107TH CONGRESS
2D SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

Mr. BAUCUS (for himself and Mr. GRASSLEY) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

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

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 ''Beneficiary Access to Care and Medicare Equity Act of 2002''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this

Act an amendment 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 that section or other provision of the Social Security 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:

TITLE I—RURAL HEALTH CARE IMPROVEMENTS

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

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

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

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

''(II) For discharges occurring during fiscal year 2003, the operating standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the operating standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

''(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an operating standardized amount for hos-

pitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

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

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking ''each of which is'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

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

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

''(I) the applicable operating standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

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

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

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

SEC. 102. ADJUSTMENT TO WAGE INDEX.

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

(1) by striking "WAGE LEVELS.—The Secretary" and inserting "WAGE LEVELS.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary"; and

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

"(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED IN FISCAL YEARS 2003, 2004, AND 2005.—

"(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2002, and before October 1, 2005, the Secretary shall substitute '68 percent' for the proportion described in the first sentence of clause (i).

"(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—For discharges occurring on or after October 1, 2002, and before October 1, 2005,

if the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.

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

(c) MEDPAC STUDY AND REPORT.—

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

(A) conduct a study of the methodology used to determine the proportion of hospitals' costs attributable to wages and wage-related costs (as determined under section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsections (a) and (b)), which is used to adjust payments under such section, in order to determine whether such methodology is appropriate; and

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

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1) together with any recommendation developed under paragraph (1)(B).

SEC. 103. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) BLENDING OF PAYMENT AMOUNTS.—

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

"(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined

under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

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

''(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 90 percent, for each subsequent year (through 2011) is the old blend proportion under this subclause for the previous year minus 10 percentage points, and for each year beginning with 2012 is 0 percent.''.

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

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (viii), by striking ''The formula'' and inserting ''Subject to clause (xiv), the formula''; and

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 2002.

SEC. 104. ONE-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

Section 1833(t)(7)(D)(i) (42 U.S.C. 1395*l*(t)(7)(D)(i)) is amended by striking ''2004'' and inserting ''2005''.

SEC. 105. TEMPORARY INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) INCREASE.—

(1) IN GENERAL.—In the case of an applicable covered OPD service (as defined in paragraph (2))

that is furnished by a hospital described in paragraph (7)(D)(i) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) on or after January 1, 2003, and before January 1, 2006, the Secretary of Health and Human Services shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) APPLICABLE COVERED OPD SERVICES DEFINED.—For purposes of this section, the term ''applicable covered OPD service'' means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) established under paragraph (2)(B) of such section.

(b) NO EFFECT ON COPAYMENT AMOUNT.—The Secretary of Health and Human Services shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395*l*(t)(8)(A)) as if this section had not been enacted.

(c) NO EFFECT ON INCREASE UNDER HOLD HARMLESS OR OUTLIER PROVISIONS.—The Secretary of Health and Human Services shall apply the temporary hold harmless provision under paragraph (7)(D)(i) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) WAIVING BUDGET NEUTRALITY AND NO REVISION OR ADJUSTMENTS.—The Secretary of Health and Human Services shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395*l*(t)(9)) because of the application of subsection (a)(1).

(e) NO EFFECT ON PAYMENTS AFTER INCREASE PERIOD ENDS.—The Secretary of Health and Human Services shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) under such section that are furnished after January 1, 2006.

(f) TECHNICAL AMENDMENT.—Section 1833(t)(2)(B) (42 U.S.C. 1395*l*(t)(2)(B)) is amended by

inserting ''(and periodically revise such groups pursuant to paragraph (9)(A))'' after ''establish groups''.

SEC. 106. TWO-YEAR TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

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

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) NO BENEFICIARY COST-SHARING.—No coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 107. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (C);

(2) by adding ''and'' at the end of subparagraph (D); and

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

''(E) inpatient critical access hospital services;''.

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

''The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the critical access hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.''.

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

(1) in the heading—

(A) by inserting ''CERTAIN'' before ''EMERGENCY''; and

(B) by striking ''PHYSICIANS'' and inserting ''PROVIDERS'';

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

(3) by striking ''physicians' services'' and inserting ''services covered under this title''.

(d) PROHIBITION OF RETROACTIVE RECOUPMENT.—The Secretary shall not recoup (or otherwise seek to recover) overpayments made for outpatient critical access hospital services under part B of title XVIII of the Social Security Act, for services furnished in cost reporting periods that began before October 1, 2002, insofar as such overpayments are attributable to payment being based on 80 percent of reasonable costs (instead of 100 percent of reasonable costs minus 20 percent of charges).

(e) INCREASED FLEXIBILITY FOR STATES WITH RESPECT TO CERTAIN FRONTIER CRITICAL ACCESS HOSPITALS.—Section 1820(c) (42 U.S.C. 1395i–4(c)) is amended—

(1) in paragraph (2)(B)(ii), by striking ''makes'' and inserting ''subject to paragraph (3), makes''; and

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

''(3) STATE AUTHORITY TO TEMPORARILY WAIVE EMERGENCY COVERAGE REQUIREMENT.—

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

''(i) complies with alternative emergency care procedures established by the State;

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

''(iii) has less than 500 emergency room visits (determined with respect to all patients and not just individuals receiving

benefits under this title) per year (as determined by the State).''.

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

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

''(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) or acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds''.

(g) PROVISIONS RELATED TO CERTAIN RURAL GRANTS.—

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

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

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

''(4) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—

''(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

''(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

''(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.''.

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

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) HI TRUST FUND.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under—

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

''(B) paragraphs (1) and (2) of subsection (g), $40,000,000 in each of the fiscal years 2003 through 2007.

''(2) GENERAL REVENUES.—There are authorized to be appropriated from amounts in the treasury not otherwise appropriated for making grants to

all States under subsection (g)(4), $25,000,000 in each of the fiscal years 2003 through 2007.''.

(3) REQUIREMENT THAT STATES AWARDED GRANTS CONSULT WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE SUCH GRANTS.—Section 1820(g) (42 U.S.C. 1395i–4(g)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

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

(h) COORDINATED SURVEY DEMONSTRATION PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a demonstration program to test and evaluate the effectiveness of permitting all the entities within a health care organization to be subject to a coordinated survey for purposes of determining whether such entities are in compliance with the requirements for participation

under the medicare and medicaid programs with respect to all items and services provided by those entities under such programs rather than being subject to multiple surveys for different types of items and services provided by such entities under such programs.

(B) DEVELOPMENT OF GUIDELINES FOR COORDINATED SURVEY.—

(i) SUBMISSION OF PROPOSALS BY STATES PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Under the demonstration program under this subsection a State participating in the demonstration (as determined by the Secretary pursuant to subparagraph (C)) shall submit to the Secretary a proposal for guidelines with respect to the coordinated survey described in subparagraph (A) that will be applicable to health care organizations located in the State. Such proposal shall be submitted to the Secretary at such time and in such manner as the Secretary determines appropriate.

