plans for medical assistance under the medicaid
18 program under title XIX of the Social Security
19 Act, as well as best practices in the private sec-
20 tor or other areas, of methods that permit pa-
21 tients to self-direct the provision of personal
22 care services. The Secretary shall evaluate such
23 practices for a 1-year period and, based on such
24 evaluation, shall design the demonstration
25 project.

1 (B) REQUIREMENT FOR ESTIMATE OF
2 BUDGET NEUTRAL COSTS.—As part of the eval-
3 uation under subparagraph (A), the Secretary
4 shall evaluate the costs of furnishing care under
5 the projects. The Secretary may not implement
6 the demonstration projects under this section
7 unless the Secretary determines that the costs
8 of providing care to individuals with chronic
9 conditions under the project will not exceed the
10 costs, in the aggregate, of furnishing care to
11 such individuals under title XVIII of the Social
12 Security Act, that would otherwise be paid
13 without regard to the demonstration projects
14 for the period of the project.

15 (2) SCOPE OF SERVICES.—The Secretary shall
16 determine the appropriate scope of personal care
17 services that would apply under the demonstration
18 projects.

19 (c) VOLUNTARY PARTICIPATION.—Participation of
20 providers of services and suppliers, and of individuals with
21 chronic conditions, in the demonstration projects shall be
22 voluntary.

23 (d) DEMONSTRATION PROJECT SITES.—Not later
24 than 2 years after the date of the enactment of this Act,
25 the Secretary shall conduct a demonstration project in at

1 least one area that the Secretary determines has a popu-
2 lation of individuals entitled to benefits under part A of
3 title XVIII of the Social Security Act, and enrolled under
4 part B of such title, with a rate of incidence of diabetes
5 that significantly exceeds the national average rate of all
6 areas.

7 (e) EVALUATION AND REPORT.—

8 (1) EVALUATIONS.—The Secretary shall con-
9 duct evaluations of the clinical and cost effectiveness
10 of the demonstration projects.

11 (2) REPORTS.—Not later than 2 years after the
12 commencement of the demonstration projects, and
13 biannually thereafter, the Secretary shall submit to
14 Congress a report on the evaluation, and shall in-
15 clude in the report the following:

16 (A) An analysis of the patient outcomes
17 and costs of furnishing care to the individuals
18 with chronic conditions participating in the
19 projects as compared to such outcomes and
20 costs to other individuals for the same health
21 conditions.

22 (B) Evaluation of patient satisfaction
23 under the demonstration projects.

24 (C) Such recommendations regarding the
25 extension, expansion, or termination of the

1 projects as the Secretary determines appro-
2 priate.

3 (f) WAIVER AUTHORITY.—The Secretary shall waive
4 compliance with the requirements of title XVIII of the So-
5 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
6 and for such period as the Secretary determines is nec-
7 essary to conduct demonstration projects.

8 (g) AUTHORIZATION OF APPROPRIATIONS.—(1) Pay-
9 ments for the costs of carrying out the demonstration
10 project under this section shall be made from the Federal
11 Supplementary Medical Insurance Trust Fund under sec-
12 tion 1841 of such Act (42 U.S.C. 1395t).

13 (2) There are authorized to be appropriated from
14 such Trust Fund such sums as may be necessary for the
15 Secretary to enter into contracts with appropriate organi-
16 zations for the design, implementation, and evaluation of
17 the demonstration project.

18 (3) In no case may expenditures under this section
19 exceed the aggregate expenditures that would otherwise
20 have been made for the provision of personal care services.

21 **SEC. 349. MEDICARE CARE MANAGEMENT PERFORMANCE**
22 **DEMONSTRATION.**

23 (a) ESTABLISHMENT.—

24 (1) IN GENERAL.—The Secretary shall establish
25 a pay-for-performance demonstration program with

1 physicians to meet the needs of eligible beneficiaries
2 through the adoption and use of health information
3 technology and evidence-based outcomes measures
4 for—

5 (A) promoting continuity of care;

6 (B) helping stabilize medical conditions;

7 (C) preventing or minimizing acute exacer-
8 bations of chronic conditions; and

9 (D) reducing adverse health outcomes,
10 such as adverse drug interactions related to
11 polypharmacy.

12 (2) SITES.—The Secretary shall designate no
13 more than 4 sites at which to conduct the dem-
14 onstration program under this section, of which—

15 (A) 2 shall be in an urban area;

16 (B) 1 shall be in a rural area; and

17 (C) 1 shall be in a State with a medical
18 school with a Department of Geriatrics that
19 manages rural outreach sites and is capable of
20 managing patients with multiple chronic condi-
21 tions, one of which is dementia.

22 (3) DURATION.—The Secretary shall conduct
23 the demonstration program under this section for a
24 3-year period.

1 (4) CONSULTATION.—In carrying out the dem-
2 onstration program under this section, the Secretary
3 shall consult with private sector and non-profit
4 groups that are undertaking similar efforts to im-
5 prove quality and reduce avoidable hospitalizations
6 for chronically ill patients.

7 (b) PARTICIPATION.—

8 (1) IN GENERAL.—A physician who provides
9 care for a minimum number of eligible beneficiaries
10 (as specified by the Secretary) may participate in
11 the demonstration program under this section if
12 such physician agrees, to phase-in over the course of
13 the 3-year demonstration period and with the assist-
14 ance provided under subsection (d)(2)—

15 (A) the use of health information tech-
16 nology to manage the clinical care of eligible
17 beneficiaries consistent with paragraph (3); and

18 (B) the electronic reporting of clinical
19 quality and outcomes measures in accordance
20 with requirements established by the Secretary
21 under the demonstration program.

22 (2) SPECIAL RULE.—In the case of the sites re-
23 ferred to in subparagraphs (B) and (C) of sub-
24 section (a)(2), a physician who provides care for a
25 minimum number of beneficiaries with two or more

1 chronic conditions, including dementia (as specified
2 by the Secretary), may participate in the program
3 under this section if such physician agrees to the re-
4 quirements in subparagraphs (A) and (B) of para-
5 graph (1).

6 (3) PRACTICE STANDARDS.—Each physician
7 participating in the demonstration program under
8 this section must demonstrate the ability—

9 (A) to assess each eligible beneficiary for
10 conditions other than chronic conditions, such
11 as impaired cognitive ability and co-morbidities,
12 for the purposes of developing care manage-
13 ment requirements;

14 (B) to serve as the primary contact of eli-
15 gible beneficiaries in accessing items and serv-
16 ices for which payment may be made under the
17 medicare program;

18 (C) to establish and maintain health care
19 information system for such beneficiaries;

20 (D) to promote continuity of care across
21 providers and settings;

22 (E) to use evidence-based guidelines and
23 meet such clinical quality and outcome meas-
24 ures as the Secretary shall require;

1 (F) to promote self-care through the provi-
2 sion of patient education and support for pa-
3 tients or, where appropriate, family caregivers;

4 (G) when appropriate, to refer such bene-
5 ficiaries to community service organizations;
6 and

7 (H) to meet such other complex care man-
8 agement requirements as the Secretary may
9 specify.

10 The guidelines and measures required under sub-
11 paragraph (E) shall be designed to take into account
12 beneficiaries with multiple chronic conditions.

13 (c) PAYMENT METHODOLOGY.—Under the dem-
14 onstration program under this section the Secretary shall
15 pay a per beneficiary amount to each participating physi-
16 cian who meets or exceeds specific performance standards
17 established by the Secretary with respect to the clinical
18 quality and outcome measures reported under subsection
19 (b)(1)(B). Such amount may vary based on different levels
20 of performance or improvement.

21 (d) ADMINISTRATION.—

22 (1) USE OF QUALITY IMPROVEMENT ORGANIZA-
23 TIONS.—The Secretary shall contract with quality
24 improvement organizations or such other entities as
25 the Secretary deems appropriate to enroll physicians

1 and evaluate their performance under the dem-
2 onstration program under this section.

3 (2) TECHNICAL ASSISTANCE.—The Secretary
4 shall require in such contracts that the contractor be
5 responsible for technical assistance and education as
6 needed to physicians enrolled in the demonstration
7 program under this section for the purpose of aiding
8 their adoption of health information technology,
9 meeting practice standards, and implementing re-
10 quired clinical and outcomes measures.

11 (e) FUNDING.—

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

19 (2) BUDGET NEUTRALITY.—In conducting the
20 demonstration program under this section, the Sec-
21 retary shall ensure that the aggregate payments
22 made by the Secretary do not exceed the amount
23 which the Secretary estimates would have been paid
24 if the demonstration program under this section was
25 not implemented.

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

6 (g) REPORT.—Not later than 12 months after the
7 date of completion of the demonstration program under
8 this section, the Secretary shall submit to Congress a re-
9 port on such program, together with recommendations for
10 such legislation and administrative action as the Secretary
11 determines to be appropriate.

12 (h) DEFINITIONS.—In this section:

13 (1) ELIGIBLE BENEFICIARY.—The term “eligi-
14 ble beneficiary” means any individual who—

15 (A) is entitled to benefits under part A and
16 enrolled for benefits under part B of title XVIII
17 of the Social Security Act and is not enrolled in
18 a plan under part C of such title; and

19 (B) has one or more chronic medical condi-
20 tions specified by the Secretary (one of which
21 may be cognitive impairment).

22 (2) HEALTH INFORMATION TECHNOLOGY.—The
23 term “health information technology” means email
24 communication, clinical alerts and reminders, and
25 other information technology that meets such

1 functionality, interoperability, and other standards
2 as prescribed by the Secretary.

3 **SEC. 350. GAO STUDY AND REPORT ON THE PROPAGATION**
4 **OF CONCIERGE CARE.**

5 (a) STUDY.—

6 (1) IN GENERAL.—The Comptroller General of
7 the United States shall conduct a study on concierge
8 care (as defined in paragraph (2)) to determine the
9 extent to which such care—

10 (A) is used by medicare beneficiaries (as
11 defined in section 1802(b)(5)(A) of the Social
12 Security Act (42 U.S.C. 1395a(b)(5)(A))); and

13 (B) has impacted upon the access of medi-
14 care beneficiaries (as so defined) to items and
15 services for which reimbursement is provided
16 under the medicare program under title XVIII
17 of the Social Security Act (42 U.S.C. 1395 et
18 seq.).

19 (2) CONCIERGE CARE.—In this section, the
20 term “concierge care” means an arrangement under
21 which, as a prerequisite for the provision of a health
22 care item or service to an individual, a physician,
23 practitioner (as described in section 1842(b)(18)(C)
24 of the Social Security Act (42 U.S.C.
25 1395u(b)(18)(C))), or other individual—

1 (A) charges a membership fee or another
 2 incidental fee to an individual desiring to re-
 3 ceive the health care item or service from such
 4 physician, practitioner, or other individual; or

5 (B) requires the individual desiring to re-
 6 ceive the health care item or service from such
 7 physician, practitioner, or other individual to
 8 purchase an item or service.

9 (b) REPORT.—Not later than the date that is 12
 10 months after the date of enactment of this Act, the Comp-
 11 troller General of the United States shall submit to Con-
 12 gress a report on the study conducted under subsection
 13 (a)(1) together with such recommendations for legislative
 14 or administrative action as the Comptroller General deter-
 15 mines to be appropriate.

16 **SEC. 351. DEMONSTRATION OF COVERAGE OF CHIRO-**
 17 **PRACTIC SERVICES UNDER MEDICARE.**

18 (a) DEFINITIONS.—In this section:

19 (1) CHIROPRACTIC SERVICES.—The term
 20 “chiropractic services” has the meaning given that
 21 term by the Secretary for purposes of the dem-
 22 onstration projects, but shall include, at a min-
 23 imum—

24 (A) care for neuromusculoskeletal condi-
 25 tions typical among eligible beneficiaries; and

1 (B) diagnostic and other services that a
2 chiropractor is legally authorized to perform by
3 the State or jurisdiction in which such treat-
4 ment is provided.

5 (2) DEMONSTRATION PROJECT.—The term
6 “demonstration project” means a demonstration
7 project established by the Secretary under sub-
8 section (b)(1).

9 (3) ELIGIBLE BENEFICIARY.—The term “eligi-
10 ble beneficiary” means an individual who is enrolled
11 under part B of the medicare program.

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

16 (b) DEMONSTRATION OF COVERAGE OF CHIRO-
17 PRACTIC SERVICES UNDER MEDICARE.—

18 (1) ESTABLISHMENT.—The Secretary shall es-
19 tablish demonstration projects in accordance with
20 the provisions of this section for the purpose of eval-
21 uating the feasibility and advisability of covering
22 chiropractic services under the medicare program (in
23 addition to the coverage provided for services con-
24 sisting of treatment by means of manual manipula-
25 tion of the spine to correct a subluxation described

1 in section 1861(r)(5) of the Social Security Act (42
2 U.S.C. 1395x(r)(5)).

3 (2) NO PHYSICIAN APPROVAL REQUIRED.—In
4 establishing the demonstration projects, the Sec-
5 retary shall ensure that an eligible beneficiary who
6 participates in a demonstration project, including an
7 eligible beneficiary who is enrolled for coverage
8 under a Medicare+Choice plan (or, on and after
9 January 1, 2006, under a Medicare Advantage
10 plan), is not required to receive approval from a
11 physician or other health care provider in order to
12 receive a chiropractic service under a demonstration
13 project.

14 (3) CONSULTATION.—In establishing the dem-
15 onstration projects, the Secretary shall consult with
16 chiropractors, organizations representing chiroprac-
17 tors, eligible beneficiaries, and organizations rep-
18 resenting eligible beneficiaries.

19 (4) PARTICIPATION.—Any eligible beneficiary
20 may participate in the demonstration projects on a
21 voluntary basis.

22 (c) CONDUCT OF DEMONSTRATION PROJECTS.—

23 (1) DEMONSTRATION SITES.—

1 (A) SELECTION OF DEMONSTRATION
2 SITES.—The Secretary shall conduct dem-
3 onstration projects at 4 demonstration sites.

4 (B) GEOGRAPHIC DIVERSITY.—Of the sites
5 described in subparagraph (A)—

6 (i) 2 shall be in rural areas; and

7 (ii) 2 shall be in urban areas.

8 (C) SITES LOCATED IN HPSAS.—At least 1
9 site described in clause (i) of subparagraph (B)
10 and at least 1 site described in clause (ii) of
11 such subparagraph shall be located in an area
12 that is designated under section 332(a)(1)(A) of
13 the Public Health Service Act (42 U.S.C.
14 254e(a)(1)(A)) as a health professional short-
15 age area.

16 (2) IMPLEMENTATION; DURATION.—

17 (A) IMPLEMENTATION.—The Secretary
18 shall not implement the demonstration projects
19 before October 1, 2004.

20 (B) DURATION.—The Secretary shall com-
21 plete the demonstration projects by the date
22 that is 2 years after the date on which the first
23 demonstration project is implemented.

24 (d) EVALUATION AND REPORT.—

1 (1) EVALUATION.—The Secretary shall conduct
2 an evaluation of the demonstration projects—

3 (A) to determine whether eligible bene-
4 ficiaries who use chiropractic services use a
5 lesser overall amount of items and services for
6 which payment is made under the medicare pro-
7 gram than eligible beneficiaries who do not use
8 such services;

9 (B) to determine the cost of providing pay-
10 ment for chiropractic services under the medi-
11 care program;

12 (C) to determine the satisfaction of eligible
13 beneficiaries participating in the demonstration
14 projects and the quality of care received by such
15 beneficiaries; and

16 (D) to evaluate such other matters as the
17 Secretary determines is appropriate.

18 (2) REPORT.—Not later than the date that is
19 1 year after the date on which the demonstration
20 projects conclude, the Secretary shall submit to Con-
21 gress a report on the evaluation conducted under
22 paragraph (1) together with such recommendations
23 for legislation or administrative action as the Sec-
24 retary determines is appropriate.

1 (e) WAIVER OF MEDICARE REQUIREMENTS.—The
2 Secretary shall waive compliance with such requirements
3 of the medicare program to the extent and for the period
4 the Secretary finds necessary to conduct the demonstra-
5 tion projects.

6 (f) FUNDING.—

7 (1) DEMONSTRATION PROJECTS.—

8 (A) IN GENERAL.—Subject to subpara-
9 graph (B) and paragraph (2), the Secretary
10 shall provide for the transfer from the Federal
11 Supplementary Insurance Trust Fund under
12 section 1841 of the Social Security Act (42
13 U.S.C. 1395t) of such funds as are necessary
14 for the costs of carrying out the demonstration
15 projects under this section.

16 (B) LIMITATION.—In conducting the dem-
17 onstration projects under this section, the Sec-
18 retary shall ensure that the aggregate payments
19 made by the Secretary under the medicare pro-
20 gram do not exceed the amount which the Sec-
21 retary would have paid under the medicare pro-
22 gram if the demonstration projects under this
23 section were not implemented.

24 (2) EVALUATION AND REPORT.—There are au-
25 thorized to be appropriated such sums as are nec-

1 essary for the purpose of developing and submitting
2 the report to Congress under subsection (d).

3 **TITLE IV—PROVISIONS**
4 **RELATING TO PARTS A AND B**
5 **Subtitle A—Home Health Services**

6 **SEC. 401. DEMONSTRATION PROJECT TO CLARIFY THE**
7 **DEFINITION OF HOMEBOUND.**

8 (a) DEMONSTRATION PROJECT.—Not later than 180
9 days after the date of the enactment of this Act, the Sec-
10 retary shall conduct a 2-year demonstration project under
11 part B of title XVIII of the Social Security Act under
12 which medicare beneficiaries with chronic conditions de-
13 scribed in subsection (b) are deemed to be homebound for
14 purposes of receiving home health services under the medi-
15 care program.

16 (b) MEDICARE BENEFICIARY DESCRIBED.—For pur-
17 poses of subsection (a), a medicare beneficiary is eligible
18 to be deemed to be homebound, without regard to the pur-
19 pose, frequency, or duration of absences from the home,
20 if—

21 (1) the beneficiary has been certified by one
22 physician as an individual who has a permanent and
23 severe, disabling condition that is not expected to
24 improve;

1 (2) the beneficiary is dependent upon assistance
2 from another individual with at least 3 out of the 5
3 activities of daily living for the rest of the bene-
4 ficiary's life;

5 (3) the beneficiary requires skilled nursing serv-
6 ices for the rest of the beneficiary's life and the
7 skilled nursing is more than medication manage-
8 ment;

9 (4) an attendant is required to visit the bene-
10 ficiary on a daily basis to monitor and treat the
11 beneficiary's medical condition or to assist the bene-
12 ficiary with activities of daily living;

13 (5) the beneficiary requires technological assist-
14 ance or the assistance of another person to leave the
15 home; and

16 (6) the beneficiary does not regularly work in a
17 paid position full-time or part-time outside the
18 home.

19 (c) DEMONSTRATION PROJECT SITES.—The dem-
20 onstration project established under this section shall be
21 conducted in 3 States selected by the Secretary to rep-
22 resent the Northeast, Midwest, and Western regions of the
23 United States.

1 (d) LIMITATION ON NUMBER OF PARTICIPANTS.—
2 The aggregate number of such beneficiaries that may par-
3 ticipate in the project may not exceed 15,000.

4 (e) DATA.—The Secretary shall collect such data on
5 the demonstration project with respect to the provision of
6 home health services to medicare beneficiaries that relates
7 to quality of care, patient outcomes, and additional costs,
8 if any, to the medicare program.

9 (f) REPORT TO CONGRESS.—Not later than 1 year
10 after the date of the completion of the demonstration
11 project under this section, the Secretary shall submit to
12 Congress a report on the project using the data collected
13 under subsection (e). The report shall include the fol-
14 lowing:

15 (1) An examination of whether the provision of
16 home health services to medicare beneficiaries under
17 the project has had any of the following effects:

18 (A) Has adversely affected the provision of
19 home health services under the medicare pro-
20 gram.

21 (B) Has directly caused an increase of ex-
22 penditures under the medicare program for the
23 provision of such services that is directly attrib-
24 utable to such clarification.

1 (2) The specific data evidencing the amount of
2 any increase in expenditures that is directly attrib-
3 utable to the demonstration project (expressed both
4 in absolute dollar terms and as a percentage) above
5 expenditures that would otherwise have been in-
6 curred for home health services under the medicare
7 program.

8 (3) Specific recommendations to exempt perma-
9 nently and severely disabled homebound beneficiaries
10 from restrictions on the length, frequency, and pur-
11 pose of their absences from the home to qualify for
12 home health services without incurring additional
13 costs to the medicare program.

14 (g) WAIVER AUTHORITY.—The Secretary shall waive
15 compliance with the requirements of title XVIII of the So-
16 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
17 and for such period as the Secretary determines is nec-
18 essary to conduct demonstration projects.

19 (h) CONSTRUCTION.—Nothing in this section shall be
20 construed as waiving any applicable civil monetary pen-
21 alty, criminal penalty, or other remedy available to the
22 Secretary under title XI or title XVIII of the Social Secu-
23 rity Act for acts prohibited under such titles, including
24 penalties for false certifications for purposes of receipt of
25 items or services under the medicare program.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—Pay-
2 ments for the costs of carrying out the demonstration
3 project under this section shall be made from the Federal
4 Supplementary Medical Insurance Trust Fund under sec-
5 tion 1841 of such Act (42 U.S.C. 1395t).

6 (j) DEFINITIONS.—In this section:

7 (1) MEDICARE BENEFICIARY.—The term
8 “medicare beneficiary” means an individual who is
9 enrolled under part B of title XVIII of the Social
10 Security Act.

11 (2) HOME HEALTH SERVICES.—The term
12 “home health services” has the meaning given such
13 term in section 1861(m) of the Social Security Act
14 (42 U.S.C. 1395x(m)).

15 (3) ACTIVITIES OF DAILY LIVING DEFINED.—
16 The term “activities of daily living” means eating,
17 toileting, transferring, bathing, and dressing.

18 **SEC. 402. DEMONSTRATION PROJECT FOR MEDICAL ADULT**
19 **DAY-CARE SERVICES.**

20 (a) ESTABLISHMENT.—Subject to the succeeding
21 provisions of this section, the Secretary shall establish a
22 demonstration project (in this section referred to as the
23 “demonstration project”) under which the Secretary shall,
24 as part of a plan of an episode of care for home health
25 services established for a medicare beneficiary, permit a

1 home health agency, directly or under arrangements with
2 a medical adult day-care facility, to provide medical adult
3 day-care services as a substitute for a portion of home
4 health services that would otherwise be provided in the
5 beneficiary's home.

6 (b) PAYMENT.—

7 (1) IN GENERAL.—Subject to paragraph (2),
8 the amount of payment for an episode of care for
9 home health services, a portion of which consists of
10 substitute medical adult day-care services, under the
11 demonstration project shall be made at a rate equal
12 to 95 percent of the amount that would otherwise
13 apply for such home health services under section
14 1895 of the Social Security Act (42 U.S.C. 1395fff).
15 In no case may a home health agency, or a medical
16 adult day-care facility under arrangements with a
17 home health agency, separately charge a beneficiary
18 for medical adult day-care services furnished under
19 the plan of care.

20 (2) ADJUSTMENT IN CASE OF OVERUTILIZA-
21 TION OF SUBSTITUTE ADULT DAY-CARE SERVICES
22 TO ENSURE BUDGET NEUTRALITY.—The Secretary
23 shall monitor the expenditures under the demonstra-
24 tion project and under title XVIII of the Social Se-
25 curity Act for home health services. If the Secretary

1 estimates that the total expenditures under the dem-
2 onstration project and under such title XVIII for
3 home health services for a period determined by the
4 Secretary exceed expenditures that would have been
5 made under such title XVIII for home health serv-
6 ices for such period if the demonstration project had
7 not been conducted, the Secretary shall adjust the
8 rate of payment to medical adult day-care facilities
9 under paragraph (1) in order to eliminate such ex-
10 cess.

11 (c) DEMONSTRATION PROJECT SITES.—The dem-
12 onstration project established under this section shall be
13 conducted in not more than 5 sites in States selected by
14 the Secretary that license or certify providers of services
15 that furnish medical adult day-care services.

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

18 (e) VOLUNTARY PARTICIPATION.—Participation of
19 medicare beneficiaries in the demonstration project shall
20 be voluntary. The total number of such beneficiaries that
21 may participate in the project at any given time may not
22 exceed 15,000.

23 (f) PREFERENCE IN SELECTING AGENCIES.—In se-
24 lecting home health agencies to participate under the dem-
25 onstration project, the Secretary shall give preference to

1 those agencies that are currently licensed or certified
2 through common ownership and control to furnish medical
3 adult day-care services.

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

10 (h) EVALUATION AND REPORT.—The Secretary shall
11 conduct an evaluation of the clinical and cost-effectiveness
12 of the demonstration project. Not later than 6 months
13 after the completion of the project, the Secretary shall
14 submit to Congress a report on the evaluation, and shall
15 include in the report the following:

16 (1) An analysis of the patient outcomes and
17 costs of furnishing care to the medicare beneficiaries
18 participating in the project as compared to such out-
19 comes and costs to beneficiaries receiving only home
20 health services for the same health conditions.

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

24 (i) DEFINITIONS.—In this section:

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

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

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

11 (B) is engaged in providing skilled nursing
12 services and other therapeutic services directly
13 or under arrangement with a home health agen-
14 cy;

15 (C) is licensed and certified by the State in
16 which it operates or meets such standards es-
17 tablished by the Secretary to assure quality of
18 care and such other requirements as the Sec-
19 retary finds necessary in the interest of the
20 health and safety of individuals who are fur-
21 nished services in the facility; and

22 (D) provides medical adult day-care serv-
23 ices.

24 (3) MEDICAL ADULT DAY-CARE SERVICES.—
25 The term “medical adult day-care services” means—

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

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

7 (i) meet such criteria as the Secretary
 8 determines appropriate; and

9 (ii) is designed to promote physical
 10 and mental health of the individuals; and

11 (C) such other services as the Secretary
 12 may specify.

13 (4) **MEDICARE BENEFICIARY.**—The term
 14 “medicare beneficiary” means an individual entitled
 15 to benefits under part A of this title, enrolled under
 16 part B of this title, or both.

17 **SEC. 403. TEMPORARY SUSPENSION OF OASIS REQUIRE-**
 18 **MENT FOR COLLECTION OF DATA ON NON-**
 19 **MEDICARE AND NON-MEDICAID PATIENTS.**

20 (a) **IN GENERAL.**—During the period described in
 21 subsection (b), the Secretary may not require, under sec-
 22 tion 4602(e) of the Balanced Budget Act of 1997 (Public
 23 Law 105–33; 111 Stat. 467) or otherwise under OASIS,
 24 a home health agency to gather or submit information that
 25 relates to an individual who is not eligible for benefits

1 under either title XVIII or title XIX of the Social Security
2 Act (such information in this section referred to as “non-
3 medicare/medicaid OASIS information”).

4 (b) PERIOD OF SUSPENSION.—The period described
5 in this subsection—

6 (1) begins on the date of the enactment of this
7 Act; and

8 (2) ends on the last day of the second month
9 beginning after the date as of which the Secretary
10 has published final regulations regarding the collec-
11 tion and use by the Centers for Medicare & Medicaid
12 Services of non-medicare/medicaid OASIS informa-
13 tion following the submission of the report required
14 under subsection (c).

15 (c) REPORT.—

16 (1) STUDY.—The Secretary shall conduct a
17 study on how non-medicare/medicaid OASIS infor-
18 mation is and can be used by large home health
19 agencies. Such study shall examine—

20 (A) whether there are unique benefits from
21 the analysis of such information that cannot be
22 derived from other information available to, or
23 collected by, such agencies; and

24 (B) the value of collecting such informa-
25 tion by small home health agencies compared to

1 shall use the partial or full-year cost reports filed by home
2 health agencies.

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

6 **SEC. 405. COVERAGE OF RELIGIOUS NONMEDICAL HEALTH**
7 **CARE INSTITUTION SERVICES FURNISHED IN**
8 **THE HOME.**

9 (a) IN GENERAL.—Section 1821(a) (42 U.S.C.
10 1395i–5(a)) is amended—

11 (1) in the matter preceding paragraph (1), by
12 inserting “and for home health services furnished an
13 individual by a religious nonmedical health care in-
14 stitution” after “religious nonmedical health care in-
15 stitution”; and

16 (2) in paragraph (2)—

17 (A) by striking “or extended care services”
18 and inserting “, extended care services, or home
19 health services”; and

20 (B) by inserting “, or receiving services
21 from a home health agency,” after “skilled
22 nursing facility”.

23 (b) DEFINITION.—Section 1861 (42 U.S.C. 1395x),
24 as amended by section 342, is amended by adding at the
25 end the following new section:

1 “Extended Care in Religious Nonmedical Health Care
2 Institutions

3 “(aaa)(1) The term ‘home health agency’ also in-
4 cludes a religious nonmedical health care institution (as
5 defined in subsection (ss)(1)), but only with respect to
6 items and services ordinarily furnished by such an institu-
7 tion to individuals in their homes, and that are comparable
8 to items and services furnished to individuals by a home
9 health agency that is not religious nonmedical health care
10 institution.

11 “(2)(A) Subject to subparagraphs (B), payment may
12 be made with respect to services provided by such an insti-
13 tution only to such extent and under such conditions, limi-
14 tations, and requirements (in addition to or in lieu of the
15 conditions, limitations, and requirements otherwise appli-
16 cable) as may be provided in regulations consistent with
17 section 1821.

18 “(B) Notwithstanding any other provision of this
19 title, payment may not be made under subparagraph
20 (A)—

21 “(i) in a year insofar as such payments exceed
22 \$700,000; and

23 “(ii) after December 31, 2006.”.

1 **Subtitle B—Graduate Medical**
2 **Education**

3 **SEC. 411. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR**
4 **GERIATRIC RESIDENCY OR FELLOWSHIP**
5 **PROGRAMS.**

6 (a) CLARIFICATION OF CONGRESSIONAL INTENT.—
7 Congress intended section 1886(h)(5)(F)(ii) of the Social
8 Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added
9 by section 9202 of the Consolidated Omnibus Budget Rec-
10 onciliation Act of 1985 (Public Law 99–272), to provide
11 an exception to the initial residency period for geriatric
12 residency or fellowship programs such that, where a par-
13 ticular approved geriatric training program requires a
14 resident to complete 2 years of training to initially become
15 board eligible in the geriatric specialty, the 2 years spent
16 in the geriatric training program are treated as part of
17 the resident’s initial residency period, but are not counted
18 against any limitation on the initial residency period.

19 (b) INTERIM FINAL REGULATORY AUTHORITY AND
20 EFFECTIVE DATE.—The Secretary shall promulgate in-
21 terim final regulations consistent with the congressional
22 intent expressed in this section after notice and pending
23 opportunity for public comment to be effective for cost re-
24 porting periods beginning on or after October 1, 2003.

1 **SEC. 412. TREATMENT OF VOLUNTEER SUPERVISION.**

2 (a) MORATORIUM ON CHANGES IN TREATMENT.—

3 During the 1-year period beginning on January 1, 2004,
4 for purposes of applying subsections (d)(5)(B) and (h) of
5 section 1886 of the Social Security Act (42 U.S.C.
6 1395ww), the Secretary shall allow all hospitals to count
7 residents in osteopathic and allopathic family practice pro-
8 grams in existence as of January 1, 2002, who are train-
9 ing at non-hospital sites, without regard to the financial
10 arrangement between the hospital and the teaching physi-
11 cian practicing in the non-hospital site to which the resi-
12 dent has been assigned.

13 (b) STUDY AND REPORT.—

14 (1) STUDY.—The Inspector General of the De-
15 partment of Health and Human Services shall con-
16 duct a study of the appropriateness of alternative
17 payment methodologies under such sections for the
18 costs of training residents in non-hospital settings.

19 (2) REPORT.—Not later than 1 year after the
20 date of the enactment of this Act, the Inspector
21 General shall submit to Congress a report on the
22 study conducted under paragraph (1), together with
23 such recommendations as the Inspector General de-
24 termines appropriate.

1 **Subtitle C—Chronic Care**
2 **Improvement**

3 **SEC. 421. VOLUNTARY CHRONIC CARE IMPROVEMENT**
4 **UNDER TRADITIONAL FEE-FOR-SERVICE.**

5 (a) IN GENERAL.—Title XVIII is amended by insert-
6 ing after section 1806 the following new section:

7 “CHRONIC CARE IMPROVEMENT
8 “SEC. 1807. (a) IMPLEMENTATION OF CHRONIC
9 CARE IMPROVEMENT PROGRAMS.—

10 “(1) IN GENERAL.—The Secretary shall provide
11 for the phased-in development, testing, evaluation,
12 and implementation of chronic care improvement
13 programs in accordance with this section. Each such
14 program shall be designed to improve clinical quality
15 and beneficiary satisfaction and achieve spending
16 targets with respect to expenditures under this title
17 for targeted beneficiaries with one or more threshold
18 conditions.

19 “(2) DEFINITIONS.—For purposes of this sec-
20 tion:

21 “(A) CHRONIC CARE IMPROVEMENT PRO-
22 GRAM.—The term ‘chronic care improvement
23 program’ means a program described in para-
24 graph (1) that is offered under an agreement
25 under subsection (b) or (c).

1 “(B) CHRONIC CARE IMPROVEMENT ORGA-
2 NIZATION.—The term ‘chronic care improve-
3 ment organization’ means an entity that has
4 entered into an agreement under subsection (b)
5 or (c) to provide, directly or through contracts
6 with subcontractors, a chronic care improve-
7 ment program under this section. Such an enti-
8 ty may be a disease management organization,
9 health insurer, integrated delivery system, phy-
10 sician group practice, a consortium of such en-
11 tities, or any other legal entity that the Sec-
12 retary determines appropriate to carry out a
13 chronic care improvement program under this
14 section.

15 “(C) CARE MANAGEMENT PLAN.—The
16 term ‘care management plan’ means a plan es-
17 tablished under subsection (d) for a participant
18 in a chronic care improvement program.

19 “(D) THRESHOLD CONDITION.—The term
20 ‘threshold condition’ means a chronic condition,
21 such as congestive heart failure, diabetes,
22 chronic obstructive pulmonary disease (COPD),
23 or other diseases or conditions, as selected by
24 the Secretary as appropriate for the establish-
25 ment of a chronic care improvement program.

1 “(E) TARGETED BENEFICIARY.—The term
2 ‘targeted beneficiary’ means, with respect to a
3 chronic care improvement program, an indi-
4 vidual who—

5 “(i) is entitled to benefits under part
6 A and enrolled under part B, but not en-
7 rolled in a plan under part C;

8 “(ii) has one or more threshold condi-
9 tions covered under such program; and

10 “(iii) has been identified under sub-
11 section (d)(1) as a potential participant in
12 such program.

