At the request of Mr. Kennedy, the name of the Senator from South Dakota (Mr. Johnson) was added as a cosponsor of S. 1853, a bill to provide extended unemployment benefits to displaced workers.

At the request of Mr. Cochran, the names of the Senator from Kansas (Mr. Roberts), the Senator from Georgia (Mr. Miller), and the Senator from Michigan (Ms. Stabenow) were added as cosponsors of S. 1858, a bill to authorize the Secretary of Agriculture to conduct a loan repayment program to encourage the delivery of emergency services in shortage and emergency situations.

At the request of Mr. Bunning, the Senator from Oklahoma (Mr. Inhofe) and the Senator from Virginia (Mr. Burr) were added as cosponsors of S. 1907, a bill to promote rural safety and improve rural law enforcement.

At the request of Ms. Mikulski, the name of the Senator from New Hampshire (Mr. Gregg) was added as a cosponsor of S. 1979, a bill to amend the Public Service Act to extend provisions relating to mammography quality standards.

At the request of Mr. Daschle, the name of the Senator from North Dakota (Mr. Dorgan) was added as a cosponsor of S. 1980, a bill to promote rural safety and improve rural law enforcement.

At the request of Mr. Sessions, the names of the Senator from Utah (Mr. Hatch), the Senator from Iowa (Mr. Grassley), the Senator from Kentucky (Mr. Bunning), the Senator from Oklahoma (Mr. Inhofe) and the Senator from Georgia (Mr. Chambliss) were added as cosponsors of S. Con. Res. 77, a concurrent resolution expressing the sense of Congress supporting vigorous enforcement of the Federal obscenity laws.

At the request of Ms. Feinstein, the name of the Senator from Ohio (Mr. Voinovich) was added as a cosponsor of S. Con. Res. 81, a concurrent resolution expressing the deep concern of Congress regarding the failure of the Islamic Republic of Iran to adhere to its obligations under a safeguards agreement with the International Atomic Energy Agency and the engagement by Iran in activities that appear to be designed to develop nuclear weapons.

At the request of Mr. Bunning, the name of the Senator from Vermont (Mr. Leahy) was added as a cosponsor of S. Res. 120, a resolution commemorating the 25th anniversary of Vietnam Veterans of America.

At the request of Mr. Campbell, the name of the Senator from Massachusetts (Mr. Reed) was added as a cosponsor of S. Res. 253, a resolution to recognize the evolution and importance of motorsports.

STATMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. Jeffords (for himself, Ms. Snowe, and Mr. Hatch):

S. 1912. A bill to amend the Internal Revenue Code of 1986 to expand pension coverage and savings opportunities and to provide other pension reforms; to the Committee on Finance.

Mr. Jeffords. Mr. President, today, together with Senators Hatch and Snowe, am introducing, the Retirement Account Portability and Improvement Act of 2003. This legislation improves the portability of retirement savings by eliminating unnecessary complexities and barriers in the retirement savings system, and helps preserve retirement savings by giving American workers tools that will help them consolidate their retirement savings into one easily managed account.

In brief, this bill will make a number of improvements in the retirement savings system to help families preserve retirement assets. It will, for example, enhance the portability of retirement savings by expanding rollover options in traditional IRAs, Roth IRAs, and SIMPLE Plans. The bill also clarifies that when employees are permitted to make after-tax contributions to retirement plans, those after-tax amounts may be rolled over into other retirement plans eligible to receive such rollovers. This clarification will make it easier for workers to move all elements of their 401(k) or 403(b) savings when they change jobs and move between private sector and the tax-exempt sector.

In addition, the bill builds on defined contribution pension reforms enacted in 2001 by requiring a shortened vesting schedule for employer non-elective contributions, such as profit-sharing contributions, to defined contribution plans. As a result, employer contributions will become employee property more quickly, helping workers to build more meaningful retirement benefits. This new vesting schedule corresponds to rules for 401(k) matching contributions enacted in 2001.

Another provision in the bill would end an unfair tax penalty faced by non-spouse beneficiaries. Today, when an employee dies, the benefits in that employee’s retirement account are paid out to a non-spouse beneficiary in one payment. The beneficiary must pay tax on the entire amount, and is often forced into a higher tax bracket as a result of the payment. A provision in this bill would allow non-spouse beneficiaries—siblings, children, domestic partners, parents—to roll over the money from the plan to an IRA. This will prevent an immediate tax bite to grieving beneficiaries and allow them to withdraw the money from their IRA over five years or over their own life expectancy.

The bill also helps preserve retirement savings by allowing plans to designate default IRAs or annuity contracts to which employee rollovers may be directed. Employees would be more willing to establish default IRA and annuity rollover options as a result, making it easier for employees to keep savings in the retirement system when they change jobs.

For workers who leave a job without claiming their retirement benefits, the bill improves on the automatic rollover provisions enacted in 2001, by allowing certain small distributions from retirement plans to be sent to the Pension Benefit Guaranty Corporation (PBGC), ensuring that participants are ultimately reunited with their earned benefits. The bill also expands the scope of the PBGC’s successful Missing Participants program that matches workers with their pensions.

Employees of state and local governments, including teachers, will benefit from a number of this bill’s technical corrections that will facilitate the purchase of service credits in public pension programs, allowing state and local employees to more easily attain a full pension in the jurisdiction where they conclude their career. The bill also contains provisions that would clarify eligibility rights of certain state and local employees who participate in a Section 457 deferred compensation plan.

Congress must take every opportunity to encourage American workers not only to save for retirement, but also to preserve their hard-earned retirement savings. These portability improvements offer one set of tools for making it easier to navigate the retirement savings system and reach retirement with an adequate nest egg. There are many pressing and complex retirement issues that demand attention, but I am hopeful that this legislation, narrowly focused on portability, can be considered quickly and on its own merits.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1912

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Retirement Account Portability Act of 2003”.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever any provision in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be construed to mean any reference to a section or other provision of the Internal Revenue Code of 1986.
(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendment of 1986 Code; table of contents.

TITLE I—BUILDING AND PRESERVING RETIREMENT ASSETS AND ENHANCING PORTABILITY

Sec. 101. Allow rollovers by nonspouse beneficiaries of certain retirement plans.

Sec. 102. Facilitation under fiduciary rules of certain rollovers and annuity distributions.

Sec. 103. Fiduciary responsibilities of employer non-elective contributions.

Sec. 104. Allow rollover of after-tax amounts in annuity contracts.

TITLE II—EXPANDING RETIREMENT PLAN COVERAGE TO EMPLOYEES OF SMALL BUSINESSES

Sec. 201. Elimination of higher penalty on certain Simple distributions.


TITLE III—EXPANDING RETIREMENT SAVINGS FOR TAX-EXEMPT ORGANIZATION AND GOVERNMENT EMPLOYEES

Sec. 301. Clarifications regarding purchase of service credit.

Sec. 302. Eligibility for participation in retirement plans.

TITLE IV—SIMPLIFICATION AND EQUITY

Sec. 401. Allow rollovers from retirement plans to Roth IRAs.

SEC. 101. ALLOW ROLLOVERS BY NONSPOUSE BENEFICIARIES OF CERTAIN RETIREMENT PLAN DISTRIBUTIONS.

(a) IN GENERAL.—Paragraph (2) of section 402(c) (relating to rollovers from exempt trusts) is amended by adding at the end the following new paragraph:

“(i) DISTRIBUTIONS TO INHERITED INDIVIDUAL RETIREMENT PLAN OF NONSPOUSE BENEFICIARY.—

“(A) IN GENERAL.—If, with respect to any portion of a distribution from an eligible retirement plan of a deceased employee, a directly traceable amount is made to an individual retirement plan described in clause (i) or (ii) of paragraph (8) of section 402 of the Internal Revenue Code of 1986 to an individual retirement plan or annuity contract as being a trust designated beneficiary of the employee and who is not the surviving spouse of the employee—

“(i) the participant or beneficiary elected such transfer or distribution, and

“(ii) in connection with such election, the participant or beneficiary was given an opportunity to elect any other individual retirement plan or annuity contract as a retirement plan or annuity contract described in subparagraph (B) (in the case of a distribution).

“(B) ANNUITY CONTRACTS.—An annuity contract is described in this subparagraph if it provides, either on an immediate or deferred basis, a series of substantially equal periodic payments (not less frequently than annually) for the life of the participant or beneficiary or the joint lives of the participant or beneficiary and such individual’s designated beneficiary.

“(C) AMOUNTS DISTRIBUTED.—Amounts distributed shall be treated as part of a series of substantially equal periodic payments because the amount of the periodic payments may vary in accordance with investment experience, reallocation among investment options, actuarial gains or losses, cost of living indices, or similar fluctuating criteria. The availability of a commutation benefit, a minimum period of payments certain, or a minimum amount to be paid in any event shall not affect the treatment of an annuity contract as an annuity contract described in this subparagraph.

“(D) NOTWITHSTANDING THE PRECEDING PROVISIONS.—This paragraph shall not apply with respect to the receipt by the participant or beneficiary or the joint lives of the participant and beneficiary of a minimum amount to be paid in any event.

“(E) APPLICABILITY.—This paragraph shall apply to distributions described in subparagraph (B) and to payments under this subparagraph if it satisfies the requirements of clause (i) or (ii).

“(F) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 2003.

“(G) CONFORMING AMENDMENT.—Section 401(a)(9) of the Internal Revenue Code of 1986 (as in effect on the date of the enactment of this Act) is amended by—

“(1) inserting ‘‘(i)’’ after ‘‘(h)’’ of section 401(a)(9)(A), and

“(2) striking ‘‘(ii)’’ after ‘‘(A)’’ of section 401(a)(9)(B).
“(iii) A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee’s accrued benefit derived from employer contributions determined under the following table:

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<th>Years of service:</th>
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<td>100%</td>
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(2) CONFORMING AMENDMENT.—Section 401(a)(45) of the Internal Revenue Code of 1986, as amended by section 103 of the Economic Growth and Tax Relief Reconciliation Act of 2001, shall be amended by inserting after subsection (b), the following new subsection:

(1) In general.—Subsection (b) of such section is amended by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(b) Section 402(c)(8)(B) is amended by adding at the end the following new sentence: “Individual retirement accounts and individual retirement annuities described in clauses (i) and (ii) shall be treated as eligible retirement plans if they are part of a simplified employee pension (within the meaning of section 403(k) or a simplified retirement account (within the meaning of section 408(p)).”

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to contributions for plan years beginning after December 31, 2003.

TITLE III—EXPANDING RETIREMENT SAVINGS FOR TAX-EXEMPT ORGANIZATION AND GOVERNMENT EMPLOYEES

SEC. 301. CLARIFICATIONS REGARDING PURCHASE OF PERMISSIVE SERVICE CREDIT.

(a) In General.—Subparagraph (A) of section 457(e)(17) (relating to trustee-to-trustee transfers to purchase permissive service credit), and subparagraph (A) of section 403(b)(13) (relating to trustee-to-trustee transfers to purchase permissive service credit), is inserted by striking “section 415(n)(3)(A)” and inserting “section 415(n)(3)(B)” (without regard to subparagraphs (B) and (C) thereof).

(b) DISTRIBUTION REQUIREMENTS.—Section 415(e)(17) and section 403(b)(13) are both amended by adding at the end the following sentence: “Amounts transferred under this paragraph shall be distributed solely in accordance with section 401(a) as applicable to such defined benefit plan.”

(c) Service Credit.—Clause (i) of section 415(n)(3)(A) is amended to read as follows: “(i) which relates to benefits with respect to which such participant is not otherwise entitled.”

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as included in the amendments made by section 647 of the Economic Growth and Tax Relief Reconciliation Act of 2001.

SEC. 302. ELIGIBILITY FOR PARTICIPATION IN RETIREMENT PLANS.

An individual’s participation shall be excluded from participating in an eligible deferred compensation plan by reason of having received a distribution under section 457(e)(9) of the Internal Revenue Code of 1986, or section 401(a)(31) (relating to benefits of a missing participant or beneficiary), as in effect prior to the enactment of the Small Business Job Protection Act of 1996.

TITLE IV—SIMPLIFICATION AND EQUITY

SEC. 401. ALLOW DIRECT ROLLOVERS FROM RETIREMENT PLANS TO ROTH IRAS.

(a) In General.—Subsection (e) of section 408A (defining qualified rollover contribution) is amended to read as follows:

“(e) QUALIFIED MISCHEL Contribution.—For purposes of this section, the term ‘qualified rollover contribution’ means a rollover contribution—

(1) to a Roth IRA from another such account,

(2) from an eligible retirement plan, but only if—

(A) in the case of an individual retirement plan, such rollover contribution meets the requirements of section 408(d)(3), and

(B) in the case of a multiple employer plan (as defined in section 408(d)(8)) other than plans without regard to section 401(a)(37) and redesignated subparagraph (G) as subparagraph (H),

(3) Section 408A(d)(3)(B) is amended by striking “applicable” and inserting “applied on the day before the date of the enactment of the Retirement Account Portability Act of 2003”;

(4) Section 457(a)(2) is amended by striking “section 72(t)(8)” and inserting “section 72(t)(9)”;

(5) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2003.
(3) PAYMENT BY THE CORPORATION.—If benefits of a missing participant or beneficiary were transferred to the corporation under paragraph (1), the corporation shall, upon location of the participant or beneficiary, pay to the participant or beneficiary the amount transferred (or the appropriate survivor benefit) either—
(A) in a single sum (plus interest), or
(B) in such other form as is specified in regulations of the corporation.

(4) PLANS DESCRIBED.—A plan is described in this paragraph if—
(A) the plan is a pension plan (within the meaning of section 3(2))—
(i) which is not a plan described in paragraphs (1) through (10) of section 4021(b), and
(ii) which is not a plan described in paragraphs (1) through (11) of section 4021(b), or the appropriate survivor benefit) either—
(A) in a single sum (plus interest), or
(B) in such other form as is specified in regulations of the corporation.

(2) INFORMATION TO THE CORPORATION.—To the extent provided in regulations, the plan administrator of a plan described in paragraph (3) shall, upon transferred to the corporation under section 401(a)(31)(B) of the Internal Revenue Code of 1986, provide the corporation information with respect to benefits of the participant or beneficiary so transferred.

(3) PLANS DESCRIBED.—A plan is described in this paragraph if the plan is a pension plan (within the meaning of section 3(2))—
(A) which provides for mandatory distributions under section 401(a)(31)(B) of the Internal Revenue Code of 1986, and
(B) which is not a plan described in paragraphs (2) through (11) of section 4021(b).

(4) CERTAIN PROVISIONS NOT TO APPLY.—Subsections (a)(1) and (a)(3) shall not apply to a plan described in paragraph (4).

(e) IN VOLUNTARY CASHOUTS.—
(1) PAYMENT BY THE CORPORATION.—If benefits of a missing participant or beneficiary were transferred to the corporation under section 401(a)(31)(B) of the Internal Revenue Code of 1986, the corporation shall, upon application filed by the participant or beneficiary with the corporation in such form and manner as may be prescribed in regulations of the corporation, pay to the participant or beneficiary the amount transferred (or the appropriate survivor benefit) either—
(A) in a single sum (plus interest), or
(B) in such other form as is specified in regulations of the corporation.

(2) INFORMATION TO THE CORPORATION.—To the extent provided in regulations, the plan administrator of a plan described in paragraph (3) shall, upon transferred to the corporation under section 401(a)(31)(B) of such Code, provide the corporation information with respect to benefits of the participant or beneficiary so transferred.

(3) PLANS DESCRIBED.—A plan is described in this paragraph if the plan is a pension plan (within the meaning of section 3(2))—
(A) which is not a plan described in paragraphs (1) through (10) of section 4021(b), and
(B) which is not a plan described in paragraphs (1) through (11) of section 4021(b).

(4) CERTAIN PROVISIONS NOT TO APPLY.—Subsections (a)(1) and (a)(3) shall not apply to a plan described in paragraph (4).

(2) CONFORMING AMENDMENTS.—Section 206(f) of such Act (29 U.S.C. 1056(f)) is amended—
(A) by striking “title IV” and inserting “section 4050”; and
(B) by striking “the plan shall provide that,”
(4) EFFECTIVE DATE.—
(1) INTERNAL REVENUE CODE OF 1986 PROVISIONS.—The amendments made by subsections (a) and (b) shall take effect as if included in the amendments made by section 657 of the Economic Growth and Tax Relief Reconciliation Act of 2001.

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PROVISIONS.—The amendments made by subsection (c), (d), and (e) of section 4021(a) of the Employee Retirement Income Security Act of 1974 (as added by subsection (c), respectively, are prescribed.

(3) REGULATIONS.—The Pension Benefit Guaranty Corporation shall issue regulations necessary to carry out the amendments made by subsection (c) not later than December 31, 2004.

By Mr. MCCAIN (for himself and Mr. FEINGOLD)
S. 1313.
Mr. MCCAIN. Mr. President, along with Senator RUSS FEINGOLD, I am proud today to introduce the Presidential Funding Act of 2003. This legislation will improve and reform the presidential public financing system. With major presidential candidates opting out of public financing for their 2004 primary campaigns, reform of the system of financing presidential nominations is needed more than ever.

The presidential public financing system has been under decades and has achieved broad public acceptance. From 1976 to 2000, every major party presidential nominee has accepted public financing for the general election. The nominees have also accepted it for their primary elections. A total of 46 Democrats and 29 Republicans have accepted public financing for the presidential primaries during this period. Since its creation, the presidential financing system has worked non-ideologically, with victories for three Republicans and two Democrats. It has also provided for competitive elections.

In the five races that have been run under the system for an incumbent president, challengers have won in three of those elections. This system of voluntary spending limits in exchange for public funding has been a non-partisan success.

Last year’s enactment of a ban on soft money addressed what had become a basic problem for the effectiveness and credibility of the presidential system. For the system to continue serving as an engine for remaining campaign problems now must be solved. This legislation will repair and revitalize the presidential campaign finance system in the following ways.

First, our legislation increases the overall spending limit for the presidential primaries and provides more public matching funds for presidential primary candidates.

The overall spending limit in the primaries for publicly financed candidates has failed to keep pace with reality. This was demonstrated when in 2000, public financing and spending limits for the primaries were rejected and a record $100 million in private contributions were used by an independent candidate to gain the Republican party’s nomination—more than twice the amount that the publicly financed candidates were allowed to spend. During the 2004 presidential primary period, it is expected that Republicans will raise and spend as much as $200 million.

Our legislation increases the individual contribution limit from $1,000 to $2,000. Therefore, it will be easier over time for other candidates to reject public financing and raise private money in excess of the overall primary spending limit, thereby worsening the competitive disadvantage of publicly-financed candidates.

In addition, the “front-loading” of presidential primaries has created a much shorter nominating period—now likely to end by early March—and a much shorter general election period than existed when the presidential financing system was created in 1974. As a result, a potential “gap” exists in funds available for a publicly financed nominee to spend between gaining the party nomination in March and the party’s summer nominating convention, when the nominee receives public funds for the general election. This creates a further competitive disadvantage.

To address these problems, our legislation increases the overall spending limit for the presidential primaries to $75 million from the $45 million limit in effect for the 2004 presidential election. This would equal the $75 million spending limit in effect for the general election, which applies to a much shorter period than the primaries.

The amount of public matching funds for individual contributions in the primaries is also increased from the current one-to-one match to a four-to-one match for up to $250 of each individual contribution. This would greatly increase the value of smaller contributions in the presidential nominating process, as was intended at the time the presidential financing system began. It would also provide for competitive elections.

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The purpose of the presidential public financing system is to allow candidates to run competitive races for the presidency without becoming dependent on or obligated to campaign donors. That purpose is undermined when a candidate who has run out of the system raises and spends large amounts of private money for a primary or general election race. Such candidates should not be able to reject public financing and then get the system’s benefits when it suits their tactical advantage.

Third, our legislation repeals the state-by-state primary spending limits and allows publicly financed primary candidates to receive their public matching funds before January 1st of the presidential election year.

The State-by-State primary spending limits have not worked. The limits have proven to be ineffective and have served to unjustifiably micromanage presidential campaigns.

Under current law, primary candidates can begin to raise private contributions eligible to be matched beginning on January 1 of the year before a presidential election year. They are not eligible, however, to receive any of the matching public funds until January 1 of the presidential election year.

With the current “front-loaded” primary system, and with the nomination likely to be decided in the early months of a presidential election year, primary candidates need to be able to spend more funds at an earlier period than before. As a result, under our legislation, presidential primary candidates will be eligible to start receiving matching public funds on July 1 of the year before a presidential election year.

Fourth, our legislation provides additional public funds in the presidential general election for a publicly financed presidential candidate facing a privately financed candidate who has substantially outspent the combined primary and general election spending limits.

As more wealthy individuals decide to spend their personal wealth to run for public office, the potential grows for an individual to spend an enormous amount of personal wealth to seek the presidency. There already have been candidates for the U.S. Senate and in mayoral races, for example, who have spent millions of dollars on their races as each major party presidential nominee received in public funds in 2000 to run their general election campaign.

In addition, with the increased individual contribution limit, a presidential candidate could decide to forgo public funding and raise and spend private contributions far in excess of the spending limits for publicly financed candidates.

To address this potential problem, our legislation makes a publicly financed major party nominee eligible to receive an additional $75 million for the general election race, when a privately financed general election candidate has spent more than 50 percent above the total primary and general election spending limit for the publicly financed candidate.

In other words, once a presidential general election candidate has spent more than a total of $225 million to seek the presidency, a publicly financed major party nominee, subject to a spending limit of $75 million for the primaries and $75 million for the general election, could receive an additional $75 million for the general election race.

Fifth, our legislation increases the funds available to finance the presidential public financing system.

Currently, the public financing system is funded by a voluntary $3 check-off available to taxpayers on their tax forms on an annual basis. This mechanism will not raise sufficient resources in the long term to finance the costs of a revised public finance law.

The $3 tax check-off is increased to $6 and indexed for inflation to help ensure there are sufficient funds available for future presidential elections. In addition, the Federal Election Commission would be required to run an education campaign to explain to citizens why the check-off exists and how it works, including the fact that it does not increase the tax liability of taxpayers.

The current presidential public financing law creates a priority system that allocates available public funds from the check-off to the nomination conventions, the presidential general election and the presidential primaries in that order. This order of priority does not make sense.

Our legislation revises the order of priority for use of public funds to make funding of the nomination conventions the first priority, funding of the presidential general election the second priority, and funding of the nomination conventions the third priority.

Furthermore, a U.S. Department of the Treasury ruling prohibits taking into account the tax check-off revenues that will be received in April of the presidential election year in determining at the start of each presidential election year the total amount of funds available to be given to eligible candidates from the fund. This has had the effect of artificially lowering the amount of funds available and creating temporary shortfalls for primary candidates during the opening months of the presidential election year at the time when they need the funds the most.

Our legislation revises the law to require the U.S. Department of the Treasury (as it used to do) to estimate at the end of the year prior to a presidential election year the amount of check-off funds that will be received in the presidential election year and to take these funds into account in determining the total amount of funds available under the presidential system.

Finally, our legislation implements the soft money ban to ensure that the parties and federal officeholders and candidates do not raise or spend soft money on connecting the presidential nominating conventions.

Despite the passage of the new campaign finance law and its ban on soft money, federal officeholders and national party officials have continued to raise soft money from the national nominations conventions on the fictional premise that such funds are not in connection with a “federal election” but rather are for municipal or civic purposes.

The reality is that a presidential nominating convention is defined as a “federal election” under the campaign finance law. Furthermore, federal officeholders and candidates and national party officials who raise soft money for the conventions are subject precisely the problems of corruption and the appearance of corruption that the new law prevents by banning soft money.

To reaffirm that the soft money ban applies to the presidential nominating conventions, our legislation explicitly prohibits the national parties and federal officeholders and candidates from raising and spending soft money to pay for the presidential nominating conventions, including for a host committee, civic committee or municipality.

The highly expensive, front-loaded, nationalized, primary system requires that we more than ever fix the presidential public funding system. We must continue to promote competition in order to give voters choices. Our legislation not only saves the existing system but improves it as well. It not only shores up the financial foundations of the system but it would also bring more donors into the system, making financial participation more democratic. It would give our citizens a stake in their government. It is our hope that with the enactment of this legislation, candidates will no longer take small donors for granted and finally hear their voices. In return, all of our citizens will feel reconnected to the presidential financing process that at times, has left them behind.

Mr. FEINGOLD. Mr. President, it is a pleasure to join my friend and colleague Senator McCain in introducing a bill to repair and strengthen the presidential public financing system. The Presidential Funding Act of 2003 will ensure that this system that has served our country so well for over a generation will continue to fulfill its promise in the 21st century.

The presidential public financing system was put into place in the wake of the Watergate scandals as part of the Federal Election Campaign Act of 1974. It was held to be constitutional by the Supreme Court in Buckley v. Valeo. Every major party nominee for President since 1976 has participated in the
Mr. President, I ask unanimous consent that the text of the bill be printed in the Record.

This bill seeks to stop this closure and ensure that the thousands of veterans who live in central and northern Michigan have access to the medical services they deserve. I urge my colleagues to support this bill.

Mr. President, I ask unanimous consent that the text of the bill be printed in the Record.

As of August 2003, there were almost one million veterans in lower Michigan and Northwestern Ohio. These one million veterans are served by four V.A. Medical Centers—Saginaw, Detroit, Ann Arbor and Battle Creek—and 12 Community Based Outpatient Clinics (CBOCs), all located in lower Michigan and Toledo, OH.

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SECTION 1. PROHIBITION ON CLOSURE OR REALIGNMENT OF INPATIENT SERVICES AT ALEDA E. LUTZ DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER IN SAGINAW, MICHIGAN.

The Secretary of Veterans Affairs shall not carry out the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, proposed under the Capital Asset Realignment for Enhanced Services (CARES) initiative.

By Mrs. HUTCHISON:

S. 1917. A bill to amend the Internal Revenue Code of 1986 to permit the issuance of tax-exempt bonds for certain air and water pollution control facilities, and to provide that the volume cap for private activity bonds shall not apply to bonds for facilities for the furnishing of water, sewage facilities, and air or water pollution control facilities; to the Committee on Finance.

Mrs. HUTCHISON. Mr. President, I am pleased to offer the Clean Air and Water Investment and Infrastructure Act.

Texas, like many States, faces increasingly difficult challenges in improving air and water quality.

That is why the Environmental Protection Agency to set air quality standards and establishes deadlines for State and local governments to achieve those levels. Today, more than 90 communities across the country are out of compliance with the Clean Air Act. These so-called “non-attainment” areas are threatened with regulatory sanctions, such as loss of federal highway funding, if they do not meet mandated ozone levels by 2007.

Texas has four non-attainment areas: Beaumont-Port Arthur, Dallas-Port Worth, El Paso and Houston. The Houston area alone needs an estimated $4.1 billion annually in order to meet Federal air quality standards.

These communities will not achieve compliance without assistance. Too many industrial plants need to install expensive equipment. If these environmental investments do not become more affordable, communities will either suffer sanctions or face industrial facilities to close and move offshore, causing substantial economic hardship.

Texas and many areas of the country, especially in the Southwest and West, also face critical water and wastewater problems. Investments in sources of clean water can be made or air and water will face shortages in the coming decades. However, necessary water infrastructure improvements are extremely expensive. According to the Texas State Water Plan, the cost of water supply acquisition projects--water and wastewater treatment, and other infrastructure projects in Texas through 2050 will be more than $100 billion.

Currently, air and water pollution control facilities cannot be financed by tax-exempt bonds. Even if they could, they would be limited by a cap which sets the total amount of tax-exempt private activity bonds issued by a state. Given the demands of other projects, such as housing, relatively few of the air and water pollution projects would have an opportunity to access this financing option.

In order to help us meet the challenges, I am introducing the Clean Air and Water Investment and Infrastructure Act. My bill will allow federal tax-exempt bonds to be used by private firms for air and water pollution control projects. Given the importance of these critical projects, these bonds also would be issued outside the constraints of the private activity bond caps. The Texas Water Development Board estimates this could save 30 percent in financing costs for water projects.

For example, this bill would allow tax-exempt debt to be used to finance private systems along the Gulf Coast that desalinate seawater and brackish groundwater, and to install air pollution facilities on electric utility plants. States and communities would have an important new tool for addressing air and water pollution control needs.

Pollution control is a problem for all of us. It is to everyone’s benefit to develop ways to promote public and private partnerships which can finance projects to improve air and water quality. I hope my colleagues will support this effort.

I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1917

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Clean Air and Water Investment and Infrastructure Act”.

SEC. 2. TAX-EXEMPT BONDS FOR AIR AND WATER POLLUTION CONTROL FACILITIES.

(a) In General.—Subsection (a) of section 142 of the Internal Revenue Code of 1986 (defining exempt electric utility bond) is amended by striking “or” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “; or,” and by adding at the end the following new paragraph:

“(14) air or water pollution control facilities.”.

(b) AIR OR WATER POLLUTION CONTROL FACILITIES.—Section 142 of the Internal Revenue Code of 1986 (relating to exempt facility bond) is amended by adding at the end the following new subsection:

“(1) POLLUTION CONTROL FACILITIES ACQUIRED BY REGIONAL POLLUTION CONTROL AUTHORITIES.—

“(1) In General.—For purposes of paragraph (14) of subsection (a), a bond shall be treated as described in such paragraph if it is part of an issue substantially all of the proceeds of which are used by a qualified regional pollution control authority to acquire existing air or water pollution control facilities which the authority itself will operate in order to maintain or improve the control of pollutants.

“(2) RESTRICTIONS.—Paragraph (1) shall apply only if—

“(A) the amount paid, directly or indirectly, for a facility does not exceed the fair market value of the facility.

“(B) the fees or charges imposed, directly or indirectly, on the seller for any use of the facility after the sale of such facility are not less than the amounts that would be charged for the facility were financed with obligations the interest on which is not exempt from tax, and

“(C) no person other than the qualified regional pollution control authority is considered after the sale as the owner of the facility for the purposes of Federal income taxes.

“(3) QUALIFIED REGIONAL POLLUTION CONTROL AUTHORITY.—For purposes of this subsection, the term ‘qualified regional pollution control authority’ means an authority which—

“(A) is a political subdivision created by State law to control air or water pollution,

“(B) has within its jurisdictional boundaries all or part of at least 2 counties (or equivalent political subdivisions), and

“(C) operates air or water pollution control facilities.

“(4) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

SEC. 3. EXEMPTION FROM VOLUME CAP FOR FACILITIES FURNISHING WATER, SEWAGE FACILITIES, AND AIR OR WATER POLLUTION CONTROL FACILITIES.

(a) In General.—Paragraph (3) of section 168(g) of the Internal Revenue Code of 1986 (relating to exception for certain bonds) is amended—

“(1) by inserting “(4), (5),” after “(2),”;

“(2) by striking “or (13)” and inserting “(13), or (14);”;

“(3) by striking “, or water pollution control facilities after “wharves,”;

“(4) by striking “and before “qualified”, and

“(5) by inserting “, and air or water pollution control facilities after “educational facilities”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

By Mr. SANTORUM (for himself and Mrs. FEINSTEIN):

S. 1918. A bill to amend the Internal Revenue Code of 1986 to provide that qualified homeowner downpayment assistance is a charitable purpose; to the Committee on Finance.

Mr. SANTORUM. Mr. President, I am proud to introduce this bill in cooperation with my colleague from California, Senator FEINSTEIN, legislation that will further one of the most important public policy goals we have as a Nation—the goal of homeownership. Homeownership is a significant part of the American dream. It has been called the backbone of our economy. It is widely considered the primary means by which American families create middle-class wealth and build financial security.

Homeownership is all those things and more. It is the cornerstone of healthy communities across our Nation. It is good for families, good for our schools, good for our neighborhoods. Equity in homes is the leading source for collateral for small business start-up borrowing, and home equity loans are the leading provider of funds for a college education. Some experts even say homeowners are more likely to vote.