(ii) REVIEW AND APPROVAL.—

(I) IN GENERAL.—Under the demonstration program under this subsection the Secretary shall establish procedures for reviewing and approving proposals submitted under clause (i).

(II) CONSULTATION.—The Secretary shall consult with State hospital associations in establishing the procedures under subclause (I).

(C) SITES.—The Secretary shall conduct the demonstration program under this subsection in up to 5 States and shall ensure that all health care organizations located in those States are permitted at the option of the organization to participate in the program.

(D) DURATION.—The demonstration program under this subsection shall be conducted for not more than 5 years.

(2) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this subsection.

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

(4) DEFINITIONS.—In this subsection:

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

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

(i) a critical access hospital; and

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

(C) MEDICAID PROGRAM.—The term ''medicaid program'' means the health benefits program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(D) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(i) EFFECTIVE DATES.—

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

(2) PHYSICIAN PAYMENT ADJUSTMENT CONDITION.—The amendment made by subsection (b) shall take effect on January 1, 2003.

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

(4) REQUIRED CONSULTATION FOR CERTAIN RURAL GRANTS.—The amendment made by subsection (g)(3) shall take effect on the date of the enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

SEC. 108. TEMPORARY RELIEF FOR CERTAIN NON-TEACHING HOSPITALS.

(a) IN GENERAL.—In the case of a non-teaching hospital that meets the condition of subsection (b), in each of fiscal years 2003, 2004, and 2005, the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during such fiscal year under section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) had been increased by 5 percentage points. The previous sentence shall be applied for each such fiscal year separately without regard to its application in a previous fiscal year and shall not affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 2005.

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

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

(a)(4) of such section) for all subsection (d) hospitals in such areas in such State with respect to such cost reporting periods; or

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

The amounts under paragraphs (1) and (2) shall be determined by the Secretary of Health and Human Services based on data of the Medicare Payment Advisory Commission.

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

(1) NON-TEACHING HOSPITAL.—The term ''non-teaching hospital'' means, for a cost reporting period, a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act, 42 U.S.C. 1395ww)) that is not receiving any additional payment under subsection (d)(5)(B) of such section or a payment under subsection (h)

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

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

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

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

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

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

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

"(D) FLOOR FOR WORK GEOGRAPHIC INDICES.—

"(i) IN GENERAL.—Notwithstanding the work geographic index otherwise calculated under subparagraph (A)(iii) (after the application of the second sentence of subparagraph (C)), no such index applied for payment under this section shall be less than 1.000 for services furnished during 2003, 2004, and 2005.

"(ii) EXEMPTION FROM LIMITATION ON ANNUAL ADJUSTMENTS.—The increase in expenditures attributable to clause (i) shall not be taken into account in applying subsection (c)(2)(B)(ii)(II).".

SEC. 110. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) PROCEDURES FOR SECRETARY, AND NOT PHYSICIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE MADE.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

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

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

(b) EDUCATIONAL PROGRAM REGARDING THE MEDICARE INCENTIVE PAYMENT PROGRAM.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)).

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

(1) ONGOING STUDY.—The Secretary shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) ANNUAL REPORTS.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary considers appropriate.

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

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts 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—

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

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

(3) 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 and variation in such increases by State

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

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under section 1848(e)(1)(D) of the Social Security Act, as added by section 109, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

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

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

(6) an evaluation of appropriateness of extending such adjustment or making such adjustment permanent.

(b) 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 subsection (a). The report shall include recommendations regarding the use of more current data in computing geo-

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

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

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

(1) by striking ''24-MONTH INCREASE BEGINNING APRIL 1, 2001'' and inserting ''IN GENERAL''; and

(2) by striking ''April 1, 2003'' and inserting ''January 1, 2005''.

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

SEC. 113. TEN PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA.

Section 1814(i)(1) (42 U.S.C. 1395f(i)(1)) is amended by adding at the end the following new subparagraph:

''(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such

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

SEC. 114. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE MEDICARE PPS FOR SKILLED NURSING FACILITIES.

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

(1) in paragraph (2)(A)(i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

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

''(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

''(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

''(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by a physician or practitioner not affiliated with a rural health clinic or a Federally qualified health center.''.

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

SEC. 115. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

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

''CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

''SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of land necessary for the capital improvements;

''(B) the renovation or modernization of any building;

''(C) the acquisition or repair of fixed or major movable equipment; and

''(D) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

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

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan and for and on behalf of the project for which the loan was made, amounts sufficient to reduce by not more than 3 percent of the net effective interest rate otherwise payable on such loan.

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

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

''(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

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

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2006.''.

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

"(15)(A) The term 'rural entity' includes—

"(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

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

"(I) a county that is not part of a metropolitan statistical area; or

"(II) 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. 6725));

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

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

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

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

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

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

(2) in subsection (d)—

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

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

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

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

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

''(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and''.

(b) GAO STUDY AND REPORT ON APPROPRIATENESS AND NEED TO REBASE 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 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 subsection (d)(1)(B) of such section); and

(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas and different hospitals.

(2) REPORT.—Not later than 18 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.

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

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2003, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 203. THREE-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).

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

(1) in subclause (VI)—

(A) by striking ''fiscal year 2002'' and inserting ''fiscal years 2002, 2003, and 2004''; and

(B) by striking ''and'' at the end;

(2) by redesignating subclause (VII) as subclause (VIII);

(3) in subclause (VIII) as so redesignated, by striking ''2002'' and inserting ''2005''; and

(4) by inserting after subclause (VI) the following new subclause:

''(VII) during fiscal year 2005, 'c' is equal to 1.47; and''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

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

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

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, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(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, 1987, and September 30, 1997, 25 percent)'' 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) between October 1, 1987, and September 30, 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 October 1, 2002, the applicable Puerto Rico percent-

age is 50 percent and the applicable Federal percentage is 50 percent; and

''(iii) on or after October 1, 2002, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 205. INCREASE IN GRADUATE MEDICAL EDUCATION LIMITATIONS FOR CERTAIN GERIATRIC RESIDENTS.

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

''(iii) INCREASE IN LIMITATION FOR GERIATRIC FELLOWSHIPS.—For cost reporting periods beginning on or after July 1, 2003, in applying the limitations regarding the total number of full-time equivalent residents in the field of allopathic or osteopathic medicine under clause (i) for a hospital, the Secretary shall not take into account a maximum of the applicable number of residents (as defined in clause (iv)) enrolled in a fellowship in geriatric medicine within an approved medical residency training program to the extent that the hospital increases the number of geriatric

residents above the number of such residents for the hospital's most recent cost reporting period ending before July 1, 2003.

