



# Committee On Finance

Max Baucus, Chairman

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## NEWS RELEASE

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## SUMMARY OF THE BENEFICIARY ACCESS TO CARE AND MEDICARE EQUITY ACT OF 2002

**Total cost over 10 years: approximately \$43 billion\***

### TITLE I – RURAL HEALTH CARE IMPROVEMENTS

**(Approx. \$12.8 billion over 10 years)**

- Sec. 101** Full standardized amount for rural and small urban hospitals by FY04 and thereafter.
- Sec. 102** Wage index changes: labor-related share for hospitals with a wage index below 1.0 is 68% for FY03 through FY05; labor-related share for hospitals with a wage index above 1.0 is held harmless (i.e. remains at current level of 71%).
- Sec. 103** Medicare disproportionate share (DSH) payments: increases the maximum DSH adjustment for rural hospitals and urban hospitals with under 100 beds to 10% (phased-in over ten years).
- Sec. 104** 1-year extension of hold harmless from outpatient PPS for small rural hospitals.
- Sec. 105** 5% add-on for clinic and ER visits for small rural hospitals.
- Sec. 106** 2-year extension of reasonable cost payments for diagnostic lab tests in Sole Community Hospitals.
- Sec. 107** Critical Access Hospital improvements:
- (a) Reinstatement of periodic interim payments;
  - (b) Condition for application of special physician payment adjustment;
  - (c) Coverage of costs for certain emergency room on-call providers;
  - (d) Prohibition on retroactive recoupment;

- (e) Increased flexibility for states with respect to certain frontier critical access hospitals;
  - (f) Permitting hospitals to allocate swing beds and acute care inpatient beds subject to a total limit of 25 beds;
  - (g) Provisions related to certain rural grants;
  - (h) Coordinated survey demonstration program.
- Sec. 108** Temporary relief for certain non-teaching hospital for FY03 through FY05 (same as House-passed provision).
- Sec. 109** Physician work Geographic Practice Cost Index at 1.0 for CY03 through CY05, holding harmless those areas with work GPCIs over 1.0.
- Sec. 110** Make existing Medicare Incentive Payment 10% bonus payments on claims by physicians serving patients in rural Health Professional Shortage Areas automatic, rather than requiring special coding on such claims.
- Sec. 111** GAO study on geographic differences in physician payments.
- Sec. 112** Extension of 10% rural add-on for home health through FY04.
- Sec. 113** 10% add-on for frontier hospice for CY03 through CY07.
- Sec. 114** Exclude services provided by Rural Health Clinic-based practitioners from Skilled Nursing Facility consolidated billing.
- Sec. 115** Rural Hospital Capital Loan Authorization.

## **TITLE II – PROVISIONS RELATING TO PART A**

**(Approx. \$9.0 billion over 10 years)**

### ***Subtitle A – Inpatient Hospital Services***

- Sec. 201** FY03 inflation adjustment of market basket minus -0.25% for PPS hospitals; full market basket for Sole Community Hospitals.
- Sec. 202** Update hospital market basket weights more frequently.
- Sec. 203** IME Adjustment: 6.5% in FY03, 6.5% in FY04, 6.0% in FY05.
- Sec. 204** Puerto Rico: 75%-25% Federal-Puerto Rico blend beginning in FY 03.

**Sec. 205** Geriatric GME programs: certain geriatric residents do not count against caps.

**Sec. 206** DSH increase for Pickle hospitals from 35% to 40%.

***Subtitle B – Skilled Nursing Facility Services***

**Sec. 211** Increase to nursing component of RUGs: 15% in FY03, 13% in FY04, 11% in FY05; increase in payment for AIDS patients cared for by SNFs; GAO study.

**Sec. 212** Require collection of staffing data; require staffing measure in CMS quality initiative.

***Subtitle C – Hospice***

**Sec. 221** Allow payment for hospice consultation services based on fee schedule set by Secretary; remove one-time limit set by House.