Despite the many benefits, there are still too many Americans for whom the...
American dream of homeownership is unreachable. There are too many American families who pay rent month after month, never accumulating equity, never experiencing the joy of raising their children in a home they own, and look forward to passing along to future generations. That is especially true among Americans from minority populations. Though nationwide nearly 70 percent of Americans own their own home, homeownership rates among African-Americans and Hispanics is less than 50 percent.

There are any number of obstacles to homeownership, but there is one problem that is widely considered the single biggest obstacle: the lack of funds for a down payment. Again, this is disproportionately true among minority families, which frequently have less accumulated wealth that can be used for a down payment.

President Bush has proposed creating the American Dream Down Payment Fund. A number of organizations have provided down payment assistance to 40,000 families every year. I support that effort, and I applaud President Bush for proposing this bold new initiative. The President has set a goal of increasing the number of minority homeowners by at least 5 million by the end of this decade, which the Department of Housing and Urban Development estimates would create $256 billion in economic activity. I believe that is an important goal for us as a Nation. I also believe that as we work to find ways for the Federal Government to increase homeownership, we need to encourage the private sector to do the same. There are a number of non-profit organizations in our country doing just that by providing a gift of down payment assistance to potential homeowners. These gifts of down payment assistance go to families and individuals who have the income to afford a mortgage but would otherwise be prevented from buying a home because they lack funds for a down payment. Last year non-profit organizations provided gifts of down payment assistance to over 85,000 home buyers—and the number will likely be much higher this year. One organization alone has helped over 160,000 individuals and families become homeowners, by providing a gift of funds for a down payment. And all without collecting a single dime of government funding.

This is why I am so pleased to be introducing this legislation today. I want to be sure the private sector can continue playing such a vital role in increasing homeownership by providing down payment assistance. Although many charities holding tax exemptions under section 501(c)(3) of the Internal Revenue Code provide down payment assistance, IRS regulations do not clearly address down payment assistance programs.

Our legislation will clarify that, under certain circumstances, the provision of down payment assistance to American families for use in purchasing low or moderate price homes constitutes charitable activity. Rather than developing our own standard for eligible home purchases, we have relied on the National Housing Act rule for FHA-insured loans. Our provision applies to purchases of a principal residence where the mortgage amount eligible for FHA insurance in the geographic area in which the home is located. That will ensure that a charitable down payment assistance program that finances the purchase of rental properties or expensive homes.

Our legislation also includes one other provision designed to protect the Treasury. Home sellers often contribute to charitable down payment assistance programs, in connection with the sale of a home. Those contributions are used to replenish the pool to make available gift assistance for other home buyers. Although the contributions to charitable down payment assistance programs are not charitable in nature; they are expenses of selling a home. The legislation clarifies that a party to a home sale transaction may not claim a charitable contribution deduction for a contribution to a down payment assistance provider made in connection with the sale.

Although IRS regulations do not clearly address down payment assistance programs, our legislation merely codifies current practice. As a result, I do not anticipate that the legislation will result in a significant change in tax revenues.

Non-profit providers of down payment assistance help tens of thousands of Americans every year become homeowners. These organizations are changing lives, changing families, changing our communities—and they are doing it all without a single dime of taxpayer funds. I am pleased my colleagues from California, Senator FEINSTEIN, has joined me in this legislation. I ask all of my colleagues to join us in this important effort.

Mrs. FEINSTEIN. Mr. President, I am pleased to join with the distinguished Senator from Pennsylvania, Senator SANTORUM, to introduce legislation that will promote the American dream of homeownership.

Our legislation will specify that providing homeownership down payment assistance to American families constitutes a charitable activity under the regulations of the Internal Revenue Service.

As the cornerstone of middle-class wealth in our nation, we should be doing everything possible to promote broad investment in owner-occupied housing. Today, we have that chance. It should not be a surprise that homeownership among low to moderate income families is lower than for those with higher incomes. The single biggest obstacle to achieving this dream is the lack of a downpayment.

Across America there are organizations that assist low to moderate income families with that first important step toward homeownership. In California, one of these groups, the Nehemiah Corporation, helps literally thousands of families each year by providing down payments.

While the Federal Government provides tax incentives for increased homeownership, we should make it easier for the private sector to provide their own brand of incentives. Importantly, this legislation will do several things to ensure that the private sector continues to have the tools it needs to provide this important assistance.

One, our legislation will specify that homeownership down payment assistance to American families constitutes a charitable activity.

Two, our bill is structured to ensure that the charitable down payment assistance program is not used to support the purchase of rental properties or expensive homes.

Three, our legislation is designed so that the taxpayers do not pick-up the tab. Home sellers often contribute to charitable down payment assistance providers in connection with the sale of a home, those contributions are not charitable in nature; they are an expense related to selling a home.

This legislation clarifies that a party to a home sale transaction may not claim a charitable contribution deduction for a contribution to a down payment assistance organization made in connection with the sale.

And, although Internal Revenue Service regulations do not specifically address down payment assistance programs, our legislation merely codifies current practice.

This legislation will ensure the continued growth of this essential segment of the financial services market at no cost to the taxpayers.

And, as my friend from Pennsylvania has said, equity in homes is the leading source for collateral for small business start-up borrowing.

At a time when the economy still fails to produce jobs, the expansion of small business and the employment they provide is essential to the health of our economy.

It is a win-win situation in the truest sense of the term and I urge my colleagues to support it.

By Mr. SMITH (for himself and Mr. BREAUX):

S. 1922. A bill to amend the Internal Revenue Code of 1986 to comply with the World Trade Organization rulings on the FSC/ETI benefit in a manner that preserves manufacturing jobs and production activities in the United States, and for other purposes; to the Committee on Finance. Mr. SMITH. Mr. President, I rise today to introduce The American Manufacturing Jobs Bill of 2003—which will
provide a tax rate cut for all manufacturers who employ American workers. I am pleased to be joined in this effort by Senator JOHN BREAUX. On October 1, 2003, the Senate Finance Committee approved on a bipartisan basis S. 1673, the centerpiece of which resolves the FSC/ETI issue by replacing the export tax benefit with a reduction in the tax burden on domestic manufacturing companies.

I applaud S. 1673, a balanced piece of legislation by Chairman CHARLES GRASSLEY, R–IA, and ranking member Senator MAX BAUCUS, D–MT. I am, however, concerned that the domestic manufacturing benefit in S. 1673 is not applied equally to all U.S. manufacturers. This bill includes a provision—a “haircut”—that provides less of a benefit to companies that also manufacture abroad.

For example, a company that has 55 percent of its manufacturing in the United States and 45 percent abroad will only receive a benefit under this bill and then reduce that benefit by a fraction—the numerator of which is the gross receipts from domestic manufacturing over the same derived from worldwide manufacturing. The company thus suffers twice. First, the domestic manufacturing benefit in S. 1673 is less valuable than the benefit currently provided under FSC/ETI. Second, this company’s manufacturing benefit is further reduced by the “haircut” because it also has overseas manufacturing operations in order to be closer to their markets. The “haircut” is a discriminatory measure that hurls both foreign-owned and U.S.-owned companies alike. It is structured so that the more a company manufactures abroad, the less of a manufacturing rate cut it gets. The “haircut” makes the United States a less competitive location for current and future investment because multinational companies will believe they are being “cheated” and discriminated against.

At a time when American manufacturing jobs are leaving our country in record numbers, Congress should support all companies that employ Americans. U.S. companies with global operations employ more than 23 million Americans—9 million of which are in manufacturing jobs—this is tantamount to three out of every five manufacturing jobs in the United States. Also foreign-owned companies with U.S. operations employ more than 2 million manufacturing workers in the United States. It is these many of millions of manufacturing workers who will suffer if the “haircut” remains and companies are therefore discouraged to invest in the United States.

Moreover, the “haircut” is inconsistent with historic tax and trade policies to encourage U.S. companies to open up facilities outside the United States. In fact, there is an entire large state department—the Department of Commerce—set up to assist U.S. companies going global and then to promote and facilitate those same companies’ efforts once they have established themselves in-country. I am also concerned that the “haircut” invites mirror legislation in other countries and may invite another WTO challenge to this legislation. I believe we have a duty to encourage the retention and creation of manufacturing jobs in the United States. We must not treat U.S. jobs created by multinational companies as “less worthy” than U.S. jobs created by strictly domestic manufacturers. Congress should be in the business of rewarding all well-paid, manufacturing jobs that are created in the United States, not just those created by domestic manufacturers. I believe that by eliminating the “haircut” and providing a tax rate cut for all manufacturers who employ American workers, we can help to revitalize the U.S. manufacturing sector. I ask unanimous consent that the full text of this important legislation be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1922

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE.

(a) SHORT TITLE.—This Act may be cited as the “American Manufacturing Jobs Act of 2003”.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 2. REPEAL OF EXCLUSION FOR EXTRATERRITORIAL INCOME.

(a) IN GENERAL.—Section 114 is hereby repealed.

(b) CONFORMING AMENDMENTS.—

(1) Subpart E of part III of subchapter N of chapter 1 (relating to qualifying foreign trade income) is hereby repealed.

(2) The table of subparts for such part III is amended by striking the item relating to subpart E.

(3) The table of sections for part III of subchapter B of chapter 1 is amended by striking the item relating to section 114.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to transactions occurring after the date of the enactment of this Act.

(2) BINDING CONTRACTS.—The amendments made by this section shall not apply to any transaction in the ordinary course of a trade or business which occurs pursuant to a binding contract.

(A) which is between the taxpayer and a person who is not a related person as defined in section 267(b) of such Code, as in effect on the day before the date of the enactment of this Act, and

(B) which is in effect on September 17, 2003, and at all times thereafter.

(d) REVOCATION OF SECTION 943(e) ELECTIONS.—

(1) IN GENERAL.—In the case of a corporation that elected to be treated as a domestic corporation under section 943(e) of the Internal Revenue Code of 1986 (as in effect on the day before the date of the enactment of this Act),

(A) the corporation may, during the 1-year period beginning on the date of the enactment of this Act, revoke such election, effective as of such date of enactment;

(B) if the corporation does revoke such election—

(i) such corporation shall be treated as a domestic corporation transferring (as of such date of enactment) all of its property to a foreign corporation in connection with an exchange described in section 351 of such Code, and

(ii) no gain or loss shall be recognized on such transfer.

(2) EXCEPTION.—Subparagraph (B)(i) of paragraph (1) shall not apply to any asset held by the revoking corporation if—

(A) the basis of such asset is determined in whole or in part by reference to the basis of such asset in the hands of a person from whom the revoking corporation acquired such asset;

(B) the asset was acquired by transfer (not as a result of the election under section 943(e) of such Code) occurring on or after the 1st day on which its election under section 943(e) of such Code was effective, and

(C) a principal purpose of the acquisition was the reduction or avoidance of tax (other than a reduction in tax under section 114 of this Act) as in effect on the day before the date of the enactment of this Act.

(3) NEWLY APPOINTED OR ELECTED OFFICERS.—A corporation shall be treated as a domestic corporation under section 943(e) of such Code if it is not subject to section 943(e) of such Code and an election to be treated as a domestic corporation under section 943(e) of such Code is made by such corporation.

(4) EFFECTIVE DATE.—The amendments made by this section shall apply to elections made after the date of the enactment of this Act.

(5) IN GENERAL.—In the case of a corporation that elected to be treated as a foreign-owned domestic corporation under section 943(e) of such Code, as in effect on the day before the date of the enactment of this Act, and

(A) the corporation may, during the 1-year period beginning on the date of the enactment of this Act, revoke such election, effective as of such date of enactment;

(B) if the corporation does revoke such election—

(i) such corporation shall be treated as a foreign-owned domestic corporation transferring (as of such date of enactment) all of its property to a foreign corporation in connection with an exchange described in section 351 of such Code, and

(ii) no gain or loss shall be recognized on such transfer.

(2) EXCEPTION.—Subparagraph (B)(i) of paragraph (1) shall not apply to any asset held by the revoking corporation if—

(A) the basis of such asset is determined in whole or in part by reference to the basis of such asset in the hands of a person from whom the revoking corporation acquired such asset;

(B) the asset was acquired by transfer (not as a result of the election under section 943(e) of such Code) occurring on or after the 1st day on which its election under section 943(e) of such Code was effective, and

(C) a principal purpose of the acquisition was the reduction or avoidance of tax (other than a reduction in tax under section 114 of this Act) as in effect on the day before the date of the enactment of this Act.

(3) TRANSITION AMOUNT.—For purposes of this subsection—

(A) PHASEOUT PERCENTAGE.—The phaseout percentage applicable to any current FSC/ETI beneficiary for any taxable year is the phaseout percentage of the base period amount.

(B) PHASEOUT PERCENTAGE.—(1) In general.—In the case of a taxpayer using the calendar year as its taxable year, the phaseout percentage shall be determined under the following table:

<table>
<thead>
<tr>
<th>Years:</th>
<th>Percentage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>100%</td>
</tr>
<tr>
<td>2002</td>
<td>90%</td>
</tr>
<tr>
<td>2003</td>
<td>80%</td>
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<tr>
<td>2004</td>
<td>70%</td>
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<tr>
<td>2005</td>
<td>60%</td>
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<tr>
<td>2006</td>
<td>50%</td>
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<td>2007</td>
<td>40%</td>
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<td>2008</td>
<td>30%</td>
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<tr>
<td>2009</td>
<td>20%</td>
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<td>2010</td>
<td>10%</td>
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<tr>
<td>2011</td>
<td>0%</td>
</tr>
</tbody>
</table>

(2) PHASEOUT PERCENTAGE.—(2) In general.—In the case of a taxpayer using the calendar year as its taxable year, the phaseout percentage shall be determined under the following table:
The phaseout percentage for 2003 shall be the amount that bears the same ratio to 100 percent as the number of days after the date of the enactment of this Act bears to 365.

(11) SPECIAL RULE FOR 2003.—The phaseout percentage for 2003 shall be the weighted average of the phaseout percentages determined under the preceding provisions of this paragraph with respect to calendar years any portion of which is included in the taxpayer's taxable year. The weighted average shall be determined on the basis of the respective portions of the taxable year in each calendar year.

"(C) SHORT TAXABLE YEAR.—The Secretary may prescribe.

(12) SPECIAL RULE FOR FISCAL YEAR TAXPAYERS.—In the case of a taxpayer not using the calendar year as its taxable year, the phaseout percentage shall be the weighted average of the phaseout percentages determined under the preceding provisions of this paragraph with respect to calendar years any portion of which is included in the taxpayer's taxable year. The weighted average shall be determined on the basis of the respective portions of the taxable year in each calendar year.

"(C) SHORT TAXABLE YEAR.—The Secretary may prescribe rules for the proper allocation of deductions, losses, and expenses that are not directly allocable to a transaction occurring during the taxable year ending on the date of the enactment of this Act.

(13) DEDUCTION RELATING TO DOMESTIC PRODUCTION ACTIVITIES.—

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 of title 26, except subpart D of subchapter 2 of such chapter (as added by this Act), is amended by adding at the end the following new section:

"SEC. 199. INCOME ATTRIBUTABLE TO DOMESTIC PRODUCTION ACTIVITIES.

"(a) IN GENERAL.—Part VI of subchapter B of chapter 1 of title 26, except subpart D of subchapter 2 of such chapter (as added by this Act), is amended by adding at the end the following new section:

"(b) DEDUCTION LIMITED TO WAGES PAID.—

(1) In general.—The amount of the deduction allowable under subsection (a) for any taxable year shall not exceed 50 percent of the W-2 wages of the employer for the taxable year.

(2) W-2 wages.—For purposes of paragraph (1), the term 'W-2 wages' means the sum of—

(A) W-2 wages that the employer is required to include on statements under paragraphs (3) and (8) of section 6051(a) with respect to employees of the taxpayer during the taxable year of the taxpayer,

(B) Pass-thru entities.—In the case of any S corporation, partnership, estate, or trust, or other pass-thru entity, the limitation under this subsection shall apply at the entity level.

(8) SPECIAL RULE FOR FISCAL YEAR TAXPAYERS.—In the case of a taxpayer not using the calendar year as its taxable year, the phaseout percentage shall be the weighted average of the phaseout percentages determined under the preceding provisions of this paragraph with respect to calendar years any portion of which is included in the taxpayer's taxable year. The weighted average shall be determined on the basis of the respective portions of the taxable year in each calendar year.

"(C) SHORT TAXABLE YEAR.—The Secretary may prescribe.

(14) SPECIAL RULES FOR DETERMINING COSTS.—

(A) IN GENERAL.—For purposes of determining costs under clause (i) of paragraph (4) of section 199 of title 26, any item or property described in subsection (a)(1) of such section which is received by the United States shall be treated as acquired by purchase, and its cost shall be treated as not less than its fair market value immediately before the date on which the United States acquired the United States. A similar rule shall apply in determining the adjusted basis of leased or rented property where the lease or rental gives rise to domestic production gross receipts.

(B) EXPORTS FOR FURTHER MANUFACTURE.—In the case of any property described in subsection (a)(9) of section 199 of such title which has been exported by the taxpayer for further manufacture, the increase in cost or adjusted basis of such property under subparagraph (A) shall not exceed the difference between the lower of the value of the property when exported and the value of the property when brought back into the United States after further manufacture.

(15) DOMESTIC PRODUCTION GROSS RECEIPTS.—

For purposes of this section—

"(1) IN GENERAL.—The term 'domestic production gross receipts' means the gross receipts of the taxpayer which are derived from—

(A) any sale, exchange, or other disposition of, or

(B) any lease, rental, or license of, property which was manufactured, produced, grown, or extracted within the United States by the taxpayer.

"(2) SPECIAL RULE FOR CERTAIN PROPERTY.—In the case of any property described in subsection (t)(1)(C)—

(A) such property shall be treated for purposes of paragraph (1) as produced in significant part by the taxpayer within the United States if more than 50 percent of the aggregate development and production costs are incurred by the taxpayer within the United States, and

(B) if a taxpayer acquires such property before such property begins to generate substantial gross receipts, any development or production costs that are attributable to the acquisition shall be treated as incurred by the taxpayer for purposes of subparagraph (A) and paragraph (1).

(16) QUALIFYING PRODUCTION PROPERTY.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'qualifying production property' means—

(A) any tangible personal property,

(B) any computer software, and

(C) any property described in section 168(f) (3) or (4), including any underlying copyright or trademark.

"(2) EXCLUSIONS FROM QUALIFYING PRODUCTION PROPERTY.—The term 'qualifying production property' shall not include—

(A) property that is sold, leased, or licensed by the taxpayer as an integral part of the provision of services,

(B) oil or gas,

(C) electricity,

(D) water supplied by pipeline to the consumer,

(E) utility services, or

(F) any film, tape, recording, book, magazine, newspaper, or similar property the market for which is primarily topical or otherwise essentially transitory in nature.

(17) DEFINITIONS AND SPECIAL RULES.—

"(1) APPLICATION OF SECTION TO PASS-THRU ENTITIES.—In the case of a partnership, estate, or trust, or other pass-thru entity, the regulations prescribed by the Secretary shall apply in determining the adjusted basis of the property described in subsection (a)(9) to which this paragraph applies.

"(2) ROYALTIES.—The term 'royalties' includes any payment made in exchange for the right to use any copyright, including any necessary copyright license.
"(A) subject to the provisions of paragraph (2) and subsection (b)(3)(A), this section shall be applied at the shareholder, partner, or similar level, and

"(B) the Secretary shall prescribe rules for the application of this section, including rules relating to—

"(i) restrictions on the allocation of the deduction to taxpayers at the partner or similar level, and

"(ii) additional reporting requirements.

(2) EXCLUSION FOR PATRIOTIC AGRICULTURAL AND HORTICULTURAL COOPERATIVES.—

"(A) IN GENERAL.—If any amount described in paragraph (1) or (3) of section 1385(a)—

"(i) is received by a person from an organization which its patrons have so extracted in whole or significant part any
tax return, and

"(ii) is allocable to the portion of the qualified production activities income of the organization which is deductible under section (a) and designated as such by the or-

organization in a written notice mailed to its patrons during the payment period described in section 1382(d),

then such person shall be allowed an exclu-

sion from gross income with respect to such amount. The taxable income of the organiza-
tion and its patrons, described under section 1382 by the portion of such amount with re-

spect to which an exclusion is allowable to a person by reason of this paragraph.

(3) SPECIAL RULE FOR AFFILIATED GROUPS.—

"(A) IN GENERAL.—All members of an ex-
panded affiliated group shall be treated as a single corporation for purposes of this sec-

section.

"(B) EXPANDED AFFILIATED GROUP.—The term 'expanded affiliated group' means an affiliated group as defined in section 1504(a), determined—

"(i) by substituting '50 percent' for '80 per-
cent' each place it appears, and

"(ii) without regard to paragraphs (2) and (4) of section 1504(b), and

"(C) COORDINATION WITH MINIMUM TAX.—The de-

duction under this section shall be applied by only taking into account the de-

duction limit under subsection (b) for any tax-

able year—

"(i) in determining the amount of any credit allowable under section 36A or 936 for the taxable year, there shall not be taken into account any wages which are taken into account in applying such limitation.

"(B) COORDINATION WITH TRANSITION RULES.—For purposes of this section—

"(A) domestic production gross receipts shall not include gross receipts from any transaction if the binding contract transi-
tion rules of section 263A(d) or (2) of the American

Manufacturing Jobs Act of 2003 applies to such transaction,

and

"(B) any deduction allowed under section 263A(d) or (2) of the Internal Revenue Code of 1986 shall apply to the amendments made by this section as if they were changes in a rate of tax.

(3) A PPLICATION OF SECTION 15.—Section 15 applies to the taxable year, there shall not be taken into account the domestic production gross receipts.

(B) MINIMUM TAX.—Section 56(g)(4)(C) (re-

lating to disallowance of items not deductible in computing earnings and profits) is amended by adding at the end the following new clause:

"(V) DEDUCTION FOR DOMESTIC PRODUC-

TION.—Clause (i) shall not apply to any amount attributable to domestic production activities.''.

(4) COORDINATION WITH MINIMUM TAX.—The table of contents for part VI of subchapter B of chap-

ter 1 is amended by adding at the end the following new item:

"Sec. 199. Income attributable to domestic production activities.''.

(d) EFFECTIVE DATE.—

"(1) IN GENERAL.—The amendments made by this section shall apply to taxable years end-

ing after the date of the enactment of this Act.

"(2) APPLICATION OF SECTION 15.—Section 15 of the Internal Revenue Code of 1986 shall apply to the amendments made by this sec-

tion as if they were changes in a rate of tax.

By Mr. LEAHY:

S. 1923. A bill to reauthorize and amend the National Film Preservation Act of 1996; to the Committee on the

Judiciary.

Mr. LEAHY. Mr. President, I call at-

tention today to a part of American heritage that is literally disintegrating faster than can be saved. Motion pic-

tures are an important part of our American experience and provide an extraordinary record of our history, our dreams, and our aspirations. The National Film Preservation Board and the National Film Preservation Foundation were created by Congress under the auspices of the Library of Congress, to help save America's film heritage. Today, I am introducing the “National Film Preservation Act of 2003,” which will reauthorize and extend the “Na-

tional Film Preservation Act of 1996.”

We first acted in 1988 in order to rec-

ognize both the educational, cultural, and historical importance of our film heritage, and its inherently fragile na-

ture. The “National Film Preservation Act of 2003” will allow the Library of Congress to continue its important work in preserving America’s faded

treasures, as well as providing grants that will help libraries, museums, and archives preserve films, and make those works available for study and research. These continued efforts are more critical today than ever before. Fewer than 20 percent of the features of the 1920s exist in any form, and less than 10 percent of the features of the 1910s have survived into the new millennium.

The films saved by the National Film Preservation Board are precisely those types of films that would be unlikely to survive without public support. Art

risk documentaries, silent-era films, avant-garde works, ethnic films, news-

reels, and home movies are in many ways more illuminating on the ques-
tion of who we are as a society than the Hollywood sound features kept and preserved by major studios. What is more, in many cases only one copy of these “orphaned” works exists. As the Librarian of Congress, Dr. James H. Billington, has noted, “Our film herit-

age is America’s living past.” I encour-

age my colleagues to support the “Film Preservation Act of 2003” so that America’s past can survive in order to enlighten and entertain future generations.

I ask unanimous consent that the text of this bill be printed in the

RECORD. There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1923

Be it enacted by the Senate and House of Rep-

sentatives of the United States of America in Congress assembled,

TITLE I—REAUTHORIZATION OF THE NATIONAL FILM PRESERVATION BOARD

SEC. 101. SHORT TITLE.

This title may be cited as the “National Film Preservation Act of 2003.”

SEC. 102. REAUTHORIZATION AND AMENDMENT.

(a) DUTIES OF THE LIBRARIAN OF CON-

GRESS.—Section 103 of the National Film Preservation Act of 1996 (2 U.S.C. 179m) is amended:

(1) in subsection (b)—

(A) by striking “film copy” each place that term appears and inserting “film or other approved copy”; and

(B) by striking “film copies” each place that term appears and inserting “film or other approved copies”; and

(2) by adding at the end the following:

"(c) COORDINATION OF PROGRAM WITH OTHER COLLECTION, PRESERVATION, AND AC-

CESSIBILITY ACTIVITIES.—In carrying out the comprehensive national film preservation program for motion pictures established under the National Film Preservation Act of 1992, the Librarian, in consultation with the Board established pursuant to section 194, shall—

"(1) carry out activities to make films in-

cluded in the National Film registry more broadly accessible for research and edu-

cational purposes, and to generate public awareness and support of the Registry and the comprehensive national film preserva-

tion program.

"(2) review the comprehensive national film preservation plan, and amend it to the

Congress assembled, representatives of the United States of America in Congress assembled,
extensive necessary to ensure that it addresses technological advances in the preservation and storage of, and access to film collections in multiple formats; and

"(3)_unicode_2031, undertaken under section 5702 and 5703 of title 5, United States Code, and supporting the work of the National Audio-Visual Conservation Center of the Library of Congress, and other appropriate nonprofit archival and preservation organizations." (b) NATIONAL FILM PRESERVATION BOARD.— Section 104 of the National Film Preservation Act of 1996 (2 U.S.C. 179n) is amended—

(1) in subsection (a)(1) by striking "20" and inserting "22":

(2) in subsection (a) (2) by striking "three" and inserting "five":

(3) in subsection (d) by striking "11" and inserting "12": and

(4) by striking subsection (e) and inserting the following:

"(e) REIMBURSEMENT OF EXPENSES.—Members of the Board shall serve without pay, but may receive travel expenses, including per diem in lieu of subsistence, in accordance with section 5702 and 5703 of title 5, United States Code.

"(c) RESPONSIBILITIES AND POWERS OF BOARD.—The National Film Preservation Board shall review special projects submitted for its approval by the National Film Preservation Foundation under section 151711 of title 36, United States Code.

"(d) NATIONAL FILM REGISTRY.—Section 106 of the National Film Preservation Act of 1996 (2 U.S.C. 179q) is amended by adding at the end the following:

"(2) in paragraph (2), by striking "or film"

"(e) NATIONAL AUDIO-VISUAL CONSERVATION CENTER.—The Librarian shall utilize the National Audio-Visual Conservation Center of the Library of Congress at Culpeper, Virginia, to ensure that preserved films included in the National Film Registry are stored in a proper manner, and disseminated to researchers, scholars, and the public as may be appropriate in accordance with—

"(1) title 17 of the United States Code; and

"(2) the terms of any agreements between the Librarian and those who hold copyright rights to such audiovisual works.

"(f) USE OF SEAL.—Section 107 (a) of the National Film Preservation Act of 1996 (2 U.S.C. 179g) is amended—

(1) in paragraph (1), by inserting "in any format"; and

(2) in paragraph (2), by striking "or film copy" and inserting "in any format".

"(g) EFFECTIVE DATE.—Section 113 of the National Film Preservation Act of 1996 (2 U.S.C. 179w) is amended by striking "7" and inserting "17".

TITLE II—REAUTHORIZATION OF THE NA- TIONAL FILM PRESERVATION FOUNDA TION

SEC. 201. SHORT TITLE. This title may be cited as the "National Film Preservation Foundation Reauthorization Act of 2003".

SEC. 202. REAUTHORIZATION AND AMENDMENT. (a) NATIONAL FILM FOUNDATION.—Section 151703 of title 36, United States Code, is amended—

(1) in subsection (b)(2)(A), by striking "nine" and inserting "12"; and

(2) in subsection (c), by striking the second sentence and inserting "There shall be no limit to the number of terms to which any individual may be appointed.

(b) NATIONAL FILM FOUNDATION.—Section 151703 of title 36, United States Code, is amended in subsection (b) by striking "District of Columbia" and inserting "the jurisdiction in which the principal office of the corporation is located".

(c) PRINCIPAL OFFICE.—Section 151706 of title 36, United States Code, is amended by inserting in section 151705 of title 36, United States Code, as determined by the board of directors after "District of Columbia.

(d) AUTHORIZATION OF APPROPRIATIONS.— Section 151711 of title 36, United States Code, is amended by striking subsections (a) and (b) and inserting the following:

"(a) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated to the Library of Congress amounts necessary to carry out an amount not to exceed $500,000 for each of the fiscal years 2004 and 2005, and not to exceed $1,000,000 for each of the fiscal years 2006 through 2013. These amounts are to be available to the corporation to match any private contributions (whether in currency, services, or property) made to the corporation by private persons and State and local governments.

"(b) LIMITATION RELATED TO ADMINISTRATIVE EXPENSES.—Amounts authorized under this section may not be used for any corporation for management and general or fund-raising expenses as reported to the Internal Revenue Service as part of an annual information return required under the Internal Revenue Code of 1986.

(e) COOPERATIVE FILM PRESERVATION.—

(1) IN GENERAL.—Chapter 1517 of title 36, United States Code, is amended—

(A) in section 151711 (2) by redesignating sections 151711 and 151712 as sections 151712 and 151713, respectively; and

(B) by adding at the end the following:

"151711. Cooperative film preservation.

"(a) COOPERATIVE FILM PRESERVATION.—

"(1) IN GENERAL.—The corporation shall design and support cooperative national film preservation initiatives. Such initiatives shall be approved by the corporation, the Librarian of Congress, and the National Film Preservation Board of the Library of Congress under section 151711 of the National Film Preservation Act of 1996.

"(2) SCOPE.—Cooperative initiatives authorized under paragraph (1) may include—

(A) the repatriation and preservation of American films that may be found in archives outside of the United States;

(B) the exhibition and dissemination via broadcast or cable of "orphan" films;

(C) the production of educational materials in various formats to encourage film preservation, preservation initiatives undertaken by 3 or more archives; and

(D) other activities undertaken in light of significant unfunded film preservation and access needs.

"(b) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to the Library of Congress amounts not to exceed $1,000,000 for each of the fiscal years 2006 through 2013, to carry out the purposes of this section.

"(2) MATCHING.—The amounts made available under this section shall be made available to the corporation to match any private contributions (whether in currency, services, or property) made to the corporation by private persons and State and local governments.

"(3) LIMITATION RELATED TO ADMINISTRATIVE EXPENSES.—Amounts authorized under this section may not be used for any corporation for management and general or fund-raising expenses as reported to the Internal Revenue Service as part of an annual information return required under the Internal Revenue Code of 1986.

"151712. Authorization of appropriations.

"151713. Annual report.

By Mr. JEFFORDS:

S. 242. A bill to provide for the coverage of milk price production under the H-2A nonimmigrant worker program; to the Committee on Agriculture.

Mr. JEFFORDS. Mr. President, today I rise to introduce the Dairy Farm Workers Fairness Act.