"(iv) APPLICABLE NUMBER OF RESIDENTS.—For purposes of clause (i), the term 'applicable number of residents' means—

"(I) for the period beginning on July 1, 2003, and ending on June 30, 2005, one;

"(II) for the period beginning on July 1, 2005, and ending on June 30, 2007, two; and

"(II) on or after July 1, 2007, three.".

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

"(ix) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.".

SEC. 206. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking ''35 percent'' and inserting ''35 percent (or, for discharges occurring on or after April 1, 2003, 40 percent)''.

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

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv), by striking the period at the end and inserting '', and''; and

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

''(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).''.

Subtitle B—Skilled Nursing Facility Services

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

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

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

(b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

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

''(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

''(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 per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

''(B) SUNSET.—Subparagraph (A) shall not apply on and after such date 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.''.

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

(c) GAO AUDIT OF NURSE STAFFING RATIOS.—

(1) AUDIT.—The Comptroller General of the United States shall conduct an audit of nurse staffing ratios in a representative sample of medicare skilled nursing facilities. Such sample shall cover selected States and shall include broad representation with respect to size, ownership, location, and medicare volume. Such audit shall include an examination of payroll records and medicaid cost reports of individual facilities and the nurse staffing data submitted under sections 1819(b)(8)(D) and 1919(b)(8)(D) of the Social Security Act (as added by paragraphs (1)(B) and (2)(B), respectively, of section 212(a)).

(2) REPORT.—Not later than June 1, 2004, the Comptroller General shall submit to Congress a report on the audits conducted under paragraph (1). Such report shall include an assessment of the impact of the increased payments by reason of the amendments made by subsections (a) and (b) on increased nurse staffing ratios and shall make recommendations as to whether increased payments under section 312(a) of BIPA (114 Stat. 2763A–498), as amended by subsection (a), should be continued.

SEC. 212. IMPROVING THE AVAILABILITY OF NURSING FACILITY STAFFING INFORMATION.

(a) NURSING FACILITY STAFFING INFORMATION.—

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

(A) in subparagraph (A), by adding at the end the following new sentence: ''The information posted under this subparagraph shall include information regarding nurse staffing with respect to beds made available by reason of an agreement under section 1883.''; and

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

"(C) SUBMISSION AND POSTING OF DATA.—Beginning on July 1, 2003, a skilled nursing facility shall submit to the Secretary in a uniform manner (as prescribed by the Secretary) the nurse staffing data described in subparagraph (A) through electronic data submission not less frequently than quarterly and the Secretary shall make such data publicly available, including by posting such data on an Internet website.

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

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

(A) in subparagraph (A), by adding at the end the following new sentence: "The information posted under this subparagraph shall include information regarding nurse staffing with respect to beds made available by reason of an agreement under section 1883."; and

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

''(C) SUBMISSION AND POSTING OF DATA.—Beginning on July 1, 2003, a nursing facility shall submit to the Secretary in a uniform manner (as prescribed by the Secretary) the nurse staffing data described in subparagraph (A) through electronic data submission not less frequently than quarterly and the Secretary shall make such data publicly available, including by posting such data on an Internet website.

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

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

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

(B) the most effective mechanisms for auditing nurse staffing data under sections 1819(b)(8)(D) and 1919(b)(8)(D) of the Social

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

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to calendar quarters beginning on and after January 1, 2003.

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

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

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

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

(C) indicates the percentile in which each nursing facility falls compared with other nursing facilities in the State.

The Secretary shall not be required to comply with the requirements of subparagraph (B) to the extent that the development of a methodology to comply with such requirement would delay the implementation of this section.

(2) FORM AND MANNER.—The nursing facility staffing measure described in paragraph (1) shall be displayed in the same form and manner as information that the Secretary displays to help the public compare the quality of care that nursing facilities provide.

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

Subtitle C—Hospice

SEC. 221. 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 and who have not made an election under subsection (d)(1), services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management, including the need for hospice care;

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

''(C) if appropriate, advising the individual regarding advanced care planning.''.

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

''(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 part A shall be the amount determined under a fee schedule established by the Secretary.''.

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

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

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

SEC. 222. AUTHORIZING USE OF ARRANGEMENTS WITH OTHER HOSPICE PROGRAMS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

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

''(D) In extraordinary, exigent, or other nonroutine 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's service area, 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)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.''.

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

221(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 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

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

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 301. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) REVISION.—

(1) UPDATE FOR 2003 THROUGH 2005.—

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

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

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

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

''(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

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

''(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

''(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, and 2005 is deemed to be increased by 1 percentage point.''.

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

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

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

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

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

(i) by striking ''projected'' and inserting ''annual average''; and

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

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

(3) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Section 1848(d)(4)(F) (42 U.S.C. 1395w–4(d)(4)(F)) is amended by striking ''subparagraph (A)'' and all that follows and inserting ''subparagraph (A), for each of 2001 and 2002, of −0.2 percent.''.

(b) GAO STUDY ON BENEFICIARY ACCESS TO PHYSICIANS' SERVICES.—

(1) 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—

(A) 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;

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

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

(2) 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 paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

SEC. 302. THREE-YEAR EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

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

Subtitle B—Other Services

SEC. 311. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

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

''COMPETITIVE ITEM AND SERVICE ACQUISITION PROGRAM

''SEC. 1866B. (a) PROGRAM AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall implement programs and demonstration projects to purchase, on behalf of individuals enrolled under part B, certain competitively priced items and services in competitive acquisition areas (in accordance with the succeeding provisions of this section) for which payment is made under such part. Such areas may differ in the items and services provided.

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

''(A) The Secretary may reject unreasonably low bids.

''(B) If the Secretary determines that the product quality or service quality of an entity with a contract has deteriorated since the contract was entered into, the Secretary may cancel the contract prior to the date on which the contract is scheduled to end and award a contract to a different entity for the remainder of the term of the contract.

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

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

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

''(A) at least ¼ of such areas in 2003;

''(B) at least ¾ of such areas in 2004; and

''(C) at least ¾ of such areas in 2005.

''(b) IMPLEMENTATION OF PROGRAMS IN COMPETITIVE ACQUISITION AREAS.—

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

''(A) covered items (as defined in section 1834(a)(13)) and inhalation drugs used in conjunction with durable medical equipment (other than items used in infusion therapy); and

''(B) leg, arm, back, and neck braces described in section 1861(s)(9), other than custom fabricated orthotics (as defined by the Secretary).

''(2) PROGRAM REQUIREMENTS.—Each program implemented under paragraph (1) shall—

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

''(B) be conducted in such competitive acquisition areas as the Secretary determines are appropriate.