13 “(3) CONSTRUCTION.—Nothing in this section
14 shall be construed as—

15 “(A) expanding the amount, duration, or
16 scope of benefits under this title;

17 “(B) providing an entitlement to partici-
18 pate in a chronic care improvement program
19 under this section;

20 “(C) providing for any hearing or appeal
21 rights under section 1869, 1878, or otherwise,
22 with respect to a chronic care improvement pro-
23 gram under this section; or

24 “(D) providing benefits under a chronic
25 care improvement program for which a claim

1 may be submitted to the Secretary by any pro-
2 vider of services or supplier (as defined in sec-
3 tion 1861(d)).

4 “(b) DEVELOPMENTAL PHASE (PHASE I).—

5 “(1) IN GENERAL.—In carrying out this sec-
6 tion, the Secretary shall enter into agreements con-
7 sistent with subsection (f) with chronic care im-
8 provement organizations for the development, test-
9 ing, and evaluation of chronic care improvement pro-
10 grams using randomized controlled trials. The first
11 such agreement shall be entered into not later than
12 12 months after the date of the enactment of this
13 section.

14 “(2) AGREEMENT PERIOD.—The period of an
15 agreement under this subsection shall be for 3 years.

16 “(3) MINIMUM PARTICIPATION.—

17 “(A) IN GENERAL.—The Secretary shall
18 enter into agreements under this subsection in
19 a manner so that chronic care improvement
20 programs offered under this section are offered
21 in geographic areas that, in the aggregate, con-
22 sist of areas in which at least 10 percent of the
23 aggregate number of medicare beneficiaries re-
24 side.

1 “(B) MEDICARE BENEFICIARY DEFINED.—

2 In this paragraph, the term ‘medicare bene-
3 ficiary’ means an individual who is entitled to
4 benefits under part A, enrolled under part B, or
5 both, and who resides in the United States.

6 “(4) SITE SELECTION.—In selecting geographic
7 areas in which agreements are entered into under
8 this subsection, the Secretary shall ensure that each
9 chronic care improvement program is conducted in a
10 geographic area in which at least 10,000 targeted
11 beneficiaries reside among other individuals entitled
12 to benefits under part A, enrolled under part B, or
13 both to serve as a control population.

14 “(5) INDEPENDENT EVALUATIONS OF PHASE I
15 PROGRAMS.—The Secretary shall contract for an
16 independent evaluation of the programs conducted
17 under this subsection. Such evaluation shall be done
18 by a contractor with knowledge of chronic care man-
19 agement programs and demonstrated experience in
20 the evaluation of such programs. Each evaluation
21 shall include an assessment of the following factors
22 of the programs:

23 “(A) Quality improvement measures, such
24 as adherence to evidence-based guidelines and
25 rehospitalization rates.

1 “(B) Beneficiary and provider satisfaction.

2 “(C) Health outcomes.

3 “(D) Financial outcomes, including any
4 cost savings to the program under this title.

5 “(c) EXPANDED IMPLEMENTATION PHASE (PHASE
6 II).—

7 “(1) IN GENERAL.—With respect to chronic
8 care improvement programs conducted under sub-
9 section (b), if the Secretary finds that the results of
10 the independent evaluation conducted under sub-
11 section (b)(6) indicate that the conditions specified
12 in paragraph (2) have been met by a program (or
13 components of such program), the Secretary shall
14 enter into agreements consistent with subsection (f)
15 to expand the implementation of the program (or
16 components) to additional geographic areas not cov-
17 ered under the program as conducted under sub-
18 section (b), which may include the implementation of
19 the program on a national basis. Such expansion
20 shall begin not earlier than 2 years after the pro-
21 gram is implemented under subsection (b) and not
22 later than 6 months after the date of completion of
23 such program.

24 “(2) CONDITIONS FOR EXPANSION OF PRO-
25 GRAMS.—The conditions specified in this paragraph

1 are, with respect to a chronic care improvement pro-
2 gram conducted under subsection (b) for a threshold
3 condition, that the program is expected to—

4 “(A) improve the clinical quality of care;

5 “(B) improve beneficiary satisfaction; and

6 “(C) achieve targets for savings to the pro-

7 gram under this title specified by the Secretary

8 in the agreement within a range determined to

9 be appropriate by the Secretary, subject to the

10 application of budget neutrality with respect to

11 the program and not taking into account any

12 payments by the organization under the agree-

13 ment under the program for risk under sub-

14 section (f)(3)(B).

15 “(3) INDEPENDENT EVALUATIONS OF PHASE II

16 PROGRAMS.—The Secretary shall carry out evalua-

17 tions of programs expanded under this subsection as

18 the Secretary determines appropriate. Such evalua-

19 tions shall be carried out in the similar manner as

20 is provided under subsection (b)(5).

21 “(d) IDENTIFICATION AND ENROLLMENT OF PRO-

22 SPECTIVE PROGRAM PARTICIPANTS.—

23 “(1) IDENTIFICATION OF PROSPECTIVE PRO-

24 GRAM PARTICIPANTS.—The Secretary shall establish

25 a method for identifying targeted beneficiaries who

1 may benefit from participation in a chronic care im-
2 provement program.

3 “(2) INITIAL CONTACT BY SECRETARY.—The
4 Secretary shall communicate with each targeted ben-
5 efiiciary concerning participation in a chronic care
6 improvement program. Such communication may be
7 made by the Secretary and shall include information
8 on the following:

9 “(A) A description of the advantages to
10 the beneficiary in participating in a program.

11 “(B) Notification that the organization of-
12 fering a program may contact the beneficiary
13 directly concerning such participation.

14 “(C) Notification that participation in a
15 program is voluntary.

16 “(D) A description of the method for the
17 beneficiary to participate or for declining to
18 participate and the method for obtaining addi-
19 tional information concerning such participa-
20 tion.

21 “(3) VOLUNTARY PARTICIPATION.—A targeted
22 beneficiary may participate in a chronic care im-
23 provement program on a voluntary basis and may
24 terminate participation at any time.

25 “(e) CHRONIC CARE IMPROVEMENT PROGRAMS.—

1 “(1) IN GENERAL.—Each chronic care improve-
2 ment program shall—

3 “(A) have a process to screen each tar-
4 geted beneficiary for conditions other than
5 threshold conditions, such as impaired cognitive
6 ability and co-morbidities, for the purposes of
7 developing an individualized, goal-oriented care
8 management plan under paragraph (2);

9 “(B) provide each targeted beneficiary par-
10 ticipating in the program with such plan; and

11 “(C) carry out such plan and other chronic
12 care improvement activities in accordance with
13 paragraph (3).

14 “(2) ELEMENTS OF CARE MANAGEMENT
15 PLANS.—A care management plan for a targeted
16 beneficiary shall be developed with the beneficiary
17 and shall, to the extent appropriate, include the fol-
18 lowing:

19 “(A) A designated point of contact respon-
20 sible for communications with the beneficiary
21 and for facilitating communications with other
22 health care providers under the plan.

23 “(B) Self-care education for the bene-
24 ficiary (through approaches such as disease
25 management or medical nutrition therapy) and

1 education for primary caregivers and family
2 members.

3 “(C) Education for physicians and other
4 providers and collaboration to enhance commu-
5 nication of relevant clinical information.

6 “(D) The use of monitoring technologies
7 that enable patient guidance through the ex-
8 change of pertinent clinical information, such as
9 vital signs, symptomatic information, and
10 health self-assessment.

11 “(E) The provision of information about
12 hospice care, pain and palliative care, and end-
13 of-life care.

14 “(3) CONDUCT OF PROGRAMS.—In carrying out
15 paragraph (1)(C) with respect to a participant, the
16 chronic care improvement organization shall—

17 “(A) guide the participant in managing the
18 participant’s health (including all co-
19 morbidities, relevant health care services, and
20 pharmaceutical needs) and in performing activi-
21 ties as specified under the elements of the care
22 management plan of the participant;

23 “(B) use decision-support tools such as evi-
24 dence-based practice guidelines or other criteria
25 as determined by the Secretary; and

1 “(C) develop a clinical information data-
2 base to track and monitor each participant
3 across settings and to evaluate outcomes.

4 “(4) ADDITIONAL RESPONSIBILITIES.—

5 “(A) OUTCOMES REPORT.—Each chronic
6 care improvement organization offering a
7 chronic care improvement program shall mon-
8 itor and report to the Secretary, in a manner
9 specified by the Secretary, on health care qual-
10 ity, cost, and outcomes.

11 “(B) ADDITIONAL REQUIREMENTS.—Each
12 such organization and program shall comply
13 with such additional requirements as the Sec-
14 retary may specify.

15 “(5) ACCREDITATION.—The Secretary may pro-
16 vide that chronic care improvement programs and
17 chronic care improvement organizations that are ac-
18 credited by qualified organizations (as defined by the
19 Secretary) may be deemed to meet such require-
20 ments under this section as the Secretary may speci-
21 fy.

22 “(f) TERMS OF AGREEMENTS.—

23 “(1) TERMS AND CONDITIONS.—

24 “(A) IN GENERAL.—An agreement under
25 this section with a chronic care improvement

1 organization shall contain such terms and con-
2 ditions as the Secretary may specify consistent
3 with this section.

4 “(B) CLINICAL, QUALITY IMPROVEMENT,
5 AND FINANCIAL REQUIREMENTS.—The Sec-
6 retary may not enter into an agreement with
7 such an organization under this section for the
8 operation of a chronic care improvement pro-
9 gram unless—

10 “(i) the program and organization
11 meet the requirements of subsection (e)
12 and such clinical, quality improvement, fi-
13 nancial, and other requirements as the
14 Secretary deems to be appropriate for the
15 targeted beneficiaries to be served; and

16 “(ii) the organization demonstrates to
17 the satisfaction of the Secretary that the
18 organization is able to assume financial
19 risk for performance under the agreement
20 (as applied under paragraph (3)(B)) with
21 respect to payments made to the organiza-
22 tion under such agreement through avail-
23 able reserves, reinsurance, withholds, or
24 such other means as the Secretary deter-
25 mines appropriate.

1 “(2) MANNER OF PAYMENT.—Subject to para-
2 graph (3)(B), the payment under an agreement
3 under—

4 “(A) subsection (b) shall be computed on
5 a per-member per-month basis; or

6 “(B) subsection (c) may be on a per-mem-
7 ber per-month basis or such other basis as the
8 Secretary and organization may agree.

9 “(3) APPLICATION OF PERFORMANCE STAND-
10 ARDS.—

11 “(A) SPECIFICATION OF PERFORMANCE
12 STANDARDS.—Each agreement under this sec-
13 tion with a chronic care improvement organiza-
14 tion shall specify performance standards for
15 each of the factors specified in subsection
16 (c)(2), including clinical quality and spending
17 targets under this title, against which the per-
18 formance of the chronic care improvement orga-
19 nization under the agreement is measured.

20 “(B) ADJUSTMENT OF PAYMENT BASED
21 ON PERFORMANCE.—

22 “(i) IN GENERAL.—Each such agree-
23 ment shall provide for adjustments in pay-
24 ment rates to an organization under the
25 agreement insofar as the Secretary deter-

1 mines that the organization failed to meet
2 the performance standards specified in the
3 agreement under subparagraph (A).

4 “(ii) FINANCIAL RISK FOR PERFORM-
5 ANCE.—In the case of an agreement under
6 subsection (b) or (c), the agreement shall
7 provide for a full recovery for any amount
8 by which the fees paid to the organization
9 under the agreement exceed the estimated
10 savings to the programs under this title at-
11 tributable to implementation of such agree-
12 ment.

13 “(4) BUDGET NEUTRAL PAYMENT CONDI-
14 TION.—Under this section, the Secretary shall en-
15 sure that the aggregate sum of medicare program
16 benefit expenditures for beneficiaries participating in
17 chronic care improvement programs and funds paid
18 to chronic care improvement organizations under
19 this section, shall not exceed the medicare program
20 benefit expenditures that the Secretary estimates
21 would have been made for such targeted bene-
22 ficiaries in the absence of such programs.

23 “(g) FUNDING.—(1) Subject to paragraph (2), there
24 are appropriated to the Secretary, in appropriate part
25 from the Federal Hospital Insurance Trust Fund and the

1 Federal Supplementary Medical Insurance Trust Fund,
2 such sums as may be necessary to provide for agreements
3 with chronic care improvement programs under this sec-
4 tion.

5 “(2) In no case shall the funding under this section
6 exceed \$100,000,000 in aggregate increased expenditures
7 under this title (after taking into account any savings at-
8 tributable to the operation of this section) over the 3-fis-
9 cal-year period beginning on October 1, 2003.”.

10 (b) REPORTS.—The Secretary shall submit to Con-
11 gress reports on the operation of section 1807 of the So-
12 cial Security Act, as added by subsection (a), as follows:

13 (1) Not later than 2 years after the date of the
14 implementation of such section, the Secretary shall
15 submit to Congress an interim report on the scope
16 of implementation of the programs under subsection
17 (b) of such section, the design of the programs, and
18 preliminary cost and quality findings with respect to
19 those programs based on the following measures of
20 the programs:

21 (A) Quality improvement measures, such
22 as adherence to evidence-based guidelines and
23 rehospitalization rates.

24 (B) Beneficiary and provider satisfaction.

25 (C) Health outcomes.

1 (D) Financial outcomes.

2 (2) Not later than 3 years and 6 months after
3 the date of the implementation of such section the
4 Secretary shall submit to Congress an update to the
5 report required under paragraph (1) on the results
6 of such programs.

7 (3) The Secretary shall submit to Congress 2
8 additional biennial reports on the chronic care im-
9 provement programs conducted under such section.
10 The first such report shall be submitted not later
11 than 2 years after the report is submitted under
12 paragraph (2). Each such report shall include infor-
13 mation on—

14 (A) the scope of implementation (in terms
15 of both regions and chronic conditions) of the
16 chronic care improvement programs;

17 (B) the design of the programs; and

18 (C) the improvements in health outcomes
19 and financial efficiencies that result from such
20 implementation.

21 **SEC. 422. MEDICARE ADVANTAGE QUALITY IMPROVEMENT**
22 **PROGRAMS.**

23 (a) IN GENERAL.—Section 1852(e) (42 U.S.C.
24 1395w-22(e)) is amended—

1 (1) in the heading, by striking “ASSURANCE”
2 and inserting “IMPROVEMENT”;

3 (2) by amending paragraphs (1) through (3) to
4 read as follows:

5 “(1) IN GENERAL.—Each MA organization
6 shall have an ongoing quality improvement program
7 for the purpose of improving the quality of care pro-
8 vided to enrollees in each MA plan offered by such
9 organization (other than an MA private fee-for-serv-
10 ice plan or an MSA plan).

11 “(2) CHRONIC CARE IMPROVEMENT PRO-
12 GRAMS.—As part of the quality improvement pro-
13 gram under paragraph (1), each MA organization
14 shall have a chronic care improvement program.
15 Each chronic care improvement program shall have
16 a method for monitoring and identifying enrollees
17 with multiple or sufficiently severe chronic condi-
18 tions that meet criteria established by the organiza-
19 tion for participation under the program.

20 “(3) DATA.—

21 “(A) COLLECTION, ANALYSIS, AND RE-
22 PORTING.—

23 “(i) IN GENERAL.—Except as pro-
24 vided in clauses (ii) and (iii) with respect
25 to plans described in such clauses and sub-

1 ject to subparagraph (B), as part of the
2 quality improvement program under para-
3 graph (1), each MA organization shall pro-
4 vide for the collection, analysis, and report-
5 ing of data that permits the measurement
6 of health outcomes and other indices of
7 quality.

8 “(ii) APPLICATION TO MA REGIONAL
9 PLANS.—The Secretary shall establish as
10 appropriate by regulation requirements for
11 the collection, analysis, and reporting of
12 data that permits the measurement of
13 health outcomes and other indices of qual-
14 ity for MA organizations with respect to
15 MA regional plans. Such requirements may
16 not exceed the requirements under this
17 subparagraph with respect to MA local
18 plans that are preferred provider organiza-
19 tion plans.

20 “(iii) APPLICATION TO PREFERRED
21 PROVIDER ORGANIZATIONS.—Clause (i)
22 shall apply to MA organizations with re-
23 spect to MA local plans that are preferred
24 provider organization plans only insofar as
25 services are furnished by providers or serv-

1 ices, physicians, and other health care
2 practitioners and suppliers that have con-
3 tracts with such organization to furnish
4 services under such plans.

5 “(iv) DEFINITION OF PREFERRED
6 PROVIDER ORGANIZATION PLAN.—In this
7 subparagraph, the term ‘preferred provider
8 organization plan’ means an MA plan
9 that—

10 “(I) has a network of providers
11 that have agreed to a contractually
12 specified reimbursement for covered
13 benefits with the organization offering
14 the plan;

15 “(II) provides for reimbursement
16 for all covered benefits regardless of
17 whether such benefits are provided
18 within such network of providers; and

19 “(III) is offered by an organiza-
20 tion that is not licensed or organized
21 under State law as a health mainte-
22 nance organization.

23 “(B) LIMITATIONS.—

24 “(i) TYPES OF DATA.—The Secretary
25 shall not collect under subparagraph (A)

1 data on quality, outcomes, and beneficiary
2 satisfaction to facilitate consumer choice
3 and program administration other than the
4 types of data that were collected by the
5 Secretary as of November 1, 2003.

6 “(ii) CHANGES IN TYPES OF DATA.—
7 Subject to subclause (iii), the Secretary
8 may only change the types of data that are
9 required to be submitted under subpara-
10 graph (A) after submitting to Congress a
11 report on the reasons for such changes
12 that was prepared in consultation with MA
13 organizations and private accrediting bod-
14 ies.

15 “(iii) CONSTRUCTION.—Nothing in
16 the subsection shall be construed as re-
17 stricting the ability of the Secretary to
18 carry out the duties under section
19 1851(d)(4)(D).”;

20 (3) in paragraph (4)(B), by amending clause (i)
21 to read as follows:

22 “(i) Paragraphs (1) through (3) of
23 this subsection (relating to quality im-
24 provement programs).”; and

25 (4) by striking paragraph (5).

1 (b) CONFORMING AMENDMENT.—Section
 2 1852(c)(1)(I) (42 U.S.C. 1395w-22(c)(1)(I)) is amended
 3 to read as follows:

4 “(I) QUALITY IMPROVEMENT PROGRAM.—
 5 A description of the organization’s quality im-
 6 provement program under subsection (e).”.

7 (c) EFFECTIVE DATE.—The amendments made by
 8 this section shall apply with respect to contract years be-
 9 ginning on and after January 1, 2006.

10 **SEC. 423. CHRONICALLY ILL MEDICARE BENEFICIARY RE-**
 11 **SEARCH, DATA, DEMONSTRATION STRATEGY.**

12 (a) DEVELOPMENT OF PLAN.—Not later than 6
 13 months after the date of the enactment of this Act, the
 14 Secretary shall develop a plan to improve quality of care
 15 and reduce the cost of care for chronically ill medicare
 16 beneficiaries.

17 (b) PLAN REQUIREMENTS.—The plan will utilize ex-
 18 isting data and identify data gaps, develop research initia-
 19 tives, and propose intervention demonstration programs to
 20 provide better health care for chronically ill medicare bene-
 21 ficiaries. The plan shall—

22 (1) integrate existing data sets including, the
 23 Medicare Current Beneficiary Survey (MCBS), Min-
 24 imum Data Set (MDS), Outcome and Assessment

1 Information Set (OASIS), data from Quality Im-
2 provement Organizations (QIO), and claims data;

3 (2) identify any new data needs and a method-
4 ology to address new data needs;

5 (3) plan for the collection of such data in a
6 data warehouse; and

7 (4) develop a research agenda using such data.

8 (c) CONSULTATION.—In developing the plan under
9 this section, the Secretary shall consult with experts in
10 the fields of care for the chronically ill (including clini-
11 cians).

12 (d) IMPLEMENTATION.—Not later than 2 years after
13 the date of the enactment of this Act, the Secretary shall
14 implement the plan developed under this section. The Sec-
15 retary may contract with appropriate entities to imple-
16 ment such plan.

17 (e) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to the Secretary such
19 sums as may be necessary in fiscal years 2004 and 2005
20 to carry out this section.

1 **Subtitle D—Other Provisions**

2 **SEC. 431. IMPROVEMENTS IN NATIONAL AND LOCAL COV-**
 3 **ERAGE DETERMINATION PROCESS TO RE-**
 4 **SPOND TO CHANGES IN TECHNOLOGY.**

5 (a) NATIONAL AND LOCAL COVERAGE DETERMINA-
 6 TION PROCESS.—

7 (1) IN GENERAL.—Section 1862 (42 U.S.C.
 8 1395y), as amended by sections 948 and 950, is
 9 amended—

10 (A) in the third sentence of subsection (a),
 11 by inserting “consistent with subsection (l)”
 12 after “the Secretary shall ensure”; and

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

15 “(l) NATIONAL AND LOCAL COVERAGE DETERMINA-
 16 TION PROCESS.—

17 “(1) FACTORS AND EVIDENCE USED IN MAKING
 18 NATIONAL COVERAGE DETERMINATIONS.—The Sec-
 19 retary shall make available to the public the factors
 20 considered in making national coverage determina-
 21 tions of whether an item or service is reasonable and
 22 necessary. The Secretary shall develop guidance doc-
 23 uments to carry out this paragraph in a manner
 24 similar to the development of guidance documents

1 under section 701(h) of the Federal Food, Drug,
2 and Cosmetic Act (21 U.S.C. 371(h)).

3 “(2) TIMEFRAME FOR DECISIONS ON REQUESTS
4 FOR NATIONAL COVERAGE DETERMINATIONS.—In
5 the case of a request for a national coverage deter-
6 mination that—

7 “(A) does not require a technology assess-
8 ment from an outside entity or deliberation
9 from the Medicare Coverage Advisory Com-
10 mittee, the decision on the request shall be
11 made not later than 6 months after the date of
12 the request; or

13 “(B) requires such an assessment or delib-
14 eration and in which a clinical trial is not re-
15 quested, the decision on the request shall be
16 made not later than 9 months after the date of
17 the request.

18 “(3) PROCESS FOR PUBLIC COMMENT IN NA-
19 TIONAL COVERAGE DETERMINATIONS.—

20 “(A) PERIOD FOR PROPOSED DECISION.—
21 Not later than the end of the 6-month period
22 (or 9-month period for requests described in
23 paragraph (2)(B)) that begins on the date a re-
24 quest for a national coverage determination is
25 made, the Secretary shall make a draft of pro-

1 posed decision on the request available to the
2 public through the Internet website of the Cen-
3 ters for Medicare & Medicaid Services or other
4 appropriate means.

5 “(B) 30-DAY PERIOD FOR PUBLIC COM-
6 MENT.—Beginning on the date the Secretary
7 makes a draft of the proposed decision available
8 under subparagraph (A), the Secretary shall
9 provide a 30-day period for public comment on
10 such draft.

11 “(C) 60-DAY PERIOD FOR FINAL DECI-
12 SION.—Not later than 60 days after the conclu-
13 sion of the 30-day period referred to under sub-
14 paragraph (B), the Secretary shall—

15 “(i) make a final decision on the re-
16 quest;

17 “(ii) include in such final decision
18 summaries of the public comments received
19 and responses to such comments;

20 “(iii) make available to the public the
21 clinical evidence and other data used in
22 making such a decision when the decision
23 differs from the recommendations of the
24 Medicare Coverage Advisory Committee;
25 and

1 “(iv) in the case of a final decision
2 under clause (i) to grant the request for
3 the national coverage determination, the
4 Secretary shall assign a temporary or per-
5 manent code (whether existing or unclassi-
6 fied) and implement the coding change.

7 “(4) CONSULTATION WITH OUTSIDE EXPERTS
8 IN CERTAIN NATIONAL COVERAGE DETERMINA-
9 TIONS.—With respect to a request for a national
10 coverage determination for which there is not a re-
11 view by the Medicare Coverage Advisory Committee,
12 the Secretary shall consult with appropriate outside
13 clinical experts.

14 “(5) LOCAL COVERAGE DETERMINATION PROC-
15 ESS.—

16 “(A) PLAN TO PROMOTE CONSISTENCY OF
17 COVERAGE DETERMINATIONS.—The Secretary
18 shall develop a plan to evaluate new local cov-
19 erage determinations to determine which deter-
20 minations should be adopted nationally and to
21 what extent greater consistency can be achieved
22 among local coverage determinations.

23 “(B) CONSULTATION.—The Secretary
24 shall require the fiscal intermediaries or car-
25 riers providing services within the same area to

1 consult on all new local coverage determinations
2 within the area.

3 “(C) DISSEMINATION OF INFORMATION.—
4 The Secretary should serve as a center to dis-
5 seminate information on local coverage deter-
6 minations among fiscal intermediaries and car-
7 riers to reduce duplication of effort.

8 “(6) NATIONAL AND LOCAL COVERAGE DETER-
9 MINATION DEFINED.—For purposes of this sub-
10 section—

11 “(A) NATIONAL COVERAGE DETERMINA-
12 TION.—The term ‘national coverage determina-
13 tion’ means a determination by the Secretary
14 with respect to whether or not a particular item
15 or service is covered nationally under this title.

16 “(B) LOCAL COVERAGE DETERMINA-
17 TION.—The term ‘local coverage determination’
18 has the meaning given that in section
19 1869(f)(2)(B).”.

20 “(2) EFFECTIVE DATE.—The amendments made
21 by paragraph (1) shall apply to national coverage
22 determinations as of January 1, 2004, and section
23 1862(l)(5) of the Social Security Act, as added by
24 such paragraph, shall apply to local coverage deter-
25 minations made on or after July 1, 2004.

1 (b) MEDICARE COVERAGE OF ROUTINE COSTS ASSO-
2 CIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY
3 A DEVICES.—

4 (1) IN GENERAL.—Section 1862 (42 U.S.C.
5 1395y), as amended by subsection (a), is amended
6 by adding at the end the following new subsection:

7 “(m) COVERAGE OF ROUTINE COSTS ASSOCIATED
8 WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DE-
9 VICES.—

10 “(1) IN GENERAL.—In the case of an individual
11 entitled to benefits under part A, or enrolled under
12 part B, or both who participates in a category A
13 clinical trial, the Secretary shall not exclude under
14 subsection (a)(1) payment for coverage of routine
15 costs of care (as defined by the Secretary) furnished
16 to such individual in the trial.

17 “(2) CATEGORY A CLINICAL TRIAL.—For pur-
18 poses of paragraph (1), a ‘category A clinical trial’
19 means a trial of a medical device if—

20 “(A) the trial is of an experimental/inves-
21 tigational (category A) medical device (as de-
22 fined in regulations under section 405.201(b) of
23 title 42, Code of Federal Regulations (as in ef-
24 fect as of September 1, 2003));

1 “(B) the trial meets criteria established by
2 the Secretary to ensure that the trial conforms
3 to appropriate scientific and ethical standards;
4 and

5 “(C) in the case of a trial initiated before
6 January 1, 2010, the device involved in the trial
7 has been determined by the Secretary to be in-
8 tended for use in the diagnosis, monitoring, or
9 treatment of an immediately life-threatening
10 disease or condition.”.

11 (2) EFFECTIVE DATE.—The amendment made
12 by paragraph (1) shall apply to routine costs in-
13 curred on and after January 1, 2005, and, as of
14 such date, section 411.15(o) of title 42, Code of
15 Federal Regulations, is superseded to the extent in-
16 consistent with section 1862(m) of the Social Secu-
17 rity Act, as added by such paragraph.

18 (3) RULE OF CONSTRUCTION.—Nothing in the
19 amendment made by paragraph (1) shall be con-
20 strued as applying to, or affecting, coverage or pay-
21 ment for a nonexperimental/investigational (category
22 B) device.

23 (c) ISSUANCE OF TEMPORARY NATIONAL CODES.—
24 Not later than July 1, 2004, the Secretary shall imple-
25 ment revised procedures for the issuance of temporary na-

1 tional HCPCS codes under part B of title XVIII of the
2 Social Security Act.

3 **SEC. 432. EXTENSION OF TREATMENT OF CERTAIN PHYSI-**
4 **CIAN PATHOLOGY SERVICES UNDER MEDI-**
5 **CARE.**

6 Section 542(c) of BIPA (114 Stat. 2763A–551) is
7 amended by inserting “, and for services furnished during
8 2005 and 2006” before the period at the end.

9 **SEC. 433. PAYMENT FOR PANCREATIC ISLET CELL INVES-**
10 **TIGATIONAL TRANSPLANTS FOR MEDICARE**
11 **BENEFICIARIES IN CLINICAL TRIALS.**

12 (a) CLINICAL TRIAL.—

13 (1) IN GENERAL.—The Secretary, acting
14 through the National Institute of Diabetes and Di-
15 gestive and Kidney Disorders, shall conduct a clin-
16 ical investigation of pancreatic islet cell transplan-
17 tation which includes medicare beneficiaries.

18 (2) AUTHORIZATION OF APPROPRIATIONS.—

19 There are authorized to be appropriated to the Sec-
20 retary such sums as may be necessary to conduct
21 the clinical investigation under paragraph (1).

22 (b) MEDICARE PAYMENT.—Not earlier than October
23 1, 2004, the Secretary shall pay for the routine costs as
24 well as transplantation and appropriate related items and
25 services (as described in subsection (c)) in the case of

1 medicare beneficiaries who are participating in a clinical
2 trial described in subsection (a) as if such transplantation
3 were covered under title XVIII of such Act and as would
4 be paid under part A or part B of such title for such bene-
5 ficiary.

6 (c) SCOPE OF PAYMENT.—For purposes of sub-
7 section (b):

8 (1) The term “routine costs” means reasonable
9 and necessary routine patient care costs (as defined
10 in the Centers for Medicare & Medicaid Services
11 Coverage Issues Manual, section 30–1), including
12 immunosuppressive drugs and other followup care.

13 (2) The term “transplantation and appropriate
14 related items and services” means items and services
15 related to the acquisition and delivery of the pan-
16 creatic islet cell transplantation, notwithstanding
17 any national noncoverage determination contained in
18 the Centers for Medicare & Medicaid Services Cov-
19 erage Issues Manual.

20 (3) The term “medicare beneficiary” means an
21 individual who is entitled to benefits under part A
22 of title XVIII of the Social Security Act, or enrolled
23 under part B of such title, or both.

24 (d) CONSTRUCTION.—The provisions of this section
25 shall not be construed—

1 (1) to permit payment for partial pancreatic tis-
2 sue or islet cell transplantation under title XVIII of
3 the Social Security Act other than payment as de-
4 scribed in subsection (b); or

5 (2) as authorizing or requiring coverage or pay-
6 ment conveying—

7 (A) benefits under part A of such title to
8 a beneficiary not entitled to such part A; or

9 (B) benefits under part B of such title to
10 a beneficiary not enrolled in such part B.

11 **SEC. 434. RESTORATION OF MEDICARE TRUST FUNDS.**

12 (a) DEFINITIONS.—In this section:

13 (1) CLERICAL ERROR.—The term “clerical
14 error” means a failure that occurs on or after April
15 15, 2001, to have transferred the correct amount
16 from the general fund of the Treasury to a Trust
17 Fund.

18 (2) TRUST FUND.—The term “Trust Fund”
19 means the Federal Hospital Insurance Trust Fund
20 established under section 1817 of the Social Security
21 Act (42 U.S.C. 1395i) and the Federal Supple-
22 mentary Medical Insurance Trust Fund established
23 under section 1841 of such Act (42 U.S.C. 1395t).

24 (b) CORRECTION OF TRUST FUND HOLDINGS.—

1 (1) IN GENERAL.—The Secretary of the Treas-
2 ury shall take the actions described in paragraph (2)
3 with respect to the Trust Fund with the goal being
4 that, after such actions are taken, the holdings of
5 the Trust Fund will replicate, to the extent prac-
6 ticable in the judgment of the Secretary of the
7 Treasury, in consultation with the Secretary, the
8 holdings that would have been held by the Trust
9 Fund if the clerical error involved had not occurred.

10 (2) OBLIGATIONS ISSUED AND REDEEMED.—
11 The Secretary of the Treasury shall—

12 (A) issue to the Trust Fund obligations
13 under chapter 31 of title 31, United States
14 Code, that bear issue dates, interest rates, and
15 maturity dates that are the same as those for
16 the obligations that—

17 (i) would have been issued to the
18 Trust Fund if the clerical error involved
19 had not occurred; or

20 (ii) were issued to the Trust Fund
21 and were redeemed by reason of the cler-
22 ical error involved; and

23 (B) redeem from the Trust Fund obliga-
24 tions that would have been redeemed from the

1 Trust Fund if the clerical error involved had
2 not occurred.

3 (c) APPROPRIATION.—There is appropriated to the
4 Trust Fund, out of any money in the Treasury not other-
5 wise appropriated, an amount determined by the Secretary
6 of the Treasury, in consultation with the Secretary, to be
7 equal to the interest income lost by the Trust Fund
8 through the date on which the appropriation is being made
9 as a result of the clerical error involved.

10 (d) CONGRESSIONAL NOTICE.—In the case of a cler-
11 ical error that occurs after April 15, 2001, the Secretary
12 of the Treasury, before taking action to correct the error
13 under this section, shall notify the appropriate committees
14 of Congress concerning such error and the actions to be
15 taken under this section in response to such error.

16 (e) DEADLINE.—With respect to the clerical error
17 that occurred on April 15, 2001, not later than 120 days
18 after the date of the enactment of this Act—

19 (1) the Secretary of the Treasury shall take the
20 actions under subsection (b)(1); and

21 (2) the appropriation under subsection (c) shall
22 be made.

1 **SEC. 435. MODIFICATIONS TO MEDICARE PAYMENT ADVI-**
2 **SORY COMMISSION (MEDPAC).**

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

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

12 (b) **CONSIDERATION OF EFFICIENT PROVISION OF**
13 **SERVICES.—**Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–
14 6(b)(2)(B)(i)) is amended by inserting “the efficient provi-
15 sion of” after “expenditures for”.

16 (c) **APPLICATION OF DISCLOSURE REQUIRE-**
17 **MENTS.—**

18 (1) **IN GENERAL.—**Section 1805(c)(2)(D) (42
19 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at
20 the end the following: “Members of the Commission
21 shall be treated as employees of Congress for pur-
22 poses of applying title I of the Ethics in Government
23 Act of 1978 (Public Law 95–521).”.

24 (2) **EFFECTIVE DATE.—**The amendment made
25 by paragraph (1) shall take effect on January 1,
26 2004.

1 (d) ADDITIONAL REPORTS.—

2 (1) DATA NEEDS AND SOURCES.—The Medicare
3 Payment Advisory Commission shall conduct a
4 study, and submit a report to Congress by not later
5 than June 1, 2004, on the need for current data,
6 and sources of current data available, to determine
7 the solvency and financial circumstances of hospitals
8 and other medicare providers of services.

9 (2) USE OF TAX-RELATED RETURNS.—Using
10 return information provided under Form 990 of the
11 Internal Revenue Service, the Commission shall sub-
12 mit to Congress, by not later than June 1, 2004, a
13 report on the following:

14 (A) Investments, endowments, and fund-
15 raising of hospitals participating under the
16 medicare program and related foundations.