Family dairy farms are critically important to educating, agricultural literacy and to the rural way of life in many parts of the country. These farms support the rural economy by supporting the local tax base and many local businesses. The working landscape created by our farms, especially a patchwork of small farms, is also the best antidote for the urban sprawl that is overtaking so much of the country. And, of course, the availability of fresh, locally produced milk is an amenity that we have to take for granted. To support our rural economies, the working landscape and our local food supply systems we need to help small family dairy farms survive and thrive.

The most difficult challenge to the family dairy farm, after the volatility in milk price, is finding and hiring workers. In my home State of Vermont, dairy farms are not only an important part of our economy; they are an institution that has come to define our landscape and beauty. Vermont lies in the green fields, the red barns and the cows grazing on the hillside. When a farm family sells their land, which in many cases may have been worked by them and their ancestors for one or more generations, the decision is often driven by the non-stop, 7 days a week, 365 days a year work schedule. As fewer rural residents choose to work in agriculture, these farmers have been forced to take on more themselves. The whole family can end up working without taking weekends off. Although dairy farming might not seem seasonal, the burden becomes particularly heavy during the growing season when planting, haying, harvesting and storage of feed must all occur.

Dairy farmers are being forced to explore other options to find a predictable source of qualified labor. While other agricultural businesses in the country benefit from the temporary workers to take for granted the H-2A Work Visa Program, dairy farms do not. The job of milking cows on dairy farms has been judged under the current H2A program to not meet the definition of temporary or seasonal and is thus excluded. The largest labor need on dairy farms during the growing season, remains the need for assistance with milking. The cows must be milked two or three times a day by hired help so the farmer is able to take on the more complex and specialized work of operating the milking machines and the harvest. While the work of milking is not seasonal or temporary, the need for additional labor to accomplish the
work is seasonal and temporary. I believe the exclusion of dairy farming under the H2A program is an unintended problem in definitions, and our legislation is designed to fix that glitch. We must do this out of fairness, so that dairy farms can benefit from the seasonal labor that other farms have, and more importantly to help our farms survive.

Recently, I heard from a farmer who owns and operates, along with his wife, a small dairy farm in central Vermont. The couple is nearing retirement age and have no children of their own. They had attempted to find a farm hand that could live on the farm and help with milking and some of the heavier chores. After placing ads in the paper and working with the state of Vermont's Department of Employment and Training, it became clear that their best option was to hire a family friend who had a strong desire to learn farming. Since the young man was from Honduras, they began the visa process only to have their request for certification by the U.S. Department of Labor denied because their need was considered neither temporary nor seasonal. This farm plays such an important role in their rural Vermont community that I heard from several other constituents who asked for my assistance on this family's behalf. The couple continues to work their land but in doing so they are straining their health and pushing themselves harder than they should. They continue to operate their farm because they do not want to sell it since it is land that has been farmed for generations.

The legislation I am introducing today would allow this family farm, and so many others like it, to avail themselves of a labor source that exists for virtually every other farm in this country. By creating a period based on the summer growing season, dairy farms will be able to bring on extra help during the busiest part of the year, providing much-needed relief for our farm families. I urge my colleagues to join me in supporting dairy farms across the United States by cosponsoring this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1926
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE. This Act may be cited as the "Dairy Farm Workers Fairness Act".

SEC. 2. COVERAGE OF MILK PRODUCTION UNDER H2A NONIMMIGRANT WORKER PROGRAM.

(a) IN GENERAL.—For purposes of the administration of the H2A nonimmigrant worker program in a year, performed in the production of milk for commercial use not earlier than April 15 or later than October 15 of that year shall qualify as agriculture labor or services of a seasonal nature.

(b) DEFINITIONS.—In this section:

(1) H2A NONIMMIGRANT WORKER PROGRAM.—The term "H2A nonimmigrant worker program" means the program for the admission to the United States of H2A nonimmigrant workers.


By 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):
S. 1926. A bill to amend title XVIII of the Social Security Act to restore the Medicare program and for other purposes; to the Committee on Finance. Ms. STABENOW. Mr. President, I rise today to introduce legislation that would allow us to help our providers and patients now.

If we immediately pass this bill, we can make our providers whole and then go back to the drawing board to get a better Medicare prescription drug benefit bill.

The bill includes all of the provider givebacks in the Conference Report accompanying H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

It includes all adjustments, word for word, for the rural provisions, physician updates, graduate medical education, GME, and home health services. It does not add new language. It does not include any provider cuts or premium increases in H.R.1.

Congress should pass these provisions on their own help to hospitals, physicians, and patients and not hold them hostage to a prescription drug bill that privatizes Medicare and provides a mediocre benefit to most seniors.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1926

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE, AMENDMENTS TO SOCIAL SECURITY ACT, REFERENCES TO BIPA AND SECRETARY, TABLE OF CONTENTS.

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

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, wherever a term is defined in other sections of this Act, such term means the definition given to such term in such other section of this Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA," means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106-554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of 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 standard Medicare beneficiary payments.

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 hospitals.

Sec. 107. Treatment of missing cost reporting periods for sole community hospitals.

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 start-up.

Sec. 114. Payment for rural and urban ambulance services.

Sec. 115. Providing appropriate coverage for rural air ambulance services.

Sec. 116. Treatment of certain clinical diagnostic laboratory tests furnished to hospital inpatients in certain rural areas from the prospective payment system for skilled nursing facilities.

Sec. 117. Extension of telemedicine demonstration project.

Sec. 118. Report on demonstration project permitting inclusion of nursing facilities to be originating tele- health 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.
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(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

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

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

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before October 1, 1997,” after “a regional DRG prospective payment rate for each region.”.

(3) ADDITIONAL TECHNICAL AMENDMENT.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)(III)) is amended by striking “in an other urban area” and inserting “in an urban area.”

(4) EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.—

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

(1) by striking “(iv) For discharges” and inserting “(iv)(I) Subject to subclause (ii),” for discharges; and

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

“(II) For discharges occurring in a fiscal year beginning on or after October 1, 2003, the Secretary shall compute a standardized amount (specified in subparagraph (E)) of—

(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area;

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

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

and

(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D) for hospitals located in any area, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

(b) APPLICABILITY OF PUBLIC LAW 108–89.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

“(xvi)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subparagraph (I) or under clause (vi), (x), (xii), (xiii), or (xvii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).
(viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large urban hospitals)."

Second paragraph: Clause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (A)."

Second paragraph: paragraphs (III), (IV), (V), and (VI) of clause (iv), by inserting "subject to clause (xvii) and before "for discharges occurring after July 1, 2004.""

Second paragraph: (B) in clause (viii), by striking "the formula" and inserting "subject to clause (xiv), the formula"; and"(C) each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "subject to clause (xiv) for purposes;" and...
if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were a hospital (as defined in section 1861(aa)); and

(ii) in paragraph (2) of section 1861(aa), by striking "(ii)" and inserting "(ii) hospital being denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in financial intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.".

(2) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 106. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

(1) IN GENERAL.—In addition to any payment calculated under this section for a hospital (as defined in section 1861(aa)), the Secretary shall determine an applicable percentage increase for purposes of subparagraph (B) as follows:

(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of inpatient discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

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

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

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services that are otherwise provided, in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395xx(d)); and

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

The Secretary may require the program to comply with such additional quality assurance standards as its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to the Committees on the in the report recommendations regarding extension of such project to hospice programs serving rural areas.

SEC. 110. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(1) IN GENERAL.—Section 1886(e)(7)(A) (42 U.S.C. 1395yy(e)(7)(A)) is amended by inserting "or to medicare beneficiaries." after "attending physician (as defined in paragraph (1) of section 1861(aa)); and

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

SEC. 110A. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(1) IN GENERAL.—The Secretary shall conduct a demonstration project to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)(A) of such Act) in rural areas.

(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary.
the Secretary in States with low population densities, as determined by the Secretary.

(3) APPLICATION.—Each rural community hospital that is located in a demonstration area described under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

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

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

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

(b) PAYMENT.

(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in an inpatient rehabilitation unit of the hospital which is a distinct part of the hospital, is determined under paragraph (1)(A), and

(2) for discharge occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

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

(ii) the target amount (as defined in paragraph (2), applicable to the cost reporting period involved).

(2) TARGET AMOUNT.—For purposes of paragraph (1)(B), the term ‘target amount’ means, with respect to a rural community hospital for a particular 12-month cost reporting period—

(A) in the case of the second such reporting period for which this subsection is in effect, the reasonable costs of providing covered inpatient hospital services as determined under paragraph (1)(A), and

(B) for discharge occurring in a subsequent cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase (under clause (i) of section 1886(d)(3)(D)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(D)(i))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1117 of the Social Security Act (42 U.S.C. 1395) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

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

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in the case of a demonstration program for the purpose of carrying out the demonstration program under this section.

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

(f) DEFINITIONS.

(1) RURAL COMMUNITY HOSPITAL DEFINED.—

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

(i) is located in a rural area (as defined in section 1866(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1866(d)(2)(E) of such Act (42 U.S.C. 1395ww(d)(2)(E));

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

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

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1862.

(B) IN GENERAL.—The term ‘rural community hospital’ means a hospital (as defined in section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) that—

(i) is located in a rural area (as defined in section 1866(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1866(d)(2)(E) of such Act (42 U.S.C. 1395ww(d)(2)(E));

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

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

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1862.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program, the reasonable costs of providing such services include—

(A) in the heading, by striking ‘‘SMALL’’ and inserting ‘‘CERTAIN’’;

(B) by inserting ‘‘SPECIALIZED AND REHABILITATION UNITS.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital, shall be counted.

(2) COVERED INPATIENT HOSPITAL SERVICES.—The term ‘‘covered inpatient hospital services’’ means inpatient hospital services, furnished by a rural community hospital under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395l).

Subtitle B—Provisions Relating to Part B Only

SEC. 111. 2-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

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

(A) in the heading, by striking ‘‘SMALL’’ and inserting ‘‘CERTAIN’’;

(B) by inserting ‘‘A SOLE COMMUNITY HOSPITAL (as defined in section 1866(d)(3)(D)(i)) located in a rural area’’ after ‘‘100 beds’’;

(C) by striking ‘‘2004’’ and inserting ‘‘2006’’; and

(D) by striking ‘‘1.4’’ and inserting ‘‘1.0’’.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(B) shall apply with respect to cost reporting periods beginning on and after January 1, 2006.

(b) STUDY: AUTHORIZATION OF ADJUSTMENT.—

(1) STUDY.—The Secretary shall conduct a study to determine if, under the system established under subparagraph (A)(i), hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(2) AUTHORIZATION OF ADJUSTMENT.—In no case as the Secretary determines under subparagraph (A)(i) for purposes of the payment system established under such subsection (A)(ii), to the number of individuals determined under subparagraph (A)(ii)); or

(3) IDENTIFICATION OF COUNTIES.—

(A) IN GENERAL.—The Secretary shall identify those counties in (a) paragraph referred to as ‘primary care shortage counties’ with the lowest primary care ratio.”
aggregate total of 20 percent of the total of the individuals determined under such paragraph;

(ii) those counties and areas (in this subsection referred to as ‘specialist care scarcity counties’) with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined to be suffering from health professional shortage areas, an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(3) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(4) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, otherwise, respecting—

(i) the identification of a county or area;

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

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

(iv) the assignment of a postal ZIP Code to a county or other area under this section.

(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 67251), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term ‘physician’ means a physician described in section 1861(r)(1) and the term ‘specialist’ means a specialist who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) PUBLICATION OF LIST OF COUNTIES POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

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

(A) by inserting ‘‘(1)’’ after ‘‘(m)’’;

(B) in paragraph (1), as designated by subsection (a), is amended by adding after ‘‘(1)’’ the following:

(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to be determined to be suffering from health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (a)(4)(C).

(3) The Secretary may post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) and determine the additional payment under paragraph (1) in such areas.

(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

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

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

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

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

(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payments under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians’ services in different geographic areas. Such study shall include—

(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

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

(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums over the last decade.

(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(c)(1)(E) of the Social Security Act, as added by section 112, on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations for the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians’ costs (rather than those of medical practices).

SEC. 114. PAYMENT FOR RURAL AND URBAN AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (a)(2)(E) for each level of ground ambulance services furnished on or after July 1, 2009, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (with regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

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

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

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

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

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

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886I(d)(2)) using the methodology used in establishing the fee schedule under paragraph (1) to calculate a regional conversion factor and a regional mileage rate payment and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for the transportation of a patient to a qualified rural area (identified under subsection (b)(ii)), the Secretary shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by 15 percent per mile otherwise applicable to miles in excess of 50 miles in such trip.

(c) IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.—

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

(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITIES.—In the case of ground ambulance services furnished on or after July 1, 2014, and before January 1, 2015, for the transportation of a patient to a qualified rural area (identified under paragraph (b)(iii)), the Secretary shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by 25 percent per mile otherwise applicable to miles in excess of 50 miles in such trip.

(2) IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.—

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

(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITIES.—In the case of ground ambulance services furnished on or after July 1, 2014, and before January 1, 2015, for the transportation of a patient to a qualified rural area (identified under paragraph (b)(iii)), the Secretary shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by 25 percent per mile otherwise applicable to miles in excess of 50 miles in such trip.
average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(ii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—(A) IN GENERAL.—The Secretary shall rank each such area based on such population density. 

(B) USE OF DATA.—In order to promptly implement section 1834(l)(12) of the Social Security Act, as added by paragraph (1), the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall furnish to the Comptroller General of the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, a population density for that area.

(ii) IMPLEMENTATION.—The Secretary shall rank each such area based on such population density.

(ii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as ‘qualified rural areas’) with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

(iv) RURAL AREA.—For purposes of this paragraph, the term ‘rural area’ has the meaning given such term in section 1886(d)(1). For purposes of computing such an aggregate total, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modifiable Area Unit System published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.

(2) USE OF DATA.—In order to promptly implement section 1834(l)(12) of the Social Security Act, as added by paragraph (1), the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall furnish to the Comptroller General of the United States.

(d) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—Section 1834(l)(42 U.S.C. 1395vic(l)), as amended by subsections (a), (b), and (c), is amended by adding at the end the following new paragraph:

(2) in subsection (d)(3), by striking ‘‘8-year’’; and

(b) R EPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress an initial report on how the data made by this subsection shall apply to services furnished on or after January 1, 2005. Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to

(f) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how the data made by this subsection shall apply to services furnished on or after January 1, 2005. Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to

(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services to such hospital are under common control (ie, shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member of such requester and such entity.

(b) CONFIRMING AMENDMENT.—Section 1834(l)(42 U.S.C. 1395vic(l)) is amended by inserting ‘‘, subject to section 1834(l)(14),’’ after ‘‘but’’.

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

(a) IN GENERAL.—Notwithstanding subsections (a), (b), and (c) of section 1834(l) of the Social Security Act (42 U.S.C. 1395vic(l)) and section 1834(d)(1) of such Act (42 U.S.C. 1395vic(d)(1)), in the case of a clinical diagnostic laboratory test covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

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

(ii) complies with equipment and crew requirements established by the Secretary.

(b) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

(i) subject to subparagraph (D), such service is furnished by a physician or other qualified medical personnel (as specified by the Secretary) who reasonably determines or certifies that the service is such that the time needed to transport the individual by land or the instability of transport by land poses a threat to the individual’s survival or seriously endangers the individual’s health; or

(ii) such service is furnished pursuant to a protocol that is established by a State or by a regional emergency medical services (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

(c) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term ‘rural air ambulance service’ means a service furnished by a fixed wing or rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1834(l)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modifiable Area Unit System published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(d) LIMITATION.—

(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if the relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, an organization with which the entity furnishing the air ambulance service, or a financial relationship between an

immediate family member of such requester and such entity.

(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services to such hospital are under common control (ie, shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member of such requester and such entity.

Sec. 115. PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.

Sec. 115. PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.

(a) COVERAGE.—Section 1834(l)(42 U.S.C. 1395vic(l)), as amended by subsections (a), (b), (c), and (d) of section 114, is amended by adding a new section 1834(l)(14) to read as follows:

Sec. 114. EXTENSION OF MEDICINE DEMONSTRATION PROJECT.

Sec. 114. EXTENSION OF MEDICINE DEMONSTRATION PROJECT.

Section 2420 of the Balanced Budget Act of 1997 (Public Law 105–33) is amended—

Sec. 118. REPORT ON DENTAL PROGRAM PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELE-HEALTH SITES AUTHORITY TO IMPLEMENT.

(a) EVALUATION.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395m(e)(3)(A))) are treated as originating sites for telehealth services.

(b) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a) and any recommendations for amendments to section 1819(a) of the Social Security Act (42 U.S.C. 1395m(e)(3)(A)).
serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits for which an individual or the individual's personal representative seeks services under section 1834(m) of the Social Security Act (42 U.S.C. 1395ww(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

(c) **AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES**—Insofar as the Secretary concludes in the report required under subsection (b) that is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395ww(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(i) of such section beginning on January 1, 2006.

Subtitle C—Provisions Relating to Parts A and B

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

(a) **IN GENERAL.**—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, in the case of home health services furnished in a rural area (as defined in section 1866(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary shall increase the payment amount otherwise made under section 1835 of such Act (42 U.S.C. 1395ff) for such services by 5 percent.

(b) **WAIVING BUDGET NEUTRALITY.**—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1835 of the Social Security Act (42 U.S.C. 1395ff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) **NO EFFECT ON SUBSEQUENT PERIODS.**—The payment increase provided under subsection (a) for a period under such section—

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

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 122. REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.

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

(1) in paragraph (4)(F)(i), by inserting “subject to paragraph (7),” after “October 1, 1997;”;

(2) in paragraph (4)(H)(i), by inserting “and subject to paragraph (7),” after “subparagraph (G)”; and

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

“(7) **REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.**—

“(A) **REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.**—

“(i) **PROGRAMS SUBJECT TO REDUCTION.**—

“(I) Programs subject to reduction. In determining for which hospitals the increase in the otherwise applicable resident limit is limited under clause (i), the Secretary shall distribute the increase in the otherwise applicable resident limit to hospitals located in the following hospital priority order:

“(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(i)(I));

“(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d));

“(III) Third, to other hospitals in a State if the resident limit otherwise applicable to such hospitals is in a specialty for which there are not other residency training programs in the State.

(b) **AFFILIATION.**—The provisions of paragraph (3)(C) of section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) are amended—

(1) in paragraph (5)(A)(i) of subsection (d), by inserting “subject to clause (ix), for discharges;” and

(2) in subsection (d)(5)(B), by adding at the end the following new paragraph:

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

(c) **REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.**—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits made under section 1886(h)(4)(D)(II) of the Social Security Act (as added by subsection (a)).
Subtitle D—Other Provisions

SEC. 131. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT REDUCE MEDICALLY UNDER-SERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a-7(b)(3)), as amended by section 101(e) of the Act, is amended—

(1) in subparagraph (F), by striking “and inserting ‘‘,” and;’’; and

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

“(h) any remuneration between a health center entity and a hospital described under clause (i) or (ii) of section 1905(a)(2)(B) and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such entity pursuant to a contract, lease, grant, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.”.

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

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by section 101(e) of the Act, for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

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

(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual’s freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party projects a health care professional’s independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception described in this section.

(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act the Secretary shall publish final regulations establishing the standards described in paragraph (1).

SEC. 132. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking “and” after the comma at the end;

(2) in paragraph (4), by striking the period at the end and inserting “, and”;

and

(3) by inserting after paragraph (4) the following new paragraph:

“(b) REPORTS.—

(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress, in a form and manner and at a time, specified by the Comptroller General, a report on the demonstration project, together with such recommendations for legislative or administrative action as the Secretary determines appropriate.

(2) DEFINITIONS.—In this section, the terms “hospital” and “critical access hospital” have the meanings given such terms in sections 1861(s) and 1861(s)-2 of the Social Security Act (42 U.S.C. 1395x and 1395x-2).

TITLE II—PROVISIONS RELATING TO MEDICAID

Subtitle A—Inpatient Hospital Services

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

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

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

(2) by striking subclause (XIX); and

(3) by inserting after subclause (XVIII) the following new subclauses:

“(XX) for each of fiscal years 2004 through 2007, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with such subsection (d), such reduce shall be reduced by 0.4 percentage points.

Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under such clause for a fiscal year thereafter.”.

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

“(viii)(I) For purposes of clause (i)(XIX) for each of fiscal years 2004 through 2007, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with such subsection (d), such reduce shall be reduced by 0.4 percentage points.

Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under such clause for a fiscal year thereafter.”.

(II) Each subsection (d) hospital shall submit to the Secretary such data (vii) in a set of 10 indicators established by the Secretary as of November 1, 2003, that relate to the quality of care furnished by the hospital in inpatient settings in the hospital, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.”.

(c) GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.—

(1) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(B) whether there is a need to adjust such payments under such subsection (d) in light of legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(2) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.
“(XII) on or after October 1, 2007, ‘c’ is equal to 1.35.”

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended—

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

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

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

SEC. 203. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

“(v) charges occurring on or after April 1, 2004.

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLIERS.—

(1) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(1) (42 U.S.C. 1395ww(d)(5)(K)(1)) is amended by inserting “(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.”

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

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

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

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

“(I) The Secretary shall publish and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

“(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

“(III) The Secretary shall provide for a meeting at which organizations representing hospitals, medical suppliers, technology manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

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

“(ix) Before establishing any add-on payment under this subparagraph with respect to a new service or technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group based upon the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).”.

(d) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY INTEGRATION.

SEC. 204. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

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

(1) in subparagraph (A)—

(A) in clause (i), by striking “for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1997, and September 30, 1997, 75 percent)” and inserting “the applicable Puerto Rico percentage (specified in subparagraph (E))”;

(B) in clause (ii), by striking “for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1997, and September 30, 1997)” and inserting “the applicable Federal percentage (specified in subparagraph (E))”; and

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

“(E) For purposes of subparagraph (A), for discharges occurring—

“(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

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

“(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent; and

“(iv) on or after October 1, 2004, the applicable Federal percentage is 25 percent and the applicable Federal percentage is 75 percent.”

(b) APPLICABILITY.—

SEC. 205. WAGE INDEX ADJUSTMENT RECLASSIFICATION FILING REFORM.

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

“(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary may establish a process for application or otherwise for an increase of the wage index applied under paragraph (3)(E) and paragraph (4)(C)(iii). The process (d) for a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county based on the out-migration of hospital employees who reside in that county to any higher wage index area.

(C) The Secretary shall, using such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for the total number of hospital employees in the higher wage index areas involved; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county or counties be at least 50 percent of the average hourly wage of all the hospitals in the area in which the qualifying county is located.

The mechanism under this paragraph, the term ‘higher wage index area’ means, with respect to a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate for this process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1886(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall reestablish the process under which a sub-section (d) hospital may elect to waive the application of such wage index increase.

(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; and

(ii) applying any extraordinary adjustment with respect to such index under paragraph (8)(D).
“(1) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (A) shall be final and shall not be subject to judicial review.”;

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

(1) in subparagraph (R), by striking “and, at the end of subparagraph (S), by striking the period at the end and inserting “; and”; and

(3) in subparagraph (S), by inserting after subparagraph (R) the following new subparagraph:

“(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such information as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section.”;

(c) EFFECTIVE DATE.—The amendments made by this section shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing the changes in hospital geographic reclassification, the Secretary may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395nn(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification.

SEC. 206. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIVIDUALS ELIGIBLE FOR MEDICARE PARTICIPATING HOSPITALS.

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

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

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

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

“(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(1) if, under such program and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program and

(2) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in subsection 4), in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for services).”;

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act) to Medicare participation agreements in effect (or entered into) on or after such date.

(c) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsection (a).

SEC. 207. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITATION OF PHYSICIAN REFERRALS.—(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.

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

(i) by striking “, and” at the end of subparagraph (A) and inserting a semicolon;

(ii) by inserting after subparagraph (A) the following new subparagraph:

“(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Provider Restoration Act of 2003, the hospital is not a specialty hospital (as defined in subsection (b)(4)); and

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

“(T) SPECIALLY HOSPITAL.—

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

(i) Patients with a cardiac condition.

(ii) Patients with an orthopedic condition.

(iii) Patients receiving a surgical procedure.

(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

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

(i) determined by the Secretary—

(I) to be in operation before November 18, 2003; or

(II) under development as of such date;

(ii) for which the number of physician investors at any time or after such date is no greater than the number of such investors as of such date;

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

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

(v) that meets such other requirements as the Secretary may specify.

(C) STUDIES.—

(1) IN GENERAL.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

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

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Provider Restoration Act of 2003, the hospital is under development as of November 18, 2003, or

(C) the hospital is substantially under development as of November 18, 2003, and the Secretary may specify.’’.

(b) APPLICATION OF EXCEPTIO FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning and necessary permits have been obtained, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

(c) STUDIES.—

(1) PC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

(1) the differences in Medicare spending for health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

(2) the extent to which specialty hospitals, relative to local full-service community hospitals that patients in diagnosis-related groups within a category, such as cardiac, and an analysis of the selection;

(3) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

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

(2) HHS STUDY.—The Secretary shall conduct a study of a representative sample of specialty hospitals—

(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative impact of any tax exemption available to such hospitals.

(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act, the Secretaries of Health and Human Services, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.

SEC. 208. 1-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION.

(a) ESTABLISHMENT OF PROCESS.—

(1) IN GENERAL.—The Secretary shall establish not later than January 1, 2004, by statute or otherwise, a process under which any hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

(b) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

(1) Such an appeal may be filed as soon after the date of the enactment of this Act but shall be filed by not later than February 1, 2004;

(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.
(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital (as defined in subsection (a) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) and is reclassified to the area selected under paragraph (1), such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, subparagraphs (A) and (B) of section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)) shall not apply to an appeal under this section.

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

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

(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

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

(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term "wage index classification" means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust payments under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) for area differences in hospital wage levels that apply to such hospital under paragraph (3)(E) of such section.

(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900,000,000.

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

Subtitle B—Other Provisions

SEC. 211. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—Paragraph (12) of section 1886(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

"(12) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—(A) In general.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the payment made under such provisions shall be applicable (determined without regard to any increase under section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, or under section 315(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), paid by 128 percent to reflect increased costs associated with such residents.

"(B) SUNSET.—Subparagraph (A) shall not apply after January 1, 2005, unless as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.

"(c) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2004.

SEC. 212. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ‘‘and’’ at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ‘‘; and’’; and

(3) by inserting after paragraph (4) the following new paragraph:

‘‘(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1819(r)(1)) who is either the medical director or an employee of a hospice program and that—

‘‘(A) consist of—

‘‘(i) an evaluation of the individual’s need for pain and symptom management, including the individual’s need for hospice care; and

‘‘(ii) counseling the individual with respect to hospice care and other care options; and

‘‘(B) may include advising the individual regarding advanced care planning.’’;

(b) PAYMENT.—Section 1814(1) (42 U.S.C. 1395f(c)) is amended to add the following paragraph at the end of subsection (a):

‘‘(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this paragraph shall be equal to an amount established for an office or other outpatient visit furnished to patients in skilled nursing facilities in accordance with section 1848(e)(1), less the portion of such amount attributable to the practice expense component.’’;

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

(1) by striking ‘‘and’’ at the end of paragraph (3); and

(2) by striking the period at the end of subsection (c), by inserting ‘‘and paragraphs (B), (C), (E), (F) and (G)’’ after ‘‘paragraph (D)’’.

SEC. 301. REVISION OF UPDATES FOR PHYSICIAN SERVICES.

(a) UPDATE FOR 2004 AND 2005.—

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

‘‘(4) For the year 2004 and 2005, the update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.’’.

(2) CONFORMING AMENDMENT.—Paragraph (4) of such section is amended, in the matter before clause (1), by inserting ‘‘and paragraph (5)’’ after subparagraph (D).

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

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

(A) by striking ‘‘projected’’ and inserting ‘‘annual average’’; and

(B) by striking ‘‘from the previous applicable period to the applicable period involved’’ and inserting ‘‘during the 10-year period ending with the applicable period involved’’.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2005.

SEC. 302. TREATMENT OF PHYSICIANS’ SERVICES FURNISHED IN ALASKA.

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

(1) by inserting ‘‘and paragraphs (B), (C), (E), (F) and (G)’’ after subparagraphs (B), (C), (E), (F) and (G)’’ and inserting ‘‘subparagraphs (B), (C), (E), (F) and (G)’’; and

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

‘‘(G) FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—The Secretary may make adjustments for the purposes of payment for services furnished in Alaska on or after January 1, 2004, and before
January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall adjust the base index to 1.67 if such index would otherwise be less than 1.67.

SEC. 303. INCLUSION OF PODIATRISTS, DENTISTS, AND OPTOMETRISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking "index to 1.67" and inserting "paragraphs (1), (2), (3), and (4) of section 1861(r)".

SEC. 304. GAO STUDY ON ACCESS TO PHYSICIANS’ SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on access of Medicare beneficiaries to physicians’ services under the Medicare program. The study shall include—

(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the Medicare program;

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

(3) an examination of the extent to which physicians are not accepting new Medicare beneficiaries as patients.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include a determination whether—

(1) data from claims submitted by physicians in the Medicare program indicate potential access problems for Medicare beneficiaries in certain geographic areas;

(2) data submitted by Medicare beneficiaries to physicians’ services may have improved, remained constant, or deteriorated over time.

SEC. 305. COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT DATA.

(a) IN GENERAL.—Not later than January 1, 2005, the Secretary shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate professional and consumer groups, and with alternative data sources from those currently used in establishing the geographic index for the practice expense component under the Medicare program, submit to Congress a report on the sustained growth in the components that the Secretary includes under the sustainable growth measure, with the goal of health promotion and disease prevention, has affected the volume of physicians’ services under part B of the Medicare program.

(b) REPORT.—Not later than 6 months after the date under section 1848(e)(1)(A)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(1)), the Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

(c) REPORT AND RECOMMENDATIONS.—

(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the review and consideration conducted under subsection (a). Such report shall include information on the alternative developed in the review conducted under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the Medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index and the estimated impacts of using such alternative data.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations as to which data, selected and reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the Medicare physician fee schedule.

SEC. 306. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS’ SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the practice expense component of payments for physicians’ services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians’ services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians’ services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by Medicare beneficiaries to physicians’ services.

(5) The effect of such refinements on physician participation under the Medicare program.

(b) VOLUME OF PHYSICIANS’ SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians’ services under part B of the Medicare program are a result of care that improves the health and well-being of Medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth measure, with the goal of health promotion and disease prevention, has affected the volume of physicians’ services.

(2) An examination of the impact on volume of physicians’ services between Medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians’ services.

(4) An examination of the impact on volume of physicians’ services of the transition to a full resource-based payment system under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(5) An examination of shifts in the site of service or services that influence the number of physicians’ services under part B of the Medicare program and other providers that have effected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 311. COVERAGE OF AN INITIATIVE PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended by striking "services described in subsection (ww)(1)" after "services described in subsection (ww)(1)".

(b) EFFECTIVE DATE.—The amendments made by this section are effective January 1, 2005.

SEC. 312. COVERAGE OF CARDIOVASCULAR SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended by striking "services described in subsection (ww)(1)" after "services described in subsection (ww)(1)".

(b) EFFECTIVE DATE.—The amendments made by this section are effective January 1, 2005.

Subtitle C—Managed Care

SEC. 313. COVERAGE OF SPECIALIZED SERVICES.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended by inserting "services described in subsection (ww)(1)" after "services described in subsection (ww)(1)".