''(3) CRITERIA FOR ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—Each competitive acquisition area established under a program implemented under paragraph (1) shall—

''(A)(i) be, or shall be within, a metropolitan statistical area (as defined by the Director of the Office of Management and Budget and the Secretary of Commerce) with a population in excess of 500,000; or

''(ii) be an area that was designated as a competitive acquisition area under section 1847 as of the date of the enactment of the Beneficiary Access to Care and Medicare Equity Act of 2002;

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

the furnishing of items and services in such area; and

''(C) have multiple suppliers for each product category.

''(c) AWARDING OF CONTRACTS IN COMPETITIVE ACQUISITION AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying the items and services to be furnished under the program implemented under subsection (b)(1) for each competitive acquisition area established under subsection (b)(3) for that program.

''(2) ADMINISTRATION BY CONTRACT.—

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

''(B) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted under paragraph (1) to furnish an item or service unless the Secretary finds that—

''(i) the entity meets quality and financial standards specified by the Secretary or developed by accreditation enti-

ties or organizations recognized by the Secretary;

''(ii) beneficiary liability is limited to the applicable percentage of the contract award price;

''(iii) the entity has an agreement in effect under section 1866 and has an active National Supplier Clearinghouse identification number;

''(iv) the entity complies with all Federal and State licensure and regulatory requirements;

''(v) the entity is in compliance with all the provisions of title XI and this title, such provisions of title XIX as the Secretary determines are relevant to competitive bidding, and any regulations relating thereto;

''(vi) the entity is in compliance with all billing guidelines relating to the program under this title;

''(vii) the entity has not been suspended within the 12 months preceding the date on which a bid is submitted by any

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

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

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

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

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

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

''(B) small suppliers to bid for only 1 or a few product categories instead of all the products in a competitive acquisition area; and

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

''(d) EVALUATIONS AND ANNUAL REPORTS.—

''(1) EVALUATIONS.—The Secretary shall evaluate the impact of the implementation of the programs implemented under subsection (b)(1) on—

''(A) payments made and savings realized under this title;

''(B) the access of beneficiaries to items and services furnished under such programs and demonstration projects;

''(C) the diversity of product selection under such programs and demonstration projects; and

''(D) the quality of items and services furnished under such programs and demonstration projects.

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

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

''(e) DIAGNOSTIC TESTS AND SURGICAL DRESSINGS.—

''(1) IN GENERAL.—The Secretary shall implement demonstration projects under which competitive acquisition areas are established for contract award purposes for the furnishing under part B of—

''(A) diagnostic x-ray tests, clinical diagnostic laboratory tests, and other diagnostic tests described in paragraph (3) of section 1861(s); and

''(B) surgical dressings, splints, casts, and other devices described in paragraph (5) of such section.

''(2) PROJECT REQUIREMENTS.—Each demonstration project under paragraph (1) shall—

''(A) be conducted in not more than 3 competitive acquisition areas;

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

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

manner as such conditions apply to the programs established under subsection (a).

''(3) REPORTS.—

''(A) INITIAL REPORT.—Not later than December 31, 2004, the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate an initial report on the demonstration projects conducted under this subsection.

''(B) PROGRESS AND FINAL REPORTS.—The Secretary shall submit such progress and final reports to the committees described in subparagraph (A) after the date described in such subparagraph as the Secretary determines appropriate.

''(f) OTHER PART B ITEMS AND SERVICES.—

''(1) IN GENERAL.—The Secretary may implement not more than 5 demonstration projects under which competitive acquisition areas are established for contract award purposes for the furnishing under part B of any item or service covered under such part that the Secretary may specify other than—

''(A) any item or service described in subparagraph (A) or (B) of subsection (e)(1); or

"(B) physicians' services (as defined in section 1861(r)(1)).

"(2) PROJECT REQUIREMENTS.—Each demonstration project under paragraph (1) shall—

"(A) be conducted in not more than 3 competitive acquisition areas;

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

"(C) otherwise be subject to the conditions under subsections (b)(3) and (c) in the same manner as such conditions apply to the programs established under subsection (a).

"(3) REPORTS.—

"(A) INITIAL REPORT.—Not later than December 31, 2004, the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate an initial report on the demonstration projects conducted under this subsection.

"(B) PROGRESS AND FINAL REPORTS.—The Secretary shall submit such progress and final reports to the committees described in subparagraph (A) after the date described in such subparagraph as the Secretary determines appropriate.

''(g) EXPANSION OF PROGRAMS AND DEMONSTRATION PROJECTS.—The Secretary may expand a program or demonstration project implemented under subsection (b)(1) to additional competitive acquisition areas if the Secretary determines, based on the evaluations conducted under subsection (d)(1), that there is clear evidence that any program or demonstration project—

''(1) results in a decrease in Federal expenditures under this title; and

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

''(h) DURATION OF PROGRAMS AND DEMONSTRATION PROJECTS.—

''(1) DURABLE MEDICAL EQUIPMENT AND ORTHOTICS.—The programs implemented under subparagraph (A) or (B) of subsection (b)(1) shall terminate on such date as the Secretary may specify or may continue indefinitely (as determined by the Secretary).

''(2) DIAGNOSTIC TESTS AND SURGICAL DRESSINGS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), any demonstration project implemented under subsection (e)(1) shall terminate not later than December 31, 2007.

''(B) EXCEPTION.—If the Secretary determines that a demonstration project implemented under subsection (e)(1) meets the requirements of paragraphs (1) and (2) of subsection (g), such project shall terminate on such date as the Secretary may specify or may continue indefinitely (as determined by the Secretary).

''(3) OTHER PART B ITEMS AND SERVICES.—Any demonstration project implemented under subsection (f)(1) shall terminate not later than December 31, 2007.''.

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

''(e) TERMINATION.—

''(1) IN GENERAL.—Notwithstanding any other provision of this section, except as provided in paragraph (2), all projects under this section shall terminate not later than December 31, 2002.

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

under this section until such time as the competitive acquisition area under such a project is designated as a competitive acquisition area for purposes of section 1866B, except that no project may continue under this section after December 31, 2006.''.

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

(1) by striking ''or'' at the end of paragraph (21);

(2) by striking the period at the end of paragraph (22) and inserting ''; or''; and

(3) by inserting after paragraph (22) the following new paragraph:

''(23) except in such cases of emergency or urgent need as the Secretary shall prescribe, where the expenses are for an item or service described in section 1866B(d) that is furnished in a competitive acquisition area (as established by the Secretary under section 1866B(b)) by an entity other than an entity with which the Secretary has entered into an agreement under section 1866B(c) for the furnishing of such an item or service in that area.''.