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

19 (e) REPRESENTATION OF EXPERTS IN PRESCRIP-
20 TION DRUGS.—

21 (1) IN GENERAL.—Section 1805(c)(2)(B) (42
22 U.S.C. 1395b–6(c)(2)(B)) is amended by inserting
23 “experts in the area of pharmaco-economics or pre-
24 scription drug benefit programs,” after “other
25 health professionals,”.

1 (2) APPOINTMENT.—The Comptroller General
2 of the United States shall ensure that the member-
3 ship of the Commission complies with the amend-
4 ment made by paragraph (1) with respect to ap-
5 pointments made on or after the date of the enact-
6 ment of this Act.

7 **SEC. 436. TECHNICAL AMENDMENTS.**

8 (a) PART A.—(1) Section 1814(a) (42 U.S.C.
9 1395f(a)) is amended—

10 (A) by striking the seventh sentence, as added
11 by section 322(a)(1) of BIPA (114 Stat. 2763A–
12 501); and

13 (B) in paragraph (7)(A)—

14 (i) in clause (i), by inserting before the
15 comma at the end the following: “based on the
16 physician’s or medical director’s clinical judg-
17 ment regarding the normal course of the indi-
18 vidual’s illness”; and

19 (ii) in clause (ii), by inserting before the
20 semicolon at the end the following: “based on
21 such clinical judgment”.

22 (2) Section 1814(b) (42 U.S.C. 1395f(b)), in the
23 matter preceding paragraph (1), is amended by inserting
24 a comma after “1813”.

1 (3) Section 1815(e)(1)(B) (42 U.S.C.
2 1395g(e)(1)(B)), in the matter preceding clause (i), is
3 amended by striking “of hospital” and inserting “of a hos-
4 pital”.

5 (4) Section 1816(c)(2)(B)(ii) (42 U.S.C.
6 1395h(c)(2)(B)(ii)) is amended—

7 (A) by striking “and” at the end of subclause
8 (III); and

9 (B) by striking the period at the end of sub-
10 clause (IV) and inserting “, and”.

11 (5) Section 1817(k)(3)(A) (42 U.S.C.
12 1395i(k)(3)(A)) is amended—

13 (A) in clause (i)(I), by striking the comma at
14 the end and inserting a semicolon; and

15 (B) in clause (ii), by striking “the Medicare and
16 medicaid programs” and inserting “the programs
17 under this title and title XIX”.

18 (6) Section 1817(k)(6)(B) (42 U.S.C.
19 1395i(k)(6)(B)) is amended by striking “Medicare pro-
20 gram under title XVIII” and inserting “program under
21 this title”.

22 (7) Section 1818 (42 U.S.C. 1395i-2) is amended—

23 (A) in subsection (d)(6)(A) is amended by in-
24 serting “of such Code” after “3111(b)”; and

1 (B) in subsection (g)(2)(B) is amended by
2 striking “subsection (b).” and inserting “subsection
3 (b)”.

4 (8) Section 1819 (42 U.S.C. 1395i–3) is amended—

5 (A) in subsection (b)(4)(C)(i), by striking “at
6 least at least” and inserting “at least”;

7 (B) in subsection (d)(1)(A), by striking “phys-
8 ical mental” and inserting “physical, mental”; and

9 (C) in subsection (f)(2)(B)(iii), by moving the
10 last sentence 2 ems to the left.

11 (9) Section 1886(b)(3)(I)(i)(I) (42 U.S.C.
12 1395ww(b)(3)(I)(i)(I)) is amended by striking “the the”
13 and inserting “the”.

14 (10) The heading of subsection (mm) of section 1861
15 (42 U.S.C. 1395x) is amended to read as follows:

16 “Critical Access Hospital; Critical Access Hospital
17 Services”.

18 (11) Paragraphs (1) and (2) of section 1861(tt) (42
19 U.S.C. 1395x(tt)) are each amended by striking “rural
20 primary care” and inserting “critical access”.

21 (12) Section 1865(b)(3)(B) (42 U.S.C.
22 1395bb(b)(3)(B)) is amended by striking “section 1819
23 and 1861(j)” and inserting “sections 1819 and 1861(j)”.

24 (13) Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is
25 amended by moving subparagraph (D) 2 ems to the left.

1 (14) Section 1867 (42 U.S.C. 1395dd) is amended—

2 (A) in the matter following clause (ii) of sub-
3 section (d)(1)(B), by striking “is is” and inserting
4 “is”;

5 (B) in subsection (e)(1)(B), by striking “a
6 pregnant women” and inserting “a pregnant
7 woman”; and

8 (C) in subsection (e)(2), by striking “means
9 hospital” and inserting “means a hospital”.

10 (15) Section 1886(g)(3)(B) (42 U.S.C.
11 1395ww(g)(3)(B)) is amended by striking “(as defined in
12 subsection (d)(5)(D)(iii)” and inserting “(as defined in
13 subsection (d)(5)(D)(iii))”.

14 (b) PART B.—(1) Section 1833(h)(5)(D) (42 U.S.C.
15 1395l(h)(5)(D)) is amended by striking “clinic,,” and in-
16 serting “clinic,”.

17 (2) Section 1833(t)(3)(C)(ii) (42 U.S.C.
18 1395l(t)(3)(C)(ii)) is amended by striking “clause (iii)”
19 and inserting “clause (iv)”.

20 (3) Section 1861(v)(1)(S)(ii)(III) (42 U.S.C.
21 1395x(v)(1)(S)(ii)(III)) is amended by striking “(as de-
22 fined in section 1886(d)(5)(D)(iii)” and inserting “(as de-
23 fined in section 1886(d)(5)(D)(iii))”.

1 (4) Section 1834(b)(4)(D)(iv) (42 U.S.C.
2 1395m(b)(4)(D)(iv)) is amended by striking “clauses (vi)”
3 and inserting “clause (vi)”.

4 (5) Section 1834(m)(4)(C)(ii)(III) (42 U.S.C.
5 1395m(m)(4)(C)(ii)(III)) is amended by striking
6 “1861(aa)(s)” and inserting “1861(aa)(2)”.

7 (6) Section 1838(a)(1) (42 U.S.C. 1395q(a)(1)) is
8 amended by inserting a comma after “1966”.

9 (7) The second sentence of section 1839(a)(4) (42
10 U.S.C. 1395r(a)(4)) is amended by striking “which will”
11 and inserting “will”.

12 (8) Section 1842(c)(2)(B)(ii) (42 U.S.C.
13 1395u(c)(2)(B)(ii)) is amended—

14 (A) by striking “and” at the end of subclause
15 (III); and

16 (B) by striking the period at the end of sub-
17 clause (IV) and inserting “, and”.

18 (9) Section 1842(i)(2) (42 U.S.C. 1395u(i)(2)) is
19 amended by striking “services, a physician” and inserting
20 “services, to a physician”.

21 (10) Section 1848(i)(3)(A) (42 U.S.C. 1395w-
22 4(i)(3)(A)) is amended by striking “a comparable serv-
23 ices” and inserting “comparable services”.

1 (11) Section 1861(s)(2)(K)(i) (42 U.S.C.
2 1395x(s)(2)(K)(i)) is amended by striking “; and but” and
3 inserting “, but”.

4 (12) Section 1861(aa)(1)(B) (42 U.S.C.
5 1395x(aa)(1)(B)) is amended by striking “,,” and insert-
6 ing a comma.

7 (13) Section 128(b)(2) of BIPA (114 Stat. 2763A-
8 480) is amended by striking “Not later that” and insert-
9 ing “Not later than” each place it appears.

10 (c) PARTS A AND B.—(1) Section 1812(a)(3) (42
11 U.S.C. 1395d(a)(3)) is amended—

12 (A) by striking “for individuals not” and insert-
13 ing “in the case of individuals not”; and

14 (B) by striking “for individuals so” and insert-
15 ing “in the case of individuals so”.

16 (2)(A) Section 1814(a) (42 U.S.C. 1395f(a)) is
17 amended in the sixth sentence by striking “leave home,”
18 and inserting “leave home and”.

19 (B) Section 1835(a) (42 U.S.C. 1395n(a)) is amend-
20 ed in the seventh sentence by striking “leave home,” and
21 inserting “leave home and”.

22 (3) Section 1891(d)(1) (42 U.S.C. 1395bbb(d)(1)) is
23 amended by striking “subsection (c)(2)(C)(I)” and insert-
24 ing “subsection (c)(2)(C)(i)(I)”.

1 (4) Section 1861(v) (42 U.S.C. 1395x(v)) is amended
2 by moving paragraph (8) (including clauses (i) through
3 (v) of such paragraph) 2 ems to the left.

4 (5) Section 1866B(b)(7)(D) (42 U.S.C. 1395cc–
5 2(b)(7)(D)) is amended by striking “(c)(2)(A)(ii)” and in-
6 serting “(c)(2)(B)”.

7 (6) Section 1886(h)(3)(D)(ii)(III) (42 U.S.C.
8 1395ww(h)(3)(D)(ii)(III)) is amended by striking “and”
9 after the comma at the end.

10 (7) Section 1893(a) (42 U.S.C. 1395ddd(a)) is
11 amended by striking “Medicare program” and inserting
12 “medicare program”.

13 (8) Section 1896(b)(4) (42 U.S.C. 1395ggg(b)(4)) is
14 amended by striking “701(f)” and inserting “712(f)”.

15 (d) PART C.—(1) Section 1853 (42 U.S.C. 1395w–
16 23), as amended by section 307 of BIPA (114 Stat.
17 2763A–558), is amended—

18 (A) in subsection (a)(3)(C)(ii), by striking
19 “clause (iii)” and inserting “clause (iv)”;

20 (B) in subsection (a)(3)(C), by redesignating
21 the clause (iii) added by such section 307 as clause
22 (iv); and

23 (C) in subsection (c)(5), by striking
24 “(a)(3)(C)(iii)” and inserting “(a)(3)(C)(iv)”.

25 (2) Section 1876 (42 U.S.C. 1395mm) is amended—

1 (A) in subsection (c)(2)(B), by striking
2 “signifcant” and inserting “significant”; and

3 (B) in subsection (j)(2), by striking “this
4 setion” and inserting “this section”.

5 (e) MEDIGAP.—Section 1882 (42 U.S.C. 1395ss) is
6 amended—

7 (1) in subsection (d)(3)(A)(i)(II), by striking
8 “plan a medicare supplemental policy” and inserting
9 “plan, a medicare supplemental policy”;

10 (2) in subsection (d)(3)(B)(iii)(II), by striking
11 “to the best of the issuer or seller’s knowledge” and
12 inserting “to the best of the issuer’s or seller’s
13 knowledge”;

14 (3) in subsection (g)(2)(A), by striking “medi-
15 care supplement policies” and inserting “medicare
16 supplemental policies”;

17 (4) in subsection (p)(2)(B), by striking “, and”
18 and inserting “; and”; and

19 (5) in subsection (s)(3)(A)(iii), by striking “pre-
20 existing” and inserting “preexisting”.

1 **TITLE V—ADMINISTRATIVE IM-**
 2 **PROVEMENTS, REGULATORY**
 3 **REDUCTION, AND CON-**
 4 **TRACTING REFORM**

5 **SEC. 500. ADMINISTRATIVE IMPROVEMENTS WITHIN THE**
 6 **CENTERS FOR MEDICARE & MEDICAID SERV-**
 7 **ICES (CMS).**

8 (a) COORDINATED ADMINISTRATION OF MEDICARE
 9 PRESCRIPTION DRUG AND MEDICARE ADVANTAGE PRO-
 10 GRAMS.—Title XVIII (42 U.S.C. 1395 et seq.), as amend-
 11 ed by section 421, is amended by inserting after 1807 the
 12 following new section:

13 “PROVISIONS RELATING TO ADMINISTRATION
 14 “SEC. 1808. (a) COORDINATED ADMINISTRATION OF
 15 MEDICARE PRESCRIPTION DRUG AND MEDICARE ADVAN-
 16 TAGE PROGRAMS.—

17 “(1) IN GENERAL.—There is within the Centers
 18 for Medicare & Medicaid Services a center to carry
 19 out the duties described in paragraph (3).

20 “(2) DIRECTOR.—Such center shall be headed
 21 by a director who shall report directly to the Admin-
 22 istrator of the Centers for Medicare & Medicaid
 23 Services.

24 “(3) DUTIES.—The duties described in this
 25 paragraph are the following:

1 “(A) The administration of parts C and D.

2 “(B) The provision of notice and informa-
3 tion under section 1804.

4 “(C) Such other duties as the Secretary
5 may specify.

6 “(4) DEADLINE.—The Secretary shall ensure
7 that the center is carrying out the duties described
8 in paragraph (3) by not later than January 1,
9 2008.”.

10 (b) MANAGEMENT STAFF FOR THE CENTERS FOR
11 MEDICARE & MEDICAID SERVICES.—Such section is fur-
12 ther amended by adding at the end the following new sub-
13 section:

14 “(b) EMPLOYMENT OF MANAGEMENT STAFF.—

15 “(1) IN GENERAL.—The Secretary may employ,
16 within the Centers for Medicare & Medicaid Serv-
17 ices, such individuals as management staff as the
18 Secretary determines to be appropriate. With respect
19 to the administration of parts C and D, such indi-
20 viduals shall include individuals with private sector
21 expertise in negotiations with health benefits plans.

22 “(2) ELIGIBILITY.—To be eligible for employ-
23 ment under paragraph (1) an individual shall be re-
24 quired to have demonstrated, by their education and
25 experience (either in the public or private sector),

1 superior expertise in at least one of the following
2 areas:

3 “(A) The review, negotiation, and administra-
4 tion of health care contracts.

5 “(B) The design of health care benefit plans.

6 “(C) Actuarial sciences.

7 “(D) Compliance with health plan contracts.

8 “(E) Consumer education and decision making.

9 “(F) Any other area specified by the Secretary
10 that requires specialized management or other ex-
11 pertise.

12 “(3) RATES OF PAYMENT.—

13 “(A) PERFORMANCE-RELATED PAY.—Sub-
14 ject to subparagraph (B), the Secretary shall
15 establish the rate of pay for an individual em-
16 ployed under paragraph (1). Such rate shall
17 take into account expertise, experience, and per-
18 formance.

19 “(B) LIMITATION.—In no case may the
20 rate of compensation determined under sub-
21 paragraph (A) exceed the highest rate of basic
22 pay for the Senior Executive Service under sec-
23 tion 5382(b) of title 5, United States Code.”.

24 (c) REQUIREMENT FOR DEDICATED ACTUARY FOR
25 PRIVATE HEALTH PLANS.—Section 1117(b) (42 U.S.C.

1 1317(b)) is amended by adding at the end the following
 2 new paragraph:

3 “(3) In the office of the Chief Actuary there shall
 4 be an actuary whose duties relate exclusively to the pro-
 5 grams under parts C and D of title XVIII and related
 6 provisions of such title.”.

7 (d) INCREASE IN GRADE TO EXECUTIVE LEVEL III
 8 FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDI-
 9 CARE & MEDICAID SERVICES.—

10 (1) IN GENERAL.—Section 5314 of title 5,
 11 United States Code, is amended by adding at the
 12 end the following:

13 “Administrator of the Centers for Medicare &
 14 Medicaid Services.”.

15 (2) CONFORMING AMENDMENT.—Section 5315
 16 of such title is amended by striking “Administrator
 17 of the Health Care Financing Administration.”.

18 (3) EFFECTIVE DATE.—The amendments made
 19 by this subsection take effect on January 1, 2004.

20 (e) CONFORMING AMENDMENTS RELATING TO
 21 HEALTH CARE FINANCING ADMINISTRATION.—

22 (1) AMENDMENTS TO THE SOCIAL SECURITY
 23 ACT.—The Social Security Act is amended—

24 (A) in section 1117 (42 U.S.C. 1317)—

25 (i) in the heading to read as follows:

1 “APPOINTMENT OF THE ADMINISTRATOR AND CHIEF AC-
2 TUARY OF THE CENTERS FOR MEDICARE & MED-
3 ICAID SERVICES”;

4 (ii) in subsection (a), by striking
5 “Health Care Financing Administration”
6 and inserting “Centers for Medicare &
7 Medicaid Services”; and

8 (iii) in subsection (b)(1)—

9 (I) by striking “Health Care Fi-
10 nancing Administration” and insert-
11 ing “Centers for Medicare & Medicaid
12 Services”; and

13 (II) by striking “Administration”
14 and inserting “Centers”;

15 (B) in section 1140(a) (42 U.S.C. 1320b-
16 10(a))—

17 (i) in paragraph (1), by striking
18 “Health Care Financing Administration”
19 both places it appears in the
20 matter following subparagraph (B) and insert-
21 ing “Centers for Medicare & Medicaid Serv-
22 ices”;

23 (ii) in paragraph (1)(A)—

24 (I) by striking “Health Care Fi-
25 nancing Administration” and insert-

1 ing “Centers for Medicare & Medicaid
2 Services”; and

3 (II) by striking “HCFA” and in-
4 serting “CMS”; and

5 (iii) in paragraph (1)(B), by striking
6 “Health Care Financing Administration”
7 both places it appears and inserting “Cen-
8 ters for Medicare & Medicaid Services”;

9 (C) in section 1142(b)(3) (42 U.S.C.
10 1320b–12(b)(3)), by striking “Health Care Fi-
11 nancing Administration” and inserting “Cen-
12 ters for Medicare & Medicaid Services”;

13 (D) in section 1817(b) (42 U.S.C.
14 1395i(b))—

15 (i) by striking “Health Care Financ-
16 ing Administration”, both in the fifth sen-
17 tence of the matter preceding paragraph
18 (1) and in the second sentence of the
19 matter following paragraph (4), and inserting
20 “Centers for Medicare & Medicaid Services”;
21 and

22 (ii) by striking “Chief Actuarial Offi-
23 cer” in the second sentence of the
24 matter following paragraph (4) and inserting
25 “Chief Actuary”;

1 (E) in section 1841(b) (42 U.S.C.
2 1395t(b))—

3 (i) by striking “Health Care Financ-
4 ing Administration”, both in the fifth sen-
5 tence of the matter preceding paragraph
6 (1) and in the second sentence of the
7 matter following paragraph (4), and inserting
8 “Centers for Medicare & Medicaid Services”;
9 and

10 (ii) by striking “Chief Actuarial Offi-
11 cer” in the second sentence of the
12 matter following paragraph (4) and inserting
13 “Chief Actuary”;

14 (F) in section 1852(a)(5) (42 U.S.C.
15 1395w-22(a)(5)), by striking “Health Care Fi-
16 nancing Administration” in the
17 matter following subparagraph (B) and insert-
18 ing “Centers for Medicare & Medicaid Serv-
19 ices”;

20 (G) in section 1853 (42 U.S.C. 1395w-
21 23)—

22 (i) in subsection (b)(4), by striking
23 “Health Care Financing Administration”
24 in the first sentence and inserting “Cen-

1 ters for Medicare & Medicaid Services”;
2 and

3 (ii) in subsection (c)(7), by striking
4 “Health Care Financing Administration”
5 in the last sentence and inserting “Centers
6 for Medicare & Medicaid Services”;

7 (H) in section 1854(a)(5)(A) (42 U.S.C.
8 1395w-24(a)(5)(A)), by striking “Health Care
9 Financing Administration” and inserting “Cen-
10 ters for Medicare & Medicaid Services”;

11 (I) in section 1857(d)(4)(A)(ii) (42 U.S.C.
12 1395w-27(d)(4)(A)(ii)), by striking “Health
13 Care Financing Administration” and inserting
14 “Secretary”;

15 (J) in section 1862(b)(5)(A)(ii) (42 U.S.C.
16 1395y(b)(5)(A)(ii)), by striking “Health Care
17 Financing Administration” and inserting “Cen-
18 ters for Medicare & Medicaid Services”;

19 (K) in section 1927(e)(4) (42 U.S.C.
20 1396r-8(e)(4)), by striking “HCFA” and in-
21 serting “The Secretary”;

22 (L) in section 1927(f)(2) (42 U.S.C.
23 1396r-8(f)(2)), by striking “HCFA” and in-
24 serting “The Secretary”; and

1 (M) in section 2104(g)(3) (42 U.S.C.
2 1397dd(g)(3)) by inserting “or CMS Form 64
3 or CMS Form 21, as the case may be,” after
4 “HCFA Form 64 or HCFA Form 21”

5 (2) AMENDMENTS TO THE PUBLIC HEALTH
6 SERVICE ACT.—The Public Health Service Act is
7 amended—

8 (A) in section 501(d)(18) (42 U.S.C.
9 290aa(d)(18)), by striking “Health Care Fi-
10 nancing Administration” and inserting “Cen-
11 ters for Medicare & Medicaid Services”;

12 (B) in section 507(b)(6) (42 U.S.C.
13 290bb(b)(6)), by striking “Health Care Financ-
14 ing Administration” and inserting “Centers for
15 Medicare & Medicaid Services”;

16 (C) in section 916 (42 U.S.C. 299b–5)—

17 (i) in subsection (b)(2), by striking
18 “Health Care Financing Administration”
19 and inserting “Centers for Medicare &
20 Medicaid Services”; and

21 (ii) in subsection (c)(2), by striking
22 “Health Care Financing Administration”
23 and inserting “Centers for Medicare &
24 Medicaid Services”;

1 (D) in section 921(c)(3)(A) (42 U.S.C.
2 299c(c)(3)(A)), by striking “Health Care Fi-
3 nancing Administration” and inserting “Cen-
4 ters for Medicare & Medicaid Services”;

5 (E) in section 1318(a)(2) (42 U.S.C.
6 300e–17(a)(2)), by striking “Health Care Fi-
7 nancing Administration” and inserting “Cen-
8 ters for Medicare & Medicaid Services”;

9 (F) in section 2102(a)(7) (42 U.S.C.
10 300aa–2(a)(7)), by striking “Health Care Fi-
11 nancing Administration” and inserting “Cen-
12 ters for Medicare & Medicaid Services”; and

13 (G) in section 2675(a) (42 U.S.C. 300ff–
14 75(a)), by striking “Health Care Financing Ad-
15 ministration” in the first sentence and inserting
16 “Centers for Medicare & Medicaid Services”.

17 (3) AMENDMENTS TO THE INTERNAL REVENUE
18 CODE OF 1986.—Section 6103(l)(12) of the Internal
19 Revenue Code of 1986 is amended—

20 (A) in subparagraph (B), by striking
21 “Health Care Financing Administration” in the
22 matter preceding clause (i) and inserting “Cen-
23 ters for Medicare & Medicaid Services”; and

24 (B) in subparagraph (C)—

1 (i) by striking “HEALTH CARE FI-
2 NANCING ADMINISTRATION” in the heading
3 and inserting “CENTERS FOR MEDICARE &
4 MEDICAID SERVICES”; and

5 (ii) by striking “Health Care Financ-
6 ing Administration” in the matter pre-
7 ceding clause (i) and inserting “Centers
8 for Medicare & Medicaid Services”.

9 (4) AMENDMENTS TO TITLE 10, UNITED STATES
10 CODE.—Title 10, United States Code, is amended—

11 (A) in section 1086(d)(4), by striking “ad-
12 ministrator of the Health Care Financing Ad-
13 ministration” in the last sentence and inserting
14 “Administrator of the Centers for Medicare &
15 Medicaid Services”; and

16 (B) in section 1095(k)(2), by striking
17 “Health Care Financing Administration” in the
18 second sentence and inserting “Centers for
19 Medicare & Medicaid Services”.

20 (5) AMENDMENTS TO THE ALZHEIMER’S DIS-
21 EASE AND RELATED DEMENTIAS SERVICES RE-
22 SEARCH ACT OF 1992.—The Alzheimer’s Disease and
23 Related Dementias Research Act of 1992 (42 U.S.C.
24 11271 et seq.) is amended—

1 (A) in the heading of subpart 3 of part D
2 to read as follows:

3 “Subpart 3—Responsibilities of the Centers for Medicare
4 & Medicaid Services”;

5 (B) in section 937 (42 U.S.C. 11271)—

6 (i) in subsection (a), by striking “Na-
7 tional Health Care Financing Administra-
8 tion” and inserting “Centers for Medicare
9 & Medicaid Services”;

10 (ii) in subsection (b)(1), by striking
11 “Health Care Financing Administration”
12 and inserting “Centers for Medicare &
13 Medicaid Services”;

14 (iii) in subsection (b)(2), by striking
15 “Health Care Financing Administration”
16 and inserting “Centers for Medicare &
17 Medicaid Services”; and

18 (iv) in subsection (c), by striking
19 “Health Care Financing Administration”
20 and inserting “Centers for Medicare &
21 Medicaid Services”; and

22 (C) in section 938 (42 U.S.C. 11272), by
23 striking “Health Care Financing Administra-
24 tion” and inserting “Centers for Medicare &
25 Medicaid Services”.

1 (6) MISCELLANEOUS AMENDMENTS.—

2 (A) REHABILITATION ACT OF 1973.—Sec-
3 tion 202(b)(8) of the Rehabilitation Act of
4 1973 (29 U.S.C. 762(b)(8)) is amended by
5 striking “Health Care Financing Administra-
6 tion” and inserting “Centers for Medicare &
7 Medicaid Services”.

8 (B) INDIAN HEALTH CARE IMPROVEMENT
9 ACT.—Section 405(d)(1) of the Indian Health
10 Care Improvement Act (25 U.S.C. 1645(d)(1))
11 is amended by striking “Health Care Financing
12 Administration” in the matter preceding sub-
13 paragraph (A) and inserting “Centers for Medi-
14 care & Medicaid Services”.

15 (C) INDIVIDUALS WITH DISABILITIES EDU-
16 CATION ACT.—Section 644(b)(5) of the Individ-
17 uals with Disabilities Education Act (20 U.S.C.
18 1444(b)(5)) is amended by striking “Health
19 Care Financing Administration” and inserting
20 “Centers for Medicare & Medicaid Services”.

21 (D) THE HOME HEALTH CARE AND ALZ-
22 HEIMER’S DISEASE AMENDMENTS OF 1990.—
23 Section 302(a)(9) of the Home Health Care
24 and Alzheimer’s Disease Amendments of 1990
25 (42 U.S.C. 242q–1(a)(9)) is amended by strik-

1 ing “Health Care Financing Administration”
2 and inserting “Centers for Medicare & Medicaid
3 Services”.

4 (E) THE CHILDREN’S HEALTH ACT OF
5 2000.—Section 2503(a) of the Children’s Health
6 Act of 2000 (42 U.S.C. 247b–3a(a)) is amend-
7 ed by striking “Health Care Financing Admin-
8 istration” and inserting “Centers for Medicare
9 & Medicaid Services”.

10 (F) THE NATIONAL INSTITUTES OF
11 HEALTH REVITALIZATION ACT OF 1993.—Sec-
12 tion 1909 of the National Institutes of Health
13 Revitalization Act of 1993 (42 U.S.C. 299a
14 note) is amended by striking “Health Care Fi-
15 nancing Administration” and inserting “Cen-
16 ters for Medicare & Medicaid Services”.

17 (G) THE OMNIBUS BUDGET RECONCILI-
18 ATION ACT OF 1990.—Section 4359(d) of the
19 Omnibus Budget Reconciliation Act of 1990
20 (42 U.S.C. 1395b–3(d)) is amended by striking
21 “Health Care Financing Administration” and
22 inserting “Centers for Medicare & Medicaid
23 Services”.

24 (H) THE MEDICARE, MEDICAID, AND
25 SCHIP BENEFITS IMPROVEMENT AND PROTEC-

1 TION ACT OF 2000.—Section 104(d)(4) of the
 2 Medicare, Medicaid, and SCHIP Benefits Im-
 3 provement and Protection Act of 2000 (42
 4 U.S.C. 1395m note) is amended by striking
 5 “Health Care Financing Administration” and
 6 inserting “Health Care”.

7 (7) ADDITIONAL AMENDMENT.—Section 403 of
 8 the Act entitled, “An Act to authorize certain appro-
 9 priations for the territories of the United States, to
 10 amend certain Acts relating thereto, and for other
 11 purposes”, enacted October 15, 1977 (48 U.S.C.
 12 1574–1; 48 U.S.C. 1421q–1), is amended by strik-
 13 ing “Health Care Financing Administration” and in-
 14 serting “Centers for Medicare & Medicaid Services”.

15 **Subtitle A—Regulatory Reform**

16 **SEC. 501. CONSTRUCTION; DEFINITION OF SUPPLIER.**

17 (a) CONSTRUCTION.—Nothing in this title shall be
 18 construed—

19 (1) to compromise or affect existing legal rem-
 20 edies for addressing fraud or abuse, whether it be
 21 criminal prosecution, civil enforcement, or adminis-
 22 trative remedies, including under sections 3729
 23 through 3733 of title 31, United States Code (com-
 24 monly known as the “False Claims Act”); or

1 tablish and publish a regular timeline for the publication
2 of final regulations based on the previous publication of
3 a proposed regulation or an interim final regulation.

4 “(B) Such timeline may vary among different regula-
5 tions based on differences in the complexity of the regula-
6 tion, the number and scope of comments received, and
7 other relevant factors, but shall not be longer than 3 years
8 except under exceptional circumstances. If the Secretary
9 intends to vary such timeline with respect to the publica-
10 tion of a final regulation, the Secretary shall cause to have
11 published in the Federal Register notice of the different
12 timeline by not later than the timeline previously estab-
13 lished with respect to such regulation. Such notice shall
14 include a brief explanation of the justification for such
15 variation.

16 “(C) In the case of interim final regulations, upon
17 the expiration of the regular timeline established under
18 this paragraph for the publication of a final regulation
19 after opportunity for public comment, the interim final
20 regulation shall not continue in effect unless the Secretary
21 publishes (at the end of the regular timeline and, if appli-
22 cable, at the end of each succeeding 1-year period) a notice
23 of continuation of the regulation that includes an expla-
24 nation of why the regular timeline (and any subsequent
25 1-year extension) was not complied with. If such a notice

1 is published, the regular timeline (or such timeline as pre-
2 viously extended under this paragraph) for publication of
3 the final regulation shall be treated as having been ex-
4 tended for 1 additional year.

5 “(D) The Secretary shall annually submit to Con-
6 gress a report that describes the instances in which the
7 Secretary failed to publish a final regulation within the
8 applicable regular timeline under this paragraph and that
9 provides an explanation for such failures.”.

10 (2) EFFECTIVE DATE.—The amendment made
11 by paragraph (1) shall take effect on the date of the
12 enactment of this Act. The Secretary shall provide
13 for an appropriate transition to take into account
14 the backlog of previously published interim final reg-
15 ulations.

16 (b) LIMITATIONS ON NEW MATTER IN FINAL REGU-
17 LATIONS.—

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

22 “(4) If the Secretary publishes a final regulation that
23 includes a provision that is not a logical outgrowth of a
24 previously published notice of proposed rulemaking or in-
25 terim final rule, such provision shall be treated as a pro-

1 posed regulation and shall not take effect until there is
2 the further opportunity for public comment and a publica-
3 tion of the provision again as a final regulation.”.

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

8 **SEC. 503. COMPLIANCE WITH CHANGES IN REGULATIONS**
9 **AND POLICIES.**

10 (a) NO RETROACTIVE APPLICATION OF SUB-
11 STANTIVE CHANGES.—

12 (1) IN GENERAL.—Section 1871 (42 U.S.C.
13 1395hh), as amended by section 502(a), is amended
14 by adding at the end the following new subsection:
15 “(e)(1)(A) A substantive change in regulations, man-
16 ual instructions, interpretative rules, statements of policy,
17 or guidelines of general applicability under this title shall
18 not be applied (by extrapolation or otherwise) retroactively
19 to items and services furnished before the effective date
20 of the change, unless the Secretary determines that—

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

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

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

5 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE
6 CHANGES AFTER NOTICE.—

7 (1) IN GENERAL.—Section 1871(e)(1), as
8 added by subsection (a), is amended by adding at
9 the end the following:

10 “(B)(i) Except as provided in clause (ii), a sub-
11 stantive change referred to in subparagraph (A) shall not
12 become effective before the end of the 30-day period that
13 begins on the date that the Secretary has issued or pub-
14 lished, as the case may be, the substantive change.

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

1 “(C) No action shall be taken against a provider of
2 services or supplier with respect to noncompliance with
3 such a substantive change for items and services furnished
4 before the effective date of such a change.”.

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

9 (c) RELIANCE ON GUIDANCE.—

10 (1) IN GENERAL.—Section 1871(e), as added
11 by subsection (a), is further amended by adding at
12 the end the following new paragraph:

13 “(2)(A) If—

14 “(i) a provider of services or supplier follows
15 the written guidance (which may be transmitted
16 electronically) provided by the Secretary or by a
17 medicare contractor (as defined in section 1889(g))
18 acting within the scope of the contractor’s contract
19 authority, with respect to the furnishing of items or
20 services and submission of a claim for benefits for
21 such items or services with respect to such provider
22 or supplier;

23 “(ii) the Secretary determines that the provider
24 of services or supplier has accurately presented the

1 circumstances relating to such items, services, and
2 claim to the contractor in writing; and

3 “(iii) the guidance was in error;

4 the provider of services or supplier shall not be subject
5 to any penalty or interest under this title or the provisions
6 of title XI insofar as they relate to this title (including
7 interest under a repayment plan under section 1893 or
8 otherwise) relating to the provision of such items or serv-
9 ice or such claim if the provider of services or supplier
10 reasonably relied on such guidance.

11 “(B) Subparagraph (A) shall not be construed as pre-
12 venting the recoupment or repayment (without any addi-
13 tional penalty) relating to an overpayment insofar as the
14 overpayment was solely the result of a clerical or technical
15 operational error.”.

16 (2) EFFECTIVE DATE.—The amendment made
17 by paragraph (1) shall take effect on the date of the
18 enactment of this Act and shall only apply to a pen-
19 alty or interest imposed with respect to guidance
20 provided on or after July 24, 2003.

21 **SEC. 504. REPORTS AND STUDIES RELATING TO REGU-**
22 **LATORY REFORM.**

23 (a) GAO STUDY ON ADVISORY OPINION AUTHOR-
24 ITY.—

1 (1) STUDY.—The Comptroller General of the
2 United States shall conduct a study to determine the
3 feasibility and appropriateness of establishing in the
4 Secretary authority to provide legally binding advi-
5 sory opinions on appropriate interpretation and ap-
6 plication of regulations to carry out the medicare
7 program under title XVIII of the Social Security
8 Act. Such study shall examine the appropriate time-
9 frame for issuing such advisory opinions, as well as
10 the need for additional staff and funding to provide
11 such opinions.

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

16 (b) REPORT ON LEGAL AND REGULATORY INCON-
17 SISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as
18 amended by section 503(a)(1), is amended by adding at
19 the end the following new subsection:

20 “(f)(1) Not later than 2 years after the date of the
21 enactment of this subsection, and every 3 years thereafter,
22 the Secretary shall submit to Congress a report with re-
23 spect to the administration of this title and areas of incon-
24 sistency or conflict among the various provisions under
25 law and regulation.