(b) EFFECTIVE DATE.—The amendments made by this section are effective January 1, 2005.
risk of cardiovascular disease) that tests for the following:

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

“(B) Other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals, as determined by the Secretary) to be at risk for cardiovascular disease, including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

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

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395a(y)(1)), as amended by section 312(a), is amended—

(1) by striking “and” at the end of subparagraph (K);

(2) by striking the semicolon at the end of subparagraph (L) and inserting “,” and”; and

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

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

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

SEC. 313. COVERAGE OF DIABETES SCREENING TESTS.

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

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

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

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

“(Y) diabetes screening tests (as defined in subsection (yy));”.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395a), as amended by section 312(b), is amended by adding at the end the following new subsection:

“Diabetes Screening Tests

“(yy) The term ‘diabetes screening tests’ means tests (as defined in subsection (yy));”.

(i) A fasting plasma glucose test; and

(ii) Other such tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) For purposes of paragraph (1), the term ‘diabetes screening tests’ means an individual who has any of the following risk factors for diabetes:

“A) Hypertension.

(B) Dyslipidemia.

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

(D) Previous identification of an elevated impaired glucose tolerance.

(3) “Previous identification of impaired glucose tolerance.”

(4) A risk factor consisting of at least 2 of the following diabetes characteristics:

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

(ii) A family history of diabetes.

(iii) Gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(iv) 65 years of age or older.

“(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.”.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395a(y)(1)), as amended by section 312(c), is amended—

(1) by striking “and” at the end of subparagraph (L);

(2) by striking the semicolon at the end of subparagraph (M) and inserting “;”;

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

“(N) in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(2);”.

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

SEC. 314. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(c)(1)(B)(iv) (42 U.S.C. 1395l(c)(1)(B)(iv)) is amended by inserting before the period following “Does not include” the following:

“A. does not include screening mammography (as defined in section 1861(l)) and diagnostic mammography;”.

(b) CONFORMING AMENDMENT.—Section 1833(a)(2)(E)(1) (42 U.S.C. 1395a(2)(E)(1)) is amended by inserting “and, for services furnished on or after January 1, 2005, diagnostic mammography” after “screening mammography”.

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

(1) in the case of screening mammography, to services furnished on or after the date of the enactment of this Act; and

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

Subtitle C—Other Provisions

SEC. 221. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1861(u)(1) (42 U.S.C. 1395f(u)(1)), as amended by section 111(b), is amended by adding after paragraph (2) the following new paragraph:

“(3) the Secretary may specify.

(b) PAYMENT FOR DESIGNATED ORPHAN DRUGS.—(1) IN GENERAL.—The amount of payment under this subsection for an orphan drug for use in setting the payment rates under this subsection shall be not less than the average of the average acquisition cost for the drug.

(2) SPECIAL RULES.—(A) IN GENERAL.—The amount of payment under this subsection for a drug that is a designated orphan drug shall be not less than the average of the average acquisition cost for the drug.

(B) ANNUAL REPORT.—The Secretary shall report to the Congress at least once every year with respect to any orphan drug for which payment is made under this subsection.

(c) LIMITATION.—If the average acquisition cost for a drug is not available, the average price for the drug shall be the average of the average acquisition cost for the drug and the average price for the drug.

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

SEC. 222. MAMMOGRAPHY SERVICES.

(a) ANNUAL GAO SURVEYS IN 2004 AND 2005.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in 2004 and a survey in 2005 of the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall recommend to the Secretary for use in setting the payment rates for drugs during 2005 and 2006.

(b) PAYMENT AMOUNTS.—(1) IN GENERAL.—The amount of payment under this subsection for a drug or biological for which payment is first made on or after January 1, 2005, shall equal such amount as the Secretary may specify.

(2) EXCEPT.—Such amount does not include—

(A) a radiopharmaceutical; or

(B) a drug or biological for which payment is made under paragraph (2) (relating to pass-through payments) on or before December 31, 2002.

(2) PAYMENT AMOUNTS.—(1) IN GENERAL.—The amount of payment under this subsection for a drug or biological for which payment is first made on or after January 1, 2005, shall equal such amount as the Secretary may specify.

(2) EXCEPT.—Such amount does not include—

(A) a radiopharmaceutical; or

(B) a drug or biological for which payment is made under paragraph (2) (relating to pass-through payments) on or before December 31, 2002.

(2) PAYMENT AMOUNTS.—(1) IN GENERAL.—The amount of payment under this subsection for a drug or biological for which payment is first made on or after January 1, 2005, shall equal such amount as the Secretary may specify.

(2) EXCEPT.—Such amount does not include—

(A) a radiopharmaceutical; or

(B) a drug or biological for which payment is made under paragraph (2) (relating to pass-through payments) on or before December 31, 2002.

(2) PAYMENT AMOUNTS.—(1) IN GENERAL.—The amount of payment under this subsection for a drug or biological for which payment is first made on or after January 1, 2005, shall equal such amount as the Secretary may specify.

(2) EXCEPT.—Such amount does not include—

(A) a radiopharmaceutical; or

(B) a drug or biological for which payment is made under paragraph (2) (relating to pass-through payments) on or before December 31, 2002.

(2) PAYMENT AMOUNTS.—(1) IN GENERAL.—The amount of payment under this subsection for a drug or biological for which payment is first made on or after January 1, 2005, shall equal such amount as the Secretary may specify.

(2) EXCEPT.—Such amount does not include—

(A) a radiopharmaceutical; or

(B) a drug or biological for which payment is made under paragraph (2) (relating to pass-through payments) on or before December 31, 2002.
Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals, and that the Secretary shall submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under this paragraph (i).

(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment for ambulatory payment classifica-
tions for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made and, if so, for what level of adjustment;

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(2) REPORT TO CONGRESS.—The Secretary may adjust the weights for ambula-
tory payment classifications for specified covered outpatient drugs to take into ac-
count the recommendations contained in the report submitted under clause (i).

(F) CLASSES OF DRUGS.—For purposes of this paragraph:

(1) SOLU SOURCE DRUGS.—The term ‘sole source drug’ means—

(I) a biological product (as defined under section 1861(t)(1)); or

(II) a single source drug (as defined in section 1827(k)(7)(A)(iv)).

(2) INNOVATOR MULTIPLE SOURCE DRUGS.—The term ‘innovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(ii).

(3) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term ‘noninnovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(iii).

(G) AVERAGE WHOLESALE PRICE.—The term ‘average wholesale price’ means, with respect to a specified covered outpatient drug, the average whole-
sale price of such drug and services furnished on or after January 1, 2005, the Comptroller General shall conduct a study to determine the average wholesale price for the drug or biological.

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(16), as redesignated by section 222(d) of the Balanced Budget Act of 2001, shall not have been made but for the application of a functional equivalence standard to a drug or biological under this paragraph.

(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establish-
ment of separate ambulatory payment clas-
sification groups established under such section to $35 per administration for drugs and biologicals furnished in 2005 and 2006.

(C) EXCLUSION OF SEPARATE DRUG AND BIO-

(5) PAYMENT FOR PASS THROUGH DRUGS.—

Section 1833(t)(6)(D)(i) (42 U.S.C. 1395t(c)(6)(D)(i)) is amended by inserting after ‘‘under section 1842(o)’’ the following: ‘‘(i) SOLE SOURCE DRUGS.—The term ‘sole source drug’ means—

(II) a single source drug (as defined in section 1827(k)(7)(A)(iv)).

(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term ‘noninnovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(iii).

(iv) AVERAGE WHOLESALE PRICE.—The term ‘average wholesale price’ means, with respect to a specified covered outpatient drug, the average whole-
sale price of such drug and services furnished on or after January 1, 2005, by 1.6 per-
cent.

(C) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER PAYMENTS.—Additional ex-
penditures resulting from this paragraph shall not be taken into account in estab-
lishing the conversion, weighting, and other payments under this paragraph and not for the purpose of any other payments under this title.

(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Nothing in this subparagraph shall be construed to ef-
fect the Secretary’s authority to deem a par-
ticular drug to be identical to another drug if the two products are pharmaceutically equiv-
alent and bioequivalent, as determined by the Commissioner for Food and Drugs.”.

SEC. 323. PAYMENT FOR RENAL DIALYSIS SERV-
ICES.

(a) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED.—The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended—

(1) by striking “and” before “for such serv-
ices” the second place it appears;

(2) by inserting “and” before “January 1, 2005,” after “January 1, 2001,” and

(3) by inserting before the period at the end the following: “; and

(b) REIMBURSEMENT FOR PASS THROUGH DRUGS.—Section 1833(t)(2) (42 U.S.C. 1395t(c)(2)) is amended—

(1) by striking “and” before “for such serv-
ices” the second place it appears;

(2) by inserting “and” before “January 1, 2005,” after “January 1, 2001,” and

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

“(D) INAPPLICABILITY TO PEDIATRIC FACIL-
ITIES.—(A) Subparagraphs (A) and (B) shall not apply to the term ‘pediatric facility’ as that term is defined in section 1881(b)(7)(D) of the Medicare Act of 2000, the Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account hospital acquisition costs for drugs and biologicals, and shall include specific recom-
mendations to such devices from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radio-
active intensity of such devices furnished, including a functional equivalence standard to a drug or biological under this paragraph.

(iv) COMMENT ON PROPOSED RATES.—Not less than 30 days after the date the Sec-

(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

“(i) IN GENERAL.—The Secretary may not publish regulations that apply a func-
tional equivalence standard to a drug or biological under this paragraph.

(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equiva-

ence standard to a drug or biological prior to such date of enactment; and

THE SECRETARY.—Clause (ii) shall not have been made but for the application of a functional equivalence standard to a drug or biological under this paragraph.

SECOND LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

“(i) IN GENERAL.—The Secretary may not publish regulations that apply a func-
tional equivalence standard to a drug or biological under this paragraph.

(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equiva-

ence standard to a drug or biological prior to such date of enactment; and

(iii) ADJUSTMENT AUTHORIZED.—The Sec-

(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on payment for ambulatory payment classifica-
tions for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made and, if so, for what level of adjustment;

(iii) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) REPORT TO CONGRESS.—The Secretary may adjust the weights for ambula-
tory payment classifications for specified covered outpatient drugs to take into ac-
count the recommendations contained in the report submitted under clause (i).

(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER PAYMENTS.—Additional ex-
penditures resulting from this paragraph shall not be taken into account in estab-
lishing the conversion, weighting, and other payments under this paragraph and not for the purpose of any other payments under this title.

REFERENCES IN TEXT

The term ‘innovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(ii).

The term ‘noninnovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(iii).

The term ‘average wholesale price’ means, with respect to a specified covered outpatient drug, the average whole-
sale price of such drug and services furnished on or after January 1, 2005, by 1.6 per-
cent.

The term ‘innovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(ii).

The term ‘noninnovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(iii).

The term ‘average wholesale price’ means, with respect to a specified covered outpatient drug, the average whole-
sale price of such drug and services furnished on or after January 1, 2005, by 1.6 per-
cent.

The term ‘innovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(ii).

The term ‘noninnovator multiple source drug’ has the meaning given such term in section 1827(k)(7)(A)(iii).

The term ‘average wholesale price’ means, with respect to a specified covered outpatient drug, the average whole-
sale price of such drug and services furnished on or after January 1, 2005, by 1.6 per-
cent.
to drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the Medicare program which are separately billed by end stage renal disease facilities under title XVIII of the Social Security Act for such drugs and biologicals and the acquisition costs of such facilities for such drugs and biologicals and which are separately billed by end stage renal disease facilities, and

(b) Estimate the rates of growth of expenditures for such drugs and biologicals billed by such facilities.

(4) Reports.—

(A) Existing ERSD Drugs.—Not later than April 1, 2004, the Inspector General shall report to the Secretary on the study described in paragraph (2)(A).

(B) New ERSD Drugs.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).

(d) Basic Case-Mix Adjusted Composite Rate.—

(1) In applying paragraph (7) beginning with services furnished on January 1, 2005, the Secretary may establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(2) The system described in subparagraph (A) shall include—

(i) The services comprising the composite rate established under paragraph (7); and

(ii) The payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals furnished in a year, as determined by the Inspector General, for any drug or biological, as determined by the Inspector General, relative weights, payment amounts, the geographic adjustment factor, or the update for the case-mix system, the growth in estimated expenditures for separately billed drugs and biologicals furnished in a year, as determined by the Inspector General.

(3) Paragraph (11)(B) of such section is amended by adding at the end the following new paragraphs:

(12) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(13) The system described in subparagraph (A) shall include—

(i) The services comprising the composite rate established under paragraph (7); and

(ii) The payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals furnished in a year, as determined by the Inspector General, for any drug or biological, as determined by the Inspector General, relative weights, payment amounts, the geographic adjustment factor, or the update for the case-mix system, the growth in estimated expenditures for separately billed drugs and biologicals furnished in a year, as determined by the Inspector General.

(4) Reports.—

(A) Existing ERSD Drugs.—Not later than April 1, 2004, the Inspector General shall report to the Secretary on the study described in paragraph (2)(A).

(B) New ERSD Drugs.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).

(d) Basic Case-Mix Adjusted Composite Rate.—

(1) In applying paragraph (7) beginning with services furnished on January 1, 2005, the Secretary may establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(2) The system described in subparagraph (A) shall include—

(i) The services comprising the composite rate established under paragraph (7); and

(ii) The payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals furnished in a year, as determined by the Inspector General, for any drug or biological, as determined by the Inspector General, relative weights, payment amounts, the geographic adjustment factor, or the update for the case-mix system, the growth in estimated expenditures for separately billed drugs and biologicals furnished in a year, as determined by the Inspector General.

(3) Paragraph (11)(B) of such section is amended by adding at the end the following new paragraphs:

(12) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(13) The system described in subparagraph (A) shall include—

(i) The services comprising the composite rate established under paragraph (7); and

(ii) The payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals furnished in a year, as determined by the Inspector General, for any drug or biological, as determined by the Inspector General, relative weights, payment amounts, the geographic adjustment factor, or the update for the case-mix system, the growth in estimated expenditures for separately billed drugs and biologicals furnished in a year, as determined by the Inspector General.

(4) Reports.—

(A) Existing ERSD Drugs.—Not later than April 1, 2004, the Inspector General shall report to the Secretary on the study described in paragraph (2)(A).

(B) New ERSD Drugs.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).

(d) Basic Case-Mix Adjusted Composite Rate.—

(1) In applying paragraph (7) beginning with services furnished on January 1, 2005, the Secretary may establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(2) The system described in subparagraph (A) shall include—

(i) The services comprising the composite rate established under paragraph (7); and

(ii) The payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals furnished in a year, as determined by the Inspector General, for any drug or biological, as determined by the Inspector General, relative weights, payment amounts, the geographic adjustment factor, or the update for the case-mix system, the growth in estimated expenditures for separately billed drugs and biologicals furnished in a year, as determined by the Inspector General.

(3) Paragraph (11)(B) of such section is amended by adding at the end the following new paragraphs:

(12) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(13) The system described in subparagraph (A) shall include—

(i) The services comprising the composite rate established under paragraph (7); and

(ii) The payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals furnished in a year, as determined by the Inspector General, for any drug or biological, as determined by the Inspector General, relative weights, payment amounts, the geographic adjustment factor, or the update for the case-mix system, the growth in estimated expenditures for separately billed drugs and biologicals furnished in a year, as determined by the Inspector General.
(iv) The National Institutes of Health.
(v) Network organizations under section 1881(c) of the Social Security Act (42 U.S.C. 1395rr(c)).
(vi) Medicare contractors to monitor quality of care.
(vii) Providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(C) TERMINATION OF ADVISORY PANEL.—The advisory panel shall terminate on December 31, 2003.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 in fiscal year 2006 to conduct the demonstration under this subsection.

(7) AN 18-MONTH PROSPECTIVE PAYMENT SYSTEM FOR END STAGE RENAL DISEASE SERVICES.—

(1) REPORT.—
(A) IN GENERAL.—Not later than October 1, 2005, the Secretary shall submit to Congress a report detailing the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities including, to the maximum extent feasible, the following elements and features:

(i) Diagnoses and procedures;

(ii) Resource use of different types of patients;

(iii) The National Institutes of Health.

(B) RECOMMENDATIONS.—The Secretary shall include in such report recommendations on elements, features, and methodology for a bundled prospective payment system or other issues related to such system as the Secretary determines to be appropriate.

(C) ELEMENTS AND FEATURES OF A BUNDLED PROSPECTIVE PAYMENT SYSTEM.—The report required under paragraph (1) shall include a description of the methodology to be used for development of payment rates, including components of the new system described in paragraph (2).

(D) ADDITIONAL RECOMMENDATIONS.—Such other adjustments as may be necessary to reflect the variation in costs incurred by facilities in caring for patients with end stage renal disease.

(E) UPDATE FRAMEWORK.—A methodology for appropriate updates under the prospective payment system.

(F) CONFORMING RECOMMENDATIONS.—Such other matters as the Secretary determines to be appropriate.

SEC. 324. TWO-YEAR MORATORIUM ON THERAPY CAPS, PROVISIONS RELATING TO REPORTS.

(a) ADDITIONAL MORATORIUM ON THERAPY CAPS.


(2) REMAINDER OF 2003.—For the period beginning on the date of the enactment of this Act and ending on December 31, 2003, the Secretary shall not apply the provisions described in paragraphs (1), (2), and (3) of section 1833(g) to expenses incurred with respect to services described in such paragraphs during such period.

(b) REPORT TO CONGRESS .—Not later than January 1, 2005, the Secretary shall submit to Congress a report including a recommendation as to whether to extend the moratorium described in subparagraph (A) for one additional year.

(c) GAO REPORT IDENTIFYING CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) REPORT.—The Comptroller General of the United States shall identify conditions or diseases that may justify waiving the application of the therapy caps under section 1833(g)(4) (42 U.S.C. 1395s(g)) with respect to such conditions or diseases.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective on January 1, 2005, and each of calendar years 2006 through 2009, except that, with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996 and a calendar year beginning with 2006), the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(II) In each of the fiscal years 1996 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(III) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be further reduced by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2005, minus 3.0 percentage points.

(IV) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(b) REPEAL OF SURVEY REQUIREMENT AND IMPLEMENTATION OF NEW SYSTEM.—Section 1833(g)(2) (42 U.S.C. 1395s(g)(2)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking “The” and inserting “For services furnished prior to the first day of the period described in subparagraph (D), the’’;

(B) in clause (i), by striking “taken not later than January 1, 1995, and every 5 years thereafter.’’;

and

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

(D) Taking into account the recommendations in the report under section 326(d) of Medicare Provider Restoration Act of 2003, the Secretary shall implement a revised prospective payment system described in subparagraph (D), the’’.

(c) C ONSIDERING THE EFFECT ON THE MEDICAID PROGRAM.—

(1) IN GENERAL.—For services furnished to an individual who enrolls after the implementation date of a revised prospective payment system for services furnished in connection with a surgical procedure specified pursuant to subsection (1)(A) and furnished in an ambulatory surgical center described in such subsection, for services furnished beginning with the date of enactment of this Act, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act is a covered beneficiary (as defined in section 1861(s)(3)(B)] of title 18, United States Code), the Secretary of Health and Human Services shall furnish the services, consistent with judicial review under section 1869, 1878, or 1879, as applicable, in identifying individuals described in the previous sentence.’’.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning on or after January 1, 2004 for which a penalty does not apply under such amendment but for which a penalty was previously imposed.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who enrolls during the special enrollment period described in such subparagraph, for services furnished beginning with the first day of the month following the month in which the individual enrolls.

(c) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395a(a)(1)) is amended by adding the following new subparagraph:

(1) Covering services furnished in connection with a surgical procedure specified pursuant to subsection (1)(A) and furnished in an ambulatory surgical center described in such subsection, for services furnished beginning with the date of enactment of this Act, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act is a covered beneficiary (as defined in section 1861(s)(3)(B)] of title 18, United States Code), the Secretary of Health and Human Services shall furnish the services, consistent with judicial review under section 1869, 1878, or 1879, as applicable, in identifying individuals described in the previous sentence.”.
SEC. 329. 5-YEAR AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTIFIED INDIAN HOSPITALS AND CLINICS.

Section 1880(e)(1)(A) (42 U.S.C. 1395q(e)(1)(A)) is amended by inserting “(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)” after “for services described in paragraph (2)”.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

SEC. 341. DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) Demonstration Project.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for drugs or biologicals that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which payment may be made under such part. Such project shall be designed to allow for flexibility with respect to such drugs or biologicals.

(b) Demonstration Project Sites.—The project established under this section shall be conducted in sites selected by the Secretary.

(c) Duration.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act, but in no case may the project extend beyond December 31, 2005.

(d) Limitation.—Under the demonstration project over the duration of the project, the Secretary may not provide—

(1) coverage for more than 50,000 patients; and

(2) more than $500,000,000 in funding.

(e) Report.—Not later than January 1, 2006, the Secretary shall submit a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost-effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to the demonstration services and hospital outpatient department services for administration of the biological.

SEC. 342. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN HOSPITALS.

(a) In General.—Section 1861 (42 U.S.C. 1395l) is amended by adding—

“(w) Intravenous Immune Globulin—“(1) The term ‘intravenous immune globulin’ means an approved pooled plasma derivative for the treatment of a patient’s home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient’s home is medically appropriate.

(b) Payment as a Drug or Biological.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting ‘‘(including intravenous immune globulin in section 1861(s)(2))’’ after ‘‘with respect to drugs and biologicals’’.

(c) Effective Date.—The amendments made by this section shall apply to items furnished on or after January 1, 2004.

SEC. 343. MEDPAC STUDY OF COVERAGE OF CERTIFIED REGISTERED NURSE FIRST ASSISTANT SERVICES.

(a) Study.—The Medicare Payment Advisory Commission (in this section referred to as the “Commission”) shall conduct a study to determine whether the Commission should be authorized to conduct a study of certain Medicare services provided by certified registered nurse first assistants to Medicare beneficiaries.

(b) Report.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) Definitions.—In this section—

(1) Certified Registered Nurse Assistant.—The term ‘certified registered nurse assistant’ means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) Certified Registered Nurse First Assistant.—The term ‘certified registered nurse first assistant’ means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

SEC. 344. MEDPAC STUDY OF PAYMENT FOR CERTAIN SHOES IN CANCER PATIENTS.

(a) Study.—The Medicare Payment Advisory Commission (in this section referred to as the “Commission”) shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (as defined in subsection (w) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the actual costs that such physicians incur in providing clinical staff for patient care in hospitals.

(b) Report.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under

SEC. 327. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE.

(a) In General.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1)(B), by striking “no more than the limits established under paragraph (2)”, and inserting “no more than the amount of payment applicable under paragraph (2)”; and

(2) in paragraph (2), to read as follows:

“(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

“(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

“(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1834(h)(12) may substitute modified shoes instead of replacing one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes) with such inserts. The Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this sub-

(b) Conforming Amendments.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting “(and includes shoes described in section 1861(e)(12))” after “in section 1861(e)(9)”.

(2) Section 1824(a)(2) (42 U.S.C. 1395u(a)(2)) is amended by striking subparagraph (C).

(c) Effect of amendment.—The amendments made by this section shall apply to items furnished on or after January 1, 2005.
subsection (a) together with recommenda-
tions for such legislation or administrative action as the Commission determines to be appropriate.

SEC. 345. STUDIES RELATING TO VISION IMPAIR-
MENTS.
(a) COVERAGE OF OUTPATIENT VISION SER-
VICES FURNISHED BY VISION REHABILITATION
PROFESSIONALS UNDER PART B.—
(1) STUDY.—The Secretary shall conduct a
study to determine the feasibility and advis-
ability of providing for payment for vision rehabilita-
tion services furnished by vision rehabilitation professionals.
(b) REPORT ON APPROPRIATENESS OF A DEM-
ONSTRATION PROJECT TO TEST FEASIBILITY OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING OR DELIVERING VISION REHABILITATION SERVICES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enact-
ment of this Act, the Secretary shall submit to Congress a report consisting of two graphs (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

(3) VISION REHABILITATION PROFESSIONAL DEFINED.—In this subsection, the term ‘vision rehabilitation professional’ means an orientation and mobility specialist, a rehabil-
itation therapist, or a low vision therapist.
(b) REPORT ON APPROPRIATENESS OF A DEM-
ONSTRATION PROJECT TO TEST FEASIBILITY OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING OR DELIVERING VISION REHABILITATION SERVICES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enact-
ment of this Act, the Secretary shall submit to Congress a report consisting of two graphs (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

SEC. 346. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.
Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

SEC. 1866C. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAM.
‘‘(c) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall ap-
prove demonstration projects that examine health delivery factors that encourage the delivery of high quality care while accomplishing the objectives de-
scribed in subsection (b); and
(B) streamline documentation and report-
ing requirements otherwise required under this title.

‘‘(2) ADMINISTRATION BY CONTRACT.—(A) In order to otherwise provide in this section, the Secretary may admin-
ister the demonstration program established under this section in a manner that is similar to the manner in which the dem-
onstration program established under section 1866A is administered in accordance with section 1866B.
(B) PART C PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—
(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and
(B) streamline documentation and reporting requirements otherwise required under this title.

‘‘(3) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate ex-
penditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

‘‘(4) PARTICIPATION AND SUPPORT BY FED-
ERAL AGENCIES.—In carrying out the dem-
onstration program under this section, the Secretary may direct—

‘‘(a) the Director of the National Institutes of Health to expand to the National Insti-
tutes to evaluate current medical tech-
nologies and improve the foundation for evi-
dence-based practice;
(b) the Administrator of the Agency for Healthcare Research and Quality and to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate infor-
mation relevant to such program; and
(c) the Administrator of the Centers for Medicare & Medicaid Services and the Ad-
ministrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups and beneficiary populations served by the partici-
ating groups, for analysis supporting the purposes of the demonstration program, con-
sistent with the applicable provisions of the Health Insurance Portability and Account-
ability Act of 1996.’’.

SEC. 347. MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.
(a) STUDY.—The Medicare Payment Advi-
sory Commission (in this section referred to as the ‘Commission’) shall conduct a study of the feasibility and advisability of allow-
ing medicare fee-for-service beneficiaries di-
rect access to outpatient physical therapy services and physical therapy services fur-
nished as comprehensive rehabilitation facil-
ity services.
(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Con-
gress a report on the study conducted under subsection (a) together with recommenda-
tions for such legislation or administrative action as the Commission determines to be appropriate.
(c) DIRECT ACCESS DEFINED.—The term ‘di-
rect access’ means, with respect to out-
patient physical therapy services furnished as com-
prehensive outpatient rehabilitation facility
services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1833(a)(2), 1861(p), and 1861(c)(1) of such title (42 U.S.C. 1395(a)(2), 1395x(p), and 1395cc, respectively) shall be applied—
(1) without regard to any requirement that—
(A) an individual be under the care of (or referred by) a physician; or
(B) services be provided under the supervision of a physician; and
(2) whether a physician or a qualified physical therapist to satisfy any requirement for—
(A) certification and recertification; and
(B) establishment and periodic review of a plan of care.

SEC. 348. DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUT-PATIENT SERVICES.

(a) Establishment.—
(1) In general.—Subject to the succeeding provisions of this section, the Secretary shall establish demonstration projects (in this section referred to as “demonstration projects”) under which the Secretary shall evaluate methods that improve the quality of care for individuals with chronic conditions and that reduce expenditures that would otherwise be made under the Medicare program on behalf of such individuals for such care, such methods to include permitting those beneficiaries to direct their own health care needs and services.

(b) Design of Projects.—
(1) Evaluation before implementation of project.—
(A) In general.—In establishing the demonstration projects under this section, the Secretary shall evaluate best practices employed in the Medicare program and plans and programs under State plans for medical assistance under the Medicaid program under title XIX of the Social Security Act, as well as best practices in the private sector or other areas, of methods that permit patients to self-direct the provision of personal care services. The Secretary shall evaluate such practices in a 1-year period and, based on such evaluation, shall design the demonstration project.

(B) Requirement for estimate of budget neutral costs.—As part of the evaluation under subparagraph (A), the Secretary shall evaluate the costs of furnishing care under the projects. The Secretary may not implement demonstration projects under this section unless the Secretary determines that the costs of providing care to individuals with chronic conditions under the project will not exceed the costs, in the aggregate, of furnishing care to such individuals under title XVIII of the Social Security Act, that would otherwise be paid without regard to the demonstration projects for the period of the project.

(2) Scope of services.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) Voluntary Participation.—Participation of providers of services and suppliers, and of individuals with chronic conditions in the demonstration projects shall be voluntary.

(d) Demonstration Projects Sites.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct a demonstration project in at least one area, as defined by the Secretary, with a population of individuals entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(1) Evaluations.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) Reports.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the individuals with chronic conditions participating in the projects as compared to such outcomes and costs to other individuals for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension or expansion of the projects as the Secretary determines appropriate.

(e) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and in such manner as the Secretary determines is necessary to conduct demonstration projects.

(f) Authorization of Appropriations.—
(1) Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such title (42 U.S.C. 1395j).

(2) There are authorized to be appropriated from such Trust Fund such sums as may be necessary for the Secretary to enter into contracts with appropriate organizations for the design, implementation, and evaluation of the demonstration projects.

(g) In no case may expenditures under this section exceed the aggregate expenditures necessary for the Secretary to enter into contracts with appropriate organizations for the design, implementation, and evaluation of the demonstration projects.

(3) In no case may expenditures under this section exceed the aggregate expenditures that would otherwise be made for the provision of personal care services.

SEC. 349. MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION.

(a) Establishment.—
(1) In general.—The Secretary shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for—

(A) promoting continuity of care;

(B) helping stabilize medical conditions;

(C) preventing or minimizing acute exacerbations of chronic conditions; and

(D) reducing unnecessary hospital admissions, such as adverse drug interactions related to polypharmacy.

(2) Sites.—The Secretary shall designate no more than 10 sites at which to conduct the demonstration program under this section, of which—

(A) 2 shall be in an urban area;

(B) 1 shall be in a rural area; and

(C) 1 shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

(3) Duration.—The Secretary shall conduct the demonstration program under this section for a period of 3 years.

(d) Consultation.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are undertaking similar efforts to improve quality and reduce avoidable hospitalizations for chronic patients.

(b) Participation.—
(1) In general.—A physician who provides care for eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, subject to phase-in over the 3-year demonstration period and with the assistance provided under subsection (d)(2),

(A) the use of health information technology to manage the medical care of eligible beneficiaries consistent with paragraph (3); and

(B) the electronic reporting of clinical quality and outcome measures consistent with the requirements established by the Secretary under the demonstration program.

(2) Special Rule.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

(3) Practice Standards.—Each physician participating in the demonstration program under this section must demonstrate the ability—

(A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and comorbidities, for the purposes of developing care management requirements;

(B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the Medicare program;

(C) to establish and maintain health care information systems for such beneficiaries; and

(D) to promote continuity of care across providers and settings.

(e) Use of evidence-based guidelines and measures.—The Secretary shall promulgate guidelines and measures required under subparagraph (d) to be designed to take into account beneficiaries with multiple chronic conditions.

(f) Payment Methodology.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets the requirements established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

(g) Administration.—
(1) Use of quality improvement organizations.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to manage physicians and evaluate their performance under the demonstration program under this section.

(2) Technical Assistance.—The Secretary shall ensure that each physician and other entity with whom the Secretary contracts is responsible for technical assistance and education as needed to physicians.
enrolled in the demonstration program under this section for the purpose of aiding their practice standards, and implement measurement of clinical and outcomes measures.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the demonstration program under this section. The Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

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

(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall report to Congress on the demonstration program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means any individual who—

(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act and is not enrolled in a plan under part C of such title; and

(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

(2) HEALTH INFORMATION TECHNOLOGY.—The term "health information technology" means any information, such as medical records, which meets such functionality, interoperability, and other standards as prescribed by the Secretary.