(d) CONFORMING AMENDMENTS RELATING TO GENERAL PROVISIONS FOR ADMINISTRATION.—

(1) GENERAL ADMINISTRATIVE AUTHORITY.—Section 1866C(a) (as redesignated by subsection (a)) is amended—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''the program under section 1866A (in this section referred to as the 'demonstration program')'' and inserting ''a program or demonstration project under section 1866A or 1866B'';

(ii) in subparagraph (A), by striking ''and entitled to benefits under part A; and'' and inserting a semicolon;

(iii) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

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

''(C) in the case of the demonstration program under section 1866A, is entitled to benefits under part A.'';

(B) in paragraph (3), by striking ''Items and services shall'' and inserting ''Except as

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

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

(D) in paragraph (5)—

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

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

(E) in paragraph (6)—

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

(ii) by striking ''the demonstration program'' and inserting ''the programs and

demonstration projects under sections 1866A and 1866B'';

(F) in paragraph (7), by striking ''individual or entity'' each place it appears and inserting ''entity (or, in the case of the demonstration program under section 1866A, an individual or entity)''; and

(G) in paragraph (8)—

(i) in subparagraph (A), by striking ''the demonstration program'' and inserting ''the programs and demonstration projects under sections 1866A and 1866B''; and

(ii) in subparagraph (B), by striking ''individual or entity'' and inserting ''entity (or, in the case of the demonstration program under section 1866A, an individual or entity)''.

(2) CONTRACTS FOR PROGRAM ADMINISTRATION.—Section 1866C(b) (as so redesignated) is amended—

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

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

(C) in paragraph (7)—

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

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

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

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

"(i) individuals residing in the service area who are entitled to benefits under part A or enrolled in the program under part B;

"(ii) the entities responsible under sections 1816 and 1842 for administering payments for health care items and services furnished; and

"(iii) entities providing health care items and services in the service area.

"(F) BENEFICIARY ENROLLMENT.—Determine eligibility of individuals to enroll under a program or demonstration project under section 1866B and provide enrollment-related services (but only if the Secretary finds that the program administrator has no conflict of interest caused by a financial relationship with any entity furnishing items or services for which payment may be made under any such program, or any other conflict of interest with respect to such function).".

(3) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—Section 1866C(c) (as so redesignated) is amended—

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

(B) in paragraph (2)—

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

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

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

(C) in paragraph (3)—

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

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

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

(A) in the matter preceding paragraph (1), by striking ''the demonstration program'' and inserting ''the programs and demonstration projects under sections 1866A and 1866B'' in the matter preceding subparagraph (A);

(B) in paragraph (1), by striking ''the program'' and inserting ''a program or demonstration project under section 1866A or 1866B'';

(C) in paragraph (2), by striking ''program'' each place it appears and inserting ''program or demonstration project''; and

(D) in paragraph (5)—

(i) in the matter preceding subparagraph (A), by striking ''to the program'' and inserting ''to a program or demonstration project'';

(ii) in subparagraph (A), by striking ''or'' after the semicolon at the end; and

(iii) in subparagraph (B), by inserting ''with respect to the demonstration program under section 1866A,'' before ''as to whether''.

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

ed by striking ''or of the demonstration program'' and inserting '', section 1866A, or section 1866B''.

(6) OTHER CONFORMING AMENDMENTS.—

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

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

''GENERAL PROVISIONS FOR THE ADMINISTRATION OF CERTAIN PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT PROGRAMS''.

(e) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the coverage under the medicare program under title XVIII of the Social Security Act of new and innovative durable medical equipment, prosthetics, orthotics, supplies, and equipment and the coding of such items for purposes of payment under such program. Such study shall include an analysis of the review and approval process for the new and innovative items described in the preceding sentence, the coding process for such items, and beneficiary access to such items if such items are not covered under the medicare program.

(2) REPORT.—Not later than the date that is 2 years after the date of the enactment of this Act, the Comptroller General shall submit a report on the study conducted under paragraph (1) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

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

(a) 2-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395*l*(g)(4)) is amended by striking ''and 2002'' and inserting ''2002, 2003, and 2004''.

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

anced Budget Refinement Act of 1999 (113 Stat. 1501A–352) (relating to utilization patterns for outpatient therapy).

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

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

(2) REPORTS TO CONGRESS.—Not later than January 1, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 313. ACCELERATION OF REDUCTION OF BENEFICIARY COPAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

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

(1) in subclause (V), by striking ''and thereafter'' and inserting ''through 2011''; and

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

''(VI) For procedures performed in 2012 and thereafter, 30 percent.''.

SEC. 314. RENAL DIALYSIS SERVICES.

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

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

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

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

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

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric

facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''The Secretary'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary''.

SEC. 315. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395*l*(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and diagnostic mammography''.

(b) PAYMENT.—Section 1833(a)(2)(E)(i) (42 U.S.C. 1395*l*(a)(2)(E)(i)) is amended by inserting '', and for services furnished on or after January 1, 2004, diagnostic mammography'' after ''screening mammography''.

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

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

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ''No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, or 2003, and who demonstrates to the Secretary before December 31, 2003, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''.

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

amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

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

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 317. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

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

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by inserting ''and'' at the end; and

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

''(W) cholesterol and other blood lipid screening tests (as defined in subsection (ww));''.

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

''Cholesterol and Other Blood Lipid Screening Test

''(ww)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

''(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening 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. 1395y(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting '', and''; and

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

''(J) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 318. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

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

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

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

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

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

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

"(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

"(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent

"(B) APPLICATION OF INCREASED PAYMENTS AFTER 2005.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.".

SEC. 319. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

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

"(11) ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES.—

"(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

"(i) is medically 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) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if such service is requested—

''(i) by a physician or a hospital in accordance with the physician's or hospital's responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

''(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

''(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that the patient's condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

''(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

''(C) AIR AMBULANCE SERVICES DEFINED.—For purposes of this paragraph, the term 'air ambulance service' means fixed wing and rotary wing air ambulance services.''.

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting ", subject to section 1834(l)(11)," after "but".

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

SEC. 320. ADJUSTMENTS TO LOCAL FEE SCHEDULES FOR CLINICAL LABORATORY TESTS FOR IMPROVEMENT IN CERVICAL CANCER DETECTION.

Section 1833(h)(2) (42 U.S.C. 1395*l*(h)(2)) is amended by adding at the end the following new subparagraph:

"(C) Notwithstanding any other provision of law, in the case of a diagnostic test for the detection of cervical cancer utilizing automated thin layer preparation techniques for specimens collected in fluid medium, and for which a national limitation amount has been set pursuant to the parenthetical in paragraph (4)(B)(viii), furnished on or after July 1, 2003, and before June 30, 2005, the Secretary shall permit carriers and medicare administrative contractors, as the case may be, to raise their local fee schedule amount for purposes of determining payment for such tests under this section, up to, but not to exceed the national limitation amount previously established for

that test. Any such adjustment shall not affect such national limitation amount.

SEC. 321. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR ALL MEDICARE BENEFICIARIES.