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

3 “(A) information from individuals entitled to
4 benefits under part A or enrolled under part B, or
5 both, providers of services, and suppliers and from
6 the Medicare Beneficiary Ombudsman with respect
7 to such areas of inconsistency and conflict; and

8 “(B) information from medicare contractors
9 that tracks the nature of written and telephone in-
10 quires.

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

17 **Subtitle B—Contracting Reform**

18 **SEC. 511. 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 “(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 or supplier (or class of such
13 providers of services or suppliers), the ‘appro-
14 priate’ medicare administrative contractor is the
15 medicare administrative contractor that has a
16 contract under this section with respect to the
17 performance of that function in relation to that
18 individual, provider of services or supplier or
19 class of provider of services or supplier.

20 “(4) FUNCTIONS DESCRIBED.—The functions
21 referred to in paragraphs (1) and (2) are payment
22 functions (including the function of developing local
23 coverage determinations, as defined in section
24 1869(f)(2)(B)), provider services functions, and
25 functions relating to services furnished to individuals

1 entitled to benefits under part A or enrolled under
2 part B, or both, 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, suppliers and individuals.

10 “(B) MAKING PAYMENTS.—Making pay-
11 ments described in subparagraph (A) (including
12 receipt, disbursement, and accounting for funds
13 in making such payments).

14 “(C) BENEFICIARY EDUCATION AND AS-
15 SISTANCE.—Providing education and outreach
16 to individuals entitled to benefits under part A
17 or enrolled under part B, or both, and pro-
18 viding assistance to those individuals with spe-
19 cific issues, concerns, or problems.

20 “(D) PROVIDER CONSULTATIVE SERV-
21 ICES.—Providing consultative services to insti-
22 tutions, agencies, and other persons to enable
23 them to establish and maintain fiscal records
24 necessary for purposes of this title and other-

1 wise to qualify as providers of services or sup-
2 pliers.

3 “(E) COMMUNICATION WITH PRO-
4 VIDERS.—Communicating to providers of serv-
5 ices and suppliers any information or instruc-
6 tions furnished to the medicare administrative
7 contractor by the Secretary, and facilitating
8 communication between such providers and sup-
9 pliers and the Secretary.

10 “(F) PROVIDER EDUCATION AND TECH-
11 NICAL ASSISTANCE.—Performing the functions
12 relating to provider education, training, and
13 technical assistance.

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

19 “(5) RELATIONSHIP TO MIP CONTRACTS.—

20 “(A) NONDUPLICATION OF DUTIES.—In
21 entering into contracts under this section, the
22 Secretary shall assure that functions of medi-
23 care administrative contractors in carrying out
24 activities under parts A and B do not duplicate
25 activities carried out under a contract entered

1 into under the Medicare Integrity Program
2 under section 1893. The previous sentence shall
3 not apply with respect to the activity described
4 in section 1893(b)(5) (relating to prior author-
5 ization of certain items of durable medical
6 equipment under section 1834(a)(15)).

7 “(B) CONSTRUCTION.—An entity shall not
8 be treated as a medicare administrative con-
9 tractor merely by reason of having entered into
10 a contract with the Secretary under section
11 1893.

12 “(6) APPLICATION OF FEDERAL ACQUISITION
13 REGULATION.—Except to the extent inconsistent
14 with a specific requirement of this section, the Fed-
15 eral Acquisition Regulation applies to contracts
16 under this section.

17 “(b) CONTRACTING REQUIREMENTS.—

18 “(1) USE OF COMPETITIVE PROCEDURES.—

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

1 ing into account performance quality as well as
2 price and other factors.

3 “(B) RENEWAL OF CONTRACTS.—The Sec-
4 retary may renew a contract with a medicare
5 administrative contractor under this section
6 from term to term without regard to section 5
7 of title 41, United States Code, or any other
8 provision of law requiring competition, if the
9 medicare administrative contractor has met or
10 exceeded the performance requirements applica-
11 ble with respect to the contract and contractor,
12 except that the Secretary shall provide for the
13 application of competitive procedures under
14 such a contract not less frequently than once
15 every 5 years.

16 “(C) TRANSFER OF FUNCTIONS.—The
17 Secretary may transfer functions among medi-
18 care administrative contractors consistent with
19 the provisions of this paragraph. The Secretary
20 shall ensure that performance quality is consid-
21 ered in such transfers. The Secretary shall pro-
22 vide public notice (whether in the Federal Reg-
23 ister or otherwise) of any such transfer (includ-
24 ing a description of the functions so trans-
25 ferred, a description of the providers of services

1 and suppliers affected by such transfer, and
2 contact information for the contractors in-
3 volved).

4 “(D) INCENTIVES FOR QUALITY.—The
5 Secretary shall provide incentives for medicare
6 administrative contractors to provide quality
7 service and to promote efficiency.

8 “(2) COMPLIANCE WITH REQUIREMENTS.—No
9 contract under this section shall be entered into with
10 any medicare administrative contractor unless the
11 Secretary finds that such medicare administrative
12 contractor will perform its obligations under the con-
13 tract efficiently and effectively and will meet such
14 requirements as to financial responsibility, legal au-
15 thority, quality of services provided, and other mat-
16 ters as the Secretary finds pertinent.

17 “(3) PERFORMANCE REQUIREMENTS.—

18 “(A) DEVELOPMENT OF SPECIFIC PER-
19 FORMANCE REQUIREMENTS.—

20 “(i) IN GENERAL.—The Secretary
21 shall develop contract performance require-
22 ments to carry out the specific require-
23 ments applicable under this title to a func-
24 tion described in subsection (a)(4) and
25 shall develop standards for measuring the

1 extent to which a contractor has met such
2 requirements.

3 “(ii) CONSULTATION.—In developing
4 such performance requirements and stand-
5 ards for measurement, the Secretary shall
6 consult with providers of services, organi-
7 zations representative of beneficiaries
8 under this title, and organizations and
9 agencies performing functions necessary to
10 carry out the purposes of this section with
11 respect to such performance requirements.

12 “(iii) PUBLICATION OF STANDARDS.—
13 The Secretary shall make such perform-
14 ance requirements and measurement
15 standards available to the public.

16 “(B) CONSIDERATIONS.—The Secretary
17 shall include, as one of the standards developed
18 under subparagraph (A), provider and bene-
19 ficiary satisfaction levels.

20 “(C) INCLUSION IN CONTRACTS.—All con-
21 tractor performance requirements shall be set
22 forth in the contract between the Secretary and
23 the appropriate medicare administrative con-
24 tractor. Such performance requirements—

1 “(i) shall reflect the performance re-
2 quirements published under subparagraph
3 (A), but may include additional perform-
4 ance requirements;

5 “(ii) shall be used for evaluating con-
6 tractor performance under the contract;
7 and

8 “(iii) shall be consistent with the writ-
9 ten statement of work provided under the
10 contract.

11 “(4) INFORMATION REQUIREMENTS.—The Sec-
12 retary shall not enter into a contract with a medi-
13 care administrative contractor under this section un-
14 less the contractor agrees—

15 “(A) to furnish to the Secretary such time-
16 ly information and reports as the Secretary may
17 find necessary in performing his functions
18 under this title; and

19 “(B) to maintain such records and afford
20 such access thereto as the Secretary finds nec-
21 essary to assure the correctness and verification
22 of the information and reports under subpara-
23 graph (A) and otherwise to carry out the pur-
24 poses of this title.

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

10 “(c) TERMS AND CONDITIONS.—

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

18 “(2) PROHIBITION ON MANDATES FOR CERTAIN
19 DATA COLLECTION.—The Secretary may not require,
20 as a condition of entering into, or renewing, a con-
21 tract under this section, that the medicare adminis-
22 trative contractor match data obtained other than in
23 its activities under this title with data used in the
24 administration of this title for purposes of identi-

1 fying situations in which the provisions of section
2 1862(b) may apply.

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

5 “(1) CERTIFYING OFFICER.—No individual des-
6 ignated pursuant to a contract under this section as
7 a certifying officer shall, in the absence of the reck-
8 less disregard of the individual’s obligations or the
9 intent by that individual to defraud the United
10 States, be liable with respect to any payments cer-
11 tified by the individual under this section.

12 “(2) DISBURSING OFFICER.—No disbursing of-
13 ficer shall, in the absence of the reckless disregard
14 of the officer’s obligations or the intent by that offi-
15 cer to defraud the United States, be liable with re-
16 spect to any payment by such officer under this sec-
17 tion if it was based upon an authorization (which
18 meets the applicable requirements for such internal
19 controls established by the Comptroller General of
20 the United States) of a certifying officer designated
21 as provided in paragraph (1) of this subsection.

22 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE
23 CONTRACTOR.—

24 “(A) IN GENERAL.—No medicare adminis-
25 trative contractor shall be liable to the United

1 States for a payment by a certifying or dis-
2 bursing officer unless, in connection with such
3 payment, the medicare administrative con-
4 tractor acted with reckless disregard of its obli-
5 gations under its medicare administrative con-
6 tract or with intent to defraud the United
7 States.

8 “(B) RELATIONSHIP TO FALSE CLAIMS
9 ACT.—Nothing in this subsection shall be con-
10 strued to limit liability for conduct that would
11 constitute a violation of sections 3729 through
12 3731 of title 31, United States Code.

13 “(4) INDEMNIFICATION BY SECRETARY.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graphs (B) and (D), in the case of a medicare
16 administrative contractor (or a person who is a
17 director, officer, or employee of such a con-
18 tractor or who is engaged by the contractor to
19 participate directly in the claims administration
20 process) who is made a party to any judicial or
21 administrative proceeding arising from or relat-
22 ing directly to the claims administration process
23 under this title, the Secretary may, to the ex-
24 tent the Secretary determines to be appropriate
25 and as specified in the contract with the con-

1 contractor, indemnify the contractor and such per-
2 sons.

3 “(B) CONDITIONS.—The Secretary may
4 not provide indemnification under subparagraph
5 (A) insofar as the liability for such costs arises
6 directly from conduct that is determined by the
7 judicial proceeding or by the Secretary to be
8 criminal in nature, fraudulent, or grossly neg-
9 ligent. If indemnification is provided by the Sec-
10 retary with respect to a contractor before a de-
11 termination that such costs arose directly from
12 such conduct, the contractor shall reimburse the
13 Secretary for costs of indemnification.

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

20 “(D) WRITTEN APPROVAL FOR SETTLE-
21 MENTS OR COMPROMISES.—A contractor or
22 other person described in subparagraph (A)
23 may not propose to negotiate a settlement or
24 compromise of a proceeding described in such
25 subparagraph without the prior written ap-

1 proval of the Secretary to negotiate such settle-
2 ment or compromise. Any indemnification under
3 subparagraph (A) with respect to amounts paid
4 under a settlement or compromise of a pro-
5 ceeding described in such subparagraph are
6 conditioned upon prior written approval by the
7 Secretary of the final settlement or compromise.

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

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

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

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

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

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

9 (7) Subsection (l) is repealed.

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

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

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

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

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

21 (3) Subsection (b) is amended—

22 (A) by striking paragraph (1);

23 (B) in paragraph (2)—

24 (i) by striking subparagraphs (A) and

25 (B);

1 (ii) in subparagraph (C), by striking
2 “carriers” and inserting “medicare admin-
3 istrative contractors”; and

4 (iii) by striking subparagraphs (D)
5 and (E);
6 (C) in paragraph (3)—

7 (i) in the matter before subparagraph
8 (A), by striking “Each such contract shall
9 provide that the carrier” and inserting
10 “The Secretary”;

11 (ii) by striking “will” the first place it
12 appears in each of subparagraphs (A), (B),
13 (F), (G), (H), and (L) and inserting
14 “shall”;

15 (iii) in subparagraph (B), in the mat-
16 ter before clause (i), by striking “to the
17 policyholders and subscribers of the car-
18 rier” and inserting “to the policyholders
19 and subscribers of the medicare adminis-
20 trative contractor”;

21 (iv) by striking subparagraphs (C),
22 (D), and (E);

23 (v) in subparagraph (H)—

24 (I) by striking “if it makes deter-
25 minations or payments with respect to

1 physicians' services," in the matter
2 preceding clause (i); and

3 (II) by striking "carrier" and in-
4 serting "medicare administrative con-
5 tractor" in clause (i);

6 (vi) by striking subparagraph (I);

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

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

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

16 (D) by striking paragraph (5);

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

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

23 (4) Subsection (c) is amended—

24 (A) by striking paragraph (1);

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

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

10 (D) in paragraph (4), in the matter pre-
11 ceding subparagraph (A), by striking “carrier”
12 and inserting “medicare administrative con-
13 tractor”; and

14 (E) by striking paragraphs (5) and (6).

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

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

19 (7) Subsection (h) is amended—

20 (A) in paragraph (2)—

21 (i) by striking “Each carrier having
22 an agreement with the Secretary under
23 subsection (a)” and inserting “The Sec-
24 retary”; and

1 (ii) by striking “Each such carrier”
2 and inserting “The Secretary”;

3 (B) in paragraph (3)(A)—

4 (i) by striking “a carrier having an
5 agreement with the Secretary under sub-
6 section (a)” and inserting “medicare ad-
7 ministrative contractor having a contract
8 under section 1874A that provides for
9 making payments under this part”; and

10 (ii) by striking “such carrier” and in-
11 sserting “such contractor”;

12 (C) in paragraph (3)(B)—

13 (i) by striking “a carrier” and insert-
14 ing “a medicare administrative contractor”
15 each place it appears; and

16 (ii) by striking “the carrier” and in-
17 sserting “the contractor” each place it ap-
18 pears; and

19 (D) in paragraphs (5)(A) and (5)(B)(iii),
20 by striking “carriers” and inserting “medicare
21 administrative contractors” each place it ap-
22 pears.

23 (8) Subsection (1) is amended—

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

4 (B) in paragraph (2), by striking “carrier”
5 and inserting “medicare administrative con-
6 tractor”.

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

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

12 (d) EFFECTIVE DATE; TRANSITION RULE.—

13 (1) EFFECTIVE DATE.—

14 (A) IN GENERAL.—Except as otherwise
15 provided in this subsection, the amendments
16 made by this section shall take effect on Octo-
17 ber 1, 2005, and the Secretary is authorized to
18 take such steps before such date as may be nec-
19 essary to implement such amendments on a
20 timely basis.

21 (B) CONSTRUCTION FOR CURRENT CON-
22 TRACTS.—Such amendments shall not apply to
23 contracts in effect before the date specified
24 under subparagraph (A) that continue to retain
25 the terms and conditions in effect on such date

1 (except as otherwise provided under this Act,
2 other than under this section) until such date
3 as the contract is let out for competitive bid-
4 ding under such amendments.

5 (C) DEADLINE FOR COMPETITIVE BID-
6 DING.—The Secretary shall provide for the let-
7 ting by competitive bidding of all contracts for
8 functions of medicare administrative contrac-
9 tors for annual contract periods that begin on
10 or after October 1, 2011.

11 (2) GENERAL TRANSITION RULES.—

12 (A) AUTHORITY TO CONTINUE TO ENTER
13 INTO NEW AGREEMENTS AND CONTRACTS AND
14 WAIVER OF PROVIDER NOMINATION PROVISIONS
15 DURING TRANSITION.—Prior to October 1,
16 2005, the Secretary may, consistent with sub-
17 paragraph (B), continue to enter into agree-
18 ments under section 1816 and contracts under
19 section 1842 of the Social Security Act (42
20 U.S.C. 1395h, 1395u). The Secretary may
21 enter into new agreements under section 1816
22 prior to October 1, 2005, without regard to any
23 of the provider nomination provisions of such
24 section.

1 (B) APPROPRIATE TRANSITION.—The Sec-
2 retary shall take such steps as are necessary to
3 provide for an appropriate transition from
4 agreements under section 1816 and contracts
5 under section 1842 of the Social Security Act
6 (42 U.S.C. 1395h, 1395u) to contracts under
7 section 1874A, as added by subsection (a)(1).

8 (3) AUTHORIZING CONTINUATION OF MIP
9 FUNCTIONS UNDER CURRENT CONTRACTS AND
10 AGREEMENTS AND UNDER TRANSITION CON-
11 TRACTS.—Notwithstanding the amendments made
12 by this section, the provisions contained in the ex-
13 ception in section 1893(d)(2) of the Social Security
14 Act (42 U.S.C. 1395ddd(d)(2)) shall continue to
15 apply during the period that begins on the date of
16 the enactment of this Act and ends on October 1,
17 2011, and any reference in such provisions to an
18 agreement or contract shall be deemed to include a
19 contract under section 1874A of such Act, as in-
20 serted by subsection (a)(1), that continues the activi-
21 ties referred to in such provisions.

22 (e) REFERENCES.—On and after the effective date
23 provided under subsection (d)(1), any reference to a fiscal
24 intermediary or carrier under title XI or XVIII of the So-
25 cial Security Act (or any regulation, manual instruction,

1 interpretative rule, statement of policy, or guideline issued
2 to carry out such titles) shall be deemed a reference to
3 a medicare administrative contractor (as provided under
4 section 1874A of the Social Security Act).

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

11 (g) REPORTS ON IMPLEMENTATION.—

12 (1) PLAN FOR IMPLEMENTATION.—By not later
13 than October 1, 2004, the Secretary shall submit a
14 report to Congress and the Comptroller General of
15 the United States that describes the plan for imple-
16 mentation of the amendments made by this section.
17 The Comptroller General shall conduct an evaluation
18 of such plan and shall submit to Congress, not later
19 than 6 months after the date the report is received,
20 a report on such evaluation and shall include in such
21 report such recommendations as the Comptroller
22 General deems appropriate.

23 (2) STATUS OF IMPLEMENTATION.—The Sec-
24 retary shall submit a report to Congress not later
25 than October 1, 2008, that describes the status of

1 implementation of such amendments and that in-
 2 cludes a description of the following:

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

5 (B) The distribution of functions among
 6 contracts and contractors.

7 (C) A timeline for complete transition to
 8 full competition.

9 (D) A detailed description of how the Sec-
 10 retary has modified oversight and management
 11 of medicare contractors to adapt to full com-
 12 petition.

13 **SEC. 512. REQUIREMENTS FOR INFORMATION SECURITY**
 14 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**
 15 **TORS.**

16 (a) IN GENERAL.—Section 1874A, as added by sec-
 17 tion 511(a)(1), is amended by adding at the end the fol-
 18 lowing new subsection:

19 “(e) REQUIREMENTS FOR INFORMATION SECUR-
 20 RITY.—

21 “(1) DEVELOPMENT OF INFORMATION SECUR-
 22 RITY PROGRAM.—A medicare administrative con-
 23 tractor that performs the functions referred to in
 24 subparagraphs (A) and (B) of subsection (a)(4) (re-
 25 lating to determining and making payments) shall

1 implement a contractor-wide information security
2 program to provide information security for the op-
3 eration and assets of the contractor with respect to
4 such functions under this title. An information secu-
5 rity program under this paragraph shall meet the
6 requirements for information security programs im-
7 posed on Federal agencies under paragraphs (1)
8 through (8) of section 3544(b) of title 44, United
9 States Code (other than the requirements under
10 paragraphs (2)(D)(i), (5)(A), and (5)(B) of such
11 section).

12 “(2) INDEPENDENT AUDITS.—

13 “(A) PERFORMANCE OF ANNUAL EVALUA-
14 TIONS.—Each year a medicare administrative
15 contractor that performs the functions referred
16 to in subparagraphs (A) and (B) of subsection
17 (a)(4) (relating to determining and making pay-
18 ments) shall undergo an evaluation of the infor-
19 mation security of the contractor with respect
20 to such functions under this title. The evalua-
21 tion shall—

22 “(i) be performed by an entity that
23 meets such requirements for independence
24 as the Inspector General of the Depart-

1 ment of Health and Human Services may
2 establish; and

3 “(ii) test the effectiveness of informa-
4 tion security control techniques of an ap-
5 propriate subset of the contractor’s infor-
6 mation systems (as defined in section
7 3502(8) of title 44, United States Code)
8 relating to such functions under this title
9 and an assessment of compliance with the
10 requirements of this subsection and related
11 information security policies, procedures,
12 standards and guidelines, including policies
13 and procedures as may be prescribed by
14 the Director of the Office of Management
15 and Budget and applicable information se-
16 curity standards promulgated under sec-
17 tion 11331 of title 40, United States Code.

18 “(B) DEADLINE FOR INITIAL EVALUA-
19 TION.—

20 “(i) NEW CONTRACTORS.—In the case
21 of a medicare administrative contractor
22 covered by this subsection that has not
23 previously performed the functions referred
24 to in subparagraphs (A) and (B) of sub-
25 section (a)(4) (relating to determining and

1 making payments) as a fiscal intermediary
2 or carrier under section 1816 or 1842, the
3 first independent evaluation conducted
4 pursuant to subparagraph (A) shall be
5 completed prior to commencing such func-
6 tions.

7 “(ii) OTHER CONTRACTORS.—In the
8 case of a medicare administrative con-
9 tractor covered by this subsection that is
10 not described in clause (i), the first inde-
11 pendent evaluation conducted pursuant to
12 subparagraph (A) shall be completed with-
13 in 1 year after the date the contractor
14 commences functions referred to in clause
15 (i) under this section.

16 “(C) REPORTS ON EVALUATIONS.—

17 “(i) TO THE DEPARTMENT OF
18 HEALTH AND HUMAN SERVICES.—The re-
19 sults of independent evaluations under sub-
20 paragraph (A) shall be submitted promptly
21 to the Inspector General of the Depart-
22 ment of Health and Human Services and
23 to the Secretary.

24 “(ii) TO CONGRESS.—The Inspector
25 General of the Department of Health and

1 Human Services shall submit to Congress
2 annual reports on the results of such eval-
3 uations, including assessments of the scope
4 and sufficiency of such evaluations.

5 “(iii) AGENCY REPORTING.—The Sec-
6 retary shall address the results of such
7 evaluations in reports required under sec-
8 tion 3544(c) of title 44, United States
9 Code.”.

10 (b) APPLICATION OF REQUIREMENTS TO FISCAL
11 INTERMEDIARIES AND CARRIERS.—

12 (1) IN GENERAL.—The provisions of section
13 1874A(e)(2) of the Social Security Act (other than
14 subparagraph (B)), as added by subsection (a), shall
15 apply to each fiscal intermediary under section 1816
16 of the Social Security Act (42 U.S.C. 1395h) and
17 each carrier under section 1842 of such Act (42
18 U.S.C. 1395u) in the same manner as they apply to
19 medicare administrative contractors under such pro-
20 visions.

21 (2) DEADLINE FOR INITIAL EVALUATION.—In
22 the case of such a fiscal intermediary or carrier with
23 an agreement or contract under such respective sec-
24 tion in effect as of the date of the enactment of this
25 Act, the first evaluation under section

1 1874A(e)(2)(A) of the Social Security Act (as added
 2 by subsection (a)), pursuant to paragraph (1), shall
 3 be completed (and a report on the evaluation sub-
 4 mitted to the Secretary) by not later than 1 year
 5 after such date.

6 **Subtitle C—Education and** 7 **Outreach**

8 **SEC. 521. PROVIDER EDUCATION AND TECHNICAL ASSIST-** 9 **ANCE.**

10 (a) COORDINATION OF EDUCATION FUNDING.—

11 (1) IN GENERAL.—Title XVIII is amended by
 12 inserting after section 1888 the following new sec-
 13 tion:

14 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE
 15 “SEC. 1889. (a) COORDINATION OF EDUCATION
 16 FUNDING.—The Secretary shall coordinate the edu-
 17 cational activities provided through medicare contractors
 18 (as defined in subsection (g), including under section
 19 1893) in order to maximize the effectiveness of Federal
 20 education efforts for providers of services and suppliers.”.

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

24 (3) REPORT.—Not later than October 1, 2004,
 25 the Secretary shall submit to Congress a report that
 26 includes a description and evaluation of the steps

1 taken to coordinate the funding of provider edu-
2 cation under section 1889(a) of the Social Security
3 Act, as added by paragraph (1).

4 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-
5 FORMANCE.—

6 (1) IN GENERAL.—Section 1874A, as added by
7 section 511(a)(1) and as amended by section 512(a),
8 is amended by adding at the end the following new
9 subsection:

10 “(f) INCENTIVES TO IMPROVE CONTRACTOR PER-
11 FORMANCE IN PROVIDER EDUCATION AND OUTREACH.—
12 The Secretary shall use specific claims payment error
13 rates or similar methodology of medicare administrative
14 contractors in the processing or reviewing of medicare
15 claims in order to give such contractors an incentive to
16 implement effective education and outreach programs for
17 providers of services and suppliers.”.

18 (2) APPLICATION TO FISCAL INTERMEDIARIES
19 AND CARRIERS.—The provisions of section 1874A(f)
20 of the Social Security Act, as added by paragraph
21 (1), shall apply to each fiscal intermediary under
22 section 1816 of the Social Security Act (42 U.S.C.
23 1395h) and each carrier under section 1842 of such
24 Act (42 U.S.C. 1395u) in the same manner as they

1 apply to medicare administrative contractors under
2 such provisions.

3 (3) GAO REPORT ON ADEQUACY OF METHOD-
4 OLOGY.—Not later than October 1, 2004, the Comp-
5 troller General of the United States shall submit to
6 Congress and to the Secretary a report on the ade-
7 quacy of the methodology under section 1874A(f) of
8 the Social Security Act, as added by paragraph (1),
9 and shall include in the report such recommenda-
10 tions as the Comptroller General determines appro-
11 priate with respect to the methodology.

12 (4) REPORT ON USE OF METHODOLOGY IN AS-
13 SESSING CONTRACTOR PERFORMANCE.—Not later
14 than October 1, 2004, the Secretary shall submit to
15 Congress a report that describes how the Secretary
16 intends to use such methodology in assessing medi-
17 care contractor performance in implementing effec-
18 tive education and outreach programs, including
19 whether to use such methodology as a basis for per-
20 formance bonuses. The report shall include an anal-
21 ysis of the sources of identified errors and potential
22 changes in systems of contractors and rules of the
23 Secretary that could reduce claims error rates.

1 (c) PROVISION OF ACCESS TO AND PROMPT RE-
2 SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-
3 TORS.—

4 (1) IN GENERAL.—Section 1874A, as added by
5 section 511(a)(1) and as amended by section 512(a)
6 and subsection (b), is further amended by adding at
7 the end the following new subsection:

8 “(g) COMMUNICATIONS WITH BENEFICIARIES, PRO-
9 VIDERS OF SERVICES AND SUPPLIERS.—

10 “(1) COMMUNICATION STRATEGY.—The Sec-
11 retary shall develop a strategy for communications
12 with individuals entitled to benefits under part A or
13 enrolled under part B, or both, and with providers
14 of services and suppliers under this title.

15 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each
16 medicare administrative contractor shall, for those
17 providers of services and suppliers which submit
18 claims to the contractor for claims processing and
19 for those individuals entitled to benefits under part
20 A or enrolled under part B, or both, with respect to
21 whom claims are submitted for claims processing,
22 provide general written responses (which may be
23 through electronic transmission) in a clear, concise,
24 and accurate manner to inquiries of providers of
25 services, suppliers, and individuals entitled to bene-

1 fits under part A or enrolled under part B, or both,
2 concerning the programs under this title within 45
3 business days of the date of receipt of such inquiries.

4 “(3) RESPONSE TO TOLL-FREE LINES.—The
5 Secretary shall ensure that each medicare adminis-
6 trative contractor shall provide, for those providers
7 of services and suppliers which submit claims to the
8 contractor for claims processing and for those indi-
9 viduals entitled to benefits under part A or enrolled
10 under part B, or both, with respect to whom claims
11 are submitted for claims processing, a toll-free tele-
12 phone number at which such individuals, providers
13 of services, and suppliers may obtain information re-
14 garding billing, coding, claims, coverage, and other
15 appropriate information under this title.

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

18 “(A) IN GENERAL.—Each medicare admin-
19 istrative contractor shall, consistent with stand-
20 ards developed by the Secretary under subpara-
21 graph (B)—

22 “(i) maintain a system for identifying
23 who provides the information referred to in
24 paragraphs (2) and (3); and

1 “(ii) monitor the accuracy, consist-
2 ency, and timeliness of the information so
3 provided.

4 “(B) DEVELOPMENT OF STANDARDS.—

5 “(i) IN GENERAL.—The Secretary
6 shall establish and make public standards
7 to monitor the accuracy, consistency, and
8 timeliness of the information provided in
9 response to written and telephone inquiries
10 under this subsection. Such standards shall
11 be consistent with the performance require-
12 ments established under subsection (b)(3).

13 “(ii) EVALUATION.—In conducting
14 evaluations of individual medicare adminis-
15 trative contractors, the Secretary shall
16 take into account the results of the moni-
17 toring conducted under subparagraph (A)
18 taking into account as performance re-
19 quirements the standards established
20 under clause (i). The Secretary shall, in
21 consultation with organizations rep-
22 resenting providers of services, suppliers,
23 and individuals entitled to benefits under
24 part A or enrolled under part B, or both,
25 establish standards relating to the accu-

1 racy, consistency, and timeliness of the in-
2 formation so provided.

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

8 “(5) AUTHORIZATION OF APPROPRIATIONS.—
9 There are authorized to be appropriated such sums
10 as are necessary to carry out this subsection.”.

11 (2) EFFECTIVE DATE.—The amendment made
12 by paragraph (1) shall take effect October 1, 2004.

13 (3) APPLICATION TO FISCAL INTERMEDIARIES
14 AND CARRIERS.—The provisions of section 1874A(g)
15 of the Social Security Act, as added by paragraph
16 (1), shall apply to each fiscal intermediary under
17 section 1816 of the Social Security Act (42 U.S.C.
18 1395h) and each carrier under section 1842 of such
19 Act (42 U.S.C. 1395u) in the same manner as they
20 apply to medicare administrative contractors under
21 such provisions.

22 (d) IMPROVED PROVIDER EDUCATION AND TRAIN-
23 ING.—

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

4 “(b) ENHANCED EDUCATION AND TRAINING.—

5 “(1) ADDITIONAL RESOURCES.—There are au-
6 thorized to be appropriated to the Secretary (in ap-
7 propriate part from the Federal Hospital Insurance
8 Trust Fund and the Federal Supplementary Medical
9 Insurance Trust Fund) such sums as may be nec-
10 essary for fiscal years beginning with fiscal year
11 2005.

12 “(2) USE.—The funds made available under
13 paragraph (1) shall be used to increase the conduct
14 by medicare contractors of education and training of
15 providers of services and suppliers regarding billing,
16 coding, and other appropriate items and may also be
17 used to improve the accuracy, consistency, and time-
18 liness of contractor responses.

19 “(c) TAILORING EDUCATION AND TRAINING ACTIVI-
20 TIES FOR SMALL PROVIDERS OR SUPPLIERS.—

21 “(1) IN GENERAL.—Insofar as a medicare con-
22 tractor conducts education and training activities, it
23 shall tailor such activities to meet the special needs
24 of small providers of services or suppliers (as defined
25 in paragraph (2)). Such education and training ac-

1 activities for small providers of services and suppliers
2 may include the provision of technical assistance
3 (such as review of billing systems and internal con-
4 trols to determine program compliance and to sug-
5 gest more efficient and effective means of achieving
6 such compliance).

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

10 “(A) a provider of services with fewer than
11 25 full-time-equivalent employees; or

12 “(B) a supplier with fewer than 10 full-
13 time-equivalent employees.”.

14 (2) EFFECTIVE DATE.—The amendment made
15 by paragraph (1) shall take effect on October 1,
16 2004.

17 (e) REQUIREMENT TO MAINTAIN INTERNET
18 WEBSITES.—

19 (1) IN GENERAL.—Section 1889, as added by
20 subsection (a) and as amended by subsection (d), is
21 further amended by adding at the end the following
22 new subsection:

23 “(d) INTERNET WEBSITES; FAQs.—The Secretary,
24 and each medicare contractor insofar as it provides serv-

1 ices (including claims processing) for providers of services
2 or suppliers, shall maintain an Internet website which—

3 “(1) provides answers in an easily accessible
4 format to frequently asked questions, and

5 “(2) includes other published materials of the
6 contractor,

7 that relate to providers of services and suppliers under the
8 programs under this title (and title XI insofar as it relates
9 to such programs).”.

10 (2) EFFECTIVE DATE.—The amendment made
11 by paragraph (1) shall take effect on October 1,
12 2004.

13 (f) ADDITIONAL PROVIDER EDUCATION PROVI-
14 SIONS.—

15 (1) IN GENERAL.—Section 1889, as added by
16 subsection (a) and as amended by subsections (d)
17 and (e), is further amended by adding at the end the
18 following new subsections:

19 “(e) ENCOURAGEMENT OF PARTICIPATION IN EDU-
20 CATION PROGRAM ACTIVITIES.—A medicare contractor
21 may not use a record of attendance at (or failure to at-
22 tend) educational activities or other information gathered
23 during an educational program conducted under this sec-
24 tion or otherwise by the Secretary to select or track pro-

1 viders of services or suppliers for the purpose of con-
2 ducting any type of audit or prepayment review.

3 “(f) CONSTRUCTION.—Nothing in this section or sec-
4 tion 1893(g) shall be construed as providing for disclosure
5 by a medicare contractor—

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

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

11 “(g) DEFINITIONS.—For purposes of this section, the
12 term ‘medicare contractor’ includes the following:

13 “(1) A medicare administrative contractor with
14 a contract under section 1874A, including a fiscal
15 intermediary with a contract under section 1816 and
16 a carrier with a contract under section 1842.

17 “(2) An eligible entity with a contract under
18 section 1893.

19 Such term does not include, with respect to activities of
20 a specific provider of services or supplier an entity that
21 has no authority under this title or title IX with respect
22 to such activities and such provider of services or sup-
23 plier.”.

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

4 **SEC. 522. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**
5 **ONSTRATION PROGRAM.**

6 (a) ESTABLISHMENT.—

7 (1) IN GENERAL.—The Secretary shall establish
8 a demonstration program (in this section referred to
9 as the “demonstration program”) under which tech-
10 nical assistance described in paragraph (2) is made
11 available, upon request and on a voluntary basis, to
12 small providers of services or suppliers in order to
13 improve compliance with the applicable requirements
14 of the programs under the medicare program under
15 title XVIII of the Social Security Act (including pro-
16 visions of title XI of such Act insofar as they relate
17 to such title and are not administered by the Office
18 of the Inspector General of the Department of
19 Health and Human Services).

20 (2) FORMS OF TECHNICAL ASSISTANCE.—The
21 technical assistance described in this paragraph is—

22 (A) evaluation and recommendations re-
23 garding billing and related systems; and

1 (B) information and assistance regarding
2 policies and procedures under the medicare pro-
3 gram, including coding and reimbursement.

4 (3) SMALL PROVIDERS OF SERVICES OR SUP-
5 PLIERS.—In this section, the term “small providers
6 of services or suppliers” means—

7 (A) a provider of services with fewer than
8 25 full-time-equivalent employees; or

9 (B) a supplier with fewer than 10 full-
10 time-equivalent employees.