SEC. 350. GAO STUDY AND REPORT ON THE PROPAGATION OF CONCERG CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by Medicare beneficiaries (as defined in section 1852(b)(5)(A) of the Social Security Act (42 U.S.C. 1395(w)(5)(A))); and

(B) has impacted upon the access of Medicare beneficiaries (as so defined) to items and services reimbursed under Medicare.

(b) CONCIERGE CARE.—In this section, the term "concierge care" means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395a(b)(18)(C))), or other individual—

(1) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; and

(2) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a) with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

SEC. 351. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term "chiropractic services" has the meaning given that term by the Secretary for purposes of demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such care is provided.

(2) CONCIERGE CARE.—In this section, the term "concierge care" means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; and

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(3) MEDICARE.—The term "Medicare" means the Medicare program.

(b) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the feasibility and advisability of covering chiropractic services under the Medicare program if the demonstration projects under this section were not implemented.

(2) FUNDING.—

(A) IN GENERAL.—The Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) with such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

(c) DEMONSTRATION PROJECT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

(d) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of such demonstration projects as the Secretary determines to be appropriate for the purpose of developing and submitting the report to Congress under subsection (d).

SECTION IV—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 401. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBASED.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a demonstration project under this section to determine the number of home health care beneficiaries who would be deemed to be homebound for purposes of the definition of "medical care program" under section 1861(r) of such Act as of the date on which the Secretary determines is appropriate.

(b) REPORT.—Not later than the date that is 2 years after the date on which the demonstration projects were not implemented.

(c) FUNDING.—

(A) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1396c) of such funds as are necessary for the conduct of demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.

(d) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).
Section 402. Demonstration Project for Medical Adult Day-Care Services

(a) Establishment.—Subject to the succeeding provisions of this section, the Secretary shall make a demonstration project under this section (in this section referred to as the ‘demonstration project’), under which the Secretary shall, as part of a plan of an extension, expansion, or termination of a demonstration project and under such title XVIII of the Social Security Act (42 U.S.C. 1395t), consists of substitute medical adult day-care services for home health services. If the Secretary esti-

(b) Medicare Beneficiary Described.—For purposes of subsection (a), a medicare benefici-

(c) Demonstration Project Sites.—The demonstration project established under this section may be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) Payment on Number of Participants.—The aggregate number of such beneficiaries that may participate in the project may not exceed 3,000.

(e) Data.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) Report to Congress.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using data collected under subsection (e). The report shall include the following:

(i) An examination of whether the provision of home health services to medicare beneficiaries under the project has had any of the following effects:

(a) Has adversely affected the provision of home health services under the medicare program;

(b) Has directly caused an increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification.

(ii) The specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program.

(iii) Specific recommendations to exempt permanently and severely disabled home-bound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional costs for those services.

(g) Waiver Authority.—The Secretary shall waive compliance with the requirements of this subsection if the Secretary finds necessary in the interest of care and such other requirements as the Secretary deems appropriate.

(h) Construction.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, unless the Secretary certifies that failure to apply such penalties or such remedies would result in a demonstration project that is not expected to improve.

(i) Duration.—The Secretary shall conduct the demonstration project for a period of 3 years.
not require, under section 4602(e) of the Bal-
anced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) or otherwise under OASIS, a home health agency to gather or submit in- formation that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as ‘non-medicare/medicaid OASIS informa-
tion’).

(b) PERIOD OF SUSPENSION.—The period de-
scribed in this subsection—
(1) begins on the date of the enactment of
this Act; and
(2) ends on the last day of the second month following the date as of which the
Secretary has published final regulations regard-
ing the collection and use by the Cen-
ters for Medicare & Medicaid Services of
non-medicare/medicaid OASIS information fol-
lowing the submission of the report re-
quired under subsection (c).

(c) REPORT.—
(1) STUDY.—The Secretary shall conduct a
study on how non-medicare/medicaid OASIS
information is and can be used by large home
health agencies. Such study shall examine—
(A) whether there are unique benefits from
the analysis of such information that cannot be
derived from other information available to,
or collected by, such agencies; and
(B) whether such information can be used
by small home health agencies com-
pared to the administrative burden related to
such collection.

In conducting the study the Secretary shall obtain informa-
tions from quality assess-
ment experts in the use of such informa-
tion and the necessity of, as well as large,
home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under this subsection not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SEC. 404. MEDPAC STUDY ON MEDICARE MAR-
GINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advi-
isory Commission shall conduct a study of
payment margins of home health agencies un-
der the home health prospective payment
system under section 1855 of the Social Secu-
ritv Act (42 U.S.C. 1395f). Such study shall ex-
amine whether systematic differences in
payment margins exist as a result of differences in case mix (as measured by home health re-
source groups (HHRGs)) among such agen-
cies. The study shall use the partial or full-
year cost reports filed by home health agen-
cies.

(b) REPORT.—Not later than 2 years after
the date of the enactment of this Act, the
Commission shall submit to Congress a re-
port on the study under subsection (a).

SEC. 405. COVERAGE OF RELIGIOUS NONMED-
ICAL HEALTH CARE INSTITUTION
SERVICES FURNISHED IN THE
HOME.

(a) IN GENERAL.—Section 1821(a) (42 U.S.C.
1395x–1(a)) is amended—
(1) in the matter preceding paragraph (1), by
inserting ‘‘and for home health services furnished
by a religious non-medical health care institution’’ after ‘‘reli-
igious nonmedical health care institution’’; and
(2) in paragraph (2)—
(A) by striking ‘‘or extended care services’’ and
inserting ‘‘, extended care services, or
home health services’’; and
(B) by striking services from a home health
agency, after ‘‘skilled nursing facility’’.

(b) DEFINITION.—Section 1861 (42 U.S.C.
1395x–3), as amended by section 342, is amended by adding at the end the following new sec-
ing:

‘‘(aaa)(1) The term ‘home health agency’ also
includes a religious nonmedical health care
institution (as defined in subsection (ss)(1)) with respect to items
and services ordinarily furnished by such an
institution to individuals in their homes, and
that are comparable to items and services furnished to such individual health
agency that is not religious nonmedical
health care institution.’’

(2)(A) Subject to subparagraphs (B), pay-
ment may be made under such home health
agency programs, to the extent and under such conditions, limitations,
and requirements (in addition to or in lieu of
the conditions, limitations, and
requirements otherwise applicable) as may be
provided in regulations consistent with
section 1821.

(B) Notwithstanding any other provision of
this title, payment may not be made under
paragraph (A)—
(i) in a year insofar as such payments exceed
$700,000; and
(ii) after December 31, 2006.

Subtitle B—Graduate Medical Education

SEC. 411. EXCEPTION TO INITIAL RESIDENCY PE-
RIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL IN-
TENT.—Congress—
(1) section 1886(g)(1)(H) of the Social Security Act (42 U.S.C.
1395ww(h)(5)(F)(I)), as added, by section 9202 of the Consolidated Omnibus Bud-
get Reconciliation Act of 1985 (Public Law 99–
212), to provide, with respect to the initial residency period for geriatric residency or
fellowship programs such that, where a par-
ticular approved geriatric training program
requires a resident to complete 2 years of
training to initially become board eligible in
the geriatric specialty, the 2 years spent in
the geriatric training program are treated as
part of the resident’s initial residency pe-
riod, but are not counted against any limita-
tions on the initial residency period.

(b) INTRODUCTION, DEFINITION, AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations con-
sistent with the congressional intent ex-
pressed in this section and publish a notice and
opportunity for public comment to be ef-
fective for cost reporting periods beginning
on or after October 1, 2003.

SEC. 412. TREATMENT OF VOLUNTEER SUPER-
VISION.

(a) MORATORIUM ON CHANGES IN TREAT-
MENT.—During the 1-year period beginning
on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1866 of
the Social Security Act (42 U.S.C. 1395ww), the
Secretary shall allow all hospitals to count resident training and fellowship programs in exist-
ence as of January 1, 2002, who are training at non-hos-
pital sites, without regard to the financial
arrangement between the hospital and the
residents, with respect to services furnished to such residents in non-hospital
settings.

(b) STUDY AND REPORT.—
(1) STUDY.—The Inspector General of the
Department of Health and Human Services shall conduct a study of the appropriateness
and effectiveness of alternative payment me-
diums under this section. Each such program shall be derived from other informa-
tion available to, or collected by, such agencies; and
(B) whether such information can be used
by small home health agencies com-
pared to the administrative burden related to
such collection.

In conducting the study the Secretary shall obtain informa-
tions from quality assess-
ment experts in the use of such informa-
tion and the necessity of, as well as large,
home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under para-
graph (1), together with such recommenda-
tions as the Inspector General determines
appropriate.

Subtitle C—Chronic Care Improvement

SEC. 421. VOLUNTARY CHRONIC CARE IMPRO-
VEMENT UNDER TRADITIONAL FEE-
FOR-SERVICE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sec-
ing:

‘‘(c) PROVIDING ADDITIONAL FUNDING FOR CHRONIC CARE IMPROVEMENT PROGRAMS.—
(b) DEFINITION.—Section 1861 (42 U.S.C.
1395x–3), as amended by section 342, is amended by adding at the end the following new sec-

(b) DEFINITION.—Section 1861 (42 U.S.C.
1395x–3), as amended by section 342, is amended by adding at the end the following new sec-

(c) REPORT.—
(1) STUDY.—The Secretary shall conduct a
study on how non-medicare/medicaid OASIS
information is and can be used by large home
health agencies. Such study shall examine—
(A) whether there are unique benefits from
the analysis of such information that cannot be
derived from other information available to,
or collected by, such agencies; and
(B) whether such information can be used
by small home health agencies com-
pared to the administrative burden related to
such collection.

In conducting the study the Secretary shall obtain informa-
tions from quality assess-
ment experts in the use of such informa-
tion and the necessity of, as well as large,
home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under this subsection not later than 18 months after the date of the enactment of
this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.
“(1) IN GENERAL.—In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement programs for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 3 years after the date of enactment of this section.

“(2) AGREEMENT PERIOD.—The period of an agreement under this subsection shall be for 3 years.

“(3) MINIMUM PARTICIPATION.—

“(A) IN GENERAL.—The Secretary shall enter into an agreement under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, cover at least 10 percent of the aggregate number of Medicare beneficiaries reside.

“(B) MEDICARE BENEFICIARY DEFINED.—In this paragraph, the term ‘Medicare beneficiary’ means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

“(4) SITE SELECTION.—In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside, among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

“(5) INDEPENDENT EVALUATIONS OF PHASE I PROGRAMS.—The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluations shall be conducted with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

“(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

“(B) Beneficiary and provider satisfaction.

“(C) Health outcomes.

“(D) Financial outcomes, including any cost savings to the program under this title.

“(6) EXPANDED IMPLEMENTATION PHASE (PHASE II).—

“(1) IN GENERAL.—With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (5) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

“(2) CONDITIONS FOR EXPANSION OF PROGRAMS.—The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program and the following participants:

“(A) improve the clinical quality of care;

“(B) improve beneficiary satisfaction; and

“(C) achieve targets for savings to the program as specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk adjustment under section 1833(b)(2) of title 18, United States Code.

“(3) INDEPENDENT EVALUATIONS OF PHASE II PROGRAMS.—The Secretary shall carry out evaluations of programs expanded under this subsection. Such evaluations shall be carried out in the similar manner as is provided under subsection (1).

“(4) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS.—

“(1) IDENTIFICATION OF PROSPECTIVE PROGRAMS.—The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

“(2) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

“(A) A description of the advantages to the beneficiary in participating in a program.

“(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

“(C) Notification that participation in a program is voluntary.

“(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

“(3) VOLUNTARY PARTICIPATION.—A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

“(4) CHRONIC CARE IMPROVEMENT PROGRAMS.—

“(1) IN GENERAL.—Each chronic care improvement program shall—

“(A) have a description of each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of appropriate targeted, goal-oriented care management plan under paragraph (2);

“(B) provide each targeted beneficiary participating in the program with such plan; and

“(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

“(2) ELEMENTS OF CARE MANAGEMENT PLANS.—A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

“(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communication with other health care providers under the plan.

“(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

“(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

“(D) The use of monitoring technologies that enhance the exchange of pertinent clinical information, such as vital signs, symptoms information, and health self-assessment.

“(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

“(3) CONDUCT OF PROGRAMS.—In carrying out paragraph (1) with respect to a participant, the chronic care improvement organization shall—

“(A) enable the participant in managing the participant’s health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing any activities as specified in the care management plan of the participant.

“(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

“(C) develop a clinical information database to track and monitor each participant across settings and to meet such requirements as the Secretary determines.

“(4) ADDITIONAL RESPONSIBILITIES.—

“(A) OUTCOMES REPORT.—Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

“(B) ADDITIONAL REQUIREMENTS.—Each such organization and program shall comply with such additional requirements as the Secretary may specify.

“(C) ACCREDITATION.—The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations, as defined by the Secretary, may be deemed to meet such requirements under this section as the Secretary may specify.

“(5) TERMS OF AGREEMENTS.—

“(1) TERMS AND CONDITIONS.—

“(A) IN GENERAL.—An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

“(B) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS.—The Secretary may enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

“(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems appropriate for the targeted beneficiaries to be served; and

“(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assure financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through any incurred amount, claims, reserves, reinsurance, withholds, or in any other manner as the Secretary determines appropriate.

“(C) MANNER OF PAYMENT.—Subject to paragraph (3)(B), the payment under an agreement under—

“(A) subsection (b) shall be computed on a per-member per-month basis; or

“(B) subsection (c) shall be computed on a per-member per-month basis or such other basis as the Secretary and organization may agree.

“(5) APPLICATION OF PERFORMANCE STANDARDS.—

“(A) SPECIFICATION OF PERFORMANCE STANDARDS.—Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this title, against which the performance of the chronic care improvement organization under the agreement is measured.

“(B) ADJUSTMENT OF PAYMENT BASED ON PERFORMANCE.—

“(1) IN GENERAL.—Each such agreement shall provide for adjustments in payment
rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement;

(‘‘4’’) Financial risk for performance.—In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full repayment by the organization of any savings attributable to the operation of such agreement二人，

(‘‘4’’) Budget neutral payment condition.—

1. Under this section, the Secretary shall ensure that the aggregate sum of the claims of recipients participating in chronic care improvement programs and funds paid to chronic care improvement programs under this section, shall not exceed the Medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

(g) Funding.—

(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs.

(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this title after taking into account any savings attributable to the operation of this section over the 3-fiscal-year period beginning on October 1, 2003.

(b) Reports.—The Secretary shall submit to Congress reports on the operation of section 1807 of the Social Security Act, as added by subsection (a), as follows:

(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes.

(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update on the report required under paragraph (1) on the results of such program;

(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section, and such report shall be submitted not later than 2 years after the report is submitted under paragraph (2).

Each such report shall include information on:

(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

(B) the design of the program; and

(C) the improvements in health outcomes and financial efficiencies that result from such implementation.

SEC. 422. Medicare Advantage Quality Improvement Programs.

(a) In General.—Section 1852(e) (42 U.S.C. 1395w–22(e)) is amended—

(1) in the heading, by striking ‘‘Assurance and Improvement’’ and inserting ‘‘Quality Improvement’’;

(2) by amending paragraphs (1) through (3) to read as follows:

‘‘(1) in General.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan under this subsection (other than an MA private fee-for-service plan or an MSA plan).

‘‘(2) Chronic Care Improvement Program.—The Secretary shall implement the chronic care improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

‘‘(3) Data.—

(A) Collection, analysis, and reporting.

‘‘(i) in General.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other health indicators.

(ii) Application to MA Regional Plans.—The Secretary shall establish as appropriate by regulation, collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.

(iii) Application to Preferred Provider Organizations.—Clause (i) shall apply to MA organizations with respect to MA local plans and preferred provider organization plans only as far as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) Definition of Preferred Provider Organization Plan.—In this subparagraph, the term ‘‘preferred provider organization plan’’ means an MA plan that—

(1) has a network of providers that have agreed to a contractually specified reimbursement arrangement with the organization offering the plan;

(2) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(3) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) Limitations.

(1) types of data.—The Secretary shall not collect under subparagraph (A) data on such quality improvement measures for the purpose of facilitating consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(2) Changes in types of data.—Subject to clause (iii), the Secretary may only change the types of data that are required to be submitted under this subsection (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private entities authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.

Subtitle D—Other Provisions

SEC. 431. Improvements in National and Local Coverage Determination Process to Respond to Changes in Technology.

(a) National and Local Coverage Determination Process.

(1) In General.—Section 1862 (42 U.S.C. 1395ww), as amended by sections 948 and 950, is amended—

(A) in the third sentence of subsection (a), by inserting ‘‘consistent with subsection (i)’’ after ‘‘shall’’; and

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

(i) National and Local Coverage Determination Process.—

(1) Factors and evidence used in making national coverage determinations.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to facilitate consumer access to such information in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

(2) Timeframe for decisions on requests for national coverage determinations.—

In
the case of a request for a national coverage determination that—

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) subject to such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national coverage determinations as of January 1, 2004, and section 1862(l)(5) of the Social Security Act, as added by such paragraph, shall apply to such determinations made on or after July 1, 2004.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DEVICES

(1) IN GENERAL.—(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 1862(m) of the Social Security Act, as added by such paragraph).

(b) CONSULTATION.—The Secretary shall consult with appropriate scientific and ethical experts.

(2) RULE OF CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall apply to coverage of routine costs associated with certain clinical trials of category A devices.

(c) SCOPE OF PAYMENT.—For purposes of subsection (b),

(1) the term ‘routine costs’ means reasonable and necessary routine patient care costs (as defined in the Centers for Medicare & Medicaid Services Coverage Issues Manual, section 30–1), including immunosuppressive drugs and other followup care.

(2) the term ‘transplantation and appropriate related items and services’ means items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the Centers for Medicare & Medicaid Services Coverage Issues Manual.

(d) Authorization of Appropriations.—There are authorized to be appropriated to carry out this title:

(1) from the Medicare Trust Funds.

SEC. 434. RESTORATION OF MEDICARE TRUST FUNDS.

(a) Definitions.—In this section:

(1) CLERICAL ERROR.—The term ‘clerical error’ means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Treasury Account to the Trust Fund.

(2) TRUST FUND.—The term ‘Trust Fund’ means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act and the Federal Supplementary Medical Insurance Trust Fund established under section 1851 of such Act.

(b) Correction of Trust Fund Holdings.—In general.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

(b) Correction of Trust Fund holdings.—(1) SEC. 432. EXTENSION OF TREATMENT OF CERTAIN CANCER PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of HIPAA (114 Stat. 2783a–551) is amended by inserting ‘; and for services furnished during 2005 and 2006’ after the period at the end.
the Trust Fund if the clerical error involved had not occurred.

(c) APPROPRIATION.—There is appropriated to the Trust Fund, out of any money in the Treasury of the United States not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the period during which the appropriation is being made as a result of the clerical error involved.

Sec. 433. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding after the section the following new subsection:

"(9) Section 1819 (42 U.S.C. 1395i–3) is amended to read "! 1817 (42 U.S.C. 1395h(c)(2)(B)) (in the matter preceding paragraph (4), is amended by inserting a comma after "(b)".

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1806(m)(4)(B) (42 U.S.C. 1395l(h)(5)(D)) is amended by striking "in the case of individuals so", and inserting "a pregnant woman", and inserting "a pregnant women".

(c) APPOINTMENT.—(1) Section 1833(b)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended by striking "clinical, and inserting "clinical, and

(2) Section 1833(b)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended by inserting "clause (iii)" and inserting "clause (iv)"); and

(3) Section 1836(c)(1)(S)(II)(III) (42 U.S.C. 1395x(s)(2)(K)(ii)(III)) is amended by striking "and inserting "in subsection (d)(5)(D)(ii)"); and

(4) Section 1836(c)(2)(D)(iv) (42 U.S.C. 1395x(s)(2)(K)(ii)(IV)) is amended by striking "the efficient provision of" and inserting "the efficient provision of".

(d) DEADLINE.—With respect to appointments made on or after the date of the enactment of this Act—

(1) the Secretary of the Treasury shall take the action under subsection (b)(1); and

(2) the appropriation under subsection (c) shall be made.

A PPLICATION OF DISCLOSURE REQUIREMENTS.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following:

"(9) Section 1819 (42 U.S.C. 1395i–3) is amended to read "! 1817 (42 U.S.C. 1395h(c)(2)(B)) (in the matter preceding paragraph (4), is amended by inserting a comma after "(b)".

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

II. EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

III. EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.
S15448

CONGRESSIONAL RECORD — SENATE
November 21, 2003

SEC. 500. ADMINISTRATIVE IMPROVEMENTS WITHIN THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS).

(a) Coordinated Administration of Medicare Prescription Drug and Medicare Advantage Programs.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by sections 307 and 309 of the Omnibus Budget Reconciliation Act of 2001 (Public Law 107-107) and section 421 of the Medicare Modernization Act (Public Law 108-173), is amended—

(1) in subsection (d)(3)(A)(ii), by striking "plan a medicare supplemental policy" and inserting "plan a medicare supplemental policy";

(2) in subsection (d)(3)(B)(iii)(II), by striking "the best of the issuer or seller's knowledge" and inserting "to the best of the issuer's or seller's knowledge";

(3) in subsection (g)(2)(A), by striking "medicare supplemental policies" and inserting "medicare supplemental policies";

(4) in subsection (p)(2)(B), by striking ", and" and inserting "; and"; and

(5) in subsection (s)(3)(A)(i), by striking "pre-existing" and inserting "pre-existing".

(b) Medicare Advantage Programs.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 421, is amended by adding at the end the following new subsection:

"(A) The review, negotiation, and administration of health care contracts.

(b) Limitation.—In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

"(c) Requirement for Dedicated Actuary for Private Health Plans.—Section 1117(b) (42 U.S.C. 1317(b)) is amended by adding at the end the following new paragraph:

"(3) In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of title XVIII and related provisions of such title.

(d) Increase in Grade to Executive Level III for the Administrator of the Centers for Medicare & Medicaid Services.—

(1) In General.—Section 5311 of title 5, United States Code, is amended by adding at the end the following new paragraph:

"(2) Administrator of the Centers for Medicare & Medicaid Services.

(2) Conforming Amendment.—Section 5315 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(3) Effective Date.—The amendments made by this subsection take effect on January 1, 2004.

(e) Conforming Amendments Relating to Health Care Financing Administration.—

(1) Amendments to the Social Security Act.—The Social Security Act is amended—

(A) in section 1117 (42 U.S.C. 1317)—

(i) in subsection (a), by striking "Chief Actuary" and inserting "Center";

(ii) by striking "HCFA" and inserting "CMS";

(B) in section 1132 (42 U.S.C. 1322), by striking "HCFA Form 64 or HCFA Form 21" and inserting "CMS Form 64 or CMS Form 21";

(C) in section 1131 (42 U.S.C. 1321), by striking "HCFA" and inserting "CMS"; and

(D) in section 1133 (42 U.S.C. 1323), by striking "HCFA" and inserting "CMS".

(2) Federal Mandates Act.—Sections 10(a), 20(b), 20(c), and 29(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 102–105) are amended by striking "HCFA" and inserting "CMS".

(f) Secrecy Offices.—Section 500 of title 5, United States Code, is amended—

(1) by striking the table of contents for chapter 90, thereby redesignating chapter 90 as chapter 90A; and

(2) by inserting at the end the following: "COST EFFECTIVENESS REVIEW.

(3) In General.—The Secretary shall provide for a cost effectiveness review of all health care contracts entered into by the Administrator on or after January 1, 2008, which contract will pay for the Senior Executive Service under section 5311.

(g) Prohibition on Contractors.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 307, is amended by adding at the end the following:

"(1) In general.—There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).";

"(2) Director.—Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

(3) Duties.—The duties described in this paragraph are the following:

(A) The administration of parts C and D.

(B) The provision of notice and information under section 1804.

(C) Such other duties as the Secretary may prescribe.

(4) Deadline.—The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.

(h) Management Staff for the Centers for Medicare & Medicaid Services.—Such section is further amended by adding at the end the following new subsection:

(1) In General.—The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate and experienced (either in the public or private sector), superior expertise in at least one of the following areas:

(A) The review, negotiation, and administration of health care contracts.

(B) The design of health care benefit plans.

(2) Eligibility.—To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

(A) The review, negotiation, and administration of health care contracts.

(B) The design of health care benefit plans.

"(3) Actuarial sciences.

"(D) Compliance with health plan contracts.

"(E) Consumer education and decision making.

"(F) Any other area specified by the Secretary that requires specialized management or other expertise.

"(G) Rates determination.

(1) Performance-Related Pay.—Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employee under paragraph (1). Such rate shall take into account expertise, experience, and performance.

(2) Limitation.—In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

(2) Requirement for Dedicated Actuary for Private Health Plans.—Section 1117(b) (42 U.S.C. 1317(b)) is amended by adding at the end the following new paragraph:

"(3) In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of title XVIII and related provisions of such title.

(h) Increase in Grade to Executive Level III for the Administrator of the Centers for Medicare & Medicaid Services.—

(1) In General.—Section 3117(b) (42 U.S.C. 1317(b)) is amended by adding at the end the following new paragraph:

"(2) Administrator of the Centers for Medicare & Medicaid Services.

(2) Conforming Amendment.—Section 3115 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(3) Effective Date.—The amendments made by this subsection take effect on January 1, 2004.

(i) Conforming Amendments Relating to Health Care Financing Administration.—

(1) Amendments to the Social Security Act.—The Social Security Act is amended—

(A) in section 1117 (42 U.S.C. 1317)—

(i) in subsection (a), by striking "Chief Actuary" and inserting "Center";

(ii) by striking "HCFA" and inserting "CMS";

(B) in section 1132 (42 U.S.C. 1322), by striking "HCFA Form 64 or HCFA Form 21" and inserting "CMS Form 64 or CMS Form 21";

(C) in section 1131 (42 U.S.C. 1321), by striking "HCFA" and inserting "CMS"; and

(D) in section 1133 (42 U.S.C. 1323), by striking "HCFA" and inserting "CMS".

(2) Federal Mandates Act.—Sections 10(a), 20(b), 20(c), and 29(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 102–105) are amended by striking "HCFA" and inserting "CMS".
Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’; and

(F) in section 212(a)(7) (42 U.S.C. 300a–2(a)(7)), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’; and

(G) in section 2675(a) (42 U.S.C. 300I–7(a)), by striking ‘‘Health Care Financing Administration’’ in the first sentence and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(3) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—Section 6201(c)(12) of the Internal Revenue Code of 1986 is amended—

(A) in subparagraph (B), by striking ‘‘Health Care Financing Administration’’ in the matter preceding clause (i) and inserting ‘‘Centers for Medicare & Medicaid Services’’; and

(B) in subparagraph (C)—

(i) by striking ‘‘Health Care Financing Administration’’ in the heading and inserting ‘‘Centers for Medicare & Medicaid Services’’; and

(ii) by striking ‘‘Health Care Financing Administration’’ in the matter preceding clause (i) and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(4) AMENDMENTS TO TITLE 10, UNITED STATES CODE.—Title 10, United States Code, is amended—

(A) in section 1086(d)(4), by striking ‘‘administration, and inserting ‘‘Administrator of the Centers for Medicare & Medicaid Services’’;

(C) in section 221(1), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(D) in section 221(1), by striking ‘‘Health Care Financing Administration’’ in the second sentence and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(E) in section 221(1), by striking ‘‘Health Care Financing Administration’’ in the second sentence and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(F) in section 221(1), by inserting ‘‘Health Care Financing Administration’’ in the second sentence and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(G) in section 221(1), by striking ‘‘Health Care Financing Administration’’ in the heading and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(H) the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.—Title I (42 U.S.C. 15121 et seq.) is amended by adding the following new subsection:

(i) in section 1871 (42 U.S.C. 1395hh), as amended by section 502(a), is amended by adding a new paragraph: ‘‘

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

‘‘(a) A term ‘supplier’ means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.’’

‘‘(b) SUBPART 3—Responsibilities of the Centers for Medicare & Medicaid Services.

(1) IN GENERAL.—Section 1395hh (42 U.S.C. 1395hh) is amended by inserting ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(D) THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000.—Title IV (42 U.S.C. 14211 et seq.) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(7) ADDITIONAL AMENDMENT.—Section 403 of the Act entitled, ‘‘An Act to authorize certain appropriations for the territories of the United States, to amend certain Acts relating thereto, and for other purposes’’, enacted October 15, 1977 (42 U.S.C. 14121–14121q), is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(8) AMENDMENTS TO THE ALZHEIMER’S DISEASE AND RELATED DEMENTIAS SERVICES RESEARCH ACT OF 1992.—The Alzheimer’s Disease and Related Dementias Research Act of 1992 (42 U.S.C. 14201 et seq.) is amended—

(A) in the heading of subparagraph 3 of part D to read as follows: ‘‘Subpart 3—Responsibilities of the Centers for Medicare & Medicaid Services’’;

(B) in section 307 (42 U.S.C. 14207),—

(i) in subsection (a), by striking ‘‘National Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(ii) in subsection (b)(1), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(iii) in subsection (b)(2), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(iv) in subsection (c), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(v) in subsection (d), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(vi) in subsection (e), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(C) in section 308 (42 U.S.C. 14208), by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’;

(6) MISCELLANEOUS AMENDMENTS.—

(A) REHABILITATION ACT OF 1973.—Section 202(b)(8) of the Rehabilitation Act of 1973 (29 U.S.C. 766(b)(8)) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(B) INDIAN HEALTH CARE IMPROVEMENT ACT.—Section 405(d)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1444(b)(5)) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(C) INDIVIDUALS WITH DISABILITIES EDUCATION ACT.—Section 525(a)(1) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(b)(5)) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(D) HOME HEALTH CARE AND ALZHEIMER’S DISEASE AMENDMENTS.—Section 302(a)(9) of the Home Health Care and Alzheimer’s Disease Amendments of 1990 (42 U.S.C. 1495j–1(a)(9)) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(E) THE CHILDREN’S HEALTH ACT OF 2000.—Section 2561(h) of the Children’s Health Act of 2000 (42 U.S.C. 217b–3(a)(a)) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(F) THE NATIONAL INSTITUTES OF HEALTH RESEARCH ACT OF 1992.—Section 1010(b) of the National Institutes of Health Reauthorization Act of 1992 (42 U.S.C. 292 et seq.) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(G) THE NATIONAL INSTITUTES OF HEALTH RESEARCH ACT OF 1992.—Section 1095(k)(2) of the National Institutes of Health Reauthorization Act of 1992 (42 U.S.C. 292 et seq.) is amended by striking ‘‘Health Care Financing Administration’’ and inserting ‘‘Centers for Medicare & Medicaid Services’’.

(P) THE NATIONAL INSTITUTES OF HEALTH RESEARCH ACT OF 1992.—Section 1086(d)(4), by striking ‘‘ad- ministration, and inserting ‘‘Administrator of the Centers for Medicare & Medicaid Services’’;

(I) THE NATIONAL INSTITUTES OF HEALTH RESEARCH ACT OF 1992.—Section 1086(d)(4), by striking ‘‘ad- ministration, and inserting ‘‘Administrator of the Centers for Medicare & Medicaid Services’’;

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

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

‘‘(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed rule and shall not take effect until there is the further opportunity for public comment as provided for provisions of the provision again as a final regulation.’’.

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

SEC. 503. COMPLIANCE WITH CHANGES IN REGULATORY LATTICE AND POLICIES.