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

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

SEC. 322. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

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

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

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

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

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

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

and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary; and

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

(d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

(1) PAYMENT.—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

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

which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) 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.

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

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

(g) 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, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ACTIVITY OF DAILY LIVING.—The term ''activity of daily living'' means eating, toiling, transferring, bathing, dressing, and continence.

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

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means any individual who—

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

(B) has at least 4 complex medical conditions; and

(C) has—

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

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

(4) INSTRUMENTAL ACTIVITY OF DAILY LIVING.—The term ''instrumental activity of daily living'' means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

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

(6) PRINCIPAL CARE PHYSICIAN.—The term ''principal care physician'' means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 323. STUDY AND REPORT ON NEW TECHNOLOGY PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study of the methods by which new medical devices, new drugs, biologicals, and other new technologies are recognized for payment under the hospital outpatient department prospective payment system established under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) and on possible changes to those methods.

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

(A) The experience to date of the transitional pass-through payment mechanism for additional costs of innovative medical devices, drugs, and biologicals (provided under section 1833(t)(6) of the Social Security Act (42 U.S.C. 1395l(t)(6))) and of the provision for new technology ambulatory payment classifications provided through regulations. In particular, the study should examine the effect of such payment mechanism on access of medicare beneficiaries to orphan and single source drugs.

(B) The impact of transitional pass-through payments of payment rates for procedures not using new medical devices, drugs, biologicals, and other new technologies.

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

(D) The extent to which additional payments are necessary to facilitate access to improved treatments by medicare beneficiaries.

(3) OPTIONS CONSIDERED.—In conducting the study under paragraph (1), the Secretary shall consider the following options:

(A) Statutory, regulatory, or administrative changes that may be desirable to assure appropriate recognition of the costs to hospitals of delivering such services. In considering such changes, the Secretary shall take into account the effect of such changes on the payment for new technology services, on payment for services that do not employ such technology services, and on administrative resources of both the Department of Health and Human Services

and hospitals that may be necessary to implement various changes in a reliable fashion.

(B) Appropriate methods for assuring that decisions concerning the eligibility of new technologies for additional payment are made and implemented expeditiously (including possible methods for shortening the interval between approval of a technology by the Food and Drug Administration and commencement of additional payment in instances when a new technology qualifies for such payment) and for assuring that additional payments are directed to those services that add value for medicare beneficiaries by comparison to other technologies for which they may substitute.

(C) Methods of setting additional payment rates that may reasonably reflect hospital costs in furnishing new technology services, including alternatives to pricing new drugs based on average wholesale price.

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

(b) REPORT.—Not later than July 1, 2003, the Secretary shall submit a report on the study conducted under paragraph (1) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate together with such recommendations for legislative and administrative action as the Secretary determines appropriate.

TITLE IV—PROVISION RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 401. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM.

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

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

"(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under

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

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

''(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

''(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

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

among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''.

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

SEC. 402. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

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

(A) in paragraph (3)(B)(i)—

(i) by striking ''each fiscal year (beginning with fiscal year 2002)'' and inserting ''fiscal year 2002 and for each subsequent year (beginning with 2003)''; and

(ii) by inserting ''or year'' after ''the fiscal year'';

(B) in paragraph (3)(B)(ii)—

(i) in subclause (II), by striking ''fiscal year'' and inserting ''year'' and by re-

designating such subclause as subclause (III); and

(ii) in subclause (I), by striking ''each of fiscal years 2002 and 2003'' and inserting the following: ''fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

''(II) 2003'';

(C) in paragraph (3)(B)(iii), by inserting ''or year'' after ''fiscal year'' each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting ''or year'' after ''fiscal year'' each place it appears; and

(ii) by inserting ''or years'' after ''fiscal years''; and

(E) in paragraph (5), by inserting ''or year'' after ''fiscal year''.

(2) TRANSITION RULE.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2002, shall be such amount (or amounts) for the previous calendar quarter.

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

(1) in subclause (II), by striking ''the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points'' and inserting ''2.0 percentage points'';

(2) by striking ''or'' at the end of subclause (II);

(3) by redesignating subclause (III) as subclause (V); and

(4) by inserting after subclause (II) the following new subclause:

''(III) 2004, 1.1 percentage points;

''(IV) 2005, 2.7 percentage points; or''.

(c) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C. 1395fff(b)(5)) is amended by striking ''5 percent'' and inserting ''3 percent''.

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

Subtitle B—Other Provisions

SEC. 411. INFORMATION TECHNOLOGY DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project to demonstrate the use of third-party software contractors in claims processing and quality improvement activities under parts A and B of title XVIII of the Social Security Act. The Secretary shall enter into up to 4 contracts with third-party software contractors to carry out the purposes of the project.

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

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

(d) REPORT TO CONGRESS.—Not later than 6 months after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include information on the cost-effectiveness of using third-party software contractors for claims processing and quality improvement activities under the medicare program and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 412. 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 at the end the following new paragraph:

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.''.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting ''the efficient provision of'' after ''expenditures for''.

(c) ADDITIONAL REPORT.—

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

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

(2) REPORTS IN ADDITION TO ANNUAL REPORT.—The report required under paragraph (1) shall be in addition to the report required to be submitted by June 15, 2003, under section 1805(b)(1)(D) of the Social Security Act (42 U.S.C. 1395b–6(b)(1)(D)).

(d) REDUCTION IN NUMBER OF MEMBERS.—

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

(2) APPLICATION.—In order to carry out the amendment made by paragraph (1), in each of the first 2 calendar years in which the terms of 2 or more of the members of the Medicare Payment Advisory Commission would expire (as provided in section 1805(c)(3)(A) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)(A)), the Comptroller General of the United States shall not appoint an individual to fill 1 of such vacancies.

SEC. 413. RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.

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

''(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

''(A) designate at least 1 different individual to serve as medical director for every 2 States for which such contract performs such function;

''(B) utilize such medical director in the performance of such function; and

''(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.''.

(b) CONFORMING AMENDMENT.—Section 1874A(a)(4) of the Social Security Act, as added by section 621, is amended by inserting ''including the function

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

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

TITLE V—MEDICARE+CHOICE AND RELATED PROVISIONS

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

Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following:

''(iv) For 2002, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2001.

''(v) For 2003, 104 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2002.

''(vi) For 2004, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

''(vii) For 2005 and each succeeding year, 102 percent of the annual

Medicare+Choice capitation rate under this paragraph for the area for the previous year (determined as if the amendment made by section 501 of the Beneficiary Access to Care and Medicare Equity Act of 2002 had not been enacted).''.

SEC. 502. CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.

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

''(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the values submitted under paragraphs (2)(A)(iii) and (4)(A)(iii) if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of Medicare+Choice eligible individuals.''.

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 503. EXTENSION OF REASONABLE COST CONTRACTS.