11 (b) QUALIFICATION OF CONTRACTORS.—In con-
12 ducting the demonstration program, the Secretary shall
13 enter into contracts with qualified organizations (such as
14 peer review organizations or entities described in section
15 1889(g)(2) of the Social Security Act, as inserted by sec-
16 tion 521(f)(1)) with appropriate expertise with billing sys-
17 tems of the full range of providers of services and sup-
18 pliers to provide the technical assistance. In awarding such
19 contracts, the Secretary shall consider any prior investiga-
20 tions of the entity’s work by the Inspector General of the
21 Department of Health and Human Services or the Comp-
22 troller General of the United States.

23 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The
24 technical assistance provided under the demonstration
25 program shall include a direct and in-person examination

1 of billing systems and internal controls of small providers
2 of services or suppliers to determine program compliance
3 and to suggest more efficient or effective means of achiev-
4 ing such compliance.

5 (d) GAO EVALUATION.—Not later than 2 years after
6 the date the demonstration program is first implemented,
7 the Comptroller General, in consultation with the Inspec-
8 tor General of the Department of Health and Human
9 Services, shall conduct an evaluation of the demonstration
10 program. The evaluation shall include a determination of
11 whether claims error rates are reduced for small providers
12 of services or suppliers who participated in the program
13 and the extent of improper payments made as a result
14 of the demonstration program. The Comptroller General
15 shall submit a report to the Secretary and the Congress
16 on such evaluation and shall include in such report rec-
17 ommendations regarding the continuation or extension of
18 the demonstration program.

19 (e) FINANCIAL PARTICIPATION BY PROVIDERS.—The
20 provision of technical assistance to a small provider of
21 services or supplier under the demonstration program is
22 conditioned upon the small provider of services or supplier
23 paying an amount estimated (and disclosed in advance of
24 a provider's or supplier's participation in the program) to

1 be equal to 25 percent of the cost of the technical assist-
2 ance.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated, from amounts not oth-
5 erwise appropriated in the Treasury, such sums as may
6 be necessary to carry out this section.

7 **SEC. 523. MEDICARE BENEFICIARY OMBUDSMAN.**

8 (a) IN GENERAL.—Section 1808, as added and
9 amended by section 500, is amended by adding at the end
10 the following new subsection:

11 “(c) MEDICARE BENEFICIARY OMBUDSMAN.—

12 “(1) IN GENERAL.—The Secretary shall appoint
13 within the Department of Health and Human Serv-
14 ices a Medicare Beneficiary Ombudsman who shall
15 have expertise and experience in the fields of health
16 care and education of (and assistance to) individuals
17 entitled to benefits under this title.

18 “(2) DUTIES.—The Medicare Beneficiary Om-
19 budsman shall—

20 “(A) receive complaints, grievances, and
21 requests for information submitted by individ-
22 uals entitled to benefits under part A or en-
23 rolled under part B, or both, with respect to
24 any aspect of the medicare program;

1 “(B) provide assistance with respect to
2 complaints, grievances, and requests referred to
3 in subparagraph (A), including—

4 “(i) assistance in collecting relevant
5 information for such individuals, to seek
6 an appeal of a decision or determination
7 made by a fiscal intermediary, carrier, MA
8 organization, or the Secretary;

9 “(ii) assistance to such individuals
10 with any problems arising from
11 disenrollment from an MA plan under part
12 C; and

13 “(iii) assistance to such individuals in
14 presenting information under section
15 1839(i)(4)(C) (relating to income-related
16 premium adjustment); and

17 “(C) submit annual reports to Congress
18 and the Secretary that describe the activities of
19 the Office and that include such recommenda-
20 tions for improvement in the administration of
21 this title as the Ombudsman determines appro-
22 priate.

23 The Ombudsman shall not serve as an advocate for
24 any increases in payments or new coverage of serv-

1 ices, but may identify issues and problems in pay-
2 ment or coverage policies.

3 “(3) WORKING WITH HEALTH INSURANCE
4 COUNSELING PROGRAMS.—To the extent possible,
5 the Ombudsman shall work with health insurance
6 counseling programs (receiving funding under sec-
7 tion 4360 of the Omnibus Budget Reconciliation Act
8 of 1990) to facilitate the provision of information to
9 individuals entitled to benefits under part A or en-
10 rolled under part B, or both regarding MA plans
11 and changes to those plans. Nothing in this para-
12 graph shall preclude further collaboration between
13 the Ombudsman and such programs.”.

14 (b) DEADLINE FOR APPOINTMENT.—By not later
15 than 1 year after the date of the enactment of this Act,
16 the Secretary shall appoint the Medicare Beneficiary Om-
17 budsman under section 1808(c) of the Social Security Act,
18 as added by subsection (a).

19 (c) FUNDING.—There are authorized to be appro-
20 priated to the Secretary (in appropriate part from the
21 Federal Hospital Insurance Trust Fund, established
22 under section 1817 of the Social Security Act (42 U.S.C.
23 1395i), and the Federal Supplementary Medical Insurance
24 Trust Fund, established under section 1841 of such Act
25 (42 U.S.C. 1395t)) to carry out section 1808(c) of such

1 Act (relating to the Medicare Beneficiary Ombudsman),
2 as added by subsection (a), such sums as are necessary
3 for fiscal year 2004 and each succeeding fiscal year.

4 (d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-
5 MEDICARE).—

6 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDI-
7 CARE HANDBOOK INSTEAD OF OTHER TOLL-FREE
8 NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-
9 2(b)) is amended by adding at the end the following:
10 “The Secretary shall provide, through the toll-free
11 telephone number 1-800-MEDICARE, for a means
12 by which individuals seeking information about, or
13 assistance with, such programs who phone such toll-
14 free number are transferred (without charge) to ap-
15 propriate entities for the provision of such informa-
16 tion or assistance. Such toll-free number shall be the
17 toll-free number listed for general information and
18 assistance in the annual notice under subsection (a)
19 instead of the listing of numbers of individual con-
20 tractors.”.

21 (2) MONITORING ACCURACY.—

22 (A) STUDY.—The Comptroller General of
23 the United States shall conduct a study to mon-
24 itor the accuracy and consistency of information
25 provided to individuals entitled to benefits

1 under part A or enrolled under part B, or both,
2 through the toll-free telephone number 1-800-
3 MEDICARE, including an assessment of
4 whether the information provided is sufficient
5 to answer questions of such individuals. In con-
6 ducting the study, the Comptroller General
7 shall examine the education and training of the
8 individuals providing information through such
9 number.

10 (B) REPORT.—Not later than 1 year after
11 the date of the enactment of this Act, the
12 Comptroller General shall submit to Congress a
13 report on the study conducted under subpara-
14 graph (A).

15 **SEC. 524. BENEFICIARY OUTREACH DEMONSTRATION PRO-**
16 **GRAM.**

17 (a) IN GENERAL.—The Secretary shall establish a
18 demonstration program (in this section referred to as the
19 “demonstration program”) under which medicare special-
20 ists employed by the Department of Health and Human
21 Services provide advice and assistance to individuals enti-
22 tled to benefits under part A of title XVIII of the Social
23 Security Act, or enrolled under part B of such title, or
24 both, regarding the medicare program at the location of
25 existing local offices of the Social Security Administration.

1 (b) LOCATIONS.—

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

8 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—

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

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

17 (d) EVALUATION AND REPORT.—

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

21 (A) utilization of, and satisfaction of those
22 individuals referred to in subsection (a) with,
23 the assistance provided under the program; and

24 (B) the cost-effectiveness of providing ben-
25 eficiary assistance through out-stationing medi-

1 care specialists at local offices of the Social Se-
2 curity Administration.

3 (2) REPORT.—The Secretary shall submit to
4 Congress a report on such evaluation and shall in-
5 clude in such report recommendations regarding the
6 feasibility of permanently out-stationing medicare
7 specialists at local offices of the Social Security Ad-
8 ministration.

9 **SEC. 525. INCLUSION OF ADDITIONAL INFORMATION IN NO-**
10 **TICES TO BENEFICIARIES ABOUT SKILLED**
11 **NURSING FACILITY BENEFITS.**

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

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

1 **SEC. 526. INFORMATION ON MEDICARE-CERTIFIED**
2 **SKILLED NURSING FACILITIES IN HOSPITAL**
3 **DISCHARGE PLANS.**

4 (a) AVAILABILITY OF DATA.—The Secretary shall
5 publicly provide information that enables hospital dis-
6 charge planners, medicare beneficiaries, and the public to
7 identify skilled nursing facilities that are participating in
8 the medicare program.

9 (b) INCLUSION OF INFORMATION IN CERTAIN HOS-
10 PITAL DISCHARGE PLANS.—

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

13 (A) by striking “hospice services” and in-
14 serting “hospice care and post-hospital ex-
15 tended care services”; and

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

23 (2) EFFECTIVE DATE.—The amendments made
24 by paragraph (1) shall apply to discharge plans
25 made on or after such date as the Secretary shall
26 specify, but not later than 6 months after the date

1 the Secretary provides for availability of information
2 under subsection (a).

3 **Subtitle D—Appeals and Recovery**

4 **SEC. 531. TRANSFER OF RESPONSIBILITY FOR MEDICARE**

5 **APPEALS.**

6 (a) TRANSITION PLAN.—

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

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

20 (A) WORKLOAD.—The number of such ad-
21 ministrative law judges and support staff re-
22 quired now and in the future to hear and decide
23 such cases in a timely manner, taking into ac-
24 count the current and anticipated claims vol-

1 ume, appeals, number of beneficiaries, and stat-
2 utory changes.

3 (B) COST PROJECTIONS AND FINANC-
4 ING.—Funding levels required for fiscal year
5 2005 and subsequent fiscal years to carry out
6 the functions transferred under the plan.

7 (C) TRANSITION TIMETABLE.—A timetable
8 for the transition.

9 (D) REGULATIONS.—The establishment of
10 specific regulations to govern the appeals proc-
11 ess.

12 (E) CASE TRACKING.—The development of
13 a unified case tracking system that will facili-
14 tate the maintenance and transfer of case spe-
15 cific data across both the fee-for-service and
16 managed care components of the medicare pro-
17 gram.

18 (F) FEASIBILITY OF PRECEDENTIAL AU-
19 THORITY.—The feasibility of developing a proc-
20 ess to give decisions of the Departmental Ap-
21 peals Board in the Department of Health and
22 Human Services addressing broad legal issues
23 binding, precedential authority.

24 (G) ACCESS TO ADMINISTRATIVE LAW
25 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 ADMINISTRATIVE
6 LAW JUDGES.—The steps that should be taken
7 to ensure the independence of administrative
8 law judges consistent with the requirements of
9 subsection (b)(2).

10 (I) GEOGRAPHIC DISTRIBUTION.—The
11 steps that should be taken to provide for an ap-
12 propriate geographic distribution of administra-
13 tive law judges throughout the United States to
14 carry out subsection (b)(3).

15 (J) HIRING.—The steps that should be
16 taken to hire administrative law judges (and
17 support staff) to carry out subsection (b)(4).

18 (K) PERFORMANCE STANDARDS.—The ap-
19 propriateness of establishing performance
20 standards for administrative law judges with re-
21 spect to timelines for decisions in cases under
22 title XVIII of the Social Security Act taking
23 into account requirements under subsection
24 (b)(2) for the independence of such judges and

1 consistent with the applicable provisions of title
2 5, United States Code relating to impartiality.

3 (L) SHARED RESOURCES.—The steps that
4 should be taken to carry out subsection (b)(6)
5 (relating to the arrangements with the Commis-
6 sioner of Social Security to share office space,
7 support staff, and other resources, with appro-
8 priate reimbursement).

9 (M) TRAINING.—The training that should
10 be provided to administrative law judges with
11 respect to laws and regulations under title
12 XVIII of the Social Security Act.

13 (3) ADDITIONAL INFORMATION.—The plan may
14 also include recommendations for further congres-
15 sional action, including modifications to the require-
16 ments and deadlines established under section 1869
17 of the Social Security Act (42 U.S.C. 1395ff) (as
18 amended by this Act).

19 (4) GAO EVALUATION.—The Comptroller Gen-
20 eral of the United States shall evaluate the plan
21 and, not later than the date that is 6 months after
22 the date on which the plan is received by the Comp-
23 troller General, shall submit to Congress a report on
24 such evaluation.

25 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

1 (1) IN GENERAL.—Not earlier than July 1,
2 2005, and not later than October 1, 2005, the Com-
3 missioner of Social Security and the Secretary shall
4 implement the transition plan under subsection (a)
5 and transfer the administrative law judge functions
6 described in such subsection from the Social Secu-
7 rity Administration to the Secretary.

8 (2) ASSURING INDEPENDENCE OF JUDGES.—
9 The Secretary shall assure the independence of ad-
10 ministrative law judges performing the administra-
11 tive law judge functions transferred under para-
12 graph (1) from the Centers for Medicare & Medicaid
13 Services and its contractors. In order to assure such
14 independence, the Secretary shall place such judges
15 in an administrative office that is organizationally
16 and functionally separate from such Centers. Such
17 judges shall report to, and be under the general su-
18 pervision of, the Secretary, but shall not report to,
19 or be subject to supervision by, another officer of the
20 Department of Health and Human Services.

21 (3) GEOGRAPHIC DISTRIBUTION.—The Sec-
22 retary shall provide for an appropriate geographic
23 distribution of administrative law judges performing
24 the administrative law judge functions transferred

1 under paragraph (1) throughout the United States
2 to ensure timely access to such judges.

3 (4) **HIRING AUTHORITY.**—Subject to the
4 amounts provided in advance in appropriations Acts,
5 the Secretary shall have authority to hire adminis-
6 trative law judges to hear such cases, taking into
7 consideration those judges with expertise in handling
8 medicare appeals and in a manner consistent with
9 paragraph (3), and to hire support staff for such
10 judges.

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

19 (6) **SHARED RESOURCES.**—The Secretary shall
20 enter into such arrangements with the Commissioner
21 as may be appropriate with respect to transferred
22 functions of administrative law judges to share office
23 space, support staff, and other resources, with ap-
24 propriate reimbursement from the Trust Funds de-
25 scribed in paragraph (5).

1 (c) INCREASED FINANCIAL SUPPORT.—In addition to
2 any amounts otherwise appropriated, to ensure timely ac-
3 tion on appeals before administrative law judges and the
4 Departmental Appeals Board consistent with section 1869
5 of the Social Security Act (42 U.S.C. 1395ff) (as amended
6 by this Act), there are authorized to be appropriated (in
7 appropriate part from the Federal Hospital Insurance
8 Trust Fund, established under section 1817 of the Social
9 Security Act (42 U.S.C. 1395i), and the Federal Supple-
10 mentary Medical Insurance Trust Fund, established under
11 section 1841 of such Act (42 U.S.C. 1395t)) to the Sec-
12 retary such sums as are necessary for fiscal year 2005
13 and each subsequent fiscal year to—

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

16 (2) improve education and training opportuni-
17 ties for administrative law judges (and their staffs);
18 and

19 (3) increase the staff of the Departmental Ap-
20 peals Board.

21 (d) CONFORMING AMENDMENT.—Section
22 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amend-
23 ed by striking “of the Social Security Administration”.

24 **SEC. 532. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

25 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

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

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

6 (B) by adding at the end the following new
7 paragraph:

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

10 “(A) IN GENERAL.—The Secretary shall
11 establish a process under which a provider of
12 services or supplier that furnishes an item or
13 service or an individual entitled to benefits
14 under part A or enrolled under part B, or both,
15 who has filed an appeal under paragraph (1)
16 (other than an appeal filed under paragraph
17 (1)(F)(i)) may obtain access to judicial review
18 when a review entity (described in subpara-
19 graph (D)), on its own motion or at the request
20 of the appellant, determines that the Depart-
21 mental Appeals Board does not have the au-
22 thority to decide the question of law or regula-
23 tion relevant to the matters in controversy and
24 that there is no material issue of fact in dis-
25 pute. The appellant may make such request

1 only once with respect to a question of law or
2 regulation for a specific matter in dispute in a
3 case of an appeal.

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

23 “(C) ACCESS TO JUDICIAL REVIEW.—

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

1 “(I) determines that there are no
2 material issues of fact in dispute and
3 that the only issues to be adjudicated
4 are ones of law or regulation that the
5 Departmental Appeals Board does not
6 have authority to decide; or

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

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

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

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

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

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

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

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

1 “(D) REVIEW ENTITY DEFINED.—For pur-
2 poses of this subsection, the term ‘review entity’
3 means an entity of up to three reviewers who
4 are administrative law judges or members of
5 the Departmental Appeals Board selected for
6 purposes of making determinations under this
7 paragraph.”.

8 (2) CONFORMING AMENDMENT.—Section
9 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is
10 amended to read as follows:

11 “(ii) REFERENCE TO EXPEDITED AC-
12 CESS TO JUDICIAL REVIEW.—For the pro-
13 vision relating to expedited access to judi-
14 cial review, see paragraph (2).”.

15 (b) APPLICATION TO PROVIDER AGREEMENT DETER-
16 MINATIONS.—Section 1866(h)(1) (42 U.S.C.
17 1395cc(h)(1)) is amended—

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

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

21 “(B) An institution or agency described in subpara-
22 graph (A) that has filed for a hearing under subparagraph
23 (A) shall have expedited access to judicial review under
24 this subparagraph in the same manner as providers of
25 services, suppliers, and individuals entitled to benefits

1 under part A or enrolled under part B, or both, may ob-
2 tain expedited access to judicial review under the process
3 established under section 1869(b)(2). Nothing in this sub-
4 paragraph shall be construed to affect the application of
5 any remedy imposed under section 1819 during the pend-
6 ency of an appeal under this subparagraph.”.

7 (c) EXPEDITED REVIEW OF CERTAIN PROVIDER
8 AGREEMENT DETERMINATIONS.—

9 (1) TERMINATION AND CERTAIN OTHER IMME-
10 DIATE REMEDIES.—Section 1866(h)(1) (42 U.S.C.
11 1395cc(h)(1)), as amended by subsection (b), is
12 amended by adding at the end the following new
13 subparagraph:

14 “(C)(i) The Secretary shall develop and implement a
15 process to expedite proceedings under this subsection in
16 which—

17 “(I) the remedy of termination of participation
18 has been imposed;

19 “(II) a remedy described in clause (i) or (iii) of
20 section 1819(h)(2)(B) has been imposed, but only if
21 such remedy has been imposed on an immediate
22 basis; or

23 “(III) a determination has been made as to a
24 finding of substandard quality of care that results in

1 the loss of approval of a skilled nursing facility's
2 nurse aide training program.

3 “(ii) Under such process under clause (i), priority
4 shall be provided in cases of termination described in
5 clause (i)(I).

6 “(iii) Nothing in this subparagraph shall be con-
7 strued to affect the application of any remedy imposed
8 under section 1819 during the pendency of an appeal
9 under this subparagraph.”.

10 (2) WAIVER OF DISAPPROVAL OF NURSE-AIDE
11 TRAINING PROGRAMS.—Sections 1819(f)(2) and sec-
12 tion 1919(f)(2) (42 U.S.C. 1395i-3(f)(2) and
13 1396r(f)(2)) are each amended—

14 (A) in subparagraph (B)(iii), by striking
15 “subparagraph (C)” and inserting “subpara-
16 graphs (C) and (D)”; and

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

19 “(D) WAIVER OF DISAPPROVAL OF NURSE-
20 AIDE TRAINING PROGRAMS.—Upon application
21 of a nursing facility, the Secretary may waive
22 the application of subparagraph (B)(iii)(I)(c) if
23 the imposition of the civil monetary penalty was
24 not related to the quality of care provided to
25 residents of the facility. Nothing in this sub-

1 paragraph shall be construed as eliminating any
2 requirement upon a facility to pay a civil mone-
3 tary penalty described in the preceding sen-
4 tence.”.

5 (3) INCREASED FINANCIAL SUPPORT.—In addi-
6 tion to any amounts otherwise appropriated, to re-
7 duce by 50 percent the average time for administra-
8 tive determinations on appeals under section
9 1866(h) of the Social Security Act (42 U.S.C.
10 1395cc(h)), there are authorized to be appropriated
11 (in appropriate part from the Federal Hospital In-
12 surance Trust Fund, established under section 1817
13 of the Social Security Act (42 U.S.C. 1395i), and
14 the Federal Supplementary Medical Insurance Trust
15 Fund, established under section 1841 of such Act
16 (42 U.S.C. 1395t)) to the Secretary such additional
17 sums for fiscal year 2004 and each subsequent fiscal
18 year as may be necessary. The purposes for which
19 such amounts are available include increasing the
20 number of administrative law judges (and their
21 staffs) and the appellate level staff at the Depart-
22 mental Appeals Board of the Department of Health
23 and Human Services and educating such judges and
24 staffs on long-term care issues.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to appeals filed on or after October
3 1, 2004.

4 **SEC. 533. REVISIONS TO MEDICARE APPEALS PROCESS.**

5 (a) REQUIRING FULL AND EARLY PRESENTATION OF
6 EVIDENCE.—

7 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
8 1395ff(b)), as amended by section 532(a), is further
9 amended by adding at the end the following new
10 paragraph:

11 “(3) REQUIRING FULL AND EARLY PRESEN-
12 TATION OF EVIDENCE BY PROVIDERS.—A provider
13 of services or supplier may not introduce evidence in
14 any appeal under this section that was not presented
15 at the reconsideration conducted by the qualified
16 independent contractor under subsection (c), unless
17 there is good cause which precluded the introduction
18 of such evidence at or before that reconsideration.”.

19 (2) EFFECTIVE DATE.—The amendment made
20 by paragraph (1) shall take effect on October 1,
21 2004.

22 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section
23 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amend-
24 ed by inserting “(including the medical records of the indi-
25 vidual involved)” after “clinical experience”.

1 (c) NOTICE REQUIREMENTS FOR MEDICARE AP-
2 PEALS.—

3 (1) INITIAL DETERMINATIONS AND REDETER-
4 MINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a))
5 is amended by adding at the end the following new
6 paragraphs:

7 “(4) REQUIREMENTS OF NOTICE OF DETER-
8 MINATIONS.—With respect to an initial determina-
9 tion insofar as it results in a denial of a claim for
10 benefits—

11 “(A) the written notice on the determina-
12 tion shall include—

13 “(i) the reasons for the determination,
14 including whether a local medical review
15 policy or a local coverage determination
16 was used;

17 “(ii) the procedures for obtaining ad-
18 ditional information concerning the deter-
19 mination, including the information de-
20 scribed in subparagraph (B); and

21 “(iii) notification of the right to seek
22 a redetermination or otherwise appeal the
23 determination and instructions on how to
24 initiate such a redetermination under this
25 section;

1 “(B) such written notice shall be provided
2 in printed form and written in a manner cal-
3 culated to be understood by the individual enti-
4 tled to benefits under part A or enrolled under
5 part B, or both; and

6 “(C) the individual provided such written
7 notice may obtain, upon request, information on
8 the specific provision of the policy, manual, or
9 regulation used in making the redetermination.

10 “(5) REQUIREMENTS OF NOTICE OF REDETER-
11 MINATIONS.—With respect to a redetermination in-
12 sofar as it results in a denial of a claim for bene-
13 fits—

14 “(A) the written notice on the redeter-
15 mination shall include—

16 “(i) the specific reasons for the rede-
17 termination;

18 “(ii) as appropriate, a summary of the
19 clinical or scientific evidence used in mak-
20 ing the redetermination;

21 “(iii) a description of the procedures
22 for obtaining additional information con-
23 cerning the redetermination; and

24 “(iv) notification of the right to ap-
25 peal the redetermination and instructions

1 on how to initiate such an appeal under
2 this section;

3 “(B) such written notice shall be provided
4 in printed form and written in a manner cal-
5 culated to be understood by the individual enti-
6 tled to benefits under part A or enrolled under
7 part B, or both; and

8 “(C) the individual provided such written
9 notice may obtain, upon request, information on
10 the specific provision of the policy, manual, or
11 regulation used in making the redetermina-
12 tion.”.

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

16 (A) by inserting “be written in a manner
17 calculated to be understood by the individual
18 entitled to benefits under part A or enrolled
19 under part B, or both, and shall include (to the
20 extent appropriate)” after “in writing,”; and

21 (B) by inserting “and a notification of the
22 right to appeal such determination and instruc-
23 tions on how to initiate such appeal under this
24 section” after “such decision,”.

1 (3) APPEALS.—Section 1869(d) (42 U.S.C.
2 1395ff(d)) is amended—

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

5 (B) by adding at the end the following new
6 paragraph:

7 “(4) NOTICE.—Notice of the decision of an ad-
8 ministrative law judge shall be in writing in a man-
9 ner calculated to be understood by the individual en-
10 titled to benefits under part A or enrolled under part
11 B, or both, and shall include—

12 “(A) the specific reasons for the deter-
13 mination (including, to the extent appropriate,
14 a summary of the clinical or scientific evidence
15 used in making the determination);

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

18 “(C) notification of the right to appeal the
19 decision and instructions on how to initiate
20 such an appeal under this section.”.

21 (4) SUBMISSION OF RECORD FOR APPEAL.—
22 Section 1869(c)(3)(J)(i) (42 U.S.C.
23 1395ff(c)(3)(J)(i)) is amended by striking “prepare”
24 and inserting “submit” and by striking “with re-

1 spect to” and all that follows through “and relevant
2 policies”.

3 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

4 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED
5 INDEPENDENT CONTRACTORS.—Section 1869(c)(3)
6 (42 U.S.C. 1395ff(c)(3)) is amended—

7 (A) in subparagraph (A), by striking “suf-
8 ficient training and expertise in medical science
9 and legal matters” and inserting “sufficient
10 medical, legal, and other expertise (including
11 knowledge of the program under this title) and
12 sufficient staffing”; and

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

15 “(K) INDEPENDENCE REQUIREMENTS.—

16 “(i) IN GENERAL.—Subject to clause
17 (ii), a qualified independent contractor
18 shall not conduct any activities in a case
19 unless the entity—

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

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

1 “(III) does not otherwise have a
2 conflict of interest with such a party.

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

18 (2) ELIGIBILITY REQUIREMENTS FOR REVIEW-
19 ERS.—Section 1869 (42 U.S.C. 1395ff) is amend-
20 ed—

21 (A) by amending subsection (c)(3)(D) to
22 read as follows:

23 “(D) QUALIFICATIONS FOR REVIEWERS.—
24 The requirements of subsection (g) shall be met

1 (relating to qualifications of reviewing profes-
2 sionals).”; and

3 (B) by adding at the end the following new
4 subsection:

5 “(g) QUALIFICATIONS OF REVIEWERS.—

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

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

11 “(B) compensation provided by the con-
12 tractor to each such reviewer is consistent with
13 paragraph (3); and

14 “(C) in the case of a review by a panel de-
15 scribed in subsection (c)(3)(B) composed of
16 physicians or other health care professionals
17 (each in this subsection referred to as a ‘review-
18 ing professional’), a reviewing professional
19 meets the qualifications described in paragraph
20 (4) and, where a claim is regarding the fur-
21 nishing of treatment by a physician (allopathic
22 or osteopathic) or the provision of items or
23 services by a physician (allopathic or osteo-
24 pathic), a reviewing professional shall be a phy-
25 sician (allopathic or osteopathic).

1 “(2) INDEPENDENCE.—

2 “(A) IN GENERAL.—Subject to subpara-
3 graph (B), each individual conducting a review
4 in a case shall—

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

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

10 “(iii) not otherwise have a conflict of
11 interest with such a party.

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

14 “(i) prohibit an individual, solely on
15 the basis of a participation agreement with
16 a fiscal intermediary, carrier, or other con-
17 tractor, from serving as a reviewing profes-
18 sional if—

19 “(I) the individual is not involved
20 in the provision of items or services in
21 the case under review;

22 “(II) the fact of such an agree-
23 ment is disclosed to the Secretary and
24 the individual entitled to benefits
25 under part A or enrolled under part

1 B, or both, or such individual's au-
2 thORIZED representative, and neither
3 party objects; and

4 “(III) the individual is not an
5 employee of the intermediary, carrier,
6 or contractor and does not provide
7 services exclusively or primarily to or
8 on behalf of such intermediary, car-
9 rier, or contractor;

10 “(ii) prohibit an individual who has
11 staff privileges at the institution where the
12 treatment involved takes place from serv-
13 ing as a reviewer merely on the basis of
14 having such staff privileges if the existence
15 of such privileges is disclosed to the Sec-
16 retary and such individual (or authorized
17 representative), and neither party objects;
18 or

19 “(iii) prohibit receipt of compensation
20 by a reviewing professional from a con-
21 tractor if the compensation is provided
22 consistent with paragraph (3).

23 For purposes of this paragraph, the term ‘par-
24 ticipation agreement’ means an agreement re-
25 lating to the provision of health care services by

1 the individual and does not include the provi-
2 sion of services as a reviewer under this sub-
3 section.

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

9 “(4) LICENSURE AND EXPERTISE.—Each re-
10 viewing professional shall be—

11 “(A) a physician (allopathic or osteopathic)
12 who is appropriately credentialed or licensed in
13 one or more States to deliver health care serv-
14 ices and has medical expertise in the field of
15 practice that is appropriate for the items or
16 services at issue; or

17 “(B) a health care professional who is le-
18 gally authorized in one or more States (in ac-
19 cordance with State law or the State regulatory
20 mechanism provided by State law) to furnish
21 the health care items or services at issue and
22 has medical expertise in the field of practice
23 that is appropriate for such items or services.

24 “(5) RELATED PARTY DEFINED.—For purposes
25 of this section, the term ‘related party’ means, with

1 respect to a case under this title involving a specific
2 individual entitled to benefits under part A or en-
3 rolled under part B, or both, any of the following:

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

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

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

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

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

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

22 (3) REDUCING MINIMUM NUMBER OF QUALI-
23 FIED INDEPENDENT CONTRACTORS.—Section
24 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by
25 striking “not fewer than 12 qualified independent

1 contractors under this subsection” and inserting
 2 “with a sufficient number of qualified independent
 3 contractors (but not fewer than 4 such contractors)
 4 to conduct reconsiderations consistent with the time-
 5 frames applicable under this subsection”.

6 (4) EFFECTIVE DATE.—The amendments made
 7 by paragraphs (1) and (2) shall be effective as if in-
 8 cluded in the enactment of the respective provisions
 9 of subtitle C of title V of BIPA (114 Stat. 2763A–
 10 534).

11 (5) TRANSITION.—In applying section 1869(g)
 12 of the Social Security Act (as added by paragraph
 13 (2)), any reference to a medicare administrative con-
 14 tractor shall be deemed to include a reference to a
 15 fiscal intermediary under section 1816 of the Social
 16 Security Act (42 U.S.C. 1395h) and a carrier under
 17 section 1842 of such Act (42 U.S.C. 1395u).

18 **SEC. 534. PREPAYMENT REVIEW.**

19 (a) IN GENERAL.—Section 1874A, as added by sec-
 20 tion 511(a)(1) and as amended by sections 912(b),
 21 921(b)(1), and 921(c)(1), is further amended by adding
 22 at the end the following new subsection:

23 “(h) CONDUCT OF PREPAYMENT REVIEW.—

24 “(1) CONDUCT OF RANDOM PREPAYMENT RE-
 25 VIEW.—

1 “(A) IN GENERAL.—A medicare adminis-
2 trative contractor may conduct random prepay-
3 ment review only to develop a contractor-wide
4 or program-wide claims payment error rates or
5 under such additional circumstances as may be
6 provided under regulations, developed in con-
7 sultation with providers of services and sup-
8 pliers.

9 “(B) USE OF STANDARD PROTOCOLS
10 WHEN CONDUCTING PREPAYMENT REVIEWS.—
11 When a medicare administrative contractor con-
12 ducts a random prepayment review, the con-
13 tractor may conduct such review only in accord-
14 ance with a standard protocol for random pre-
15 payment audits developed by the Secretary.

16 “(C) CONSTRUCTION.—Nothing in this
17 paragraph shall be construed as preventing the
18 denial of payments for claims actually reviewed
19 under a random prepayment review.

20 “(D) RANDOM PREPAYMENT REVIEW.—
21 For purposes of this subsection, the term ‘ran-
22 dom prepayment review’ means a demand for
23 the production of records or documentation ab-
24 sent cause with respect to a claim.

1 “(2) LIMITATIONS ON NON-RANDOM PREPAY-
2 MENT REVIEW.—

3 “(A) LIMITATIONS ON INITIATION OF NON-
4 RANDOM PREPAYMENT REVIEW.—A medicare
5 administrative contractor may not initiate non-
6 random prepayment review of a provider of
7 services or supplier based on the initial identi-
8 fication by that provider of services or supplier
9 of an improper billing practice unless there is
10 a likelihood of sustained or high level of pay-
11 ment error under section 1893(f)(3)(A).

12 “(B) TERMINATION OF NON-RANDOM PRE-
13 PAYMENT REVIEW.—The Secretary shall issue
14 regulations relating to the termination, includ-
15 ing termination dates, of non-random prepay-
16 ment review. Such regulations may vary such a
17 termination date based upon the differences in
18 the circumstances triggering prepayment re-
19 view.”.

20 (b) EFFECTIVE DATE.—

21 (1) IN GENERAL.—Except as provided in this
22 subsection, the amendment made by subsection (a)
23 shall take effect 1 year after the date of the enact-
24 ment of this Act.

1 (2) DEADLINE FOR PROMULGATION OF CER-
2 TAIN REGULATIONS.—The Secretary shall first issue
3 regulations under section 1874A(h) of the Social Se-
4 curity Act, as added by subsection (a), by not later
5 than 1 year after the date of the enactment of this
6 Act.

7 (3) APPLICATION OF STANDARD PROTOCOLS
8 FOR RANDOM PREPAYMENT REVIEW.—Section
9 1874A(h)(1)(B) of the Social Security Act, as added
10 by subsection (a), shall apply to random prepayment
11 reviews conducted on or after such date (not later
12 than 1 year after the date of the enactment of this
13 Act) as the Secretary shall specify.

14 (c) APPLICATION TO FISCAL INTERMEDIARIES AND
15 CARRIERS.—The provisions of section 1874A(h) of the So-
16 cial Security Act, as added by subsection (a), shall apply
17 to each fiscal intermediary under section 1816 of the So-
18 cial Security Act (42 U.S.C. 1395h) and each carrier
19 under section 1842 of such Act (42 U.S.C. 1395u) in the
20 same manner as they apply to medicare administrative
21 contractors under such provisions.

22 **SEC. 535. RECOVERY OF OVERPAYMENTS.**

23 (a) IN GENERAL.—Section 1893 (42 U.S.C.
24 1395ddd) is amended by adding at the end the following
25 new subsection:

1 “(f) RECOVERY OF OVERPAYMENTS.—

2 “(1) USE OF REPAYMENT PLANS.—

3 “(A) IN GENERAL.—If the repayment,
4 within 30 days by a provider of services or sup-
5 plier, of an overpayment under this title would
6 constitute a hardship (as described in subpara-
7 graph (B)), subject to subparagraph (C), upon
8 request of the provider of services or supplier
9 the Secretary shall enter into a plan with the
10 provider of services or supplier for the repay-
11 ment (through offset or otherwise) of such over-
12 payment over a period of at least 6 months but
13 not longer than 3 years (or not longer than 5
14 years in the case of extreme hardship, as deter-
15 mined by the Secretary). Interest shall accrue
16 on the balance through the period of repay-
17 ment. Such plan shall meet terms and condi-
18 tions determined to be appropriate by the Sec-
19 retary.