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

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

‘‘(1A) A substantive change in regulation—

(1) (A) the inclusion of a new substantive rule, regulation, or statement of policy; or

(2) (B) an extension of an existing substantive rule, regulation, or statement of policy beyond its original time frame; or

(3) (C) an exemption of a class of entities from a substantive rule, regulation, or statement of policy; or

(4) (D) a termination of a substantive rule, regulation, or statement of policy; or

(5) (E) an extension of a substantive rule, regulation, or statement of policy; or

(6) (F) a termination of a substantive rule, regulation, or statement of policy; or

(7) (G) a modification of a substantive rule, regulation, or statement of policy; or

(8) (H) a repeal of a substantive rule, regulation, or statement of policy; or

(9) (I) a variance from a substantive rule, regulation, or statement of policy; or

(10) (J) a variance from an existing substantive rule, regulation, or statement of policy.

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

SEC. 504. ISSUANCE OF REGULATIONS.

(a) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Subsection (a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

‘‘(1A) The term ‘supplier’ means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.’’
not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

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

(ii) failure to apply the change retroactively would be contrary to the public interest.

(b) EFFECTIVE DATE.—The amendment made by paragraph (a) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

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

"(B)(i) Except as provided in clause (i), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

(2) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.

(d) The amendment made by paragraph (a) shall only apply to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003.

SEC. 504. RESEARCH STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary to provide binding advisory opinions. The study shall include an appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such determination shall be appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 503(d)(1), is amended by adding at the end the following:

"(1) Not later than 2 years after the date of the enactment of this Act, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

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

(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency or conflict; and

(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflict, and an appropriate legislative or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflict.

Subtitle B—Contracting Reform

SEC. 511. INCLUSION OF FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1871 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

SEC. 1874A. (a) AUTHORITY.—

(1) AGENCY AUTHORITY INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (1) or (4) if the entity is appropriately accredited (as generally applicable to Federal acquisition and procurement).

(b) RELATIONSHIP TO MIP CONTRACTS.—

(1) AUTHORITY.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (1) or (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (1) or (4) if the entity is appropriately accredited (as generally applicable to Federal acquisition and procurement).

(3) RELATIONSHIP TO MIP CONTRACTS.—

(A) NONDUPlication OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of the medicare integrity program under section 1893 as necessary to carry out the purposes of this title and otherwise to quality as providers of services or suppliers.

(B) COMMUNICATION WITH PROVIDERS.—Notwithstanding any provision of this title, the Secretary may require any person entering into contracts under this section with respect to the performance of any or all of the functions described in paragraph (1) or (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities) with respect to the furnishing of items or services to provide such persons with information on such items or services furnished under this title and otherwise to quality as providers of services or suppliers.

(C) BENCHMARKING.—The Secretary shall, in entering into contracts under this section, provide such other information on such items or services furnished under this title and otherwise to quality as providers of services or suppliers relating to a particular function described in paragraph (1) or (4) if the entity is appropriately accredited (as generally applicable to Federal acquisition and procurement).

(D) DETERMINATION OF PAYMENT AMOUNTS.—Determining the subject to provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

(E) PROVIDER CONSULTATIVE SERVICES.—Performing the functions relating to providers of services or suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to education and outreach to providers of services or suppliers pursuant to the provisions of this title.

(G) ADDITIONAL FUNCTIONS.—Performing the functions relating to education and outreach to providers of services or suppliers pursuant to the provisions of this title.
relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15).

"(B) CONSTRUCTION.—An entity shall not be treated as administering a contract merely by reason of having entered into a contract with the Secretary under section 1838.

(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

"(d) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition of property or in paragraph (B), the Secretary shall use competitive procedures when entering into contracts with Medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a Medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any transfer of law required in the absence of the termination of a contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 5 years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among Medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and supplies affected by such transfer, and contact information for the contractors involved).

"(D) INCENTIVES FOR QUALITY.—The Secretary may award Medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract section shall be entered into with any Medicare administrative contractor unless the Secretary finds that such Medicare administrative contractor will perform its obligations under the contract effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

"(3) PERFORMANCE REQUIREMENTS.—

"(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title; and

"(B) INCLUSION OF CONTRACTS.—All contract performance requirements shall be set forth in the Secretary and the appropriate Medicare administrative contractor. Such performance requirements—

shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

shall be used for evaluating contractor performance under the contract; and

iii shall be consistent with the written statement of work provided under the contract.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a Medicare administrative contractor under this section unless the contractor agrees—

(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing its functions under this section;

(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and completeness of such records, and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a Medicare administrative contractor under this section may require the Medicare administrative contractor, and any of its officers, employees certifying payments or disbursing officer unless, in connection with such payment, the Medicare administrative contractor acted with reckless disregard of its obligations under its Medicare administrative contract or with intent to defraud the United States.

"(6) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

"(7) DECONTRACTING.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a Medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and necessary, terminate a Medicare administrative contract, indemnify the contractor and such persons.

"(B) CONSIDERATIONS.—The Secretary shall consider inclusion of the performance requirements under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

"(C) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(i) to change any common law immunity that may be available to a Medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under this section or under any applicable Federal Acquisition Regulation.

"(7) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under this subsection, the Secretary may incorporate those recommendations of the Medicare Payment Advisory Commission that have been granted in connection with a certification, or proposal to certify, the Medicare administrative contractor as required under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1821(b)(2) of such Act (relating to timely review of determinations and to timely processing of reconsiderations and applications for exceptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and to timely processing of reconsiderations and applications for exceptions) were in effect before the date of the enactment of this Act.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

"(A) IN GENERAL.—No Medicare administrative contractor shall be liable to the United States, a provider, or any person certifying payments or disbursing officer unless, in connection with such payment, the Medicare administrative contractor acted with reckless disregard of its obligations under its Medicare administrative contract or with intent to defraud the United States.

"(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

"(4) DECONTRACTING.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

"(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

"(C) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(i) to change any common law immunity that may be available to a Medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under this section or under any applicable Federal Acquisition Regulation.

"(7) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under this subsection, the Secretary may incorporate those recommendations of the Medicare Payment Advisory Commission that have been granted in connection with a certification, or proposal to certify, the Medicare administrative contractor as required under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1821(b)(2) of such Act (relating to timely review of determinations and to timely processing of reconsiderations and applications for exceptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and to timely processing of reconsiderations and applications for exceptions) were in effect before the date of the enactment of this Act.
(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395b) is amended as follows:

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

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

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

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A."

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

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

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

(A) by striking "an agreement with an agency or organization under this section" and inserting "a contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Section 1874A is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARROTTHERS).—Section 1842 (42 U.S.C. 1395b) is amended as follows:

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

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B".

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

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A."

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carrier" and inserting "medicare administrative contractor"; and

(iii) in subparagraphs (D) and (E);

in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such carrier shall provide, to the Secretary" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

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

(v) in subparagraph (H)—

(i) by striking "if it makes determinations or payments with respect to physicians' services," in the matter preceding clause (i); and

(ii) by striking "carrier" and inserting "medicare administrative contractor" in clause (i); and

(vi) by striking subparagraph (I);

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

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier;"

(D) by striking paragraph (5);

(E) in paragraph (2)(A), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in paragraph (2)(A), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1))", and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subparagraph (a)(1))" and inserting "section 1874A(a)(3)(B))";

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking "carrier" and inserting "medicare administrative contractor";

(E) by striking paragraphs (5) and (6).

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

(6) Subsection (g) is amended by striking "carrier" or "carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A, that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor each place it appears;

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(i), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (i) is amended—

(A) in paragraph (1)(A)(ii), by striking "carriers" and inserting "medicare administratprive contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (j) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS AND AGREEMENTS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—For the purposes of implementing the amendments made by this section, the provisions contained in the section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(2) Appropriate Transition.—The Secretary shall carry out such steps as are necessary to provide for an appropriate transition from contracts and agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395b, 1395e) to contracts under section 1874A, as added by this section.

(3) Authorizing continuation of MIP functions under current contracts and agreements and under transition contracts.—Notwithstanding the amendments made by this section, the provisions contained in the section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(4) Reports on Implementation.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section.

(5) Secretary General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(6) Status of Implementation.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid and awarded; and

(B) The distribution of functions among contracts and contractors.
(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of Medicare contractors to adapt to full competition.

SEC. 512. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 511(a)(1), is amended by adding at the end the following new subsection:

"(e) REQUIREMENTS FOR INFORMATION SECURITY.—

"(i) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A Medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of section 1874A(e)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this subsection shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

"(ii) PERFORMANCE OF ANNUAL EVALUATIONS.—Each Medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of section 1874A(e)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(I) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

"(II) test the effectiveness of information security control techniques of an appropriate subset of the contractor’s information systems (as defined in section 3502(b) of title 44, United States Code) relating to such functions and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, and shall be conducted in a clear, concise, and accurate manner to include assessments of the scope and sufficiency of such evaluations, including assessments of the scope and sufficiency of such evaluations, including—

"(1) ENSURE THAT PROVIDERS AND SUPPLIERS ARE PROVIDED ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.

"(2) RESPONSE TO WRITTEN INQUIRIES.—Each Medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title,

"(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each Medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(4) MONITORING OF CONTRACTOR PERFORMANCE.—

"(A) IN GENERAL.—Each Medicare administrative contractor shall, consistent with standards developed by the Secretary under paragraph (b), establish and maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(B) DEVELOPMENT OF STANDARDS.—
(1) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written requests or the inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET WEBSITES.—(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsections:

(d) INTERNET WEBSITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing), and each provider of services or suppliers, shall maintain an internet website which—

(1) provides answers in an easily accessible format to frequently asked questions, and

(2) includes other published materials of the contractor that relate to providers of services and suppliers under the programs under this title (and title XIX insofar as it relates to such programs).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsection:

(1) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(2) CONSTRUCTION.—Nothing in this section or section 1890(e) shall be construed as providing for disclosure by a medicare contractor—

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

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

(g) DEFINITIONS.—For purposes of this section, the term "medicare contractor" includes the following:

(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1842 of such Act (42 U.S.C. 1395h) and each carrier under section 1816 and a carrier with a contract under section 1874A, including a fiscal intermediary with a contract under section 1842 of such Act (42 U.S.C. 1395h).

(2) An eligible entity with a contract under section 1842.

(3) A provider of services with a contract under section 1874A or a provider of services or a supplier under the programs under title XVIII of the Social Security Act (including provisions of title XI of such Act).

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small providers of services or suppliers" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(Sec. 522. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.)

(a) ESTABLISHMENT.—(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements under the medicare program under title XVIII of the Social Security Act (including provisions of
SEC. 521. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) In General.—The Secretary shall establish a demonstration program (in this section referred to as the ‘‘demonstration program’’) under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A or enrolled under part B, or beneficiaries entitled to a prophylactic telephone number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In carrying out such study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(b) Deadline for Appointment.—By not later than the date of the enactment of this Act, the Comptroller General shall submit to the Congress a report on the study conducted under subparagraph (A).

SEC. 522. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) In General.—The Secretary shall establish a demonstration program (in this section referred to as the ‘‘demonstration program’’) under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A or enrolled under part B, or beneficiaries entitled to a prophylactic telephone number 1-800-MEDICARE.

(b) Duration.—The demonstration program shall be conducted over a 3-year period.

(c) Evaluation and Report.—(1) Evaluation.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(d) Transition.—The demonstration program shall succeed the program carried out under section 1808(c) of such Act, as added by subsection (a). The Secretary shall appoint the Medicare Beneficiary Ombudsman under section 1886(c) of the Social Security Act, as added by subsection (a).

(e) Funding.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395f)) to carry out section 1808(c) of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (a), such sums as may be necessary for fiscal year 2004 and each succeeding fiscal year.

(f) Use of Central, Toll-Free Number (1-800-MEDICARE).—

(1) Access to Medicare Handbook instead of other toll-free numbers.—Section 1800(b) (42 U.S.C. 1395b-2(b)) is amended by striking ‘‘and’’ and inserting ‘‘and’’ before the next sentence.

(2) IN GENERAL.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 523. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) Transfer of Functions.—(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security shall submit to Congress a report on the feasibility of establishing, in the Social Security Administration, an Office of Medicare Appeals within the Office of the Commissioner and the Social Security Administration.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 524. INFORMATION AND CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 525. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) In General.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395et seq.) with respect to hospital inpatient and extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

References to the amended provisions are made in the text of this section.

SEC. 526. INCLUSION OF CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 527. INCLUSION OF CERTIFIED HOME HEALTH AGENCY IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify home health agencies that are participating in the medicare program.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 528. INCLUSION OF CERTIFIED DURABLE MEDICAL EQUIPMENT FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify durable medical equipment facilities that are participating in the medicare program.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 529. INCLUSION OF CERTIFIED HOME HEALTH AGENT IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify home health agencies that are participating in the medicare program.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 530. INCLUSION OF CERTIFIED MEDICARE ADVISORY COMMITTEE IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify medicare advisory committees that are participating in the medicare program.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 531. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) Transfer of Functions.—(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security shall submit to Congress a report on the feasibility of establishing, in the Social Security Administration, an Office of Medicare Appeals within the Office of the Commissioner and the Social Security Administration.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

(c) Funding.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395f)) to carry out section 1808(c) of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (a), such sums as may be necessary for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

(d) Transition Timetable.—A timetable for the transition.

(e) Regulations.—The establishment of specific regulations to govern the appeals process.

(f) Case Tracking.—The establishment of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across all fee-for-service and managed care components of the medicare program.

(g) Feasibility of Precedential Authority.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal and policy questions.

(h) Access to administrative law judges.—The feasibility of—

(i) filing appeals with administrative law judges electronically;

(ii) conducting hearings using tele- or video-conference technologies.
(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

(K) PERFORMANCE STANDARDS.—The appropriateness of establishing performance standards for administrative law judges with respect to decisions made under title XVIII of the Social Security Act taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code relating to impartiality.

(L) SHARED RESOURCES.—The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) as amended by this Act.

(4) LEGISLATIVE EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the plan under subsection (a) and transfer the administrative law judge functions described in paragraph (5).

(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

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

(A) by adding at the end the following new clause;

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

(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service entitled to payment under part A or bundled under part B, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to jurisdiction by describing in a timely manner with respect to a question of law or regulation relevant to the matters in controversy that there is no material issue of fact in dispute. The appealant may make such request only once with respect to a question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require, the appropriate review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(b) APPLICATION TO PROVIDER AGREEMENT DISPUTES.—Section 1869(b)(1)(F)(i) (42 U.S.C. 1395ff(b)(1)(F)(i)) is amended to read as follows:

(2) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For purposes of this subsection, the term 'review entity' means an entity of up to three reviewers who are administrative law judges or members of the Department of Appeals Board selected for purposes of making determinations under this paragraph.

(c) DETERMINATION.—Section 1869(b)(1)(F)(i) (42 U.S.C. 1395ff(b)(1)(F)(i)) is amended to read as follows:

(2) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For purposes of this paragraph, a request for expedited access to judicial review, see paragraph (2).'

(d) TIMELINESS OF DETERMINATION.—Section 1869(b)(1)(F)(i) (42 U.S.C. 1395ff(b)(1)(F)(i)) is amended—

(1) by inserting ‘(A)’ after ‘(B)’; and

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

(2) TIMELINESS OF DETERMINATION.—If, after or coincident with filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy that there is no material issue of fact in dispute, the appeals court may order a prompt determination of the appeal. The appealant may make such request only once with respect to a question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require, the appropriate review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(2) DETERMINATION.—If, after or coincident with filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require, the appropriate review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(E) DETERMINATION.—If, after or coincident with filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require, the appropriate review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(F) DETERMINATION.—If, after or coincident with filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require, the appropriate review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(G) DETERMINATION.—If, after or coincident with filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require, the appropriate review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.
to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1689b(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

(c) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE DETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by section 3(b), is amended by striking "sufficient medical, legal, and other expertise and training and expertise in medical science and legal matters" and inserting "sufficient medical, legal, and other expertise and training and expertise in medical science and legal matters and the extent appropriate, a summary of the clinical or scientific evidence used in making the determination";

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(2) W AIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Sections 1919(f)(2) and section 1919(f)(2) (42 U.S.C. 1395f(t)(2) and 1396c(r)(2)) each are amended—

(A) in subparagraph (B)(ii), by striking "subparagraph (C)" and inserting "subparagraphs (C) and (D)"; and

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

"(D) W AIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(ii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in this subparagraph that precedes sentence (B).

(3) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(b) of the Social Security Act (42 U.S.C. 1396cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395l)), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395f(t))) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary.

The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

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

SEC. 533. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of service may not knowingly introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.

(b) USE OF PATIENTS' MEDICAL RECORDS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraphs:

"(A) the written notice on the determination shall include—

(i) the reasons for the determination, including whether a legal medical policy or a local coverage determination was used;

(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

(iii) notification of the right to seek a re-determination or otherwise appeal the determination, including the information described in this subsection;

(B) such written notice shall be provided in printed form in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the re-determination.

(2) REQUIREMENTS OF NOTICE OF REDETERMINATION.—With respect to a re-determination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the re-determination shall include—

(i) the specific reasons for the re-determination;

(ii) as appropriate, a summary of the clinical or scientific evidence used in making the re-determination;

(iii) a description of the procedures for obtaining additional information concerning the re-determination; and

(iv) notification of the right to appeal the re-determination or otherwise appeal instructions on how to initiate such an appeal under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the re-determination.

(b) NOTICE.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended—

(A) by amending subsection (c) to provide that—

"(D) REQUIREMENTS FOR REVIEWERS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3)(c)(3) (42 U.S.C. 1395ff(c)(3)(c)(3)) is amended—

(A) in subparagraph (A), by striking "sufficient medical, legal, and other expertise and training and expertise in medical science and legal matters" and inserting "sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing"; and

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

"(K) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

(I) is not a related party (as defined in section 1866(e));

(ii) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

(iii) has not obtained a conflict of interest with such a party.

(2) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

(3) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.

(c) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395f) is amended—

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

"(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (c)(3)(E) shall be met (relating to qualifications of reviewing professionals)."

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

"(E) QUALIFICATIONS OF REVIEWERS.—In reviewing determinations under this section, a qualified independent contractor shall assure that—"
“(A) each individual conducting a review shall meet the qualifications of paragraph (2); and

(B) compensation provided by the contractor to the reviewing professional shall be consistent with paragraph (3); and

(C) in the case of a review by a provider described in subsection (a)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a ‘reviewing professional’), a reviewing professional meets the qualifications described in paragraph (2) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

(2) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

(i) not be a related party (as defined in paragraph (5)); and

(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

(iii) neither party have a conflict of interest with such a party.

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

(I) the individual is not involved in the provision of items or services in the case under review;

(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

(ii) prohibit an individual who has staff privileges to the extent of the professional situation in which the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges or the existence of such privileges in the profession to which the individual is licensed to practice; and

(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term ‘participation agreement’ means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

(B) a health care professional who is legally paid in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

(5) RELATED PARTY DEFINED.—For purposes of this section, the term ‘related party’ means, with respect to a case under this title involving a specific individual entitled to benefits under part B, or both, any of the following:

(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, or employee of the Department of Health and Human Services, or of such contractor.

(B) The individual (or authorized representative).

(C) The health care professional that provides the items or services involved in the case.

(D) The institution at which the items or services (or treatment in the field of practice that is appropriate for the items or services at issue) are furnished or are arranged to be furnished, as determined by the Secretary, in consultation with providers of such items or services.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

(F) Any other party determined by the Secretary as having a substantial interest in the case involved.

(2) INDEPENDENCE.—

(A) each individual conducting a review shall meet the qualifications of paragraph (3); and

(B) compensation provided by the contractor to the reviewing professional shall be consistent with paragraph (3); and

(C) in the case of a review by a provider described in subsection (a)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a ‘reviewing professional’), a reviewing professional meets the qualifications described in paragraph (2) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall promulgate regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary significantly from date to date based upon the differences in the circumstances triggering prepayment review.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(B) LIMITATION ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high frequency of payment error under section 1395(i)(3)(A).

(C) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the initiation, including termination dates, of non-random prepayment review. Such regulations may vary significantly from date to date based upon the differences in the circumstances triggering prepayment review.

(4) E EFFECTIVE DATE .—The amendments made by subsection (a), as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(5) RECOVERY OF OVERPAYMENTS.—

(A) IN GENERAL.—Section 1810 (42 USC 1395h) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 615. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1810 (42 USC 1395dd) is amended by adding at the end the following new subsection:

‘‘(D) RECOVERY OF OVERPAYMENTS.—

‘‘(1) USE OF REPAYMENT PLANS.—

‘‘(A) IN GENERAL.—A medicare administrative contractor may conduct a repayment plan only if the repayment is for an overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Department of Health and Human Services, or of the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

‘‘(B) HARDSHIP.—

‘‘(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (overpayments) within 30 days is deemed to constitute a hardship if—

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report;

(II) in the case of the provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year;
"(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during any part of the previous year or was paid under this title only during a portion of that year.

(iii) TREATMENT OF PREVIOUS OVERPAYMENT.—A provider of services or supplier that has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under such plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

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

(1) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

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

(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest and fees) under the repayment plan.

(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

(F) LIMITATION ON RECOUPMENT.—

(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor of such determination under section 1892(b)(1), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered, if the provisions of section 1892(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination made by the fiscal intermediary or carrier involved.

(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the original notice of the overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) ACKNOWLEDGMENT OF DEBT.—For purposes of this subsection, the term ‘Medicare contractor’ means the person identified as such in accordance with section 1892(b)(1) of the Social Security Act.

(D) LIMITATION ON USE OF EXTRAPOLATION.—A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

(1) there is a sustained or high level of payment error; or

(2) the provider on whom the Secretary has imposed educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1892(a), section 1878, or otherwise with respect to a provision of services or supplier a consent settlement offer, and the Secretary shall—

(i) communicate to the provider of services or supplier—

(1) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

(2) the nature of the problems identified in such evaluation; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been identified that particular billing codes may be overutilized by that class of providers of services or suppliers under this title. The Secretary shall—

(i) provide opportunity for a statistically valid random sample; or

(ii) consent settlement offer.

The opportunity provided under clause (ii) does not affect the appeal rights with respect to the alleged overpayment involved.

(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term ‘consent settlement offer’ means an agreement between the Secretary and a contractor to use in selecting a sample of claims for review in the case of a provider of services or supplier that is determined to have received an overpayment under this title. The Secretary shall—

(i) provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(1) the opportunity for a statistically valid random sample; or

(2) a consent settlement offer.

(E) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a Medicare contractor audits a provider of services or supplier under this title, the contractor shall—

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the program; and

(ii) permit the provider of services or supplier to submit comments in writing, as well as consent settlement options (which are at the discretion of the Secretary).

(F) PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(1) USE OF REPAYMENT PLANS.—Section 1893(a)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECONSIDERATION.—Section 1893(a)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(G) USE OF EXTRAPOLATION.—Section 1893(a)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(H) PROVIDER OVERPAYMENTS.—Section 1893(a)(4) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(I) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(a)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(J) PROVIDEMENT OF SUPPORTING DOCUMENTATION.—Section 1893(a)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(K) CONSENT SETTLEMENT REFORMS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notification of overutilization of billing codes under section 1893(a)(6) of the Social Security Act, as added by subsection (a).

(L) PAYMENT AUDITS.—Section 1893(a)(7) of the Social Security Act, as added by subsection (a), shall apply to payments made after the date of the enactment of this Act.

(M) STANDARD FOR AVOIDING MISTAKES.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1892(f)(18) of the Social Security Act, as added by subsection (a).

(2) PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.—

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

(1) by adding at the end of the heading the following new subsection:

"ENROLLMENT PROCESSES;" and

(2) by adding at the end the following new subsection:
"(j) Enrollment Process for Providers of Services and Suppliers.—

"(1) Enrollment Process.—

"(A) In General.—The Secretary shall establish a process for the enrollment of providers of services and suppliers under this title.

"(B) Deadlines.—The Secretary shall establish deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) Consultation Before Changing Procedures.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

"(2) Hearing Rights in Cases of Denial or Non-Renewal.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review respecting the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

"(h) Effective Date.—

"(1) Enrollment Process.—The Secretary shall provide for the establishment of the enrollment process described in section 1862(c) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

"(2) Consultation.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

"(i) Hearing Rights.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 517. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) Claims.—The Secretary shall develop, in consultation with appropriate medicare contractors, a process for correction of minor errors and omissions under the Social Security Act, as inserted by section 301(a)(1) and representatives of providers of services and suppliers of services where, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to re-submit corrected claims.

(b) Deadline.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall adopt the process under subsection (a).

SEC. 518. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADMINISTRATIVE BENEFICIARY NOTICES.

(a) In General.—Section 1869 (42 U.S.C. 1395f(b)), as amended by section 533(b)(2)(B), is further amended by adding at the end the following new subsection:

"(h) Prior Determination Process for Certain Items and Services.—

"(1) In General.—With respect to a medicare administrative contractor that has a contract under section 1871A that provides for medicare coverage under this title with respect to physicians' services (as defined in section 1848(j)(3)), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

"(2) Eligibility Determination.—With respect to the purposes of this subsection, each of the following shall be an eligible requester:

"(i) A participating physician, but only with respect to a physician's service for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a).

"(ii) An individual entitled to benefits under this title and who has submitted a claim for such benefits that is based on the receipt of services from a physician, an advance beneficiary notice under section 1879(a), and a description of any applicable requirements.

"(j) Determination Process.—

"(1) In General.—Subject to paragraph (2), under the processes established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physician's service, as to whether the physician's service is so covered under title XVIII of such Act.

"(2) Accompanying Documentation.—The Secretary may require that the request be accompanied by a description of the physician's service and any other appropriate documentation.

"(k) Response to Request.—

"(1) In General.—With respect to a request for a determination submitted to a medicare administrative contractor, the contractor shall:

"(i) provide the determination, and a description of any applicable requirements, within 7 days of the receipt of the request (or such additional time period as the Secretary may establish).

"(2) For Claims.—

"(i) Consistency.—In the case of a request for a determination regarding a claim for payment, the determination shall be made in consultation with the appropriate medicare administrative contractor that has a contract under section 1871A that provides for medicare coverage under this title with respect to physicians' services and the provider of services or supplier.

"(ii) Binding Nature.—Such process shall include the ability to request an oral or written hearing in the case of a determination that is based, and a description of any applicable requirements.

"(l) Determination Process.—

"(1) In General.—With respect to a request for a determination submitted to a medicare administrative contractor, the contractor shall:

"(i) provide the determination, and a description of any applicable requirements, within 7 days of the receipt of the request (or such additional time period as the Secretary may establish).

"(2) For Claims.—

"(i) Consistency.—In the case of a request for a determination regarding a claim for payment, the determination shall be made in consultation with the appropriate medicare administrative contractor that has a contract under section 1871A that provides for medicare coverage under this title with respect to physicians' services and the provider of services or supplier.

"(ii) Binding Nature.—Such process shall include the ability to request an oral or written hearing in the case of a determination that is based, and a description of any applicable requirements.
(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5) of section 1870 of the Social Security Act (as added by section 9901 of the Health Care and Education Reconciliation Act of 2010)) is not timely, and whether the amount of information or data collected pursuant to such process; and

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services or other persons that have provided such notices and the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(b) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the reasons why such beneficiaries did not prevail; and the reasons why such notices do not prevail, the reasons why such notices are not timely, and whether the amount of information or data collected pursuant to such process; and

(4) USE OF PRIOR DETERMINATION PROCESS.—Not later than 36 months after the date on which section 1869(b) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning—

(i) the number and types of procedures for which a prior determination has been sought;

(ii) determinations made under the process;

(iii) the percentage of beneficiaries prevailing;

(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

(v) changes in receipt of services resulting from the application of such process;

(B) an evaluation of whether the process was useful for physicians (and other suppliers of services or other persons that would furnish the item or service) and beneficiaries to the extent timely, and whether the amount of information or data collected pursuant to such process, and the reasons why such beneficiaries did not prevail; and

(C) recommendations for improvements or continuation of such process.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ‘advance beneficiary notice’ means a written notice provided under section 1870(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service belief that payment will not be made for some or all of such items or services under such title.

SEC. 539. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

‘‘(b) INCLUSION IN MAC CONTRACTS.—Section 1874A(b)(3)(A)(i), as added by section 511(a)(1), is amended by adding at the end the following new paragraph:

‘‘(B) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;”.

(b) Pilot Projects to Test Modified or New Evaluation and Management Documentation Guidelines.—(1) In general.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(a) be voluntary;

(b) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and contractor meetings, analysis, and use and assessment of potential evaluation and management guidelines; and

(c) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists), contractors, beneficiaries, and other groups having an interest in the evaluation and management guidelines.

(3) Scope of Pilot Projects.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

(a) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

(b) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(c) at least one shall be conducted for services furnished outside an area and at least one for services furnished outside such an area; and

(d) at least one shall be conducted in a setting where the physician will bill under physicians’ services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) Subtitle F—Miscellaneous Provisions

SEC. 541. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) In General.—The Secretary shall not implement any new or modified documentation guidelines (which for purposes of this section includes changes to, or the addition of new or modified documentation guidelines) for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provides for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for implementing the use of such guidelines; and

(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

(b) Voluntary on requests submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (a)(1) shall be met and the implementation of such guidelines; and

(c) has established, and is implementing, a process to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(c) Pilot Projects to Test Modified or New Evaluation and Management Documentation Guidelines.—(1) In general.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(a) be voluntary;

(b) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and contractor meetings, analysis, and use and assessment of potential evaluation and management guidelines; and

(c) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(d) Pilot Projects to Test Modified or New Evaluation and Management Documentation Guidelines.—(1) In general.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

(b) Length and Consultation.—Each pilot project under this subsection shall—

(a) be voluntary;

(b) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and contractor meetings, analysis, and use and assessment of potential evaluation and management guidelines; and

(c) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) Scope of Pilot Projects.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

(a) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;
(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring;

(5) Report on pilot projects.—Not later than 180 days after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1), the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

(c) Objectives for Evaluation and Management Guidelines.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician’s medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) Application of Alternate Systems of Documentation for Physician Claims.—

(1) Study.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) Matters described.—The matters referred to in paragraph (1) are—

(A) developing a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which a code under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) Consultation with Practicing Physicians.—In designing and carrying out the study required under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) Application of HIPAA Uniform Coding Requirements.—In developing an alternative system under paragraph (2), the Secretary shall take into consideration the requirements of administrative simplification under part C of title XI of the Social Security Act; and

(5) Report to Congress.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall include in its report on the results of the study conducted under subparagraph (A) a recommendation as to whether the requirements of paragraphs (1) through (4) should be applied to claims for all payers.

(e) Study on Appropriate Coding of Certain Extended Office Visits.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) For purposes of this section—

(1) the term ‘‘rural area’’ has the meaning given that term in section 1861(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

(2) the term ‘‘teaching settings’’ are those settings described in section 415.150 of title 42 of the Code of Federal Regulations.

SEC. 542. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) Council for Technology and Innovation.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as ‘‘CMS’’).

(b) Composition.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(c) Objectives for Evaluation and Management Physician Claims.—

(1) Study.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) Matters described.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which a code under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(d) Application of Alternate Systems of Documentation for Physician Claims.—

(1) Study.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) Matters described.—The matters referred to in paragraph (1) are—

(A) developing a simpler, alternate system of requirements for documenting claims for evaluation and management physician services for which a code under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(e) Objectives for Evaluation and Management Guidelines.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician’s medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(f) Application of Alternate Systems of Documentation for Physician Claims.—

(1) Study.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) Matters described.—The matters referred to in paragraph (1) are—

(A) developing a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which a code under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) Consultation with Practicing Physicians.—In designing and carrying out the study required under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) Application of HIPAA Uniform Coding Requirements.—In developing an alternative system under paragraph (2), the Secretary shall take into consideration the requirements of paragraphs (1) through (4) should be applied to claims for all payers.

(g) Study on Appropriate Coding of Certain Extended Office Visits.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(h) Report to Congress.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall include in its report on the results of the study conducted under subparagraph (A) a recommendation as to whether the requirements of paragraphs (1) through (4) should be applied to claims for all payers.