**Sec. 222** Authorize use of arrangements with other hospice programs.

**TITLE III – PROVISIONS RELATING TO PART B**

**(Approx. \$10.0 billion over 10 years)**

***Subtitle A – Physicians’ Services***

**Sec. 301** Physician payment increase (same as House-passed version); GAO study; MedPAC report.

**Sec. 302** Extension of treatment of certain physician pathology services through FY05.

***Subtitle B – Other Services***

**Sec. 311** Competitive bidding for DME: begin national phase-in CY03 for MSAs with over 500,000 people.

**Sec. 312** 2-year extension of moratorium on therapy caps.

**Sec. 313** Acceleration of reduction of beneficiary copayment for hospital outpatient department services.

- Sec. 314** End-Stage Renal Disease: Increase composite rate to 1.2% in CY03 and CY04; composite rate exceptions for pediatric facilities.
- Sec. 315** Improved payment for certain mammography services.
- Sec. 316** Waiver of Part B late enrollment penalty for certain military retirees and special enrollment period.
- Sec. 317** Coverage of cholesterol and blood lipid screening.
- Sec. 318** 5% payment increase for rural ground ambulance services, 2% increase for urban ground ambulance services.
- Sec. 319** Medical necessity criteria for air ambulance services under ambulance fee schedule.
- Sec. 320** Improved payment for thin prep pap tests.
- Sec. 321** Coverage of immunosuppressive drugs.
- Sec. 322** Geriatric care assessment demonstration program.
- Sec. 323** CMS study and recommendations to Congress on revisions to outpatient payment methodology for drugs, devices and biologicals.

**TITLE IV – PROVISIONS RELATING TO PARTS A AND B**

**(Approx. \$0.0 billion over 10 years)**

***Subtitle A – Home Health Services***

- Sec. 401** Eliminate 15% reduction in payments for home health services.
- Sec. 402** Reduce inflation updates in FY03 through FY05; full market basket increases thereafter.

***Subtitle B – Other Provisions***

- Sec. 411** Information technology demonstration project.
- Sec. 412** Modifications to the Medicare Payment Advisory Commission.
- Sec. 413** Requires CMS to maintain a carrier medical director and carrier advisory committee in every state to ensure access to the local coverage process.

## **TITLE V – MEDICARE+CHOICE AND RELATED PROVISIONS**

**(Approx. \$2.3 billion over 10 years, including M+C interactions)**

- Sec. 501** Increase minimum updates to 4% in CY03 and 3% in CY04.
- Sec. 502** Clarify Secretary’s authority to disapprove certain cost-sharing.
- Sec. 503** Extend cost contracts for 5 years.
- Sec. 504** Extend the Social HMO Demonstration through 2006.
- Sec. 505** Extend specialized plans for special needs beneficiaries for 5 years (Evercare).
- Sec. 506** Extend 1% entry bonus for M+C for 2 years; bonus does not apply for private fee-for-service or demonstration plans.
- Sec. 507** PACE technical fix regarding services furnished by non-contract providers.
- Sec. 508** Reference to implementation of certain M+C provisions in 2003.

## **TITLE VI – MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS**

**(Approx. \$0.0 billion over 10 years)**

### ***Subtitle A – Regulatory Reform***

- Sec. 601** Require status report on interim final rules; limit effectiveness of interim final rules to 12 months with one extension permitted under certain circumstances.
- Sec. 602** Requires only prospective compliance with regulation changes.
- Sec. 603** Secretary report on legal and regulatory inconsistencies in Medicare.

### ***Subtitle B – Appeals Process Reform***

- Sec. 611** Requires Secretary to submit detailed plan for transfer of responsibility for medicare appeals from SSA to HHS; GAO evaluation of plan.