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

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

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

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

''(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

''(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

''(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

''(D) Section 1854(g) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

''(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

''(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits under the plan subject to the approval of the Secretary).

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

''(H) Section 1854(a)(5)(C) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).''.

SEC. 504. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 4018(b)(1) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ''the date that is 30 months after the date that the Secretary submits to Congress the report described in

section 4014(c) of the Balanced Budget Act of 1997'' and inserting ''December 31, 2006''.

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

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

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

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

''(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that

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

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

''(i) is institutionalized (as defined by the Secretary);

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

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

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

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the en-

rollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.''.

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

(e) EFFECTIVE DATES.—

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

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of the enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 506. EXTENSION OF NEW ENTRY BONUS.

Section 1853(i) (42 U.S.C. 1395w–23(i)) is amended—

(1) in paragraph (1), by inserting ", or filed notice with the Secretary as of October 3, 2002, that they will not be offering such a plan as of January 1, 2002, or as of January 1, 2003" after "January 1, 2001" in the matter preceding subparagraph (A); and

(2) in paragraph (2), by inserting "(or 4-year period in the case of a Medicare+Choice plan that is not a Medicare+Choice private fee-for-service plan or a plan operating under demonstration project authority)" after "2-year period".

SEC. 507. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking "part C or" and inserting "part C, with a PACE provider under section 1894 or 1934, or";

(B) by striking "(i)";

(C) by striking "and (ii)"; and

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

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

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

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

applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a) is amended—

(A) in paragraph (64), by striking ''and'' at the end;

(B) in paragraph (65), by striking the period at the end and inserting ''; and''; and

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

''(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).''.

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

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

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

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for serv-

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

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

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

SEC. 508. REFERENCE TO IMPLEMENTATION OF CERTAIN MEDICARE+CHOICE PROGRAM PROVISIONS IN 2003.

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

TITLE VI—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 601. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

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

''(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

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

''(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

''(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

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

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) STATUS OF PENDING INTERIM FINAL REGULATIONS.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of the enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 602. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall 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.''.

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

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

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

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

''(ii) The Secretary may provide for 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) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

SEC. 603. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 602(a)(1), is amended by adding at the end the following new subsection:

''(e)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 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 beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of all communications and correspondence.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Appeals Process Reform

SEC. 611. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2003, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2004 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

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

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) 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 issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF JUDGES.—The steps that should be taken to ensure the independence of judges performing the administrative law judge functions that are transferred under the plan from the Centers for Medicare & Medicaid Services and its contractors.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of judges performing the administrative law judge functions that are transferred under the plan throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire judges (and support staff) to perform the administrative law judge functions that are transferred under the plan.

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for judges performing the administrative law judge functions that are transferred under the plan

with respect to timelines for decisions in cases under title XVIII.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to judges performing the administrative law judge functions that are transferred under the plan with respect to laws and regulations under title XVIII.

(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 (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress a report on such evaluation.

SEC. 612. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

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

(2) 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 or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines 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. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately 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 regulations 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 for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such 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.

''(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

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

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United

States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining re-

imbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, a 'review entity' is a panel of no more than 3 members from the Departmental Appeals Board, selected for the purpose of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

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

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(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) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).".

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

SEC. 613. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

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

(A) the remedy of termination of participation has been imposed;

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

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) 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(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2003 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 614. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as

amended by section 612(a)(2), is amended by adding at the end the following new paragraph:

"(3) TIMELY COMPLETION OF THE RECORD.—

"(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

"(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

"(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90

days after the date on which the record is complete.

''(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

''(i) written or testimonial evidence, or both, submitted by the person filing the request,

''(ii) written or oral argument, or both,

''(iii) the decision of, and the record for, the prior level of appeal, and

''(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.''.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

"(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

"(A) the reasons for the determination, including, as appropriate—

"(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

"(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

"(B) the procedures for obtaining additional information concerning the determination or redetermination; and

"(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

"(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

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

"(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

"(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treat-

ment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.''.

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

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

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

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is

amended by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

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

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(ii) EXCEPTION FOR 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).

"(iii) 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."; and

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

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

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

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

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

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—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);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4).

''(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));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) a nonaffiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized rep-

resentative) and neither party objects; and

''(IV) the affiliated 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 at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, 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) involved in the case are provided.

''(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 under any regulations to have a substantial interest in the case involved.''.

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''12'' and inserting ''4''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

''(d) EFFECTIVE DATE.—

''(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2003.

''(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2002:

''(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

''(B) Subsection (c)(3)(C)(iii) of such section.

''(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

''(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.''.

(2) CONFORMING AMENDMENT.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

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

SEC. 615. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

''(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

''(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied

are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.''.

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

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 602 and 603, is amended by adding at the end the following new subsection:

''(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.''.

SEC. 616. 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:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal

any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 617. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

''(5) AGGRIEVED PARTY DEFINED.—In this section, the term 'aggrieved party' means—

''(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

''(B) with respect to a local coverage determination—

''(i) an individual who is entitled to benefits under part A, or enrolled under

part B, or both, who is adversely affected by such a determination; or

''(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.''.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting '', including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service'' before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 614(d)(2)(B), is amended by adding at the end the following new subsection:

''(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

''(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

''(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

''(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

''(B) each reversal described in subparagraph (A) involves substantially similar material facts;

''(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

''(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

''(4) APPROVAL OR REJECTION OF REQUEST.—

''(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or

the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

''(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.''.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the feasibility

and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2002;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of the enactment of this Act.

Subtitle C—Contracting Reform

SEC. 621. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER 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 (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

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

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

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

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment

functions, provider services functions, and beneficiary services functions as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the 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, physicians, practitioners, facilities, suppliers, and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable

them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (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 a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

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

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acqui-

sition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

''(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 other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the 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 6 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Fed-

eral Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

''(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this 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 efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, 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 to a function described

in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards, provider and beneficiary satisfaction levels.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) 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 his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information 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 or employees certifying payments or disbursing funds pursuant to the contract,

or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a 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.

''(4) 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 (commonly known as the ''False Claims Act'').

''(5) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, 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 specified in the contract with the contractor, indemnify the contractor (and such persons).

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the

Secretary to be criminal in nature, fraudulent, or grossly negligent.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(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 the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

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

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

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

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

''(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) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) 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 ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' 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);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(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 (6)(D)(iv), 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);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under sub-

section (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; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) 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, 2004, 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.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the let-

ting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2010.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO AGREEMENTS NEW AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

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

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

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller 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.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2007, 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 as of such date.

(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.

Subtitle D—Education and Outreach Improvements

SEC. 631. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.''.

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

(3) REPORT.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider edu-

cation under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 621(a)(1), is amended by adding at the end the following new subsection:

''(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

''(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2003, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

''(2) GAO REVIEW OF METHODOLOGY.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

''(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare con-

tractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.''.