20 “(B) HARDSHIP.—

21 “(i) IN GENERAL.—For purposes of
22 subparagraph (A), the repayment of an
23 overpayment (or overpayments) within 30
24 days is deemed to constitute a hardship
25 if—

1 “(I) in the case of a provider of
2 services that files cost reports, the ag-
3 gregate amount of the overpayments
4 exceeds 10 percent of the amount paid
5 under this title to the provider of
6 services for the cost reporting period
7 covered by the most recently sub-
8 mitted cost report; or

9 “(II) in the case of another pro-
10 vider of services or supplier, the ag-
11 gregate amount of the overpayments
12 exceeds 10 percent of the amount paid
13 under this title to the provider of
14 services or supplier for the previous
15 calendar year.

16 “(ii) RULE OF APPLICATION.—The
17 Secretary shall establish rules for the ap-
18 plication of this subparagraph in the case
19 of a provider of services or supplier that
20 was not paid under this title during the
21 previous year or was paid under this title
22 only during a portion of that year.

23 “(iii) TREATMENT OF PREVIOUS
24 OVERPAYMENTS.—If a provider of services
25 or supplier has entered into a repayment

1 plan under subparagraph (A) with respect
2 to a specific overpayment amount, such
3 payment amount under the repayment plan
4 shall not be taken into account under
5 clause (i) with respect to subsequent over-
6 payment amounts.

7 “(C) EXCEPTIONS.—Subparagraph (A)
8 shall not apply if—

9 “(i) the Secretary has reason to sus-
10 pect that the provider of services or sup-
11 plier may file for bankruptcy or otherwise
12 cease to do business or discontinue partici-
13 pation in the 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 or supplier fails to make a payment in
19 accordance with a repayment plan under this
20 paragraph, the Secretary may immediately seek
21 to offset or otherwise recover the total balance
22 outstanding (including applicable interest)
23 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) IN GENERAL.—In the case of a pro-
6 vider of services or supplier that is determined
7 to have received an overpayment under this title
8 and that seeks a reconsideration by a qualified
9 independent contractor on such determination
10 under section 1869(b)(1), the Secretary may
11 not take any action (or authorize any other per-
12 son, including any medicare contractor, as de-
13 fined in subparagraph (C)) to recoup the over-
14 payment until the date the decision on the re-
15 consideration has been rendered. If the provi-
16 sions of section 1869(b)(1) (providing for such
17 a reconsideration by a qualified independent
18 contractor) are not in effect, in applying the
19 previous sentence any reference to such a recon-
20 sideration shall be treated as a reference to a
21 redetermination by the fiscal intermediary or
22 carrier involved.

23 “(B) COLLECTION WITH INTEREST.—Inso-
24 far as the determination on such appeal is
25 against the provider of services or supplier, in-

1 terest on the overpayment shall accrue on and
2 after the date of the original notice of overpay-
3 ment. Insofar as such determination against the
4 provider of services or supplier is later reversed,
5 the Secretary shall provide for repayment of the
6 amount recouped plus interest at the same rate
7 as would apply under the previous sentence for
8 the period in which the amount was recouped.

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

13 “(3) LIMITATION ON USE OF EXTRAPO-
14 LATION.—A medicare contractor may not use ex-
15 trapolation to determine overpayment amounts to be
16 recovered by recoupment, offset, or otherwise unless
17 the Secretary determines that—

18 “(A) there is a sustained or high level of
19 payment error; or

20 “(B) documented educational intervention
21 has failed to correct the payment error.

22 There shall be no administrative or judicial review under
23 section 1869, section 1878, or otherwise, of determina-
24 tions by the Secretary of sustained or high levels of pay-
25 ment errors under this paragraph.

1 “(4) PROVISION OF SUPPORTING DOCUMENTA-
2 TION.—In the case of a provider of services or sup-
3 plier with respect to which amounts were previously
4 overpaid, a medicare contractor may request the
5 periodic production of records or supporting docu-
6 mentation for a limited sample of submitted claims
7 to ensure that the previous practice is not con-
8 tinuing.

9 “(5) CONSENT SETTLEMENT REFORMS.—

10 “(A) IN GENERAL.—The Secretary may
11 use a consent settlement (as defined in sub-
12 paragraph (D)) to settle a projected overpay-
13 ment.

14 “(B) OPPORTUNITY TO SUBMIT ADDI-
15 TIONAL INFORMATION BEFORE CONSENT SET-
16 TLEMENT OFFER.—Before offering a provider
17 of services or supplier a consent settlement, the
18 Secretary shall—

19 “(i) communicate to the provider of
20 services or supplier—

21 “(I) that, based on a review of
22 the medical records requested by the
23 Secretary, a preliminary evaluation of
24 those records indicates that there
25 would be an overpayment;

1 “(II) the nature of the problems
2 identified in such evaluation; and

3 “(III) the steps that the provider
4 of services or supplier should take to
5 address the problems; and

6 “(ii) provide for a 45-day period dur-
7 ing which the provider of services or sup-
8 plier may furnish additional information
9 concerning the medical records for the
10 claims that had been reviewed.

11 “(C) CONSENT SETTLEMENT OFFER.—The
12 Secretary shall review any additional informa-
13 tion furnished by the provider of services or
14 supplier under subparagraph (B)(ii). Taking
15 into consideration such information, the Sec-
16 retary shall determine if there still appears to
17 be an overpayment. If so, the Secretary—

18 “(i) shall provide notice of such deter-
19 mination to the provider of services or sup-
20 plier, including an explanation of the rea-
21 son for such determination; and

22 “(ii) in order to resolve the overpay-
23 ment, may offer the provider of services or
24 supplier—

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

3 “(II) a consent settlement.

4 The opportunity provided under clause (ii)(I)
5 does not waive any appeal rights with respect to
6 the alleged overpayment involved.

7 “(D) CONSENT SETTLEMENT DEFINED.—

8 For purposes of this paragraph, the term ‘con-
9 sent settlement’ means an agreement between
10 the Secretary and a provider of services or sup-
11 plier whereby both parties agree to settle a pro-
12 jected overpayment based on less than a statis-
13 tically valid sample of claims and the provider
14 of services or supplier agrees not to appeal the
15 claims involved.

16 “(6) NOTICE OF OVER-UTILIZATION OF
17 CODES.—The Secretary shall establish, in consulta-
18 tion with organizations representing the classes of
19 providers of services and suppliers, a process under
20 which the Secretary provides for notice to classes of
21 providers of services and suppliers served by the con-
22 tractor in cases in which the contractor has identi-
23 fied that particular billing codes may be overutilized
24 by that class of providers of services or suppliers

1 under the programs under this title (or provisions of
2 title XI insofar as they relate to such programs).

3 “(7) PAYMENT AUDITS.—

4 “(A) WRITTEN NOTICE FOR POST-PAY-
5 MENT AUDITS.—Subject to subparagraph (C), if
6 a medicare contractor decides to conduct a
7 post-payment audit of a provider of services or
8 supplier under this title, the contractor shall
9 provide the provider of services or supplier with
10 written notice (which may be in electronic form)
11 of the intent to conduct such an audit.

12 “(B) EXPLANATION OF FINDINGS FOR ALL
13 AUDITS.—Subject to subparagraph (C), if a
14 medicare contractor audits a provider of serv-
15 ices or supplier under this title, the contractor
16 shall—

17 “(i) give the provider of services or
18 supplier a full review and explanation of
19 the findings of the audit in a manner that
20 is understandable to the provider of serv-
21 ices or supplier and permits the develop-
22 ment of an appropriate corrective action
23 plan;

24 “(ii) inform the provider of services or
25 supplier of the appeal rights under this

1 title as well as consent settlement options
2 (which are at the discretion of the Sec-
3 retary);

4 “(iii) give the provider of services or
5 supplier an opportunity to provide addi-
6 tional information to the contractor; and

7 “(iv) take into account information
8 provided, on a timely basis, by the provider
9 of services or supplier under clause (iii).

10 “(C) EXCEPTION.—Subparagraphs (A)
11 and (B) shall not apply if the provision of no-
12 tice or findings would compromise pending law
13 enforcement activities, whether civil or criminal,
14 or reveal findings of law enforcement-related
15 audits.

16 “(8) STANDARD METHODOLOGY FOR PROBE
17 SAMPLING.—The Secretary shall establish a stand-
18 ard methodology for medicare contractors to use in
19 selecting a sample of claims for review in the case
20 of an abnormal billing pattern.”.

21 (b) EFFECTIVE DATES AND DEADLINES.—

22 (1) USE OF REPAYMENT PLANS.—Section
23 1893(f)(1) of the Social Security Act, as added by
24 subsection (a), shall apply to requests for repayment

1 plans made after the date of the enactment of this
2 Act.

3 (2) LIMITATION ON RECOUPMENT.—Section
4 1893(f)(2) of the Social Security Act, as added by
5 subsection (a), shall apply to actions taken after the
6 date of the enactment of this Act.

7 (3) USE OF EXTRAPOLATION.—Section
8 1893(f)(3) of the Social Security Act, as added by
9 subsection (a), shall apply to statistically valid ran-
10 dom samples initiated after the date that is 1 year
11 after the date of the enactment of this Act.

12 (4) PROVISION OF SUPPORTING DOCUMENTA-
13 TION.—Section 1893(f)(4) of the Social Security
14 Act, as added by subsection (a), shall take effect on
15 the date of the enactment of this Act.

16 (5) CONSENT SETTLEMENT.—Section
17 1893(f)(5) of the Social Security Act, as added by
18 subsection (a), shall apply to consent settlements en-
19 tered into after the date of the enactment of this
20 Act.

21 (6) NOTICE OF OVERUTILIZATION.—Not later
22 than 1 year after the date of the enactment of this
23 Act, the Secretary shall first establish the process
24 for notice of overutilization of billing codes under

1 section 1893A(f)(6) of the Social Security Act, as
2 added by subsection (a).

3 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of
4 the Social Security Act, as added by subsection (a),
5 shall apply to audits initiated after the date of the
6 enactment of this Act.

7 (8) STANDARD FOR ABNORMAL BILLING PAT-
8 TERNS.—Not later than 1 year after the date of the
9 enactment of this Act, the Secretary shall first es-
10 tablish a standard methodology for selection of sam-
11 ple claims for abnormal billing patterns under sec-
12 tion 1893(f)(8) of the Social Security Act, as added
13 by subsection (a).

14 **SEC. 536. PROVIDER ENROLLMENT PROCESS; RIGHT OF AP-**
15 **PEAL.**

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

18 (1) by adding at the end of the heading the fol-
19 lowing: “; ENROLLMENT PROCESSES”; and

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

22 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF
23 SERVICES AND SUPPLIERS.—

24 “(1) ENROLLMENT PROCESS.—

1 “(A) IN GENERAL.—The Secretary shall
2 establish by regulation a process for the enroll-
3 ment of providers of services and suppliers
4 under this title.

5 “(B) DEADLINES.—The Secretary shall es-
6 tablish by regulation procedures under which
7 there are deadlines for actions on applications
8 for enrollment (and, if applicable, renewal of
9 enrollment). The Secretary shall monitor the
10 performance of medicare administrative con-
11 tractors in meeting the deadlines established
12 under this subparagraph.

13 “(C) CONSULTATION BEFORE CHANGING
14 PROVIDER ENROLLMENT FORMS.—The Sec-
15 retary shall consult with providers of services
16 and suppliers before making changes in the pro-
17 vider enrollment forms required of such pro-
18 viders and suppliers to be eligible to submit
19 claims for which payment may be made under
20 this title.

21 “(2) HEARING RIGHTS IN CASES OF DENIAL OR
22 NON-RENEWAL.—A provider of services or supplier
23 whose application to enroll (or, if applicable, to
24 renew enrollment) under this title is denied may
25 have a hearing and judicial review of such denial

1 under the procedures that apply under subsection
2 (h)(1)(A) to a provider of services that is dissatisfied
3 with a determination by the Secretary.”.

4 (b) EFFECTIVE DATES.—

5 (1) ENROLLMENT PROCESS.—The Secretary
6 shall provide for the establishment of the enrollment
7 process under section 1866(j)(1) of the Social Secu-
8 rity Act, as added by subsection (a)(2), within 6
9 months after the date of the enactment of this Act.

10 (2) CONSULTATION.—Section 1866(j)(1)(C) of
11 the Social Security Act, as added by subsection
12 (a)(2), shall apply with respect to changes in pro-
13 vider enrollment forms made on or after January 1,
14 2004.

15 (3) HEARING RIGHTS.—Section 1866(j)(2) of
16 the Social Security Act, as added by subsection
17 (a)(2), shall apply to denials occurring on or after
18 such date (not later than 1 year after the date of
19 the enactment of this Act) as the Secretary specifies.

20 **SEC. 537. PROCESS FOR CORRECTION OF MINOR ERRORS**
21 **AND OMISSIONS WITHOUT PURSUING AP-**
22 **PEALS PROCESS.**

23 (a) CLAIMS.—The Secretary shall develop, in con-
24 sultation with appropriate medicare contractors (as de-
25 fined in section 1889(g) of the Social Security Act, as in-

1 sserted by section 301(a)(1)) and representatives of pro-
 2 viders of services and suppliers, a process whereby, in the
 3 case of minor errors or omissions (as defined by the Sec-
 4 retary) that are detected in the submission of claims under
 5 the programs under title XVIII of such Act, a provider
 6 of services or supplier is given an opportunity to correct
 7 such an error or omission without the need to initiate an
 8 appeal. Such process shall include the ability to resubmit
 9 corrected claims.

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

13 **SEC. 538. PRIOR DETERMINATION PROCESS FOR CERTAIN**
 14 **ITEMS AND SERVICES; ADVANCE BENE-**
 15 **FICIARY NOTICES.**

16 (a) IN GENERAL.—Section 1869 (42 U.S.C.
 17 1395ff(b)), as amended by section 533(d)(2)(B), is fur-
 18 ther amended by adding at the end the following new sub-
 19 section:

20 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN
 21 ITEMS AND SERVICES.—

22 “(1) ESTABLISHMENT OF PROCESS.—

23 “(A) IN GENERAL.—With respect to a
 24 medicare administrative contractor that has a
 25 contract under section 1874A that provides for

1 making payments under this title with respect
2 to physicians' services (as defined in section
3 1848(j)(3)), the Secretary shall establish a
4 prior determination process that meets the re-
5 quirements of this subsection and that shall be
6 applied by such contractor in the case of eligible
7 requesters.

8 “(B) ELIGIBLE REQUESTER.—For pur-
9 poses of this subsection, each of the following
10 shall be an eligible requester:

11 “(i) A participating physician, but
12 only with respect to physicians' services to
13 be furnished to an individual who is enti-
14 tled to benefits under this title and who
15 has consented to the physician making the
16 request under this subsection for those
17 physicians' services.

18 “(ii) An individual entitled to benefits
19 under this title, but only with respect to a
20 physicians' service for which the individual
21 receives, from a physician, an advance ben-
22 efiary notice under section 1879(a).

23 “(2) SECRETARIAL FLEXIBILITY.—The Sec-
24 retary shall establish by regulation reasonable limits
25 on the physicians' services for which a prior deter-

1 mination of coverage may be requested under this
2 subsection. In establishing such limits, the Secretary
3 may consider the dollar amount involved with re-
4 spect to the physicians' service, administrative costs
5 and burdens, and other relevant factors.

6 “(3) REQUEST FOR PRIOR DETERMINATION.—

7 “(A) IN GENERAL.—Subject to paragraph
8 (2), under the process established under this
9 subsection an eligible requester may submit to
10 the contractor a request for a determination,
11 before the furnishing of a physicians' service, as
12 to whether the physicians' service is covered
13 under this title consistent with the applicable
14 requirements of section 1862(a)(1)(A) (relating
15 to medical necessity).

16 “(B) ACCOMPANYING DOCUMENTATION.—

17 The Secretary may require that the request be
18 accompanied by a description of the physicians'
19 service, supporting documentation relating to
20 the medical necessity for the physicians' service,
21 and any other appropriate documentation. In
22 the case of a request submitted by an eligible
23 requester who is described in paragraph
24 (1)(B)(ii), the Secretary may require that the

1 request also be accompanied by a copy of the
2 advance beneficiary notice involved.

3 “(4) RESPONSE TO REQUEST.—

4 “(A) IN GENERAL.—Under such process,
5 the contractor shall provide the eligible re-
6 quester with written notice of a determination
7 as to whether—

8 “(i) the physicians’ service is so cov-
9 ered;

10 “(ii) the physicians’ service is not so
11 covered; or

12 “(iii) the contractor lacks sufficient
13 information to make a coverage determina-
14 tion with respect to the physicians’ service.

15 “(B) CONTENTS OF NOTICE FOR CERTAIN
16 DETERMINATIONS.—

17 “(i) NONCOVERAGE.—If the con-
18 tractor makes the determination described
19 in subparagraph (A)(ii), the contractor
20 shall include in the notice a brief expla-
21 nation of the basis for the determination,
22 including on what national or local cov-
23 erage or noncoverage determination (if
24 any) the determination is based, and a de-

1 description of any applicable rights under
2 subsection (a).

3 “(ii) INSUFFICIENT INFORMATION.—

4 If the contractor makes the determination
5 described in subparagraph (A)(iii), the
6 contractor shall include in the notice a de-
7 scription of the additional information re-
8 quired to make the coverage determination.

9 “(C) DEADLINE TO RESPOND.—Such no-
10 tice shall be provided within the same time pe-
11 riod as the time period applicable to the con-
12 tractor providing notice of initial determinations
13 on a claim for benefits under subsection
14 (a)(2)(A).

15 “(D) INFORMING BENEFICIARY IN CASE OF
16 PHYSICIAN REQUEST.—In the case of a request
17 by a participating physician under paragraph
18 (1)(B)(i), the process shall provide that the in-
19 dividual to whom the physicians’ service is pro-
20 posed to be furnished shall be informed of any
21 determination described in subparagraph (A)(ii)
22 (relating to a determination of non-coverage)
23 and the right (referred to in paragraph (6)(B))
24 to obtain the physicians’ service and have a
25 claim submitted for the physicians’ service.

1 “(5) BINDING NATURE OF POSITIVE DETER-
2 MINATION.—If the contractor makes the determina-
3 tion described in paragraph (4)(A)(i), such deter-
4 mination shall be binding on the contractor in the
5 absence of fraud or evidence of misrepresentation of
6 facts presented to the contractor.

7 “(6) LIMITATION ON FURTHER REVIEW.—

8 “(A) IN GENERAL.—Contractor determina-
9 tions described in paragraph (4)(A)(ii) or
10 (4)(A)(iii) (relating to pre-service claims) are
11 not subject to further administrative appeal or
12 judicial review under this section or otherwise.

13 “(B) DECISION NOT TO SEEK PRIOR DE-
14 TERMINATION OR NEGATIVE DETERMINATION
15 DOES NOT IMPACT RIGHT TO OBTAIN SERVICES,
16 SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—
17 Nothing in this subsection shall be construed as
18 affecting the right of an individual who—

19 “(i) decides not to seek a prior deter-
20 mination under this subsection with re-
21 spect to physicians’ services; or

22 “(ii) seeks such a determination and
23 has received a determination described in
24 paragraph (4)(A)(ii),

1 from receiving (and submitting a claim for)
2 such physicians' services and from obtaining
3 administrative or judicial review respecting such
4 claim under the other applicable provisions of
5 this section. Failure to seek a prior determina-
6 tion under this subsection with respect to physi-
7 cians' service shall not be taken into account in
8 such administrative or judicial review.

9 “(C) NO PRIOR DETERMINATION AFTER
10 RECEIPT OF SERVICES.—Once an individual is
11 provided physicians' services, there shall be no
12 prior determination under this subsection with
13 respect to such physicians' services.”.

14 (b) EFFECTIVE DATE; SUNSET; TRANSITION.—

15 (1) EFFECTIVE DATE.—The Secretary shall es-
16 tablish the prior determination process under the
17 amendment made by subsection (a) in such a man-
18 ner as to provide for the acceptance of requests for
19 determinations under such process filed not later
20 than 18 months after the date of the enactment of
21 this Act.

22 (2) SUNSET.—Such prior determination process
23 shall not apply to requests filed after the end of the
24 5-year period beginning on the first date on which

1 requests for determinations under such process are
2 accepted.

3 (3) TRANSITION.—During the period in which
4 the amendment made by subsection (a) has become
5 effective but contracts are not provided under sec-
6 tion 1874A of the Social Security Act with medicare
7 administrative contractors, any reference in section
8 1869(g) of such Act (as added by such amendment)
9 to such a contractor is deemed a reference to a fiscal
10 intermediary or carrier with an agreement under
11 section 1816, or contract under section 1842, re-
12 spectively, of such Act.

13 (4) LIMITATION ON APPLICATION TO SGR.—For
14 purposes of applying section 1848(f)(2)(D) of the
15 Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)),
16 the amendment made by subsection (a) shall not be
17 considered to be a change in law or regulation.

18 (c) PROVISIONS RELATING TO ADVANCE BENE-
19 FICIARY NOTICES; REPORT ON PRIOR DETERMINATION
20 PROCESS.—

21 (1) DATA COLLECTION.—The Secretary shall
22 establish a process for the collection of information
23 on the instances in which an advance beneficiary no-
24 tice (as defined in paragraph (5)) has been provided
25 and on instances in which a beneficiary indicates on

1 such a notice that the beneficiary does not intend to
2 seek to have the item or service that is the subject
3 of the notice furnished.

4 (2) OUTREACH AND EDUCATION.—The Sec-
5 retary shall establish a program of outreach and
6 education for beneficiaries and providers of services
7 and other persons on the appropriate use of advance
8 beneficiary notices and coverage policies under the
9 medicare program.

10 (3) GAO REPORT ON USE OF ADVANCE BENE-
11 FICIARY NOTICES.—Not later than 18 months after
12 the date on which section 1869(h) of the Social Se-
13 curity Act (as added by subsection (a)) takes effect,
14 the Comptroller General of the United States shall
15 submit to Congress a report on the use of advance
16 beneficiary notices under title XVIII of such Act.
17 Such report shall include information concerning the
18 providers of services and other persons that have
19 provided such notices and the response of bene-
20 ficiaries to such notices.

21 (4) GAO REPORT ON USE OF PRIOR DETER-
22 MINATION PROCESS.—Not later than 36 months
23 after the date on which section 1869(h) of the Social
24 Security Act (as added by subsection (a)) takes ef-
25 fect, the Comptroller General of the United States

1 shall submit to Congress a report on the use of the
2 prior determination process under such section. Such
3 report shall include—

4 (A) information concerning—

5 (i) the number and types of proce-
6 dures for which a prior determination has
7 been sought;

8 (ii) determinations made under the
9 process;

10 (iii) the percentage of beneficiaries
11 prevailing;

12 (iv) in those cases in which the bene-
13 ficiaries do not prevail, the reasons why
14 such beneficiaries did not prevail; and

15 (v) changes in receipt of services re-
16 sulting from the application of such pro-
17 cess;

18 (B) an evaluation of whether the process
19 was useful for physicians (and other suppliers)
20 and beneficiaries, whether it was timely, and
21 whether the amount of information required
22 was burdensome to physicians and beneficiaries;
23 and

24 (C) recommendations for improvements or
25 continuation of such process.

1 (5) ADVANCE BENEFICIARY NOTICE DE-
 2 FINED.—In this subsection, the term “advance bene-
 3 ficiary notice” means a written notice provided
 4 under section 1879(a) of the Social Security Act (42
 5 U.S.C. 1395pp(a)) to an individual entitled to bene-
 6 fits under part A or enrolled under part B of title
 7 XVIII of such Act before items or services are fur-
 8 nished under such part in cases where a provider of
 9 services or other person that would furnish the item
 10 or service believes that payment will not be made for
 11 some or all of such items or services under such
 12 title.

13 **SEC. 539. APPEALS BY PROVIDERS WHEN THERE IS NO**
 14 **OTHER PARTY AVAILABLE.**

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

18 “(h) Notwithstanding subsection (f) or any other pro-
 19 vision of law, the Secretary shall permit a provider of serv-
 20 ices or supplier to appeal any determination of the Sec-
 21 retary under this title relating to services rendered under
 22 this title to an individual who subsequently dies if there
 23 is no other party available to appeal such determination.”.

24 (b) EFFECTIVE DATE.—The amendment made by
 25 subsection (a) shall take effect on the date of the enact-

1 ment of this Act and shall apply to items and services fur-
2 nished on or after such date.

3 **SEC. 540. REVISIONS TO APPEALS TIMEFRAMES AND**
4 **AMOUNTS.**

5 (a) TIMEFRAMES.—Section 1869 (42 U.S.C. 1395ff)
6 is amended—

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

10 (2) in subsection (c)(3)(C)(i), by striking “30-
11 day period” and inserting “60-day period”.

12 (b) AMOUNTS.—

13 (1) IN GENERAL.—Section 1869(b)(1)(E) (42
14 U.S.C. 1395ff(b)(1)(E)) is amended by adding at
15 the end the following new clause:

16 “(iii) ADJUSTMENT OF DOLLAR
17 AMOUNTS.—For requests for hearings or
18 judicial review made in a year after 2004,
19 the dollar amounts specified in clause (i)
20 shall be equal to such dollar amounts in-
21 creased by the percentage increase in the
22 medical care component of the consumer
23 price index for all urban consumers (U.S.
24 city average) for July 2003 to the July
25 preceding the year involved. Any amount

1 determined under the previous sentence
2 that is not a multiple of \$10 shall be
3 rounded to the nearest multiple of \$10.”.

4 (2) CONFORMING AMENDMENTS.—(A) Section
5 1852(g)(5) (42 U.S.C. 1395w–22(g)(5)) is amended
6 by adding at the end the following: “The provisions
7 of section 1869(b)(1)(E)(iii) shall apply with respect
8 to dollar amounts specified in the first 2 sentences
9 of this paragraph in the same manner as they apply
10 to the dollar amounts specified in section
11 1869(b)(1)(E)(i).”.

12 (B) Section 1876(b)(5)(B) (42 U.S.C.
13 1395mm(b)(5)(B)) is amended by adding at the end
14 the following: “The provisions of section
15 1869(b)(1)(E)(iii) shall apply with respect to dollar
16 amounts specified in the first 2 sentences of this
17 subparagraph in the same manner as they apply to
18 the dollar amounts specified in section
19 1869(b)(1)(E)(i).”.

20 **SEC. 540A. MEDIATION PROCESS FOR LOCAL COVERAGE**
21 **DETERMINATIONS.**

22 (a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff),
23 as amended by section 538(a), is amended by adding at
24 the end the following new subsection:

1 “(i) MEDIATION PROCESS FOR LOCAL COVERAGE
2 DETERMINATIONS.—

3 “(1) ESTABLISHMENT OF PROCESS.—The Sec-
4 retary shall establish a mediation process under this
5 subsection through the use of a physician trained in
6 mediation and employed by the Centers for Medicare
7 & Medicaid Services.

8 “(2) RESPONSIBILITY OF MEDIATOR.—Under
9 the process established in paragraph (1), such a me-
10 diator shall mediate in disputes between groups rep-
11 resenting providers of services, suppliers (as defined
12 in section 1861(d)), and the medical director for a
13 medicare administrative contractor whenever the re-
14 gional administrator (as defined by the Secretary)
15 involved determines that there was a systematic pat-
16 tern and a large volume of complaints from such
17 groups regarding decisions of such director or there
18 is a complaint from the co-chair of the advisory com-
19 mittee for that contractor to such regional adminis-
20 trator regarding such dispute.”.

21 (b) INCLUSION IN MAC CONTRACTS.—Section
22 1874A(b)(3)(A)(i), as added by section 511(a)(1), is
23 amended by adding at the end the following: “Such re-
24 quirements shall include specific performance duties ex-
25 pected of a medical director of a medicare administrative

1 contractor, including requirements relating to professional
2 relations and the availability of such director to conduct
3 medical determination activities within the jurisdiction of
4 such a contractor.”.

5 **Subtitle E—Miscellaneous**
6 **Provisions**

7 **SEC. 541. POLICY DEVELOPMENT REGARDING EVALUATION**
8 **AND MANAGEMENT (E & M) DOCUMENTATION**
9 **GUIDELINES.**

10 (a) IN GENERAL.—The Secretary may not implement
11 any new or modified documentation guidelines (which for
12 purposes of this section includes clinical examples) for
13 evaluation and management physician services under the
14 title XVIII of the Social Security Act on or after the date
15 of the enactment of this Act unless the Secretary—

16 (1) has developed the guidelines in collaboration
17 with practicing physicians (including both generalists
18 and specialists) and provided for an assessment of
19 the proposed guidelines by the physician community;

20 (2) has established a plan that contains specific
21 goals, including a schedule, for improving the use of
22 such guidelines;

23 (3) has conducted appropriate and representa-
24 tive pilot projects under subsection (b) to test such
25 guidelines;

1 (4) finds, based on reports submitted under
2 subsection (b)(5) with respect to pilot projects con-
3 ducted for such or related guidelines, that the objec-
4 tives described in subsection (c) will be met in the
5 implementation of such guidelines; and

6 (5) has established, and is implementing, a pro-
7 gram to educate physicians on the use of such guide-
8 lines and that includes appropriate outreach.

9 The Secretary shall make changes to the manner in which
10 existing evaluation and management documentation guide-
11 lines are implemented to reduce paperwork burdens on
12 physicians.

13 (b) PILOT PROJECTS TO TEST MODIFIED OR NEW
14 EVALUATION AND MANAGEMENT DOCUMENTATION
15 GUIDELINES.—

16 (1) IN GENERAL.—With respect to proposed
17 new or modified documentation guidelines referred
18 to in subsection (a), the Secretary shall conduct
19 under this subsection appropriate and representative
20 pilot projects to test the proposed guidelines.

21 (2) LENGTH AND CONSULTATION.—Each pilot
22 project under this subsection shall—

23 (A) be voluntary;

24 (B) be of sufficient length as determined
25 by the Secretary (but in no case to exceed 1

1 year) to allow for preparatory physician and
2 medicare contractor education, analysis, and
3 use and assessment of potential evaluation and
4 management guidelines; and

5 (C) be conducted, in development and
6 throughout the planning and operational stages
7 of the project, in consultation with practicing
8 physicians (including both generalists and spe-
9 cialists).

10 (3) RANGE OF PILOT PROJECTS.—Of the pilot
11 projects conducted under this subsection with re-
12 spect to proposed new or modified documentation
13 guidelines—

14 (A) at least one shall focus on a peer re-
15 view method by physicians (not employed by a
16 medicare contractor) which evaluates medical
17 record information for claims submitted by phy-
18 sicians identified as statistical outliers relative
19 to codes used for billing purposes for such serv-
20 ices;

21 (B) at least one shall focus on an alter-
22 native method to detailed guidelines based on
23 physician documentation of face to face encoun-
24 ter time with a patient;

1 (C) at least one shall be conducted for
2 services furnished in a rural area and at least
3 one for services furnished outside such an area;
4 and

5 (D) at least one shall be conducted in a
6 setting where physicians bill under physicians'
7 services in teaching settings and at least one
8 shall be conducted in a setting other than a
9 teaching setting.

10 (4) STUDY OF IMPACT.—Each pilot project
11 shall examine the effect of the proposed guidelines
12 on—

13 (A) different types of physician practices,
14 including those with fewer than 10 full-time-
15 equivalent employees (including physicians);
16 and

17 (B) the costs of physician compliance, in-
18 cluding education, implementation, auditing,
19 and monitoring.

20 (5) REPORT ON PILOT PROJECTS.—Not later
21 than 6 months after the date of completion of pilot
22 projects carried out under this subsection with re-
23 spect to a proposed guideline described in paragraph
24 (1), the Secretary shall submit to Congress a report
25 on the pilot projects. Each such report shall include

1 a finding by the Secretary of whether the objectives
2 described in subsection (c) will be met in the imple-
3 mentation of such proposed guideline.

4 (c) OBJECTIVES FOR EVALUATION AND MANAGE-
5 MENT GUIDELINES.—The objectives for modified evalua-
6 tion and management documentation guidelines developed
7 by the Secretary shall be to—

8 (1) identify clinically relevant documentation
9 needed to code accurately and assess coding levels
10 accurately;

11 (2) decrease the level of non-clinically pertinent
12 and burdensome documentation time and content in
13 the physician's medical record;

14 (3) increase accuracy by reviewers; and

15 (4) educate both physicians and reviewers.

16 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF
17 DOCUMENTATION FOR PHYSICIAN CLAIMS.—

18 (1) STUDY.—The Secretary shall carry out a
19 study of the matters described in paragraph (2).

20 (2) MATTERS DESCRIBED.—The matters re-
21 ferred to in paragraph (1) are—

22 (A) the development of a simpler, alter-
23 native system of requirements for documenta-
24 tion accompanying claims for evaluation and
25 management physician services for which pay-

1 ment is made under title XVIII of the Social
2 Security Act; and

3 (B) consideration of systems other than
4 current coding and documentation requirements
5 for payment for such physician services.

6 (3) CONSULTATION WITH PRACTICING PHYSI-
7 CIANS.—In designing and carrying out the study
8 under paragraph (1), the Secretary shall consult
9 with practicing physicians, including physicians who
10 are part of group practices and including both gen-
11 eralists and specialists.

12 (4) APPLICATION OF HIPAA UNIFORM CODING
13 REQUIREMENTS.—In developing an alternative sys-
14 tem under paragraph (2), the Secretary shall con-
15 sider requirements of administrative simplification
16 under part C of title XI of the Social Security Act.

17 (5) REPORT TO CONGRESS.—(A) Not later than
18 October 1, 2005, the Secretary shall submit to Con-
19 gress a report on the results of the study conducted
20 under paragraph (1).

21 (B) The Medicare Payment Advisory Commis-
22 sion shall conduct an analysis of the results of the
23 study included in the report under subparagraph (A)
24 and shall submit a report on such analysis to Con-
25 gress.

1 (e) STUDY ON APPROPRIATE CODING OF CERTAIN
2 EXTENDED OFFICE VISITS.—The Secretary shall conduct
3 a study of the appropriateness of coding in cases of ex-
4 tended office visits in which there is no diagnosis made.
5 Not later than October 1, 2005, the Secretary shall submit
6 a report to Congress on such study and shall include rec-
7 ommendations on how to code appropriately for such visits
8 in a manner that takes into account the amount of time
9 the physician spent with the patient.

10 (f) DEFINITIONS.—In this section—

11 (1) the term “rural area” has the meaning
12 given that term in section 1886(d)(2)(D) of the So-
13 cial Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

14 (2) the term “teaching settings” are those set-
15 tings described in section 415.150 of title 42, Code
16 of Federal Regulations.