- Sec. 612** Allows expedited access to judicial review for Medicare appeals involving legal issues that the DAB does not have the authority to decide.
- Sec. 613** Allows expedited appeals for certain provider agreement determinations, including terminations.
- Sec. 614** Tightens eligibility requirements for QICs and reviewers; ensures notice and improved explanations on determination and redetermination decisions; delays implementation of Section 521 of BIPA for 14 months, but continues implementation of expedited redeterminations; expands CMS discretion on the number of QICs.
- Sec. 615** Creates hearing rights in cases of denial or nonrenewal of enrollment agreements; requires consultation before CMS changes provider enrollment forms.
- Sec. 616** Permits providers to appeal determinations relating to services rendered to an individual who subsequently dies if there is no other party available to appeal.
- Sec. 617** Permits providers to seek appeal of local coverage decisions and to request development of local coverage decisions under certain circumstances.

***Subtitle C – Contracting Reform***

- Sec. 621** Authorizes Medicare contractor reform beginning in October 2004.

***Subtitle D – Education and Outreach Improvements***

- Sec. 631** New education and technical assistance requirements.
- Sec. 632** Requires CMS and contractors to provide written responses to health care providers' and beneficiaries' questions within 45 days.
- Sec. 633** Suspends penalties and interest payments for providers that have followed incorrect guidance.
- Sec. 634** Creates new ombudsmen offices for health care providers and beneficiaries.
- Sec. 635** Authorizes beneficiary outreach demonstration.

***Subtitle E – Review, Recovery, and Enforcement Reform***

- Sec. 641** Requires CMS to establish standards for random prepayment audits.

- Sec. 642** Requires CMS to enter into overpayment repayment plans. Prevents CMS from recovering overpayments until the second level of appeal is exhausted.
- Sec. 643** Establishes a process for the correction of incomplete or missing data without pursuing the appeals process.
- Sec. 644** Expands the current waiver of program exclusions in cases where the provider is a sole community physician or sole source of essential health care.

**TITLE VII – MEDICAID-SCHIP**

**(Approx. \$10.8 billion over 10 years)**

- Sec. 701** Extend Medicaid disproportionate share hospital (DSH) inflation updates (for 2001 and 2002) to 2003, 2004 and 2005 allotments; update District of Columbia DSH allotment.
- Sec. 702** Raise cap from 1% to 3% for states classified as low Medicaid DSH in FY03 through FY05.
- Sec. 703** Five year extension of QI-1 Program.
- Sec. 704** Enable public safety net hospitals to access discount drug pricing for inpatient drugs.
- Sec. 705** CHIP Redistribution: give states an additional year to spend expiring funds that would otherwise return to the Treasury; continue BIPA arrangement for SCHIP redistribution; establish caseload stabilization pool beginning in FY04; allow certain states to use a portion of unspent SCHIP funds to cover specified Medicaid beneficiaries; GAO study to evaluate program implementation and funding.
- Sec. 706** Improvements to Section 1115 waiver process for Medicaid and State Children’s Health Insurance Program (SCHIP) waiver.
- Sec. 707** Increase the federal medical assistance percentage in Medicaid (FMAP) by 1.3% for 12 months for all states; “hold harmless” states scheduled to have a lower FMAP in FY03; \$1 billion increase in Social Services Block Grant for FY03.

**TITLE VIII – OTHER PROVISIONS**

**(Approx. \$0.9 billion over 10 years)**

- Sec. 801**      Extend funding for Special Diabetes Programs for FY04, FY05, and FY06 at \$150 million per program per year.
  
- Sec. 802**      Disregard of certain payments under the Emergency Supplemental Act, 2000 in the administration of Federal programs and federally assisted programs.
  
- Sec. 803**      Create Safety Net Organizations and Patient Advisory Commission.
  
- Sec. 804**      Guidance on prohibitions against discrimination by national origin.
  
- Sec. 805**      Extend grants to hospitals for EMTALA treatment of undocumented aliens.
  
- Sec. 806**      Extend Medicare Municipal Health Services Demonstration for 1 year.
  
- Sec. 807**      Provides for delayed implementation of certain provisions.