(i) Study on Appropriate Coding of Certain Extended Office Visits.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(j) Report to Congress.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall include in its report on the results of the study conducted under subparagraph (A) a recommendation as to whether the requirements of paragraphs (1) through (4) should be applied to claims for all payers.

(k) Study on Appropriate Coding of Certain Extended Office Visits.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(l) Report to Congress.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall include in its report on the results of the study conducted under subparagraph (A) a recommendation as to whether the requirements of paragraphs (1) through (4) should be applied to claims for all payers.
have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;
(2) 7 shall be practicing physicians drawn from the following fields: cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, or any other specialty where the patient's presenting symptoms or complaint at the time the item or service was ordered or furnished by the physician or practitioner and in which the patient's principal diagnosis. When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.
(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

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

"(7) The Secretary shall provide notice to the provider, the provider's organization, and the public regarding the implementation of such regulations.";
(3) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS INVOLVING TERMINATION OF PARTICIPATION.—
(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—
(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and
(B) by adding at the end the following new sentence: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriate screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under this part R.",

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of enactment of this Act.

SEC. 545. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL AMENDMENTS.

(a) Establishment.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the Patient Protection and Affordable Care Act (42 U.S.C. 1395dd).

(b) Membership.—The Advisory Group shall consist of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services, each of which—
(1) 4 shall be representatives of hospitals, including at least one public hospital, that

SEC. 544. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—
(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395f(c)) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of a service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician (or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and in which the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(2) EFFECTIVE DATE.—The amendment made by section 212(b) is amended by adding at the end the following new paragraph:

"(5) In the case of hospice care provided by a hospice program under arrangements under section 1867(d)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

(b) CONFORMING PAYMENT PROVISION.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 547. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc), as amended by section 206, is amended—
(1) in subsection (a)(1)—
(A) in subparagraph (T), by striking "and" at the end;
(B) in subparagraph (U), by striking the period at the end and inserting "and"; and
(C) by inserting after subparagraph (U) the following new subparagraph:

"(V) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) shall be subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

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

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties imposed under section 11(a) of such Act.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—
(1) shall review EMTALA regulations;
(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;
(3) may solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations;
(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public;
(5) shall provide advice to the Secretary on the establishment of the Advisory Group notwithstanding any limitations imposed on deliberations or recommendations of the Advisory Group.

(d) ADMINISTRATIVE OFFICERS.—
(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member of the Advisory Group to serve as chairperson of the Advisory Group for the life of the advisory committee.

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

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Administrative Limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services).

SEC. 546. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(d)(5) (42 U.S.C. 1395xv(d)(5)) is amended by adding at the end the following:

"(G) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii).

(ii) The provisions of paragraph (2)(A)(ii) shall apply with respect to the services provided under such arrangements.

"(H) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are provided by hospice program described in paragraph (2)(A)(i).";

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to hospice arrangements as of July 1, 2004.

SEC. 548. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—
(A) is transferred to section 1101 (42 U.S.C. 1301); and
(B) is redesignated as subsection (i).

(2) Section 1862 (42 U.S.C. 1395w) is amended—
(A) in the last sentence of subsection (a), by striking "established under section 1114(d)"; and
(B) in subsection (j), as so transferred and redesignated—
(i) by striking "and"; and
(ii) by inserting "section 1862(a)(1)"

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(D)(I) (42 U.S.C. 1395cc(c)(3)(D)(I)) is amended—
(A) in clause (II), by striking "policy" and inserting "determination"; and
(B) in clause (IV), by striking "medical review policies" and inserting "coverage determination policies".

(2) Section 1862(a)(2)(C) (42 U.S.C. 1395w- 22(a)(2)(C)) is amended by striking "policy"
and “POLICY” and inserting “determination” each place it appears and “DETERMINATION”, respectively.

c) REFERENCE CORRECTIONS.—Section 1886(d)(1)(B) of the Social Security Act, as amended—

(1) in subparagraph (A)(iv), by striking “subclause (I), (II), or (III)” and inserting “clause (I), (II), or (III)”;

(2) in subparagraph (B), by striking “clause (I)(IV) and (clause (I)(III)” and inserting “paragraph (A)(iv)” and “paragraph (A)(i)”, respectively;

(3) in subparagraph (C), by striking “clause (I)” and “subclause (IV)” and “subparagraph (A)” and inserting “paragraph (A)” and “clause (IV)” and “paragraph (1)(A)”, respectively;

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 221(c) of BIPA, subsection 1195(e) of 42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 549. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) of 42 U.S.C. 1395w–4 is amended to read as follows: “Subject to subparagraph (B), in the case of a hospital, the period of exclusion shall be not less than five years, except that, upon application of the Secretary, the period of exclusion may be less than five years.”

SEC. 550. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 of 42 U.S.C. 1395y is amended by adding at the end, after the subsection transferred and redesignated by section 548(a), the following new subsection:

“(k)(1) Subject to paragraph (2), a group health plan may require that a claim for payment of a covered benefit under title XVIII of the Social Security Act be denied on the basis of a determination that the claim was made by a person who is not entitled to benefits under title XVIII on the basis of such data.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

SEC. 551. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FOR THE FISCAL YEAR.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall furnish to each hospital a report containing the information necessary to compute the disproportionate share hospital payments for the fiscal year under consideration.

(a) IN GENERAL.—Section 1822(b)(6)(A) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B) the data necessary for such hospitals to compute the number of patients treated in a fiscal year, the proportion of patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 552. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A) (42 U.S.C. 1395ww(d)(1)(B)) is amended by striking “or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service,” and inserting “or (ii) to an employer or entity as described in subsection (d)(2) the appropriateness and feasibility of hospitals providing a service to such beneficiaries before they completely exhaust such lifetime reserve days.

(b) EFFECTIVE DATE.—Subsection (b) and the amendments made by subsection (a) shall be effective as if included in the enactment of the social securities act.

TITLE VI—MEDICAID AND MISC. PROVISIONS

Subtitle A—Medicaid Provisions

SEC. 601. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) TEMPORARY INCREASE IN ALLOWANCE FOR THE FISCAL YEAR 2004.

(b) INCREASE IN FLOOR FOR TREATMENT AS A LOW DSH HOSPITAL.

(c) SPECIAL RULE FOR LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including any expenditures under the State plan that would have been the subject of Medicaid disproportionate share hospital payments under section 1866 of title XVIII) in fiscal year 2004 is greater than the per capita income for urban consumers (all items; U.S. city average), for the previous fiscal year, the Secretary, in accordance with section 1866, shall increase the State DSH allotment for fiscal year 2004 by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(d) FISCAL YEAR SPECIFIED.—For purposes of section 1866 of title XVIII, “fiscal year” means—

(1) for fiscal year 2004, the fiscal year ending 31, 2003, but less than 3 percent of the State’s total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

(“A)” fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent; and

(“B) each succeeding fiscal year before fiscal year 2008 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent;

(“C)” fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for...
the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A)."

(c) ALLOTMENT ADJUSTMENT.—Section 1923(c) of U.S.C. 1396d–4 is amended—

(1) in paragraph (3)(A), by striking "The DSH" and inserting "Except as provided in paragraph (6), the DSH";

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

"(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 is revoked or terminated before the end of either such fiscal year, and there is no DSH allotment for the State, the Secretary shall—

'(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities other than State-owned institutions, on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

'(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that would not exceed the amount allowed under paragraph (3)(B)(iii) and that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

In determining or amending an appropriate DSH allotment under subparagraph (B) for a State, the Secretary shall take into account the level of DSH expenditures for the State for the preceding the fiscal year in which the waiver commenced.

(d) INCREASED REPORTING AND OTHER REQUIREMENTS TO ENSURE THE APPROPRIATE USE OF MEDICAID DSH PAYMENT ADJUSTMENTS.—Section 1923 (42 U.S.C. 1396d–4) is amended by adding at the end the following new subsection:

"(j) INCREASED REPORTING AND OTHER REQUIREMENTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require an appropriate condition of receipt of a payment under section 1905(a)(1) with respect to a payment adjustment made under this section, to do the following:

'(1) a State shall submit an annual report that includes the following:

'(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

'(B) Any other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

'(2) INDEPENDENT CERTIFIED AUDIT.—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

'(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

'(B) Payments under this section to hospitals that comply with the requirements of subparagraph (a)(1).

'(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

'D. The amount to make allotments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

(f) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS.—

'(1) IN GENERAL.—Nothing in section 1903(p)(1) of the Social Security Act (42 U.S.C. 1396p) shall be construed by the Secretary as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX effective as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

'(2) MODIFICATION.—The amendment made by subparagraph (a) shall take effect on the date of enactment of this Act.

Subtitle B—Miscellaneous Provisions

SEC. 611. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FOR UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENTS.—

'(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 for each of fiscal years 2005 through 2006 for the purpose of making payments for such section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

(b) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(c) STATE ALLOTMENTS.—

'(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

'(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall make allotments under paragraph (1) for such amount to make allotments for such fiscal year in accordance with subparagraph (B).

'(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

'(i) the total amount available for allotments under this paragraph for the fiscal year; and

'(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

'(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSIONS.—

'(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $33,000,000 of such amount to make allotments, in addition to amounts allocated under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

'(B) ALLOCATIONS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

'(i) the total amount available for allotments under this paragraph for the fiscal year; and

'(ii) the percentage of undocumented aliens apprehended in the State in the fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

'(C) USE OF FUNDS.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

Subsection B—Medicare Part B Premiums

SEC. 602. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO MEDICAID ELIGIBLE PROVIDERS IN THE BEST PRICE EXCISIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—

'Section 1922(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended by inserting before the second clause the following: "(including inpatient prices charged to hospitals described in section 340B(a)(3)(L) of the Public Health Service Act)"

(b) ANTI-DIVERSION PROTECTION.—

'Section 1922(c)(1)(C) (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

'(2) 'APPLICABILIT TO AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(3)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to auditing and recordkeeping requirements described in section 340B(a)(3)(K)(C) of the Public Health Service Act.'

SEC. 603. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—


'(1) by striking "until December 31, 2002" and

'(2) by striking "Kent Community Hospital Complex in Michigan or.

(b) EFFECTIVE DATE.—

'(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

'(2) MODIFICATION.—The amendment made by subparagraph (a)(2) shall take effect on the date of enactment of this Act.'
the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

(2) DETERMINATION OF PAYMENT AMOUNT.—
(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—
(i) the amount that the provider demonstrates was incurred for the provision of such services; or
(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

(B) PRO-RATA REDUCTION.—If the amount of funds available under paragraph (a)(1)(B) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(i), the Secretary—
(A) may establish different methodologies for types of eligible providers;
(B) may base payments for hospital services on estimated hospital charges, adjusted to take into account the application of hospital-specific cost-to-charge ratios;
(C) shall provide for the election by a hospital to receive either payments to the hospital for—
(i) hospital and physician services; or
(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians;
(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C), the hospital shall pay a reimbursement amount for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

(5) ALIENS DESCRIBED.—For purposes of paragraphs (1), (2), (3), and (4), the term "aliens" includes in this paragraph any of the following:
(A) Undocumented aliens.
(B) Aliens who have been paroled into the United States shall be United States port of entry for the purpose of receiving eligible services.
(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a "laser visa") issued in accordance with regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

(6) APPLICATIONS; ADVANCE PAYMENTS.—
(A) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—
(1) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

(B) PROHIBITION OF COMPENSATION FOR ALIENS.—The Secretary shall—
(A) provide a means of communicating with the Secretary and to the|||
that department or agency to the Commission to assist it in carrying out its duties under this Act.

(b) POWER OF COMMISSION.—

(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate.

(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

(3) RIGHTS TO OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish information to the Commission.

(4) GIFTS, REQUESTS, AND DEVICES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission. For purposes of Federal income, estate, and gift taxes, property accepted under this section shall be considered as a gift, bequest, or devise to the United States.

(5) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(6) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administration for General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

(7) CONTRACT AUTHORITY.—The Commission may enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 709 of the Revised Statutes (41 U.S.C. 5)).

SEC. 613. RESEARCH ON OUTCOMES OF HEALTH CARE ITEMS AND SERVICES.

(a) RESEARCH, DEMONSTRATIONS, AND EVALUATIONS.

(1) IMPROVEMENT OF EFFECTIVENESS AND EFFICIENCY.—

(A) IN GENERAL.—To improve the quality, effectiveness, and efficiency of health care delivered through the programs established under titles XVIII, XIX, and XXI of the Social Security Act, the Secretary shall ensure that there is broad and ongoing consultation with relevant stakeholders in identifying the highest priorities for research, demonstrations, and evaluations which will guide the research, demonstrations, and support research to meet the scientific evidence is insufficient with respect to outcomes and quality of patient care, including clinical and patient outcomes, technology assessments, or other relevant information through easily accessible and searchable electronic mechanisms, and in hard copy formats as appropriate.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as—

(i) making publicly available all scientific evidence relied upon and the methodologies used; or

(ii) waiving the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

(c) Process.—In carrying out subparagraph (A), the Secretary—

(1) establish a list—

(i) present such evaluations and syntheses or findings at every decision point in the health care system, shall—

(I) present such evaluations and syntheses or findings in a form that is easily understood by health care providers, patients, and public and private sector entities to facilitate the development of new scientific knowledge regarding health care items and services (including prescription drugs); and

(ii) ensure that any information needs and unresolved issues identified in subparagraph (B) are not protected from public disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act (42 U.S.C. 295 et seq.), such data and information shall be protected in accordance with the confidentiality requirements of title XIX of the Public Health Service Act.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require or permit the disclosure of information the Secretary deems otherwise protected from disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act, or other applicable law so that the research, evaluations, and analyses of outcomes and syntheses can be evaluated or replicated; and

(ii) ensures that any information needs and unresolved issues identified in subparagraph (B) are not protected from public disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act, such data and information shall be protected in accordance with the confidentiality requirements of title XIX of the Public Health Service Act.

(C) CONFIDENTIALITY.—

(A) IN GENERAL.—In making use of administrative, clinical, and program data and information developed or collected with respect to the programs under titles XVIII, XIX, and XXI of the Social Security Act, for purposes of carrying out the requirements of this section or the activities authorized under title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), such data and information shall be protected in accordance with the confidentiality requirements of title XIX of the Public Health Service Act.

(B)檔案 DISCLOSURE.—Nothing in this section shall be construed to require or permit the disclosure of information the Secretary deems otherwise protected from disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act, the Federal Food, Drug, and Cosmetic Act, or other applicable law so that the research, evaluations, and analyses of outcomes and syntheses can be evaluated or replicated; and

(ii) ensures that any information needs and unresolved issues identified in subparagraph (B) are not protected from public disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act, such data and information shall be protected in accordance with the confidentiality requirements of title XIX of the Public Health Service Act.

(C) CONFIDENTIALITY.—

(A) IN GENERAL.—In making use of administrative, clinical, and program data and information developed or collected with respect to the programs under titles XVIII, XIX, and XXI of the Social Security Act, for purposes of carrying out the requirements of this section or the activities authorized under title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), such data and information shall be protected in accordance with the confidentiality requirements of title XIX of the Public Health Service Act.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require or permit the disclosure of information the Secretary may otherwise protected from disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act, or other applicable law so that the research, evaluations, and analyses of outcomes and syntheses can be evaluated or replicated; and

(ii) ensures that any information needs and unresolved issues identified in subparagraph (B) are not protected from public disclosure under the Federal Food, Drug, and Cosmetic Act, section 1927 of the Public Health Service Act, such data and information shall be protected in accordance with the confidentiality requirements of title XIX of the Public Health Service Act.
and XXI of the Social Security Act, and with respect to the programs established under such titles, assess the feasibility of using administrative or claims data, to—

(i) improve the accuracy and timeliness of Federal and State administrative or claims data, and

(ii) support Federal and State initiatives to improve the quality, safety, and efficiency of services provided under such programs; and

(iii) provide a basis for estimating the fiscal and coverage impact of Federal or State program and policy changes.

(b) RECOMMENDATIONS.

(1) DISCLAIMER.—In carrying out this section, the Director shall—

(A) not mandate national standards of clinical practice or quality health care standards; and

(B) include in any recommendations resulting from projects funded and published by the Director, a corresponding reference to the prohibition described in subparagraph (A).

(2) REQUIREMENT FOR IMPLEMENTATION.—Research, evaluation, and communication activities performed pursuant to this section shall reflect the principle that clinicians and patients should have the best available evidence on which to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to provide the Director with the authority to mandate national standard or require a specific approach to quality measurement and reporting.

(c) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary, acting through the Director, may conduct or support research with respect to improving methods of disseminating information in accordance with subclauses (a)(3)(C).

(d) LIMITATION ON CMS.—The Administrator of the Centers for Medicare and Medicaid Services may use data obtained in accordance with this section to withhold coverage of a prescription drug.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

SEC. 614. HEALTH CARE THAT WORKS FOR ALL AMERICANS: CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

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

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

(3) ... and how they are willing to pay for coverage.

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

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

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

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

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

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

(d) MEMBERSHIP.—The Working Group shall be composed of 15 members. One member shall be the Secretary, The Comptroller General of the United States shall appoint 14 members.

(e) QUALIFICATIONS.—

(1) I N GENERAL.—The membership of the Working Group shall include—

(A) diverse experiences with health care services that represent those individuals who have not had insurance within 2 years of appointment, that have had chronic illnesses, including mental illness, are disabled, and those who receive insurance coverage through Medicare and Medicaid; and

(B) support Federal and State initiatives to improve methods of disseminating information.

(ii) information concerning the cost of care that has been demonstrated as restoring, maintaining, or improving a patient’s health, and the use of technology in supporting providers in improving quality of care and lowering costs.

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

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

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

(A) a summary of recommendations that result from the debate.

(B) recommendations that result from the debate.

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

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

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

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

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

(A) a summary of recommendations that result from the debate.

(B) recommendations that result from the debate.

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

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

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

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

(4) COMMUNITY MEETINGS.—

(A) I N GENERAL.—Not later than 1 year after the date on which all the members of the Working Group have been appointed under subsection (d)(1), the Comptroller General shall designate the chairperson of the Working Group.

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

(C) DUTIES.—

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

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

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

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

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

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

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

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

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

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

(A) a summary of recommendations that result from the debate.

(B) recommendations that result from the debate.

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

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

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

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

(4) COMMUNITY MEETINGS.—

(A) I N GENERAL.—Not later than 1 year after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section, the Working Group shall initiate health care community meetings throughout the United States (in this paragraph referred to as “community meetings”). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

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

(1) The geographic differences throughout the United States;
(2) diverse populations; and
(3) a balance among urban and rural populations;

II. MEETING REQUIREMENTS.

(1) FACILITATOR.—A State health officer may be the facilitator at the community meetings:
(2) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting.

III. TOPICS.

(1) What health care benefits and services should be provided?
(2) How do the American public want health care delivered?
(3) How should health care coverage be financed?
(4) What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

IV. INTERACTIVE TECHNOLOGY.

The Working Group may encourage public participation in community meetings through interactive technology and other means as determined by the Working Group.

V. INTERIM REQUIREMENTS.

Not later than 180 days after the date of completion of the community meetings, the Working Group shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

VI. SUNSET OF WORKING GROUP.

The Working Group shall terminate on the date that is 2 years after the date on which all the members of the Working Group have been appointed under section (d)(1) and appropriations are first made available to carry out this section.

VII. ADMINISTRATION REVIEW AND COMMENTS.

Not later than 45 days after receiving the final recommendations of the Working Group submitted under subsection (l), the President shall submit a report to Congress which shall contain—
(1) additional views and comments on such recommendations; and
(2) recommendations for such legislation and administrative actions as the President considers appropriate.

VIII. REQUIRED CONGRESSIONAL ACTION.

Not later than 45 days after receiving the report submitted by the President under subsection (o), each committee of jurisdiction of Congress, the Committee on Finance of the Senate, the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, Committee on Education and the Workforce of the House of Representatives, shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (l).

IX. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this Act, other than subsection (h)(3), $3,000,000 for each of fiscal years 2005 and 2006.

X. HEALTH REPORT TO THE AMERICAN PEOPLE.

There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People, not to exceed $100,000 for the fiscal year in which the report is required to be submitted.

XI. FUNDING START-UP ADMINISTRATIVE COSTS FOR MEDICARE REFORM.

There are appropriated to carry out this Act (including the amendment made by this Act), to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund:
(1) not to exceed $1,000,000,000 for the Centers for Medicare & Medicaid Services; and
(2) not to exceed $500,000,000 for the Social Security Administration.

XII. AVAILABILITY.

Amounts provided under subsection (a) shall remain available until September 30, 2006.

XIII. GLOSSARY.

There are authorized to be appropriated under subsection (a)(2), the Social Security Administration may reimburse the Internal Revenue Service for expenses in carrying out this Act (and the amendments made by this Act).

XIV. TRANSFER.

The President may transfer amounts provided under subsection (a) between the Centers for Medicare & Medicaid Services and the Social Security Administration.

XV. NOTICIO.

Notice of such transfer shall be transmitted within 15 days to the authorizing committees of the House of Representatives and of the Senate.

SEC. 616. HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM.

Title XVIII is amended by adding at the end the following new section:

“HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

SEC. 1897. (a) ESTABLISHMENT.—The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

(b) APPLICATION.—No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan may be provided under this section on such terms and conditions and meet such requirements as the Secretary determines appropriate.

(c) SELECTION CRITERIA.—

(1) IN GENERAL.—The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this subsection. Such criteria may consider the extent to which the project for which loan is sought is nationally or regionally significant in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

(2) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term ‘qualifying hospital’ means a hospital that—

(A) is engaged in research in the causes, prevention, and treatment of cancer; and

(B) is designated as a cancer center for the National Cancer Institute or is designated by the State as the official cancer institute of the State.

(d) PROJECTS.—A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of a hospital, including construction, renovation, or other capital improvements.

(e) STATE AND LOCAL PERMITS.—The provisions of this Act applicable to a loan under this section with respect to a project shall not—

(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

(2) limit the right of any unit of State or local government to approve or regulate any right of the project or return on private equity invested in the project; or

(3) otherwise supersede any State or local law, regulation, or permitting system applicable to the construction or operation of the project.

(f) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan made under this section on such terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

(B) an outreach program for cancer prevention, early diagnosis, and treatment that...
provides services to multiple Indian tribes; and

"(H) unique research resources (such as population databases); or

"(ii) an institution that has unique research resources.

"(g) FUNDING.—

"(1) IN GENERAL.—There are appropriated, out of funds otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

"(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this section and a recommendation as to whether the Congress should continue the Secretary to carry out this section, more than $2,000,000 for each fiscal years 2004 through 2008.

"(3) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

"(h) REPORT TO CONGRESS.—Not later than 4 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should continue the Secretary to carry out loans under this section beyond fiscal year 2008.

By Mrs. CLINTON:

S. 1927. A bill to establish an award program to encourage the development of effective bomb-scanning technology; to the Committee on Commerce, Science, and Transportation.

Mrs. CLINTON. Mr. President, ever since the events of September 11, 2001, awakened this Nation to the very real dangers of the world we live in, we have been struggling to defend ourselves against terrorism. Our aviation system remains a primary target for terrorists, and we must be very vigilant in the fight to keep that system safe. The economic viability, not to mention a national security, of our country is at stake in that fight.

Nowhere is this more obvious than in New York. Not only did we bear the brunt of the worst terrorist attack in our Nation’s history, but we also depend on additional airports to fuel our state’s economy. John F. Kennedy Airport in Queens is the Nation’s premier international gateway and contributes approximately $30 billion to the regional economy while employing 35,000 people. LaGuardia Airport, also in Queens, handles over 20 million passengers a year despite having only two 7000-foot runways on 680 acres. Our airports in Albany, Syracuse, Rochester, and Buffalo have seen strong growth in recent years with the arrival of low-cost carriers.

Unfortunately, our economic and physical security remains at risk because we still have not developed a way to effectively scan each piece of passenger luggage for explosives. We have recognized that in the current world environment, we must scan each bag, but technology has not kept up with our needs. The current technology used in most airports in this country is known to have a false-positive rate of approximately 10 percent. This means that machines incorrectly identify 20 percent of all bags going through them as containing explosives, thus slowing down the process considerably as well as costing time and money. Even more dangerous is the false-negative rate of these machines. This number, the percentage of bags going undetected through these machines with bombs inside of them during test runs, should be close to zero. The actual false-negative rate is not publicized for obvious reasons, but it is known to be well above zero.

I am proposing a bill today that seeks to create a major incentive for firms to invent a bomb-scanning technology that actually works. It will award $20 million to any firm that can successfully produce a machine that has a false-positive rate less than 10 percent, a false negative rate less than 2 percent, and is feasible for deployment en masse at our Nation’s airports. Although we are currently spending money on researching this technology, that funding is clearly not getting us there fast enough. This new award is designed to spur the private sector to develop new technology that will make a major difference in the safety of our aviation system.

By Mr. SARBANES (for himself, Mr. SCHUMER, Ms. STABENOW, Mr. CORZINE, Mr. DURBIN, Mr. KERRY, Ms. MIKULSKI, Mrs. CLINTON, Mr. LEVIN, Mr. LEAHY, Mr. AKAKA, Mr. KENNEDY, Mr. LAUTENBERG, Mr. DAYTON, and Mr. JORDAN):

S. 1928. A bill to amend the Truth in Lending Act to protect consumers against predatory practices in connection with high-cost mortgage transactions, to strengthen the civil remedies available to consumers under existing law, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. SARBANES. Mr. President, in July of 2001, and continuing through the January of this year, the Committee on Banking, Housing, and Urban Affairs held a series of hearings to shine a bright light on the deceptive and destructive practices of predatory mortgage lenders. At those hearings, the Committee heard from housing experts, community groups, legal advocates, industry representatives and victims of predatory lending in an effort to determine how best to address this terrible problem. Today, I am introducing the “Predatory Lending Consumer Protection Act of 2003,” along with a number of my colleagues, that would begin to address the problems that came to light in those hearings.

Homeownership is the American Dream. Indeed, the Committee has already passed legislation this year that would authorize a new $200 million downpayment assistance program to ensure that more people can achieve this goal.

We have taken this step because homeownership is the best opportunity for most Americans to put down roots and start creating equity for themselves and their families. Homeownership has been the path to building wealth for generations of Americans, wealth that can be tapped to send children to college, pay for a secure retirement, or simply work as a reserve against unexpected emergencies. It has been the key to ensuring our communities, our neighborhoods, our communities, good schools, and safe streets. Common sense tells us, and the evidence confirms, that homeowners are more engaged citizens and more active in their communities.

Little wonder, then, that so many Americans, young and old, aspire to achieve this dream.

Unhappily, predatory lenders cynically play on these hopes and dreams to cheat people out of their wealth. These lenders target lower income, elderly, and, often, uneducated homeowners for their abusive practices. Study after study has shown that predatory lenders also target minorities, driving a wedge between these families and the hope of a productive life in the economic and financial mainstream of America.

We owe it to these hardworking families to provide protections against these unscrupulous players.

Let me share with you one of the stories we heard at our hearings. Mary Ann Podelco, a widowed waitress from West Virginia, used $19,000 from her husband’s life insurance to pay off the balance on her mortgage, thus owning her home free and clear. Before her husband’s death, she had never had a checking account or a credit card. She then took out a $11,921 loan for repairs. At the time, her monthly income from Social Security was $458, and her loan payments were more than half this amount. Ms. Podelco, who has a sixth grade education, said after her first refinancing, “I began getting calls from people trying to refinance my mortgage all hours of the day and night.” Within 2 years, having been advised to refinance seven times—each time seeing high points and fees being financed into her new loan—she owed $64,000, and lost her home to foreclosure.

Ms. Podelco’s story is all too typical. Unfortunately, most of the sharp practices used by unscrupulous lenders and brokers, while unethical and clearly illegal, are not illegal. This bill is designed to address that problem by tightening the interest rate and fee triggers that define high cost loans; the bill improves protections for borrowers receiving such loans by prohibiting the financing of exorbitant fees, “packing” in of unnecessary and costly products, such as single premium credit insurance, and limiting prepayment penalties. Finally, it protects these consumers’ rights to seek redress by prohibiting mandatory arbitration, as the Federal Trade Commission (FTC) proposed unanimously in 2000. We often hear about the importance of improved enforcement as a way to combat this
problem. As the FTC pointed out, mandatory arbitration prevents homeowners from exercising any of their rights to enforce existing law. We cannot extol the virtues of homeownership, as we so often do, without seeking the time to preserve this benefit for so many elderly, minority, and unsophisticated Americans who are the targets of unscrupulous lenders and brokers. This legislation will help achieve this important goal. This bill has been endorsed by the Leadership Conference on Civil Rights, the U.S. Conference of Mayors, the National Council of La Raza, the National Consumer Law Center, ACORN, the National Community Development Coalition, Consumer Federation of America, the NAACP, the Self-Help Credit Union, the National Association of Local Housing Finance Agencies, the National Community Development Association, the National Association of Consumer Advocates, and the National League of Cities, among others.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

8. 1928

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE.

This Act may be cited as the “Predatory Lending Consumer Protection Act of 2007.”

SEC. 2. TRUTH IN LENDING ACT DEFINITIONS.

(a) HIGH COST MORTGAGES.—(1) IN GENERAL.—The portion of section 103(aa) of the Truth in Lending Act (15 U.S.C. 1602(aa)) that precedes paragraph (2) is amended to read as follows:

“(aa) MORTGAGE REFERRED TO IN THIS SUBSECTION.—

“(1) DEFINITION.—

“(A) IN GENERAL.—A mortgage referred to in this subsection means a consumer credit transaction—

“(i) that is secured by the principal dwelling of the consumer, other than a reverse mortgage transaction; and

“(ii) the terms of which provide that—

“(I) the transaction is secured by a first mortgage on the principal dwelling of the consumer; and

“(II) the terms of the mortgage agreement or contract, except that, in the case of any other loan in which the rate may vary during the term of the loan, as the rate which may be charged or collected under the loan agreement, unless, at any time during the term of the loan for any reason, by including in the finance charge component of the annual percentage rate—

“(I) the interest charged on the loan at the maximum rate that may be charged during the term of the loan; and

“(II) any other applicable charges that would otherwise be included in accordance with section 106—

“(B) INTRODUCTORY RATES NOT TAKEN INTO ACCOUNT.—For purposes of subparagraph (A)(i), the annual percentage rate of interest shall be determined—

“(i) in the case of a fixed-rate loan in which the annual percentage rate will not vary during the term of the loan, the rate in effect on the date of consummation of the transaction;

“(ii) in the case of a loan in which the rate of interest on the credit may exist at any time during the term of the loan for any reason, by including in the finance charge component of the transaction to the maximum margin permitted at any time during the loan agreement; and

“(iii) in the case of any other loan in which the rate may vary at any time during the term of the loan for any reason, by including in the finance charge component of the annual percentage rate—

“(I) the interest charged on the loan at the maximum rate that may be charged during the term of the loan; and

“(II) any other applicable charges that would otherwise be included in accordance with section 106—

“(C) each of the charges listed in section 106(e) (except an escrow for future payment of taxes and insurance);

“(D) the cost of all premiums financed by the lender, directly or indirectly, for any credit life, credit disability, credit unemployment or credit property insurance, or any other life or health insurance, or any payments financed by the lender, directly or indirectly, for any debt cancellation or suspension fees calculated and paid on a monthly basis; and

“(E) the maximum prepayment penalties that may be charged or collected under the terms of the loan documents;

“(F) all prepayment fees or penalties that are charged to the borrower if the loan refinances a previous loan made by the same creditor or an affiliate of that creditor; and

“(G) HIGH COST MORTGAGE LENDER.—Section 103(f) of the Truth in Lending Act (15 U.S.C. 1602(f)) is amended by striking the last sentence and inserting “Any person who originates 2 or more mortgages referred to in subsection (aa) in any 12-month period, any person who originates 4 or more mortgages referred to in subsection (aa) in any 24-month period, or any mortgage broker between originators and consumers on more than 5 mortgages referred to in subsection (aa) within the preceding 24-month period beginning on the date the mortgage is consummated.”