17 **SEC. 542. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**
18 **AND COVERAGE.**

19 (a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—
20 Section 1868 (42 U.S.C. 1395ee), as amended by section
21 521(a), is amended by adding at the end the following new
22 subsection:

23 “(c) COUNCIL FOR TECHNOLOGY AND INNOVA-
24 TION.—

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

5 “(2) COMPOSITION.—The Council shall be com-
6 posed of senior CMS staff and clinicians and shall
7 be chaired by the Executive Coordinator for Tech-
8 nology and Innovation (appointed or designated
9 under paragraph (4)).

10 “(3) DUTIES.—The Council shall coordinate the
11 activities of coverage, coding, and payment processes
12 under this title with respect to new technologies and
13 procedures, including new drug therapies, and shall
14 coordinate the exchange of information on new tech-
15 nologies between CMS and other entities that make
16 similar decisions.

17 “(4) EXECUTIVE COORDINATOR FOR TECH-
18 NOLOGY AND INNOVATION.—The Secretary shall ap-
19 point (or designate) a noncareer appointee (as de-
20 fined in section 3132(a)(7) of title 5, United States
21 Code) who shall serve as the Executive Coordinator
22 for Technology and Innovation. Such executive coor-
23 dinator shall report to the Administrator of CMS,
24 shall chair the Council, shall oversee the execution of
25 its duties, and shall serve as a single point of con-

1 tact for outside groups and entities regarding the
2 coverage, coding, and payment processes under this
3 title.”.

4 (b) METHODS FOR DETERMINING PAYMENT BASIS
5 FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C.
6 1395l(h)) is amended by adding at the end the following:

7 “(8)(A) The Secretary shall establish by regulation
8 procedures for determining the basis for, and amount of,
9 payment under this subsection for any clinical diagnostic
10 laboratory test with respect to which a new or substan-
11 tially revised HCPCS code is assigned on or after January
12 1, 2005 (in this paragraph referred to as ‘new tests’).

13 “(B) Determinations under subparagraph (A) shall
14 be made only after the Secretary—

15 “(i) makes available to the public (through an
16 Internet website and other appropriate mechanisms)
17 a list that includes any such test for which establish-
18 ment of a payment amount under this subsection is
19 being considered for a year;

20 “(ii) on the same day such list is made avail-
21 able, causes to have published in the Federal Reg-
22 ister notice of a meeting to receive comments and
23 recommendations (and data on which recommenda-
24 tions are based) from the public on the appropriate

1 basis under this subsection for establishing payment
2 amounts for the tests on such list;

3 “(iii) not less than 30 days after publication of
4 such notice convenes a meeting, that includes rep-
5 resentatives of officials of the Centers for Medicare
6 & Medicaid Services involved in determining pay-
7 ment amounts, to receive such comments and rec-
8 ommendations (and data on which the recommenda-
9 tions are based);

10 “(iv) taking into account the comments and rec-
11 ommendations (and accompanying data) received at
12 such meeting, develops and makes available to the
13 public (through an Internet website and other appro-
14 priate mechanisms) a list of proposed determinations
15 with respect to the appropriate basis for establishing
16 a payment amount under this subsection for each
17 such code, together with an explanation of the rea-
18 sons for each such determination, the data on which
19 the determinations are based, and a request for pub-
20 lic written comments on the proposed determination;
21 and

22 “(v) taking into account the comments received
23 during the public comment period, develops and
24 makes available to the public (through an Internet
25 website and other appropriate mechanisms) a list of

1 final determinations of the payment amounts for
2 such tests under this subsection, together with the
3 rationale for each such determination, the data on
4 which the determinations are based, and responses
5 to comments and suggestions received from the pub-
6 lic.

7 “(C) Under the procedures established pursuant to
8 subparagraph (A), the Secretary shall—

9 “(i) set forth the criteria for making determina-
10 tions under subparagraph (A); and

11 “(ii) make available to the public the data
12 (other than proprietary data) considered in making
13 such determinations.

14 “(D) The Secretary may convene such further public
15 meetings to receive public comments on payment amounts
16 for new tests under this subsection as the Secretary deems
17 appropriate.

18 “(E) For purposes of this paragraph:

19 “(i) The term ‘HCPCS’ refers to the Health
20 Care Procedure Coding System.

21 “(ii) A code shall be considered to be ‘substan-
22 tially revised’ if there is a substantive change to the
23 definition of the test or procedure to which the code
24 applies (such as a new analyte or a new methodology
25 for measuring an existing analyte-specific test).”.

1 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL
2 DATA COLLECTION FOR USE IN THE MEDICARE INPA-
3 TIENT PAYMENT SYSTEM.—

4 (1) STUDY.—The Comptroller General of the
5 United States shall conduct a study that analyzes
6 which external data can be collected in a shorter
7 timeframe by the Centers for Medicare & Medicaid
8 Services for use in computing payments for inpatient
9 hospital services. The study may include an evalua-
10 tion of the feasibility and appropriateness of using
11 quarterly samples or special surveys or any other
12 methods. The study shall include an analysis of
13 whether other executive agencies, such as the Bu-
14 reau of Labor Statistics in the Department of Com-
15 merce, are best suited to collect this information.

16 (2) REPORT.—By not later than October 1,
17 2004, the Comptroller General shall submit a report
18 to Congress on the study under paragraph (1).

19 **SEC. 543. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**
20 **ICES UNDER MEDICARE SECONDARY PAYOR**
21 **(MSP) PROVISIONS.**

22 (a) IN GENERAL.—The Secretary shall not require
23 a hospital (including a critical access hospital) to ask ques-
24 tions (or obtain information) relating to the application
25 of section 1862(b) of the Social Security Act (relating to

1 medicare secondary payor provisions) in the case of ref-
2 erence laboratory services described in subsection (b), if
3 the Secretary does not impose such requirement in the
4 case of such services furnished by an independent labora-
5 tory.

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

14 **SEC. 544. EMTALA IMPROVEMENTS.**

15 (a) PAYMENT FOR EMTALA-MANDATED SCREEN-
16 ING AND STABILIZATION SERVICES.—

17 (1) IN GENERAL.—Section 1862 (42 U.S.C.
18 1395y) is amended by inserting after subsection (c)
19 the following new subsection:

20 “(d) For purposes of subsection (a)(1)(A), in the case
21 of any item or service that is required to be provided pur-
22 suant to section 1867 to an individual who is entitled to
23 benefits under this title, determinations as to whether the
24 item or service is reasonable and necessary shall be made
25 on the basis of the information available to the treating

1 physician or practitioner (including the patient's pre-
2 senting symptoms or complaint) at the time the item or
3 service was ordered or furnished by the physician or prac-
4 titioner (and not on the patient's principal diagnosis).
5 When making such determinations with respect to such
6 an item or service, the Secretary shall not consider the
7 frequency with which the item or service was provided to
8 the patient before or after the time of the admission or
9 visit.”.

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

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

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

21 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZA-
22 TIONS IN EMTALA CASES INVOLVING TERMINATION OF
23 PARTICIPATION.—

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

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

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

21 (2) EFFECTIVE DATE.—The amendments made
22 by paragraph (1) shall apply to terminations of par-
23 ticipation initiated on or after the date of the enact-
24 ment of this Act.

1 **SEC. 545. EMERGENCY MEDICAL TREATMENT AND LABOR**
2 **ACT (EMTALA) TECHNICAL ADVISORY GROUP.**

3 (a) ESTABLISHMENT.—The Secretary shall establish
4 a Technical Advisory Group (in this section referred to
5 as the “Advisory Group”) to review issues related to the
6 Emergency Medical Treatment and Labor Act
7 (EMTALA) and its implementation. In this section, the
8 term “EMTALA” refers to the provisions of section 1867
9 of the Social Security Act (42 U.S.C. 1395dd).

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

15 (1) 4 shall be representatives of hospitals, in-
16 cluding at least one public hospital, that have experi-
17 ence with the application of EMTALA and at least
18 2 of which have not been cited for EMTALA viola-
19 tions;

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

26 (3) 2 shall represent patients;

1 (4) 2 shall be staff involved in EMTALA inves-
2 tigations from different regional offices of the Cen-
3 ters for Medicare & Medicaid Services; and

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

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

13 (c) GENERAL RESPONSIBILITIES.—The Advisory
14 Group—

15 (1) shall review EMTALA regulations;

16 (2) may provide advice and recommendations to
17 the Secretary with respect to those regulations and
18 their application to hospitals and physicians;

19 (3) shall solicit comments and recommendations
20 from hospitals, physicians, and the public regarding
21 the implementation of such regulations; and

22 (4) may disseminate information on the applica-
23 tion of such regulations to hospitals, physicians, and
24 the public.

25 (d) ADMINISTRATIVE MATTERS.—

1 program’s service area, a hospice program may enter into
2 arrangements with another hospice program for the provi-
3 sion by that other program of services described in para-
4 graph (2)(A)(ii)(I). The provisions of paragraph
5 (2)(A)(ii)(II) shall apply with respect to the services pro-
6 vided under such arrangements.

7 “(E) A hospice program may provide services de-
8 scribed in paragraph (1)(A) other than directly by the pro-
9 gram if the services are highly specialized services of a
10 registered professional nurse and are provided non-rou-
11 tinely and so infrequently so that the provision of such
12 services directly would be impracticable and prohibitively
13 expensive.”.

14 (b) CONFORMING PAYMENT PROVISION.—Section
15 1814(i) (42 U.S.C. 1395f(i)), as amended by section
16 212(b), is amended by adding at the end the following new
17 paragraph:

18 “(5) In the case of hospice care provided by a hospice
19 program under arrangements under section
20 1861(dd)(5)(D) made by another hospice program, the
21 hospice program that made the arrangements shall bill
22 and be paid for the hospice care.”.

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

1 **SEC. 547. APPLICATION OF OSHA BLOODBORNE PATHO-**
2 **GENS STANDARD TO CERTAIN HOSPITALS.**

3 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc),
4 as amended by section 206, is amended—

5 (1) in subsection (a)(1)—

6 (A) in subparagraph (T), by striking
7 “and” at the end;

8 (B) in subparagraph (U), by striking the
9 period at the end and inserting “, and”; and

10 (C) by inserting after subparagraph (U)
11 the following new subparagraph:

12 “(V) in the case of hospitals that are not other-
13 wise subject to the Occupational Safety and Health
14 Act of 1970 (or a State occupational safety and
15 health plan that is approved under 18(b) of such
16 Act), to comply with the Bloodborne Pathogens
17 standard under section 1910.1030 of title 29 of the
18 Code of Federal Regulations (or as subsequently re-
19 designated).”; and

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

22 “(4)(A) A hospital that fails to comply with the re-
23 quirement of subsection (a)(1)(V) (relating to the
24 Bloodborne Pathogens standard) is subject to a civil
25 money penalty in an amount described in subparagraph

1 (B), but is not subject to termination of an agreement
2 under this section.

3 “(B) The amount referred to in subparagraph (A) is
4 an amount that is similar to the amount of civil penalties
5 that may be imposed under section 17 of the Occupational
6 Safety and Health Act of 1970 for a violation of the
7 Bloodborne Pathogens standard referred to in subsection
8 (a)(1)(U) by a hospital that is subject to the provisions
9 of such Act.

10 “(C) A civil money penalty under this paragraph shall
11 be imposed and collected in the same manner as civil
12 money penalties under subsection (a) of section 1128A are
13 imposed and collected under that section.”.

14 (b) **EFFECTIVE DATE.**—The amendments made by
15 this subsection (a) shall apply to hospitals as of July 1,
16 2004.

17 **SEC. 548. BIPA-RELATED TECHNICAL AMENDMENTS AND**
18 **CORRECTIONS.**

19 (a) **TECHNICAL AMENDMENTS RELATING TO ADVI-**
20 **SORY COMMITTEE UNDER BIPA SECTION 522.**—(1) Sub-
21 section (i) of section 1114 (42 U.S.C. 1314)—

22 (A) is transferred to section 1862 and added at
23 the end of such section; and

24 (B) is redesignated as subsection (j).

25 (2) Section 1862 (42 U.S.C. 1395y) is amended—

1 (A) in the last sentence of subsection (a), by
2 striking “established under section 1114(f)”; and

3 (B) in subsection (j), as so transferred and re-
4 designated—

5 (i) by striking “under subsection (f)”; and

6 (ii) by striking “section 1862(a)(1)” and
7 inserting “subsection (a)(1)”.

8 (b) TERMINOLOGY CORRECTIONS.—(1) Section
9 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)) is amend-
10 ed—

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

13 (B) in subclause (IV), by striking “medical re-
14 view policies” and inserting “coverage determina-
15 tions”.

16 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-
17 22(a)(2)(C)) is amended by striking “policy” and “POL-
18 ICY” and inserting “determination” each place it appears
19 and “DETERMINATION”, respectively.

20 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4)
21 (42 U.S.C. 1395ff(f)(4)) is amended—

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

1 that the exclusion would impose a hardship on individuals
2 entitled to benefits under part A of title XVIII or enrolled
3 under part B of such title, or both, the Secretary may,
4 after consulting with the Inspector General of the Depart-
5 ment of Health and Human Services, waive the exclusion
6 under subsection (a)(1), (a)(3), or (a)(4) with respect to
7 that program in the case of an individual or entity that
8 is the sole community physician or sole source of essential
9 specialized services in a community.”.

10 **SEC. 550. TREATMENT OF CERTAIN DENTAL CLAIMS.**

11 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y)
12 is amended by adding at the end, after the subsection
13 transferred and redesignated by section 548(a), the fol-
14 lowing new subsection:

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

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

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

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

6 **SEC. 551. FURNISHING HOSPITALS WITH INFORMATION TO**
7 **COMPUTE DSH FORMULA.**

8 Beginning not later than 1 year after the date of the
9 enactment of this Act, the Secretary shall arrange to fur-
10 nish to subsection (d) hospitals (as defined in section
11 1886(d)(1)(B) of the Social Security Act, 42 U.S.C.
12 1395ww(d)(1)(B)) the data necessary for such hospitals
13 to compute the number of patient days used in computing
14 the disproportionate patient percentage under such section
15 for that hospital for the current cost reporting year. Such
16 data shall also be furnished to other hospitals which would
17 qualify for additional payments under part A of title
18 XVIII of the Social Security Act on the basis of such data.

19 **SEC. 552. REVISIONS TO REASSIGNMENT PROVISIONS.**

20 (a) **IN GENERAL.**—Section 1842(b)(6)(A) (42 U.S.C.
21 1395u(b)(6)(A)) is amended by striking “or (ii) (where
22 the service was provided in a hospital, critical access hos-
23 pital, clinic, or other facility) to the facility in which the
24 service was provided if there is a contractual arrangement
25 between such physician or other person and such facility

1 under which such facility submits the bill for such serv-
2 ice,” and inserting “or (ii) where the service was provided
3 under a contractual arrangement between such physician
4 or other person and an entity, to the entity if, under the
5 contractual arrangement, the entity submits the bill for
6 the service and the contractual arrangement meets such
7 program integrity and other safeguards as the Secretary
8 may determine to be appropriate,”.

9 (b) CONFORMING AMENDMENT.—The second sen-
10 tence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is
11 amended by striking “except to an employer or facility as
12 described in clause (A)” and inserting “except to an em-
13 ployer or entity as described in subparagraph (A)”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to payments made on or after the
16 date of the enactment of this Act.

17 **SEC. 553. OTHER PROVISIONS.**

18 (a) GAO REPORTS ON THE PHYSICIAN COMPENSA-
19 TION.—

20 (1) SUSTAINABLE GROWTH RATE AND UP-
21 DATES.—Not later than 6 months after the date of
22 the enactment of this Act, the Comptroller General
23 of the United States shall submit to Congress a re-
24 port on the appropriateness of the updates in the
25 conversion factor under subsection (d)(3) of section

1 1848 of the Social Security Act (42 U.S.C. 1395w–
2 4), including the appropriateness of the sustainable
3 growth rate formula under subsection (f) of such
4 section for 2002 and succeeding years. Such report
5 shall examine the stability and predictability of such
6 updates and rate and alternatives for the use of such
7 rate in the updates.

8 (2) PHYSICIAN COMPENSATION GENERALLY.—
9 Not later than 12 months after the date of the en-
10 actment of this Act, the Comptroller General shall
11 submit to Congress a report on all aspects of physi-
12 cian compensation for services furnished under title
13 XVIII of the Social Security Act, and how those as-
14 pects interact and the effect on appropriate com-
15 pensation for physician services. Such report shall
16 review alternatives for the physician fee schedule
17 under section 1848 of such title (42 U.S.C. 1395w–
18 4).

19 (b) ANNUAL PUBLICATION OF LIST OF NATIONAL
20 COVERAGE DETERMINATIONS.—The Secretary shall pro-
21 vide, in an appropriate annual publication available to the
22 public, a list of national coverage determinations made
23 under title XVIII of the Social Security Act in the pre-
24 vious year and information on how to get more informa-
25 tion with respect to such determinations.

1 (c) GAO REPORT ON FLEXIBILITY IN APPLYING
2 HOME HEALTH CONDITIONS OF PARTICIPATION TO PA-
3 TIENTS WHO ARE NOT MEDICARE BENEFICIARIES.—Not
4 later than 6 months after the date of the enactment of
5 this Act, the Comptroller General of the United States
6 shall submit to Congress a report on the implications if
7 there were flexibility in the application of the medicare
8 conditions of participation for home health agencies with
9 respect to groups or types of patients who are not medi-
10 care beneficiaries. The report shall include an analysis of
11 the potential impact of such flexible application on clinical
12 operations and the recipients of such services and an anal-
13 ysis of methods for monitoring the quality of care provided
14 to such recipients.

15 (d) OIG REPORT ON NOTICES RELATING TO USE OF
16 HOSPITAL LIFETIME RESERVE DAYS.—Not later than 1
17 year after the date of the enactment of this Act, the In-
18 spector General of the Department of Health and Human
19 Services shall submit a report to Congress on—

20 (1) the extent to which hospitals provide notice
21 to medicare beneficiaries in accordance with applica-
22 ble requirements before they use the 60 lifetime re-
23 serve days described in section 1812(a)(1) of the So-
24 cial Security Act (42 U.S.C. 1395d(a)(1)); and

1 (2) the appropriateness and feasibility of hos-
 2 pitals providing a notice to such beneficiaries before
 3 they completely exhaust such lifetime reserve days.

4 **TITLE VI—MEDICAID AND**
 5 **MISCELLANEOUS PROVISIONS**
 6 **Subtitle A—Medicaid Provisions**

7 **SEC. 601. MEDICAID DISPROPORTIONATE SHARE HOSPITAL**
 8 **(DSH) PAYMENTS.**

9 (a) TEMPORARY INCREASE.—Section 1923(f)(3) (42
 10 U.S.C. 1396r-4(f)(3)) is amended—

11 (1) in subparagraph (A), by striking “subpara-
 12 graph (B)” and inserting “subparagraphs (B) and
 13 (C)”;

14 (2) by adding at the end the following new sub-
 15 paragraphs:

16 “(C) SPECIAL, TEMPORARY INCREASE IN
 17 ALLOTMENTS ON A ONE-TIME, NON-CUMU-
 18 LATIVE BASIS.—The DSH allotment for any
 19 State (other than a State with a DSH allot-
 20 ment determined under paragraph (5))—

21 “(i) for fiscal year 2004 is equal to
 22 116 percent of the DSH allotment for the
 23 State for fiscal year 2003 under this para-
 24 graph, notwithstanding subparagraph (B);
 25 and

1 “(ii) for each succeeding fiscal year is
2 equal to the DSH allotment for the State
3 for fiscal year 2004 or, in the case of fiscal
4 years beginning with the fiscal year speci-
5 fied in subparagraph (D) for that State,
6 the DSH allotment for the State for the
7 previous fiscal year increased by the per-
8 centage change in the consumer price
9 index for all urban consumers (all items;
10 U.S. city average), for the previous fiscal
11 year.

12 “(D) FISCAL YEAR SPECIFIED.—For pur-
13 poses of subparagraph (C)(ii), the fiscal year
14 specified in this subparagraph for a State is the
15 first fiscal year for which the Secretary esti-
16 mates that the DSH allotment for that State
17 will equal (or no longer exceed) the DSH allot-
18 ment for that State under the law as in effect
19 before the date of the enactment of this sub-
20 paragraph.”.

21 (b) INCREASE IN FLOOR FOR TREATMENT AS A LOW
22 DSH STATE.—Section 1923(f)(5) (42 U.S.C. 1396r-
23 4(f)(5)) is amended to read as follows:

24 “(5) SPECIAL RULE FOR LOW DSH STATES.—In
25 the case of a State in which the total expenditures

1 under the State plan (including Federal and State
2 shares) for disproportionate share hospital adjust-
3 ments under this section for fiscal year 2000, as re-
4 ported to the Administrator of the Centers for Medi-
5 care & Medicaid Services as of August 31, 2003, is
6 greater than 0 but less than 3 percent of the State’s
7 total amount of expenditures under the State plan
8 for medical assistance during the fiscal year, the
9 DSH allotment for the State with respect to—

10 “(A) fiscal year 2004 shall be the DSH al-
11 lotment for the State for fiscal year 2003 in-
12 creased by 16 percent;

13 “(B) each succeeding fiscal year before fis-
14 cal year 2009 shall be the DSH allotment for
15 the State for the previous fiscal year increased
16 by 16 percent; and

17 “(C) fiscal year 2009 and any subsequent
18 fiscal year, shall be the DSH allotment for the
19 State for the previous year subject to an in-
20 crease for inflation as provided in paragraph
21 (3)(A).”.

22 (c) ALLOTMENT ADJUSTMENT.—Section 1923(f) (42
23 U.S.C. 1396r-4(f)) is amended—

1 (1) in paragraph (3)(A), by striking “The
2 DSH” and inserting “Except as provided in para-
3 graph (6), the DSH”;

4 (2) by redesignating paragraph (6) as para-
5 graph (7); and

6 (3) by inserting after paragraph (5) the fol-
7 lowing:

8 “(6) ALLOTMENT ADJUSTMENT.—Only with re-
9 spect to fiscal year 2004 or 2005, if a statewide
10 waiver under section 1115 is revoked or terminated
11 before the end of either such fiscal year and there
12 is no DSH allotment for the State, the Secretary
13 shall—

14 “(A) permit the State whose waiver was
15 revoked or terminated to submit an amendment
16 to its State plan that would describe the meth-
17 odology to be used by the State (after the effec-
18 tive date of such revocation or termination) to
19 identify and make payments to disproportionate
20 share hospitals, including children’s hospitals
21 and institutions for mental diseases or other
22 mental health facilities (other than State-owned
23 institutions or facilities), on the basis of the
24 proportion of patients served by such hospitals

1 that are low-income patients with special needs;
2 and

3 “(B) provide for purposes of this sub-
4 section for computation of an appropriate DSH
5 allotment for the State for fiscal year 2004 or
6 2005 (or both) that would not exceed the
7 amount allowed under paragraph (3)(B)(ii) and
8 that does not result in greater expenditures
9 under this title than would have been made if
10 such waiver had not been revoked or termi-
11 nated.

12 In determining the amount of an appropriate DSH
13 allotment under subparagraph (B) for a State, the
14 Secretary shall take into account the level of DSH
15 expenditures for the State for the fiscal year pre-
16 ceding the fiscal year in which the waiver com-
17 menced.”.

18 (d) INCREASED REPORTING AND OTHER REQUIRE-
19 MENTS TO ENSURE THE APPROPRIATE USE OF MED-
20 ICAID DSH PAYMENT ADJUSTMENTS.—Section 1923 (42
21 U.S.C. 1396r-4) is amended by adding at the end the fol-
22 lowing new subsection:

23 “(j) ANNUAL REPORTS AND OTHER REQUIREMENTS
24 REGARDING PAYMENT ADJUSTMENTS.—With respect to
25 fiscal year 2004 and each fiscal year thereafter, the Sec-

1 retary shall require a State, as a condition of receiving
2 a payment under section 1903(a)(1) with respect to a pay-
3 ment adjustment made under this section, to do the fol-
4 lowing:

5 “(1) REPORT.—The State shall submit an an-
6 nual report that includes the following:

7 “(A) An identification of each dispropor-
8 tionate share hospital that received a payment
9 adjustment under this section for the preceding
10 fiscal year and the amount of the payment ad-
11 justment made to such hospital for the pre-
12 ceding fiscal year.

13 “(B) Such other information as the Sec-
14 retary determines necessary to ensure the ap-
15 propriateness of the payment adjustments made
16 under this section for the preceding fiscal year.

17 “(2) INDEPENDENT CERTIFIED AUDIT.—The
18 State shall annually submit to the Secretary an inde-
19 pendent certified audit that verifies each of the fol-
20 lowing:

21 “(A) The extent to which hospitals in the
22 State have reduced their uncompensated care
23 costs to reflect the total amount of claimed ex-
24 penditures made under this section.

1 “(B) Payments under this section to hos-
2 pitals that comply with the requirements of sub-
3 section (g).

4 “(C) Only the uncompensated care costs of
5 providing inpatient hospital and outpatient hos-
6 pital services to individuals described in para-
7 graph (1)(A) of such subsection are included in
8 the calculation of the hospital-specific limits
9 under such subsection.

10 “(D) The State included all payments
11 under this title, including supplemental pay-
12 ments, in the calculation of such hospital-spe-
13 cific limits.

14 “(E) The State has separately documented
15 and retained a record of all of its costs under
16 this title, claimed expenditures under this title,
17 uninsured costs in determining payment adjust-
18 ments under this section, and any payments
19 made on behalf of the uninsured from payment
20 adjustments under this section.”.

21 (e) CLARIFICATION REGARDING NON-REGULATION
22 OF TRANSFERS.—

23 (1) IN GENERAL.—Nothing in section 1903(w)
24 of the Social Security Act (42 U.S.C. 1396b(w))
25 shall be construed by the Secretary as prohibiting a

1 State's use of funds as the non-Federal share of ex-
2 penditures under title XIX of such Act where such
3 funds are transferred from or certified by a publicly-
4 owned regional medical center located in another
5 State and described in paragraph (2), so long as the
6 Secretary determines that such use of funds is prop-
7 er and in the interest of the program under title
8 XIX.

9 (2) CENTER DESCRIBED.—A center described
10 in this paragraph is a publicly-owned regional med-
11 ical center that—

12 (A) provides level 1 trauma and burn care
13 services;

14 (B) provides level 3 neonatal care services;

15 (C) is obligated to serve all patients, re-
16 gardless of State of origin;

17 (D) is located within a Standard Metro-
18 politan Statistical Area (SMSA) that includes
19 at least 3 States, including the States described
20 in paragraph (1);

21 (E) serves as a tertiary care provider for
22 patients residing within a 125 mile radius; and

23 (F) meets the criteria for a dispropor-
24 tionate share hospital under section 1923 of

1 such Act in at least one State other than the
2 one in which the center is located.

3 (3) EFFECTIVE PERIOD.—This subsection shall
4 apply through December 31, 2005.

5 **SEC. 602. CLARIFICATION OF INCLUSION OF INPATIENT**
6 **DRUG PRICES CHARGED TO CERTAIN PUBLIC**
7 **HOSPITALS IN THE BEST PRICE EXEMPTIONS**
8 **FOR THE MEDICAID DRUG REBATE PRO-**
9 **GRAM.**

10 (a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42
11 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting
12 before the semicolon the following: “(including inpatient
13 prices charged to hospitals described in section
14 340B(a)(4)(L) of the Public Health Service Act)”.

15 (b) ANTI-DIVERSION PROTECTION.—Section
16 1927(c)(1)(C) (42 U.S.C. 1396r–8(c)(1)(C)) is amended
17 by adding at the end the following:

18 “(iii) APPLICATION OF AUDITING AND
19 RECORDKEEPING REQUIREMENTS.—With
20 respect to a covered entity described in
21 section 340B(a)(4)(L) of the Public Health
22 Service Act, any drug purchased for inpa-
23 tient use shall be subject to the auditing
24 and recordkeeping requirements described

1 in section 340B(a)(5)(C) of the Public
2 Health Service Act.”.

3 **SEC. 603. EXTENSION OF MORATORIUM.**

4 (a) IN GENERAL.—Section 6408(a)(3) of the Omni-
5 bus Budget Reconciliation Act of 1989, as amended by
6 section 13642 of the Omnibus Budget Reconciliation Act
7 of 1993 and section 4758 of the Balanced Budget Act of
8 1997, is amended—

9 (1) by striking “until December 31, 2002”, and

10 (2) by striking “Kent Community Hospital
11 Complex in Michigan or.”

12 (b) EFFECTIVE DATES.—

13 (1) PERMANENT EXTENSION.—The amendment
14 made by subsection (a)(1) shall take effect as if in-
15 cluded in the amendment made by section 4758 of
16 the Balanced Budget Act of 1997.

17 (2) MODIFICATION.—The amendment made by
18 subsection (a)(2) shall take effect on the date of en-
19 actment of this Act.

20 **Subtitle B—Miscellaneous**
21 **Provisions**

22 **SEC. 611. FEDERAL REIMBURSEMENT OF EMERGENCY**
23 **HEALTH SERVICES FURNISHED TO UNDOCU-**
24 **MENTED ALIENS.**

25 (a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

1 (1) IN GENERAL.—Out of any funds in the
2 Treasury not otherwise appropriated, there are ap-
3 propriated to the Secretary \$250,000,000 for each
4 of fiscal years 2005 through 2008 for the purpose
5 of making allotments under this section for pay-
6 ments to eligible providers in States described in
7 paragraph (1) or (2) of subsection (b).

8 (2) AVAILABILITY.—Funds appropriated under
9 paragraph (1) shall remain available until expended.

10 (b) STATE ALLOTMENTS.—

11 (1) BASED ON PERCENTAGE OF UNDOCU-
12 MENTED ALIENS.—

13 (A) IN GENERAL.—Out of the amount ap-
14 propriated under subsection (a) for a fiscal
15 year, the Secretary shall use \$167,000,000 of
16 such amount to make allotments for such fiscal
17 year in accordance with subparagraph (B).

18 (B) FORMULA.—The amount of the allot-
19 ment for payments to eligible providers in each
20 State for a fiscal year shall be equal to the
21 product of—

22 (i) the total amount available for al-
23 lotments under this paragraph for the fis-
24 cal year; and

1 (ii) the percentage of undocumented
2 aliens residing in the State as compared to
3 the total number of such aliens residing in
4 all States, as determined by the Statistics
5 Division of the Immigration and Natu-
6 ralization Service, as of January 2003,
7 based on the 2000 decennial census.

8 (2) BASED ON NUMBER OF UNDOCUMENTED
9 ALIEN APPREHENSION STATES.—

10 (A) IN GENERAL.—Out of the amount ap-
11 propriated under subsection (a) for a fiscal
12 year, the Secretary shall use \$83,000,000 of
13 such amount to make allotments, in addition to
14 amounts allotted under paragraph (1), for such
15 fiscal year for each of the 6 States with the
16 highest number of undocumented alien appre-
17 hensions for such fiscal year.

18 (B) DETERMINATION OF ALLOTMENTS.—
19 The amount of the allotment for each State de-
20 scribed in subparagraph (A) for a fiscal year
21 shall be equal to the product of—

22 (i) the total amount available for al-
23 lotments under this paragraph for the fis-
24 cal year; and

1 (ii) the percentage of undocumented
2 alien apprehensions in the State in that
3 fiscal year as compared to the total of such
4 apprehensions for all such States for the
5 preceding 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 apprehension rates for the 4-con-
10 secutive-quarter period ending before the begin-
11 ning of the fiscal year for which information is
12 available for undocumented aliens in such
13 States, as reported by the Department of
14 Homeland Security.

15 (c) USE OF FUNDS.—

16 (1) AUTHORITY TO MAKE PAYMENTS.—From
17 the allotments made for a State under subsection (b)
18 for a fiscal year, the Secretary shall pay the amount
19 (subject to the total amount available from such al-
20 lotments) determined under paragraph (2) directly
21 to eligible providers located in the State for the pro-
22 vision of eligible services to aliens described in para-
23 graph (5) to the extent that the eligible provider was
24 not otherwise reimbursed (through insurance or oth-
25 erwise) for such services during that fiscal year.

1 (2) DETERMINATION OF PAYMENT AMOUNTS.—

2 (A) IN GENERAL.—Subject to subpara-
3 graph (B), the payment amount determined
4 under this paragraph shall be an amount deter-
5 mined by the Secretary that is equal to the less-
6 er of—

7 (i) the amount that the provider dem-
8 onstrates was incurred for the provision of
9 such services; or

10 (ii) amounts determined under a
11 methodology established by the Secretary
12 for purposes of this subsection.

13 (B) PRO-RATA REDUCTION.—If the
14 amount of funds allotted to a State under sub-
15 section (b) for a fiscal year is insufficient to en-
16 sure that each eligible provider in that State re-
17 ceives the amount of payment calculated under
18 subparagraph (A), the Secretary shall reduce
19 that amount of payment with respect to each el-
20 igible provider to ensure that the entire amount
21 allotted to the State for that fiscal year is paid
22 to such eligible providers.

23 (3) METHODOLOGY.—In establishing a method-
24 ology under paragraph (2)(A)(ii), the Secretary—

1 (A) may establish different methodologies
2 for types of eligible providers;

3 (B) may base payments for hospital serv-
4 ices on estimated hospital charges, adjusted to
5 estimated cost, through the application of hos-
6 pital-specific cost-to-charge ratios;

7 (C) shall provide for the election by a hos-
8 pital to receive either payments to the hospital
9 for—

10 (i) hospital and physician services; or

11 (ii) hospital services and for a portion

12 of the on-call payments made by the hos-
13 pital to physicians; and

14 (D) shall make quarterly payments under
15 this section to eligible providers.

16 If a hospital makes the election under subparagraph
17 (C)(i), the hospital shall pass on payments for serv-
18 ices of a physician to the physician and may not
19 charge any administrative or other fee with respect
20 to such payments.

21 (4) LIMITATION ON USE OF FUNDS.—Payments
22 made to eligible providers in a State from allotments
23 made under subsection (b) for a fiscal year may only
24 be used for costs incurred in providing eligible serv-
25 ices to aliens described in paragraph (5).

1 (5) ALIENS DESCRIBED.—For purposes of
2 paragraphs (1) and (2), aliens described in this
3 paragraph are any of the following:

4 (A) Undocumented aliens.

5 (B) Aliens who have been paroled into the
6 United States at a United States port of entry
7 for the purpose of receiving eligible services.

8 (C) Mexican citizens permitted to enter the
9 United States for not more than 72 hours
10 under the authority of a biometric machine
11 readable border crossing identification card
12 (also referred to as a “laser visa”) issued in ac-
13 cordance with the requirements of regulations
14 prescribed under section 101(a)(6) of the Immi-
15 gration and Nationality Act (8 U.S.C.
16 1101(a)(6)).