“(D) BONA FIDE DISCOUNT POINTS AND BENCHMARK RATES.—The term ‘bona fide discount points’ means loan discount points which are—

“(A) knowingly paid by the borrower;

“(B) paid for the express purpose of lowering the benchmark rate;

“(C) in fact reducing the interest rate or time-price differential applicable to the loan from an interest rate which does not exceed the benchmark rate; and

“(D) recouped within the first 4 years of the scheduled loan payments.

“(E) REOPUMENT.—For purposes of paragraph (2)(D), loan discount points shall be considered to be recouped within the first 4 years of the scheduled loan payments if the reduction in the interest rate that is achieved by the payment of loan discount points reduces the interest charged on the scheduled payments, such that the dollar amount of savings in payments made by the borrower over the first 4 years exceeds the dollar amount of loan discount points paid by the borrower.”.]

SEC. 3. AMENDMENTS TO EXISTING REQUIREMENTS FOR HIGH COST CONSUMER MORTGAGES.

(a) ADDITIONAL DISCLOSURES.—Section 129a(a)(1) of the Truth in Lending Act (15 U.S.C. 1639(a)(1)) is amended by adding at the end the following:

“(C) The interest rate on this loan is much higher than most people pay. This means the chance that you will lose your home is much higher if you do not make all payments under the loan.”

“(D) You may be able to get a loan with a much lower interest rate. Before you sign any papers, you have the right to go see a housing or consumer credit counseling agency, as well as to consult other lenders to find ways to get a cheaper loan.”

“(E) If you are taking out this loan to repay other loans, look to see how many months it will take to pay for this loan and what the total amount is that you will have to pay before this loan. Even though the total amount you have to pay each month for this loan may be less than the total amount you are paying each month for those other loans, you may have to pay on this loan for many more months than those other loans which will cost you more money in the end.”

(b) PREPAYMENT PENALTY PROVISIONS.—

Section 129(c) of the Truth in Lending Act (15 U.S.C. 1639(c)) is amended to read as follows:

“(C) PREPAYMENT PENALTY PROVISIONS.—

“(1) NO PREPAYMENT PENALTIES AFTER END OF 24-MONTH PERIOD.—A mortgage referred to in section 103(aa) may not contain terms under which a consumer must pay any prepayment penalty for any payment made at or before the end of the 24-month period beginning on the date the mortgage is consummated.

“(2) NO PREPAYMENT PENALTIES IF MORE THAN 3 PERCENT OF POINTS AND FEES WERE FINANCED.—Subject to subsection (1)(1), a mortgage referred to in section 103(aa) may not contain terms under which a consumer must pay any prepayment penalty for any payment made at or before the end of the 24-month period referred to in paragraph (1) if
the creditor financed points or fees in con-
nection with the consumer credit trans-
action in an amount equal to or greater than 3 percent of the total amount of credit ex-
tended in the transaction.

“(3) LIMITED PREPAYMENT PENALTY FOR
EARLY REPAYMENT UNDER CERTAIN
CIRCUMSTANCES.—Subject to paragraph (2), the terms of a mortgage referred to in section 103(aa) may contain terms under which a consumer must pay a prepayment penalty for any payment made at or before the end of the 24-month period referred to in paragraph (1) to the extent that the sum of the total amount of points or fees financed by the creditor with respect to the consumer credit transaction and the total amount payable as a prepayment penalty does not exceed the amount which is equal to 3 percent of the total amount of credit ex-
tended in the transaction.

“(4) CONSTRUCTION.—For purposes of this subsec-
tion, any method of computing a ref-
und of unearned scheduled interest is a pre-
payment penalty if it is less favorable to the consumer than the actuarial method (as that term is defined in section 93(d) of the Housing and Community Development Act of 1992).

“(5) PREPAYMENT PENALTY DEFINED.—The term ‘prepayment penalty’ means any mone-
tary payment required by a consumer for paying all or part of the principal with respect to a consumer credit transaction before the date on which the principal is due.

(c) ASSESSMENT OF ABILITY TO REPAY.—
Section 129(e) of the Truth in Lending Act (15 U.S.C. 1639(e)) is amended by striking ‘‘having a term of less than 5 years’’.

(d) ASSESSMENT OF ABILITY TO REPAY.—
Section 129(h) of the Truth in Lending Act (15 U.S.C. 1639(h)) is amended—

(1) by striking ‘‘CONSUMER.—A creditor’’ and inserting ‘‘CONSUMER.—

(1) PROHIBITION ON PATTERNS AND PRACT-
ICES.—A creditor’’; and

(2) by adding at the end the following:

‘‘(2) CASE-BY-CASE ASSESSMENTS OF CON-
SUMER ABILITY TO PAY REQUIRED.—

(A) In general.—In addition to the prohi-

bition in paragraph (1) on engaging in cer-
tain patterns and practices, a creditor may not extend any credit in connection with any mortgage referred to in section 103(aa) unless the consumer determines that the extension of such credit is extended, that 1 or more of the resident obligors, when considered individu-
ally and collectively, will be able to make the scheduled payments under the terms of the transaction based on a consideration of the current and expected income, current ob-
ligations, employment status, and other fi-
nancial resources of such obligor, with-
out taking into account any equity of any such obligor in the dwelling which is the se-
curity for the credit.

(B) REGULATIONS.—The Board shall pre-
scribe, by regulation, the appropriate format for determining the ability of a consumer to make payments and the criteria to be con-
sidered in making that determination.

(C) RESIDENT OBLIGOR.—For purposes of this par-

graphic, the term ‘resident obligor’ means an obligor for whom the dwelling se-
curing the credit is, or will be, the principal residence.

(D) VERIFICATION.—The requirements of par-

agraphs (1) and (2) shall not be deemed to have been met unless any information relied upon by the creditor for purposes of such paragraphs is independently of information provided by any resident obligor.

(e) REQUIREMENTS RELATING TO HOME
IMPROVEMENT CONTRACTS.—Section 129(b) of the Truth in Lending Act (15 U.S.C. 1639(b)) is amended—

(1) by striking ‘‘IMPROVEMENT CON-
TRACTS.—A creditor’’ and inserting ‘‘IM-
PROVEMENT CONTRACTS.—

(1) IN GENERAL.—A creditor’’; and

(2) by adding at the end the following:

‘‘(2) AFFIRMATIVE CLAIMS AND DEFENSES.—
Notwithstanding any other provision of law, any assignee or holder, in any capacity, of a mortgage referred to in section 103(aa) which was made, arranged, or assigned by a person financing home improvements to the dwell-
ing of a consumer shall be subject to all af-
firmative claims and defenses which the con-
sumer may have against the seller, home im-
provement contractor, broker, or creditor with respect to such mortgage or home im-
provements.’’

(f) CLARIFICATION OF RESCISSION RIGHTS.—
Section 129(j) of the Truth in Lending Act (15 U.S.C. 1639(j)) is amended by striking paragraphs (1) and (2) and inserting the following:

‘‘(1) CONSEQUENCE OF FAILURE TO COMPLY.—

(1) IN GENERAL.—The consummation of a
consumer credit transaction resulting in a mortgage referred to in section 103(aa) shall be treated as a failure to deliver the mate-
rial disclosures required under this title for the purpose of section 125, if—

(A) the mortgage contains a provision prohibited by this section or does not con-
tain a provision required by this section; or

(B) a creditor or other person fails to comply with the provisions of this section, whether by an act or omission, with regard to such mortgage at any time.

(2) RULE OF APPLICATION.—In any appli-
cation of this subsection, the terms described in section 103(aa) under circumstances de-
scribed in paragraph (1), paragraphs (2) and (4) of section 125(e) shall not apply or be taken into account.

SEC. 4. ADDITIONAL REQUIREMENTS FOR HIGH
COST CONSUMER MORTGAGES.

(a) SINGLE PREMIUM CREDIT INSURANCE.—
Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended—

(1) by redesignating subsections (k) and (l) as subsections (s) and (t), respectively; and

(2) by adding at the end the following:

‘‘(k) SINGLE PREMIUM CREDIT INSURANCE.—

(1) IN GENERAL.—The terms of a mortgage referred to in section 103(aa) may not include any provision which requires a consumer to pay any of the following fees or other charges:

(A) an advance collection of a premium, with respect to such mortgage or home im-
provements, which was made, arranged, or assigned by a person financing home im-
provements to the dwell-
ing of a consumer;

(B) the advance collection of a premium, with respect to such mortgage or home im-
provements, which was made, arranged, or assigned by a person financing home im-
provements to the dwell-
ing of a consumer;

(C) an advance collection of a premium, with respect to such mortgage or home im-
provements, which was made, arranged, or assigned by a person financing home im-
provements to the dwell-

(2) PREFERENCE ON FINANCING CERTAIN
FEES, POINTS, OR CHARGES.—No creditor may, in connection with the formation or consummation of a mortgage referred to in section 103(aa), finance, directly or indi-
rectly, any of the following fees or other charges payable to the creditor or any third party:—

(A) any points, fees, or other charges re-
quired to be paid by the consumer in connec-
tion with a loan or other extension of credit which is being refinanced by such mortgage or any affiliate of the creditor, is the creditor with respect to the loan or other ex-
tension of credit being refinanced.

(B) Any points, fees, or other charges re-
quired to be paid by the consumer in connec-
tion with such mortgage if—

(i) the mortgage is being entered into in order to finance an existing mortgage of the consumer that is referred to in section 103(aa); and

(ii) the creditor, with respect to such new mortgage, or any affiliate of the cred-
itor, is the creditor with respect to the exist-
ing mortgage which is being refinanced.

(c) CREDITOR CALL PROVISION.—Sec-
tion 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (i) (as added by subsection (b) of this section) the following:

‘‘(m) CREDITOR CALL PROVISION.—

(1) IN GENERAL.—A mortgage referred to in section 103(aa) may not include terms under which the indebtedness may be accel-
erated by the creditor, in the sole discretion of the creditor.

(2) EXCEPTION.—Paragraph (1) shall not apply when repayment of the loan has been accelerated as a result of a bona fide default.

(d) PROHIBITION ON ACTIONS ENCOURAGING
DEFAULT.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by insert-
ing after subsection (m) (as added by sub-
section (c) of this section) the following:

‘‘(n) PROHIBITION ON ACTIONS ENCOURAGING
DEFAULT.—No creditor may make any state-
ment, including any action or failure to act, that has the effect of encour-
aging or recommending the consumer to de-
fault on the existing loan or other extension of credit at any time before, or in connection with, the closing or any scheduled closing on such mortgage.

(e) MODIFICATION OR DEFERRAL FEES.—Sec-
section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after sub-
section (m) (as added by subsection (d) of this section) the following:

‘‘(o) MODIFICATION OR DEFERRAL FEES.—

(1) IN GENERAL.—Except as provided in par-

agraph (2), a creditor may not charge any consumer with respect to a mortgage re-
ferred to in section 103(aa) any fee or other charge:

(A) to modify, renew, extend, or amend such mortgage, or any provision of the terms of the mortgage; or

(B) to defer any payment otherwise due under the terms of the mortgage.

(2) EXCEPTION FOR MODIFICATIONS FOR THE
BENEFIT OF THE CONSUMER.—Paragraph (1) shall not apply to modifications for the benefit of the consumer:

(a) to the extent that the modification has the effect of lowering the interest rate, extending the maturity of the debt, reducing the periodic payment, or reducing the principal balance due; and

(b) any modification that is not bona fide and that is not in the best interest of the consumer.”
“(A) the action provides a material benefit to the consumer; and

“(B) the amount of the fee or charge does not exceed

“(1) a loan amount equal to 0.5 percent of the total loan amount; or

“(ii) in any case in which the total loan amount of the mortgage does not exceed $60,000, an amount in excess of $300.’’.

(f) CONSUMER COUNSELING REQUIREMENTS.—

Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (e) the following:

“(p) CONSUMER COUNSELING REQUIREMENT.—

“(1) IN GENERAL.—A creditor may not extend any credit in the form of a mortgage referred to in section 103(aa) to any consumer, unless the creditor has provided to the consumer, at such time before the consummation of the mortgage and in such manner as the Board shall provide by regulation—

“(A) all warnings and disclosures regarding the risks of the mortgage to the consumer;

“(B) a separate written statement recommending that the consumer take advantage of available counseling services before agreeing to the terms of any mortgage referred to in section 103(aa); and

“(C) a written statement containing the names, addresses, and telephone numbers of counseling agencies or programs reasonably available to the consumer that have been certified by the Secretary of Housing and Urban Development, a State housing finance authority (as defined in section 301 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989), or the agency referred to in subsection (a) or (c) of section 108 with jurisdiction over the creditor as qualified to provide counseling services—

“(i) the advisability of a high cost loan transaction; and

“(ii) the appropriateness of a high cost loan for the consumer.

“(2) COMPLETE AND UPDATED LISTS REQUIRED.—Any failure to provide as complete or updated a list under paragraph (1)(C) as is reasonably possible shall constitute a violation of this section.”.

(g) ARBITRATION.—

Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (p) (as added by subsection (e) of this section) the following:

“(q) ARBITRATION.—

“(1) IN GENERAL.—A mortgage referred to in section 103(aa) may not include terms which require arbitration or any other nonjudicial procedure as the method for resolving any controversy or settling any claims arising out of the transaction.

“(2) POST-CONTROVERSY AGREEMENTS.—Subject to paragraph (3), paragraph (1) shall not be construed as limiting the right of the consumer and the creditor to agree to arbitration or any other nonjudicial procedure as the method for resolving any controversy at any time after a dispute or claim under the transaction arises.

“(3) NO WAIVER OF STATUTORY CAUSE OF ACTION.—No provision of any mortgage referred to in section 103(aa) may be construed to limit the right of the consumer and the creditor to be applied or interpreted so as to bar a consumer from bringing an action in an appropriate court of the United States or any other court of competent jurisdiction, pursuant to section 130 or any other provision of this title, including any alleged violation of this section, any other provision of this title, or any other Federal law.

(b) PROHIBITION ON EVASIONS.—

Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (q) (as added by subsection (g) of this section) the following:

“(r) PROHIBITION ON EVASIONS, STRUCTURING OF TRANSACTIONS, AND RECIPROCAL ARRANGEMENTS.—

“(1) IN GENERAL.—A creditor may not take any action for the purpose or with the intent to circumvent or evade any requirement of this title, including structuring or reciprocating arrangements between creditors to evade any requirement of this title, including structuring or reciprocating arrangements between creditors to evade the provisions of this title, including structuring or reciprocating arrangements between creditors to evade any requirement of this section or to facilitate compliance with the requirements of this section.

“(2) OTHER ACTIONS.—In addition to the actions prohibited under paragraph (1), a creditor may not take any action which the Board determines, by regulation, constitutes a bad faith effort to evade or circumvent any requirement of this section with regard to a consumer credit transaction.

“(3) REGULATIONS.—The Board shall prescribe such regulations as the Board determines to be appropriate to prevent circumvention or evasion of the requirements of this section or to a consumer credit transaction.

“(s) RECIPROCAL ARRANGEMENTS.—

Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (r), the term ‘creditor’ includes a State housing finance authority (as defined in section 301 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989).”.

(h) PROHIBITION ON EVASIONS.—

Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended—

“(1) IN GENERAL.—Each creditor who enters into a consumer credit transaction which is a mortgage referred to in section 103(aa), and each subsequent creditor with respect to such transaction, shall report the complete payment history, favorable and unfavorable, of the obligor with respect to such transaction to a consumer credit reporting system that complies and maintains files on consumers on a nationwide basis at least quarterly, or more frequently as required by regulation or guidelines established by participants in the secondary mortgage market, while such transaction is in effect.

“(2) DEFINITIONS.—For purposes of paragraph (1), the term ‘creditor’ shall have the same meanings as in section 103 of the Truth in Lending Act (15 U.S.C. 1602).’’.”.

SEC. 5. AMENDMENTS RELATING TO RIGHT OF RESCISSION.

(a) TIMING OF WAIVER BY CONSUMER.—

Section 129(a) of the Truth in Lending Act (15 U.S.C. 1639a)(a) is amended—

“(1) by striking ‘‘(a) Except as otherwise provided’’ and inserting ‘‘(a) Except as otherwise provided’’;

“(2) by adding at the end following:

“(2) TIMING OF ELECTION OF WAIVER BY CONSUMER.—No election by a consumer to waive the right established under paragraph (1) to rescind a transaction shall be effective if—

“(A) the waiver was required by the creditor as a condition for the transaction;

“(B) the creditor advised or encouraged the consumer to waive such right of the consumer;

“(C) the creditor had any discussion with the consumer about a waiver of such right during the period beginning when the consumer provides written acknowledgement of the receipt of the disclosures and the delivery of forms required to be provided to the consumer under paragraph (1) and ending at such time as the Board determines, by regulation, to be appropriate.”.

“(b) NONCOMPLIANCE WITH REQUIREMENTS AS RECOURSE IN FORECLOSURE PROCEEDING.—

Section 130(e) of the Truth in Lending Act (15 U.S.C. 1639e)(e) is amended by inserting after the second sentence the following:

“‘This subsection also does not bar a person from asserting a rescission under section 125, a convert to a judicial or nonjudicial foreclosure after the expiration of the time periods for affirmatively or affirmatively action set forth in this section and section 125.”’.

SEC. 6. AMENDMENTS TO CIVIL LIABILITY PROVISIONS.

(a) INCREASE IN AMOUNT OF CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS.—

Section 130(a) of the Truth in Lending Act (15 U.S.C. 1639a)(a) is amended—

“(1) in paragraph (1)(ii), by striking ‘‘$2,000’’ and inserting ‘‘$10,000’’; and

“(2) in paragraph (2)(B), by striking ‘‘less of $500,000 or 1 percentum of the net worth of the creditor, whichever is greater of

“(i) the amount determined by multiplying the maximum amount of liability under sub-

paragraph (A) for such failure to comply in an individual action by the number of members in the certified class; or

“(ii) the amount equal to 2 percent of the net worth of the creditor.”.

(b) STATUTE OF LIMITATIONS EXTENDED FOR SECTION 129 VIOLATIONS.—

Section 130(e) of the Truth in Lending Act (15 U.S.C. 1639e)(e) is amended by section 5(b) of this Act is amended—

“(1) in the first sentence, by striking ‘‘Any action’’ and inserting ‘‘Except as provided in the subsection sentence, any action’’;

“(2) by inserting after the first sentence the following: ‘‘Any action under this section with respect to any violation of section 129 not brought in any United States district court, or in any other court of competent jurisdiction, before the end of the 3-year period beginning on the date of the occurrence of the violation.’’.

SEC. 7. AMENDMENT TO FAIR CREDIT REPORTING ACT.

Section 621 of the Fair Credit Reporting Act (15 U.S.C. 1681a-2) is amended by adding at the end following:

“(e) DUTY OF CREDITORS WITH RESPECT TO HIGH COST MORTGAGES.—

“(1) IN GENERAL.—Each creditor who enters into a consumer credit transaction which is a mortgage referred to in section 103(aa), and each subsequent creditor with respect to such transaction, shall report the complete payment history, favorable and unfavorable, of the obligor with respect to such transaction to a consumer credit reporting system that complies and maintains files on consumers on a nationwide basis at least quarterly, or more frequently as required by regulation or guidelines established by participants in the secondary mortgage market, while such transaction is in effect.

“(2) DEFINITIONS.—For purposes of paragraph (1), the term ‘creditor’ shall have the same meanings as in section 103 of the Truth in Lending Act (15 U.S.C. 1602).’’.”.

SEC. 8. REGULATIONS.

The Board of Governors of the Federal Reserve System shall publish regulations implementing this Act and the amendments made by this Act in final form before the end of the 6-month period beginning on the date of enactment of this Act.

By Mr. BROWNBACK (for himself, Mr. Enzi, Mr. Hagle, Mr. Inhofe, Mr. Nickles, Mr. Santorum, and Mr. Sessions):

S. 1930. A bill to provide that the approved application under the Federal Food, Drug and Cosmetic Act for the drug commonly known as RU-486 is deemed to have been withdrawn, to provide for the review by the Comptroller General of the United States of the process by which the Food and Drug Administration approved such drug, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. BROWNBACK. Mr. President, I rise today to introduce a very important piece of legislation, the RU-486 Suspension and Review Act of 2003. The abortion drug RU-486 increases in infamy as its lethal nature continues to reveal itself. As my colleagues may remember, in September, RU-486 claimed two more lives, one woman's as 18-year-old Holly Patten, a resident of the San Francisco suburb of Livermore, died from an infection caused by fragments of her baby left in

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her uterus after she was administered RU–486 at a Planned Parenthood facility. This tragedy underscores the dangerous nature of this drug. The available data from the U.S. trials of RU–486 raises serious questions as to whether this drug truly is “safe” for the women who use it. Women who participated in the U.S. trials of this drug were carefully screened, and only those who were in the most physically ideal condition were accepted. Even so, among these physically ideal participants, troubling results emerged. Two-percent of the women participating hemorrhaged; one-percent had to be hospitalized; several others required surgery to stop the bleeding; one percent of patients died; blood transfusions; and one woman in Iowa, after losing between one-half to two-thirds of her total blood volume, would have died if she had not undergone emergency surgery. If these side-effects are common in the most physically ideal candidates, what about those who are not in the physically ideal category? Is this drug “safe” for women? I believe medical results suggest it is not.

The bill I am introducing today will require the suspension of the Food and Drug Administration’s approval of RU–486. Following this suspension, the General Accounting Office is directed to review the process the FDA used to approve RU–486 and to determine whether the FDA followed its own guidelines. If it is determined that the FDA violated its guidelines, RU–486 will be suspended indefinitely. Monty and Helen Patterson, the parents of Holly, have expressed their firm support for this legislation and have requested that it be known as “Holly’s Law” in honor of their daughter whose life was prematurely ended. I ask that their open letter on this subject be printed in the Record.

The Food and Drug Administration should not have authorized this dangerous drug. RU–486 is perilous both to the baby and to the woman who uses it. Monty and Helen Patterson, the parents of Holly Patterson, have expressed their firm support for this legislation and have requested that it be known as “Holly’s Law” in honor of their daughter whose life was prematurely ended. I ask that their open letter on this subject be printed in the Record.

The FDA has failed to carry out its mission of ensuring RU–486 is a safe and effective abortion drug regimen. According to the FDA, it is “responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation’s food supply, cosmetics, and tobacco that enter into interstate commerce.” The FDA has already paid the ultimate price. The RU–486 abortion drug should not be either a Pro Life or Pro Choice issue. The most primary concern here must be the health and welfare of our children and young women. Hopefully, all parents can learn from Holly’s horrible death and our loss.

According to Danco Laboratories, the abortion drug’s distributor, the RU–486 regimen fails to work 7-8 percent of the time. Over a year ago the FDA received 400 reports of adverse reactions to the drug including several deaths. Holly is yet another victim who was subject to an unacceptable risk to a drug that has a significant failure rate. And we demand that FDA Commissioner Mark McClellan and Health and Human services Secretary Tommy Thompson take RU–486 off the market immediately pending an extensive investigation by the Comptroller General of the United States before more parents and women die.

We respectfully request the name of the bill that is to be presented to the House of Representatives, an Act as the “RU–486 Approval and Review Act” commonly known as “Holly’s Law.” With actively support a bill that halts the use of the drug that took Holly’s young life.

The FDA Commissioner and an investigation by the FDA and the California State Health Department as to why abortion clinics like Planned Parenthood are not following FDA approved regulations to administer the purity of the drugs they administer, especially when they are made in foreign countries such as China.

In addition to the dangers of this drug and its administration, we believe that health care providers such as Valley Medical Center don’t appear to be fully prepared to evaluate and treat patients with RU–486 complications in emergency situations. Holly was in the hospital twice and died within 20 minutes of her follow up appointment with Planned Parenthood.

FDA Commissioner Mark McClellan and Health and Human Services Secretary, Tommy Thompson showed through their actions no evidence to pull this drug from the market. How many more teenagers and young women will have to pay the price with their health or with their life, before the FDA decides to act?

Currently in California, teenage girls under the age of 18 can’t get their ears pierced or go on a school trip without their parents. Many can have a medical or surgical abortion without parental knowledge or consent. This prevents parents from being able to talk to their children about abortion and having the freedom to choose whether to keep a baby or to be able to follow the abortion process.

The first line of defense for a child is a parent. Kids wouldn’t be walking into clinics under a veil of secrecy if parents were notified first hand where they could talk to their children about abortion risks. We have now learned that Holly first sought a pregnancy test in the months leading up to her pregnancy while she was still 17 years old. We know now that if that parental notification law would have brought Holly’s activity to our attention and her needless death could have been prevented if we had been aware and interven尽早.

We actively support the Tell-A-Parent (TAP) ballot initiative sponsored by Life on
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The Ballot www.LifewiththeBallot.org. With enough petitions, this initiative will be on the 2004 ballot and requires parental notification 48 hours prior to an abortion in California. As parents, we are concerned about the health and welfare of all daughters; we are “Pro Life.” And look to our California Senators Barbara Boxer and Diane Feinstein to support this initiative for the safety and protection of all young women in California.

Finally, we have suffered greatly with the realization that it’s not enough to avoid the issue or talk to our children about why we don’t want them to be involved in an unplanned pregnancy or abortion, but as parents, we must also talk about the tragic realities of unwanted pregnancy and abortion and reassure both, our daughters and sons that while we don’t want this to happen, we will support them. We must focus on prevention and they must be told that they are not alone in this or any other unfortunate circumstance, regardless of the outcome.

We feel strongly that this country needs a national campaign to promote open and frank discussions in the home about unplanned pregnancy and the options that are available to our daughters who find themselves in this unfortunate predicament. We are eager to support such a campaign designed to bring about awareness, encourage parental involvement, and provide accurate information to minors, women, and parents about abstinence, birth control, unplanned pregnancy, abortion, parenting, and adoption options.

While parents would prefer that their daughters abstain from sex and many do, we must deal with the reality that many don’t. In addition to unplanned pregnancy, girls can contract HIV and other STIs. As parents we need to prevent unplanned pregnancy instead of relying upon abortion clinics and agencies to educate our children and provide them with inaccurate information. No parent wants to see his or her teenage or college age daughter in the unfortunate situation that Holly was faced with.

We have lost our daughter, Holly, but we can still help to prevent this terrible tragedy from happening in other families. Holly’s drive and determination to accomplish her goals gives us strength to pursue these critical issues in her name. Holly’s memory and light will live on in our hearts, family, friends, and our work. We will actively support the bill to suspend and review “Holly’s Law” in Congress by Reps. DeMint and Bartlett and Senator Brownback to suspend and review the abortion drug RU-486, the Tell-A-Girl bill, which requires parental notification laws in California and a campaign to encourage prevention and open dialogue about unplanned pregnancy and abortion in the home. Please contact us with any questions or requests for support of these very important issues.

Sincerely,

MONTY AND HELEN PATTERSON.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 271—URGING THE PRESIDENT AND THE UNITED STATES DIPLOMATIC CORPS TO DISSSUAD AND MEMBER STATES OF THE UNITED NATIONS FROM SUPPORTING RESOLUTIONS THAT UNFAIRLY CASTIGATE ISRAEL AND TO PROMOTE WITHIN THE UNITED NATIONS GENERAL ASSEMBLY MORE BALANCED AND CONSTRUCTIVE APPROACHES TO RESOLVING CONFLICT IN THE MIDDLE EAST

Mr. COLEMAN (for himself, Mr. CORZINE, Mr. Voinovich, and Mr. Lautenberg) submitted the following resolution; which was referred to the Committee on Foreign Relations:

Whereas the United Nations General Assembly and United Nations Security Council have over a period of many years engaged in a pattern of introducing and enacting measures and resolutions unfairly castigating and condemning the state of Israel;

Whereas despite the myriad of challenges facing the world community, the United Nations General Assembly has devoted a disproportionate amount of time and resources to castigating Israel;

Whereas during the fifty-seventh session of the United Nations General Assembly, the General Assembly adopted a total of 69 resolutions by roll call vote, 22 of which related to Israel;

Whereas many member states of the United Nations General Assembly continue to engage in a discriminatory campaign against Israel, including enacting on October 21, 2003 a resolution that condemns Israel security measures without proportional condemnation of terrorist attacks launched against Israel;

Whereas the discriminatory voting patterns in the United Nations have historically been driven by voting blocs and ideological divides originating from Cold War rivalries that are obsolete in the post-Cold War period; and

Whereas in the post-Cold War geopolitical environment, the United States has a special responsibility and equitable treatment of all nations in the context of international institutions, including the United Nations: Now, therefore, be it

Resolved, That the Senate urges the President and all members of the United States diplomatic corps:

1) to dissuade member states of the United Nations from voting in support of General Assembly resolutions that unfairly castigate Israel; and

2) to promote within the United Nations General Assembly more balanced and constructive approaches to resolving conflict in the Middle East.

Mr. COLEMAN. Mr. President, today I am proud to submit, along with my good friends Assembly Senate Chairman CORZINE, a bipartisan resolution dealing with the unfair treatment of Israel at the United Nations.

For too long, Israel has been singled out for castigation by the United Nations General Assembly. Israeli defensive actions are being labeled as terrorism while Israeli security measures are largely unnoticed. There are whole bodies designed to do nothing but produce anti-Israel materials. There is a Division of Palestinian Rights which sits at the same level in the U.N. organization as a single division for the Americas and Europe, a single division for Asia and the Pacific, and two Africa divisions. Of all the resolutions adopted by rollcall vote at the last session of the UN General Assembly, one-third singled out Israel.

Let me be clear on this point: I do think it is appropriate to help the Palestinian people, and I do share President Bush’s vision of two states living side by side in peace.

But for the United Nations to spend so much of its time on this one crisis, with an unbalanced approach, ultimately undermines its ability to contribute constructively to the peace process. To accord the Palestinian people—however serious their problems are the same level of attention as entire continents is inappropriate in a world where there are so many other divided groups and nations. Why is there no Division of Tibetan Rights? Why no Division of Chechen Rights?

If you look at the General Assembly voting records, there are too many one-sided resolutions dealing with Israel that pass with only a handful of negative votes—cast by the U.S., Israel, Micronesia, the Marshall Islands, Nauru and Palau. Last Friday, I was pleased to note Australia joined us as well.

The good news is that we are starting to see some progress. A joint U.S.-European-Israeli effort to consolidate seven resolutions on UNRWA into one resolution recently was a good start. The resolution was passed out of the committee by a vote of 109 to 0, albeit with 54 abstentions. True, several superfluous resolutions on UNRWA were also approved by the committee. But this year, it was five resolutions instead of seven.

When the U.S., Europe, and Israel come together to reach a resolution dealing with Palestinian refugees, and one that is passed without any negative votes—we get a glimpse of the U.N.’s potential for bringing parties together.

I would be remiss if I did not commend the work of U.S. diplomats, and applaud their increased attention to this issue. This resolution gives them a tool to use with their diplomatic counterparts—a strong statement from the U.S. Senate that we are paying attention to these votes, and that we support a more balanced approach toward the Middle East at the United Nations. It should be a goal we can all agree upon. By reducing the number of anti-Israel resolutions passed by the General Assembly, the United Nations can live up to the president’s oft-repeated: “to practice tolerance and live together in peace with one another as good neighbors.”

Mr. CORZINE. Mr. President, today, along with Senator COLEMAN, LAUTENBERG, and Voinovich, I am submitting a resolution to address a serious and persistent problem: the unfair and inequitable treatment of Israel in the United