17 (d) APPLICATIONS; ADVANCE PAYMENTS.—

18 (1) DEADLINE FOR ESTABLISHMENT OF APPLI-
19 CATION PROCESS.—

20 (A) IN GENERAL.—Not later than Sep-
21 tember 1, 2004, the Secretary shall establish a
22 process under which eligible providers located in
23 a State may request payments under subsection
24 (c).

1 (B) INCLUSION OF MEASURES TO COMBAT
2 FRAUD AND ABUSE.—The Secretary shall in-
3 clude in the process established under subpara-
4 graph (A) measures to ensure that inappro-
5 priate, excessive, or fraudulent payments are
6 not made from the allotments determined under
7 subsection (b), including certification by the eli-
8 gible provider of the veracity of the payment re-
9 quest.

10 (2) ADVANCE PAYMENT; RETROSPECTIVE AD-
11 JUSTMENT.—The process established under para-
12 graph (1) may provide for making payments under
13 this section for each quarter of a fiscal year on the
14 basis of advance estimates of expenditures submitted
15 by applicants for such payments and such other in-
16 vestigation as the Secretary may find necessary, and
17 for making reductions or increases in the payments
18 as necessary to adjust for any overpayment or un-
19 derpayment for prior quarters of such fiscal year.

20 (e) DEFINITIONS.—In this section:

21 (1) ELIGIBLE PROVIDER.—The term “eligible
22 provider” means a hospital, physician, or provider of
23 ambulance services (including an Indian Health
24 Service facility whether operated by the Indian

1 Health Service or by an Indian tribe or tribal orga-
2 nization).

3 (2) ELIGIBLE SERVICES.—The term “eligible
4 services” means health care services required by the
5 application of section 1867 of the Social Security
6 Act (42 U.S.C. 1395dd), and related hospital inpa-
7 tient and outpatient services and ambulance services
8 (as defined by the Secretary).

9 (3) HOSPITAL.—The term “hospital” has the
10 meaning given such term in section 1861(e) of the
11 Social Security Act (42 U.S.C. 1395x(e)), except
12 that such term shall include a critical access hospital
13 (as defined in section 1861(mm)(1) of such Act (42
14 U.S.C. 1395x(mm)(1)).

15 (4) PHYSICIAN.—The term “physician” has the
16 meaning given that term in section 1861(r) of the
17 Social Security Act (42 U.S.C. 1395x(r)).

18 (5) INDIAN TRIBE; TRIBAL ORGANIZATION.—
19 The terms “Indian tribe” and “tribal organization”
20 have the meanings given such terms in section 4 of
21 the Indian Health Care Improvement Act (25 U.S.C.
22 1603).

23 (6) STATE.—The term “State” means the 50
24 States and the District of Columbia.

1 **SEC. 612. COMMISSION ON SYSTEMIC INTEROPERABILITY.**

2 (a) ESTABLISHMENT.—The Secretary shall establish
3 a commission to be known as the “Commission on Sys-
4 temic Interoperability” (in this section referred to as the
5 “Commission”).

6 (b) DUTIES.—

7 (1) IN GENERAL.—The Commission shall de-
8 velop a comprehensive strategy for the adoption and
9 implementation of health care information tech-
10 nology standards, that includes a timeline and
11 prioritization for such adoption and implementation.

12 (2) CONSIDERATIONS.—In developing the com-
13 prehensive health care information technology strat-
14 egy under paragraph (1), the Commission shall con-
15 sider—

16 (A) the costs and benefits of the stand-
17 ards, both financial impact and quality improve-
18 ment;

19 (B) the current demand on industry re-
20 sources to implement this Act and other elec-
21 tronic standards, including HIPAA standards;
22 and

23 (C) the most cost-effective and efficient
24 means for industry to implement the standards.

25 (3) NONINTERFERENCE.—In carrying out this
26 section, the Commission shall not interfere with any

1 standards development of adoption processes under-
2 way in the private or public sector and shall not rep-
3 licate activities related to such standards or the na-
4 tional health information infrastructure underway
5 within the Department of Health and Human Serv-
6 ices.

7 (4) REPORT.—Not later than October 31,
8 2005, the Commission shall submit to the Secretary
9 and to Congress a report describing the strategy de-
10 veloped under paragraph (1), including an analysis
11 of the matters considered under paragraph (2).

12 (c) MEMBERSHIP.—

13 (1) NUMBER AND APPOINTMENT.—The Com-
14 mission shall be composed of 11 members appointed
15 as follows:

16 (A) The President shall appoint 3 mem-
17 bers, one of whom the President shall designate
18 as Chairperson.

19 (B) The Majority Leader of the Senate
20 shall appoint 2 members.

21 (C) The Minority Leader of the Senate
22 shall appoint 2 members.

23 (D) The Speaker of the House of Rep-
24 resentatives shall appoint 2 members.

1 (E) The Minority Leader of the House of
2 Representatives shall appoint 2 members.

3 (2) QUALIFICATIONS.—The membership of the
4 Commission shall include individuals with national
5 recognition for their expertise in health finance and
6 economics, health plans and integrated delivery sys-
7 tems, reimbursement of health facilities, practicing
8 physicians, practicing pharmacists, and other pro-
9 viders of health services, health care technology and
10 information systems, and other related fields, who
11 provide a mix of different professionals, broad geo-
12 graphic representation, and a balance between urban
13 and rural representatives.

14 (d) TERMS.—Each member shall be appointed for the
15 life of the Commission.

16 (e) COMPENSATION.—

17 (1) RATES OF PAY.—Members shall each be
18 paid at a rate not to exceed the daily equivalent of
19 the rate of basic pay for level IV of the Executive
20 Schedule for each day (including travel time) during
21 which they are engaged in the actual performance of
22 duties vested in the Commission.

23 (2) PROHIBITION OF COMPENSATION OF FED-
24 ERAL EMPLOYEES.—Members of the Commission
25 who are full-time officers or employees of the United

1 States or Members of Congress may not receive ad-
2 ditional pay, allowances, or benefits by reason of
3 their service on the Commission.

4 (3) TRAVEL EXPENSES.—Each member shall
5 receive travel expenses, including per diem in lieu of
6 subsistence, in accordance with applicable provisions
7 under subchapter I of chapter 57 of title 5, United
8 States Code.

9 (f) QUORUM.—A majority of the members of the
10 Commission shall constitute a quorum but a lesser number
11 may hold hearings.

12 (g) DIRECTOR AND STAFF OF COMMISSION; EX-
13 PERTS AND CONSULTANTS.—

14 (1) DIRECTOR.—The Commission shall have a
15 Director who shall be appointed by the Chairperson.
16 The Director shall be paid at a rate not to exceed
17 the rate of basic pay for level IV of the Executive
18 Schedule.

19 (2) STAFF.—With the approval of the Commis-
20 sion, the Director may appoint and fix the pay of
21 such additional personnel as the Director considers
22 appropriate.

23 (3) APPLICABILITY OF CERTAIN CIVIL SERVICE
24 LAWS.—The Director and staff of the Commission
25 may be appointed without regard to the provisions

1 of title 5, United States Code, governing appoint-
2 ments in the competitive service, and may be paid
3 without regard to the provisions of chapter 51 and
4 subchapter III of chapter 53 of that title relating to
5 classification and General Schedule pay rates, except
6 that an individual so appointed may not receive pay
7 in excess of level IV of the Executive Schedule.

8 (4) EXPERTS AND CONSULTANTS.—With the
9 approval of the Commission, the Director may pro-
10 cure temporary and intermittent services under sec-
11 tion 3109(b) of title 5, United States Code.

12 (5) STAFF OF FEDERAL AGENCIES.—Upon re-
13 quest of the Chairperson, the head of any Federal
14 department or agency may detail, on a reimbursable
15 basis, any of the personnel of that department or
16 agency to the Commission to assist it in carrying out
17 its duties under this Act.

18 (h) POWERS OF COMMISSION.—

19 (1) HEARINGS AND SESSIONS.—The Commis-
20 sion may, for the purpose of carrying out this Act,
21 hold hearings, sit and act at times and places, take
22 testimony, and receive evidence as the Commission
23 considers appropriate.

24 (2) POWERS OF MEMBERS AND AGENTS.—Any
25 member or agent of the Commission may, if author-

1 ized by the Commission, take any action which the
2 Commission is authorized to take by this section.

3 (3) OBTAINING OFFICIAL DATA.—The Commis-
4 sion may secure directly from any department or
5 agency of the United States information necessary
6 to enable it to carry out this Act. Upon request of
7 the Chairperson of the Commission, the head of that
8 department or agency shall furnish that information
9 to the Commission.

10 (4) GIFTS, BEQUESTS, AND DEVISES.—The
11 Commission may accept, use, and dispose of gifts,
12 bequests, or devises of services or property, both real
13 and personal, for the purpose of aiding or facili-
14 tating the work of the Commission. Gifts, bequests,
15 or devises of money and proceeds from sales of other
16 property received as gifts, bequests, or devises shall
17 be deposited in the Treasury and shall be available
18 for disbursement upon order of the Commission. For
19 purposes of Federal income, estate, and gift taxes,
20 property accepted under this subsection shall be con-
21 sidered as a gift, bequest, or devise to the United
22 States.

23 (5) MAILS.—The Commission may use the
24 United States mails in the same manner and under

1 the same conditions as other departments and agen-
2 cies of the United States.

3 (6) ADMINISTRATIVE SUPPORT SERVICES.—

4 Upon the request of the Commission, the Adminis-
5 trator of General Services shall provide to the Com-
6 mission, on a reimbursable basis, the administrative
7 support services necessary for the Commission to
8 carry out its responsibilities under this Act.

9 (7) CONTRACT AUTHORITY.—The Commission
10 may enter into contracts or make other arrange-
11 ments, as may be necessary for the conduct of the
12 work of the Commission (without regard to section
13 3709 of the Revised Statutes (41 U.S.C. 5)).

14 (i) TERMINATION.—The Commission shall terminate
15 on 30 days after submitting its report pursuant to sub-
16 section (b)(3).

17 (j) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated such sums as may be nec-
19 essary to carry out this section.

20 **SEC. 613. RESEARCH ON OUTCOMES OF HEALTH CARE**
21 **ITEMS AND SERVICES.**

22 (a) RESEARCH, DEMONSTRATIONS, AND EVALUA-
23 TIONS.—

24 (1) IMPROVEMENT OF EFFECTIVENESS AND EF-
25 FICIENCY.—

1 (A) IN GENERAL.—To improve the quality,
2 effectiveness, and efficiency of health care deliv-
3 ered pursuant to the programs established
4 under titles XVIII, XIX, and XXI of the Social
5 Security Act, the Secretary acting through the
6 Director of the Agency for Healthcare Research
7 and Quality (in this section referred to as the
8 “Director”), shall conduct and support research
9 to meet the priorities and requests for scientific
10 evidence and information identified by such pro-
11 grams with respect to—

12 (i) the outcomes, comparative clinical
13 effectiveness, and appropriateness of health
14 care items and services (including prescrip-
15 tion drugs); and

16 (ii) strategies for improving the effi-
17 ciency and effectiveness of such programs,
18 including the ways in which such items
19 and services are organized, managed, and
20 delivered under such programs.

21 (B) SPECIFICATION.—To respond to prior-
22 ities and information requests in subparagraph
23 (A), the Secretary may conduct or support, by
24 grant, contract, or interagency agreement, re-
25 search, demonstrations, evaluations, technology

1 assessments, or other activities, including the
2 provision of technical assistance, scientific ex-
3 pertise, or methodological assistance.

4 (2) PRIORITIES.—

5 (A) IN GENERAL.—The Secretary shall es-
6 tablish a process to develop priorities that will
7 guide the research, demonstrations, and evalua-
8 tion activities undertaken pursuant to this sec-
9 tion.

10 (B) INITIAL LIST.—Not later than 6
11 months after the date of the enactment of this
12 Act, the Secretary shall establish an initial list
13 of priorities for research related to health care
14 items and services (including prescription
15 drugs).

16 (C) PROCESS.—In carrying out subpara-
17 graph (A), the Secretary—

18 (i) shall ensure that there is broad
19 and ongoing consultation with relevant
20 stakeholders in identifying the highest pri-
21 orities for research, demonstrations, and
22 evaluations to support and improve the
23 programs established under titles XVIII,
24 XIX, and XXI of the Social Security Act;

1 (ii) may include health care items and
2 services which impose a high cost on such
3 programs, as well as those which may be
4 underutilized or overutilized and which
5 may significantly improve the prevention,
6 treatment, or cure of diseases and condi-
7 tions (including chronic conditions) which
8 impose high direct or indirect costs on pa-
9 tients or society; and

10 (iii) shall ensure that the research and
11 activities undertaken pursuant to this sec-
12 tion are responsive to the specified prior-
13 ities and are conducted in a timely man-
14 ner.

15 (3) EVALUATION AND SYNTHESIS OF SCI-
16 ENTIFIC EVIDENCE.—

17 (A) IN GENERAL.—The Secretary shall—

18 (i) evaluate and synthesize available
19 scientific evidence related to health care
20 items and services (including prescription
21 drugs) identified as priorities in accordance
22 with paragraph (2) with respect to the
23 comparative clinical effectiveness, out-
24 comes, appropriateness, and provision of

1 such items and services (including pre-
2 scription drugs);

3 (ii) identify issues for which existing
4 scientific evidence is insufficient with re-
5 spect to such health care items and serv-
6 ices (including prescription drugs);

7 (iii) disseminate to prescription drug
8 plans and MA–PD plans under part D of
9 title XVIII of the Social Security Act,
10 other health plans, and the public the find-
11 ings made under clauses (i) and (ii); and

12 (iv) work in voluntary collaboration
13 with public and private sector entities to
14 facilitate the development of new scientific
15 knowledge regarding health care items and
16 services (including prescription drugs).

17 (B) INITIAL RESEARCH.—The Secretary
18 shall complete the evaluation and synthesis of
19 the initial research required by the priority list
20 developed under paragraph (2)(B) not later
21 than 18 months after the development of such
22 list.

23 (C) DISSEMINATION.—

24 (i) IN GENERAL.—To enhance patient
25 safety and the quality of health care, the

1 Secretary shall make available and dis-
2 seminate in appropriate formats to pre-
3 scription drugs plans under part D, and
4 MA-PD plans under part C, of title XVIII
5 of the Social Security Act, other health
6 plans, and the public the evaluations and
7 syntheses prepared pursuant to subpara-
8 graph (A) and the findings of research
9 conducted pursuant to paragraph (1). In
10 carrying out this clause the Secretary, in
11 order to facilitate the availability of such
12 evaluations and syntheses or findings at
13 every decision point in the health care sys-
14 tem, shall—

15 (I) present such evaluations and
16 syntheses or findings in a form that is
17 easily understood by the individuals
18 receiving health care items and serv-
19 ices (including prescription drugs)
20 under such plans and periodically as-
21 sess that the requirements of this sub-
22 clause have been met; and

23 (II) provide such evaluations and
24 syntheses or findings and other rel-
25 evant information through easily ac-

1 cessible and searchable electronic
2 mechanisms, and in hard copy for-
3 mats as appropriate.

4 (ii) RULE OF CONSTRUCTION.—Noth-
5 ing in this section shall be construed as—

6 (I) affecting the authority of the
7 Secretary or the Commissioner of
8 Food and Drugs under the Federal
9 Food, Drug, and Cosmetic Act or the
10 Public Health Service Act; or

11 (II) conferring any authority re-
12 ferred to in subclause (I) to the Direc-
13 tor.

14 (D) ACCOUNTABILITY.—In carrying out
15 this paragraph, the Secretary shall implement
16 activities in a manner that—

17 (i) makes publicly available all sci-
18 entific evidence relied upon and the meth-
19 odologies employed, provided such evidence
20 and method are not protected from public
21 disclosure by section 1905 of title 18,
22 United States Code, or other applicable
23 law so that the results of the research,
24 analyses, or syntheses can be evaluated or
25 replicated; and

1 (ii) ensures that any information
2 needs and unresolved issues identified in
3 subparagraph (A)(ii) are taken into ac-
4 count in priority-setting for future research
5 conducted by the Secretary.

6 (4) CONFIDENTIALITY.—

7 (A) IN GENERAL.—In making use of ad-
8 ministrative, clinical, and program data and in-
9 formation developed or collected with respect to
10 the programs established under titles XVIII,
11 XIX, and XXI of the Social Security Act, for
12 purposes of carrying out the requirements of
13 this section or the activities authorized under
14 title IX of the Public Health Service Act (42
15 U.S.C. 299 et seq.), such data and information
16 shall be protected in accordance with the con-
17 fidentiality requirements of title IX of the Pub-
18 lic Health Service Act.

19 (B) RULE OF CONSTRUCTION.—Nothing in
20 this section shall be construed to require or per-
21 mit the disclosure of data provided to the Sec-
22 retary that is otherwise protected from disclo-
23 sure under the Federal Food, Drug, and Cos-
24 metic Act, section 1905 of title 18, United
25 States Code, or other applicable law.

1 (5) EVALUATIONS.—The Secretary shall con-
2 duct and support evaluations of the activities carried
3 out under this section to determine the extent to
4 which such activities have had an effect on outcomes
5 and utilization of health care items and services.

6 (6) IMPROVING INFORMATION AVAILABLE TO
7 HEALTH CARE PROVIDERS, PATIENTS, AND POLICY-
8 MAKERS.—Not later than 18 months after the date
9 of enactment of this Act, the Secretary shall identify
10 options that could be undertaken in voluntary col-
11 laboration with private and public entities (as appro-
12 priate) for the—

13 (A) provision of more timely information
14 through the programs established under titles
15 XVIII, XIX, and XXI of the Social Security
16 Act, regarding the outcomes and quality of pa-
17 tient care, including clinical and patient-re-
18 ported outcomes, especially with respect to
19 interventions and conditions for which clinical
20 trials would not be feasible or raise ethical con-
21 cerns that are difficult to address;

22 (B) acceleration of the adoption of innova-
23 tion and quality improvement under such pro-
24 grams; and

1 (C) development of management tools for
2 the programs established under titles XIX and
3 XXI of the Social Security Act, and with re-
4 spect to the programs established under such ti-
5 tles, assess the feasibility of using administra-
6 tive or claims data, to—

7 (i) improve oversight by State offi-
8 cials;

9 (ii) support Federal and State initia-
10 tives to improve the quality, safety, and ef-
11 ficiency of services provided under such
12 programs; and

13 (iii) provide a basis for estimating the
14 fiscal and coverage impact of Federal or
15 State program and policy changes.

16 (b) RECOMMENDATIONS.—

17 (1) DISCLAIMER.—In carrying out this section,
18 the Director shall—

19 (A) not mandate national standards of
20 clinical practice or quality health care stand-
21 ards; and

22 (B) include in any recommendations result-
23 ing from projects funded and published by the
24 Director, a corresponding reference to the pro-
25 hibition described in subparagraph (A).

1 (2) REQUIREMENT FOR IMPLEMENTATION.—
2 Research, evaluation, and communication activities
3 performed pursuant to this section shall reflect the
4 principle that clinicians and patients should have the
5 best available evidence upon which to make choices
6 in health care items and services, in providers, and
7 in health care delivery systems, recognizing that pa-
8 tient subpopulations and patient and physician pref-
9 erences may vary.

10 (3) RULE OF CONSTRUCTION.—Nothing in this
11 section shall be construed to provide the Director
12 with authority to mandate a national standard or re-
13 quire a specific approach to quality measurement
14 and reporting.

15 (c) RESEARCH WITH RESPECT TO DISSEMINA-
16 TION.—The Secretary, acting through the Director, may
17 conduct or support research with respect to improving
18 methods of disseminating information in accordance with
19 subsection (a)(3)(C).

20 (d) LIMITATION ON CMS.—The Administrator of the
21 Centers for Medicare & Medicaid Services may not use
22 data obtained in accordance with this section to withhold
23 coverage of a prescription drug.

24 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
25 authorized to be appropriated to carry out this section,

1 \$50,000,000 for fiscal year 2004, and such sums as may
2 be necessary for each fiscal year thereafter.

3 **SEC. 614. HEALTH CARE THAT WORKS FOR ALL AMERI-**
4 **CANS: CITIZENS HEALTH CARE WORKING**
5 **GROUP.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) In order to improve the health care system,
8 the American public must engage in an informed na-
9 tional public debate to make choices about the serv-
10 ices they want covered, what health care coverage
11 they want, and how they are willing to pay for cov-
12 erage.

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

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

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

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

23 (3) Despite increases in medical care spending
24 that are greater than the rate of inflation, popu-
25 lation growth, and Gross Domestic Product growth,

1 there has not been a commensurate improvement in
2 our health status as a nation.

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

7 (5) Common life occurrences can jeopardize the
8 ability of a family to retain private coverage or jeop-
9 ardize access to public coverage.

10 (6) Innovations in health care access, coverage,
11 and quality of care, including the use of technology,
12 have often come from States, local communities, and
13 private sector organizations, but more creative poli-
14 cies could tap this potential.

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

18 (b) PURPOSES.—The purposes of this section are—

19 (1) to provide for a nationwide public debate
20 about improving the health care system to provide
21 every American with the ability to obtain quality, af-
22 fordable health care coverage; and

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

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

6 (d) MEMBERSHIP.—

7 (1) NUMBER AND APPOINTMENT.—The Work-
8 ing Group shall be composed of 15 members. One
9 member shall be the Secretary. The Comptroller
10 General of the United States shall appoint 14 mem-
11 bers.

12 (2) QUALIFICATIONS.—

13 (A) IN GENERAL.—The membership of the
14 Working Group shall include—

15 (i) consumers of health services that
16 represent those individuals who have not
17 had insurance within 2 years of appoint-
18 ment, that have had chronic illnesses, in-
19 cluding mental illness, are disabled, and
20 those who receive insurance coverage
21 through medicare and medicaid; and

22 (ii) individuals with expertise in fi-
23 nancing and paying for benefits and access
24 to care, business and labor perspectives,
25 and providers of health care.

1 The membership shall reflect a broad geo-
2 graphic representation and a balance between
3 urban and rural representatives.

4 (B) PROHIBITED APPOINTMENTS.—Mem-
5 bers of the Working Group shall not include
6 Members of Congress or other elected govern-
7 ment officials (Federal, State, or local). Individ-
8 uals appointed to the Working Group shall not
9 be paid employees or representatives of associa-
10 tions or advocacy organizations involved in the
11 health care system.

12 (e) PERIOD OF APPOINTMENT.—Members of the
13 Working Group shall be appointed for a life of the Work-
14 ing Group. Any vacancies shall not affect the power and
15 duties of the Working Group but shall be filled in the same
16 manner as the original appointment.

17 (f) DESIGNATION OF THE CHAIRPERSON.—Not later
18 than 15 days after the date on which all members of the
19 Working Group have been appointed under subsection
20 (d)(1), the Comptroller General shall designate the chair-
21 person of the Working Group.

22 (g) SUBCOMMITTEES.—The Working Group may es-
23 tablish subcommittees if doing so increases the efficiency
24 of the Working Group in completing its tasks.

25 (h) DUTIES.—

1 (1) HEARINGS.—Not later than 90 days after
2 the date of the designation of the chairperson under
3 subsection (f), the Working Group shall hold hear-
4 ings to examine—

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

7 (B) the cost of health care and the effec-
8 tiveness of care provided at all stages of dis-
9 ease;

10 (C) innovative State strategies used to ex-
11 pand health care coverage and lower health care
12 costs;

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

15 (E) efforts to enroll individuals currently
16 eligible for public or private health care cov-
17 erage;

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

24 (G) strategies to assist purchasers of
25 health care, including consumers, to become

1 more aware of the impact of costs, and to lower
2 the costs of health care.

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

12 (3) THE HEALTH REPORT TO THE AMERICAN
13 PEOPLE.—Not later than 90 days after the hearings
14 described in paragraphs (1) and (2) are completed,
15 the Working Group shall prepare and make available
16 to health care consumers through the Internet and
17 other appropriate public channels, a report to be en-
18 titled, “The Health Report to the American People”.
19 Such report shall be understandable to the general
20 public and include—

21 (A) a summary of—

22 (i) health care and related services
23 that may be used by individuals through-
24 out their life span;

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

5 (iii) the source of coverage and pay-
6 ment, including reimbursement, for health
7 care services;

8 (iv) the reasons people are uninsured
9 or underinsured and the cost to taxpayers,
10 purchasers of health services, and commu-
11 nities when Americans are uninsured or
12 underinsured;

13 (v) the impact on health care out-
14 comes and costs when individuals are
15 treated in all stages of disease;

16 (vi) health care cost containment
17 strategies; and

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

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

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

24 (D) information concerning the cost of
25 care in different settings, including institu-

1 tional-based care and home and community-
2 based care;

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

5 (F) the role of technology in providing fu-
6 ture health care including ways to support the
7 information needs of patients and providers.

8 (4) COMMUNITY MEETINGS.—

9 (A) IN GENERAL.—Not later than 1 year
10 after the date on which all the members of the
11 Working Group have been appointed under sub-
12 section (d)(1) and appropriations are first made
13 available to carry out this section, the Working
14 Group shall initiate health care community
15 meetings throughout the United States (in this
16 paragraph referred to as “community meet-
17 ings”). Such community meetings may be geo-
18 graphically or regionally based and shall be
19 completed within 180 days after the initiation
20 of the first meeting.

21 (B) NUMBER OF MEETINGS.—The Work-
22 ing Group shall hold a sufficient number of
23 community meetings in order to receive infor-
24 mation that reflects—

1 (i) the geographic differences through-
2 out the United States;

3 (ii) diverse populations; and

4 (iii) a balance among urban and rural
5 populations.

6 (C) MEETING REQUIREMENTS.—

7 (i) FACILITATOR.—A State health of-
8 ficer may be the facilitator at the commu-
9 nity meetings.

10 (ii) ATTENDANCE.—At least 1 mem-
11 ber of the Working Group shall attend and
12 serve as chair of each community meeting.
13 Other members may participate through
14 interactive technology.

15 (iii) TOPICS.—The community meet-
16 ings shall, at a minimum, address the fol-
17 lowing questions:

18 (I) What health care benefits and
19 services should be provided?

20 (II) How does the American pub-
21 lic want health care delivered?

22 (III) How should health care cov-
23 erage be financed?

24 (IV) What trade-offs are the
25 American public willing to make in ei-

1 ther benefits or financing to ensure
2 access to affordable, high quality
3 health care coverage and services?

4 (iv) INTERACTIVE TECHNOLOGY.—

5 The Working Group may encourage public
6 participation in community meetings
7 through interactive technology and other
8 means as determined appropriate by the
9 Working Group.

10 (D) INTERIM REQUIREMENTS.—Not later
11 than 180 days after the date of completion of
12 the community meetings, the Working Group
13 shall prepare and make available to the public
14 through the Internet and other appropriate
15 public channels, an interim set of recommenda-
16 tions on health care coverage and ways to im-
17 prove and strengthen the health care system
18 based on the information and preferences ex-
19 pressed at the community meetings. There shall
20 be a 90-day public comment period on such rec-
21 ommendations.

22 (i) RECOMMENDATIONS.—Not later than 120 days
23 after the expiration of the public comment period de-
24 scribed in subsection (h)(4)(D), the Working Group shall

1 submit to Congress and the President a final set of rec-
2 ommendations.

3 (j) ADMINISTRATION.—

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

9 (2) COMPENSATION.—While serving on the
10 business of the Working Group (including travel
11 time), a member of the Working Group shall be enti-
12 tled to compensation at the per diem equivalent of
13 the rate provided for level IV of the Executive
14 Schedule under section 5315 of title 5, United
15 States Code, and while so serving away from home
16 and the member's regular place of business, a mem-
17 ber may be allowed travel expenses, as authorized
18 by the chairperson of the Working Group. For pur-
19 poses of pay and employment benefits, rights, and
20 privileges, all personnel of the Working Group shall
21 be treated as if they were employees of the Senate.

22 (3) INFORMATION FROM FEDERAL AGENCIES.—
23 The Working Group may secure directly from any
24 Federal department or agency such information as
25 the Working Group considers necessary to carry out

1 this section. Upon request of the Working Group,
2 the head of such department or agency shall furnish
3 such information.

4 (4) **POSTAL SERVICES.**—The Working Group
5 may use the United States mails in the same man-
6 ner and under the same conditions as other depart-
7 ments and agencies of the Federal Government.

8 (k) **DETAIL.**—Not more than 10 Federal Government
9 employees employed by the Department of Labor and 10
10 Federal Government employees employed by the Depart-
11 ment of Health and Human Services may be detailed to
12 the Working Group under this section without further re-
13 imbursement. Any detail of an employee shall be without
14 interruption or loss of civil service status or privilege.

15 (l) **TEMPORARY AND INTERMITTENT SERVICES.**—
16 The chairperson of the Working Group may procure tem-
17 porary and intermittent services under section 3109(b) of
18 title 5, United States Code, at rates for individuals which
19 do not exceed the daily equivalent of the annual rate of
20 basic pay prescribed for level V of the Executive Schedule
21 under section 5316 of such title.

22 (m) **ANNUAL REPORT.**—Not later than 1 year after
23 the date of enactment of this Act, and annually thereafter
24 during the existence of the Working Group, the Working
25 Group shall report to Congress and make public a detailed

1 description of the expenditures of the Working Group used
2 to carry out its duties under this section.

3 (n) SUNSET OF WORKING GROUP.—The Working
4 Group shall terminate on the date that is 2 years after
5 the date on which all the members of the Working Group
6 have been appointed under subsection (d)(1) and appro-
7 priations are first made available to carry out this section.

8 (o) ADMINISTRATION REVIEW AND COMMENTS.—
9 Not later than 45 days after receiving the final rec-
10 ommendations of the Working Group under subsection (i),
11 the President shall submit a report to Congress which
12 shall contain—

13 (1) additional views and comments on such rec-
14 ommendations; and

15 (2) recommendations for such legislation and
16 administrative actions as the President considers ap-
17 propriate.

18 (p) REQUIRED CONGRESSIONAL ACTION.—Not later
19 than 45 days after receiving the report submitted by the
20 President under subsection (o), each committee of juris-
21 diction of Congress, the Committee on Finance of the Sen-
22 ate, the Committee on Health, Education, Labor, and
23 Pensions of the Senate, the Committee on Ways and
24 Means of the House of Representatives, the Committee on
25 Energy and Commerce of the House of Representatives,

1 Committee on Education and the Workforce of the House
2 of Representatives, shall hold at least 1 hearing on such
3 report and on the final recommendations of the Working
4 Group submitted under subsection (i).

5 (q) AUTHORIZATION OF APPROPRIATIONS.—

6 (1) IN GENERAL.—There are authorized to be
7 appropriated to carry out this section, other than
8 subsection (h)(3), \$3,000,000 for each of fiscal years
9 2005 and 2006.

10 (2) HEALTH REPORT TO THE AMERICAN PEOP-
11 LE.—There are authorized to be appropriated for
12 the preparation and dissemination of the Health Re-
13 port to the American People described in subsection
14 (h)(3), such sums as may be necessary for the fiscal
15 year in which the report is required to be submitted.

16 **SEC. 615. FUNDING START-UP ADMINISTRATIVE COSTS FOR**
17 **MEDICARE REFORM.**

18 (a) IN GENERAL.—There are appropriated to carry
19 out this Act (including the amendments made by this Act),
20 to be transferred from the Federal Hospital Insurance
21 Trust Fund and the Federal Supplementary Medical In-
22 surance Trust Fund—

23 (1) not to exceed \$1,000,000,000 for the Cen-
24 ters for Medicare & Medicaid Services; and

1 “(b) APPLICATION.—No loan may be provided under
2 this section to a qualifying hospital except pursuant to an
3 application that is submitted and approved in a time, man-
4 ner, and form specified by the Secretary. A loan under
5 this section shall be on such terms and conditions and
6 meet such requirements as the Secretary determines ap-
7 propriate.

8 “(c) SELECTION CRITERIA.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish criteria for selecting among qualifying hospitals
11 that apply for a loan under this section. Such cri-
12 teria shall consider the extent to which the project
13 for which loan is sought is nationally or regionally
14 significant, in terms of expanding or improving the
15 health care infrastructure of the United States or
16 the region or in terms of the medical benefit that the
17 project will have.

18 “(2) QUALIFYING HOSPITAL DEFINED.—For
19 purposes of this section, the term ‘qualifying hos-
20 pital’ means a hospital that—

21 “(A) is engaged in research in the causes,
22 prevention, and treatment of cancer; and

23 “(B) is designated as a cancer center for
24 the National Cancer Institute or is designated

1 by the State as the official cancer institute of
2 the State.

3 “(d) PROJECTS.—A project described in this sub-
4 section is a project of a qualifying hospital that is designed
5 to improve the health care infrastructure of the hospital,
6 including construction, renovation, or other capital im-
7 provements.

8 “(e) STATE AND LOCAL PERMITS.—The provision of
9 a loan under this section with respect to a project shall
10 not—

11 “(1) relieve any recipient of the loan of any ob-
12 ligation to obtain any required State or local permit
13 or approval with respect to the project;

14 “(2) limit the right of any unit of State or local
15 government to approve or regulate any rate of re-
16 turn on private equity invested in the project; or

17 “(3) otherwise supersede any State or local law
18 (including any regulation) applicable to the construc-
19 tion or operation of the project.

20 “(f) FORGIVENESS OF INDEBTEDNESS.—The Sec-
21 retary may forgive a loan provided to a qualifying hospital
22 under this section under terms and conditions that are
23 analogous to the loan forgiveness provision for student
24 loans under part D of title IV of the Higher Education
25 Act of 1965 (20 U.S.C. 1087a et seq.), except that the

1 Secretary shall condition such forgiveness on the establish-
2 ment by the hospital of—

3 “(A) an outreach program for cancer pre-
4 vention, early diagnosis, and treatment that
5 provides services to a substantial majority of
6 the residents of a State or region, including
7 residents of rural areas;

8 “(B) an outreach program for cancer pre-
9 vention, early diagnosis, and treatment that
10 provides services to multiple Indian tribes; and

11 “(C)(i) unique research resources (such as
12 population databases); or

13 “(ii) an affiliation with an entity that has
14 unique research resources.

15 “(g) FUNDING.—

16 “(1) IN GENERAL.—There are appropriated,
17 out of amounts in the Treasury not otherwise appro-
18 priated, to carry out this section, \$200,000,000, to
19 remain available during the period beginning on July
20 1, 2004, and ending on September 30, 2008.

21 “(2) ADMINISTRATIVE COSTS.—From funds
22 made available under paragraph (1), the Secretary
23 may use, for the administration of this section, not
24 more than \$2,000,000 for each of fiscal years 2004
25 through 2008.

1 “(3) AVAILABILITY.—Amounts appropriated
2 under this section shall be available for obligation on
3 July 1, 2004.

4 “(h) REPORT TO CONGRESS.—Not later than 4 years
5 after the date of the enactment of this section, the Sec-
6 retary shall submit to Congress a report on the projects
7 for which loans are provided under this section and a rec-
8 ommendation as to whether the Congress should authorize
9 the Secretary to continue loans under this section beyond
10 fiscal year 2008.”.

○