(2) REPORT.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)'';

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject

to subparagraph (C), the amount appropriated''; and

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

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2003) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.''.

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

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

''(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.".

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

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

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

"(c) 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, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

"(d) CONSTRUCTION.—Nothing in this section or section 1893(g) 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.

''(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

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

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

SEC. 632. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 621(a)(1) and as amended by section 631(b)(1), is amended by adding at the end the following new subsection:

''(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

''(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and

suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

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

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2003.

SEC. 633. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 602(a), is amended by adding at the end the following new paragraph:

''(2) If—

''(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

''(i) by the Secretary; or

''(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

''(B) the Secretary determines that—

''(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services,

physician, practitioner, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.''.

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

SEC. 634. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

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

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

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

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—By not later than 1 year after the date of the enactment of the Beneficiary Access to Care and Medicare Equity Act of 2002, the Secretary shall appoint a Medicare Provider Ombudsman. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

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

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1807. (a) IN GENERAL.—By not later than 1 year after the date of the enactment of the Beneficiary Access to Care and Medicare Equity Act of 2002, the Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and advocacy.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

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

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.''.

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal

Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2002 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''By not later than 1 year after the date of the enactment of the Beneficiary Access to Care and Medicare Equity Act of 2002, the Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

SEC. 635. 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 medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

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

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

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

(d) 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 beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

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

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 641. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 621(a)(1) and as amended by sections 631(b)(1) and 632(a), is amended by adding at the end the following new subsection:

''(g) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review

only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as lim-

iting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

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

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment re-

views 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. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of the enactment of this Act.

SEC. 642. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 621(a)(1) and as amended by sections 631(b)(1), 632(a), and 641(a), is amended by adding at the end the following new subsection:

''(h) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of

the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

''(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

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

In developing standards with regard to financial hardship with respect to a provider of services,

physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, 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, physician, practitioner, 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) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be con-

strued as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), 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.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for

the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

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

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

''(3) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier

with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

''(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

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

''(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

"(6) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner 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

''(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physi-

cian, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services, physician, practitioner, 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, physician, practitioner, or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

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

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment

based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.''.

(b) EFFECTIVE DATES AND DEADLINES.—

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

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

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

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of the enactment of this Act.

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

(4) Section 1874A(h)(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.

SEC. 643. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 631(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, 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, physician, practitioner, facility, 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 resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 644. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

TITLE VII—MEDICAID AND SCHIP

SEC. 701. MEDICAID DSH ALLOTMENTS.

(a) CONTINUATION OF BIPA RULE FOR DETERMINATION OF ALLOTMENTS FOR FISCAL YEARS 2003 THROUGH 2005.—

(1) IN GENERAL.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)) is amended—

(A) in the paragraph heading, by striking ''AND 2002'' and inserting ''THROUGH 2005'';

(B) in subparagraph (A)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period and inserting a semicolon; and

(iii) by adding at the end the following:

''(iii) fiscal year 2003, shall be the DSH allotment determined under clause (ii) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for fiscal year 2002;

''(iv) fiscal year 2004, shall be the DSH allotment determined under clause (iii) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for fiscal year 2003; and

''(v) fiscal year 2005, shall be the DSH allotment determined under clause

(iv) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for fiscal year 2004.''; and

(C) in subparagraph (C)—

(i) in the subparagraph heading, by striking ''2002'' and inserting ''2005''; and

(ii) by striking ''2003'' and inserting ''2006''.

(2) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)), as amended by paragraph (1), is amended—

(A) in subparagraph (A), by inserting ''and except as provided in subparagraph (C)'' after ''paragraph (2)'';

(B) by redesignating subparagraph (C) as subparagraph (D);

(C) in subparagraph (D) (as so redesignated), by inserting ''or (C)'' after ''(A)''; and

(D) by inserting after subparagraph (B) the following:

''(C) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Notwithstanding subparagraph

(A), the DSH allotment for the District of Columbia for—

"(i) fiscal year 2003, shall be determined by substituting "49" for "32" in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, and 2002;

"(ii) fiscal year 2004, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for fiscal year 2003; and

"(iii) fiscal year 2005, shall be the DSH allotment determined under clause (ii) increased, subject to subparagraph (B) and paragraph (5), by the percentage

change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for fiscal year 2004.''.

(3) CONFORMING AMENDMENTS.—Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

(A) in the paragraph heading, by striking ''2003'' and inserting ''2006''; and

(B) by striking subparagraph (A) and inserting the following:

''(A) IN GENERAL.—The DSH allotment for any State—

''(i) for fiscal year 2006, is equal to the DSH allotment determined for the State for fiscal year 2002 under the table set forth in paragraph (2), increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average), for each of fiscal years 2002 through 2005; and

''(ii) for fiscal year 2007 and each succeeding fiscal year, is equal to the DSH allotment determined for the State for the preceding fiscal year under this paragraph, increased, subject to subparagraph (B) and

paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average), for the previous fiscal year.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of section 701 of BIPA (114 Stat. 2763A–569).

(b) CONTINGENT ALLOTMENT.—

(1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following:

''(6) CONTINGENT ALLOTMENT ADJUSTMENT FOR CERTAIN STATES.—In the case of a State that, as of the date of enactment of this subsection, has a DSH allotment equal to 0, and that has a State-wide waiver approved under section 1115 with respect to the requirements of this title (as in effect on such date of enactment) that is revoked or terminated after such date of enactment, the Secretary shall—

''(A) permit the State for which the 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 on the basis of their 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 that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect as if enacted on October 1, 2002.

SEC. 702. TEMPORARY INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE.

(a) TEMPORARY INCREASE.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''In the case of'' and inserting the following:

''(A) IN GENERAL.—In the case of''; and

(2) by adding at the end the following:

''(B) TEMPORARY INCREASE IN FLOOR.—During the period that begins on October 1, 2002, and ends on September 30, 2005, subparagraph (A) shall be applied—

''(i) by substituting 'fiscal year 2003' for 'fiscal year 2001';

''(ii) by substituting 'Centers for Medicare & Medicaid Services' for 'Health Care Financing Administration';

''(iii) by substituting 'August 31, 2002' for 'August 31, 2000';

''(iv) by substituting '3 percent' for '1 percent' each place it appears;

''(v) by substituting 'fiscal year 2001' for 'fiscal year 1999'; and

''(vi) by substituting for the second sentence the following: ''With respect to each of fiscal years 2004 and 2005, such increased allotment is subject to an increase for inflation as provided in paragraph (4).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 701 of BIPA (114 Stat. 2763A–569).

SEC. 703. EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR CERTAIN ADDITIONAL LOW-INCOME MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

"(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2007) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;".

(b) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(c) (42 U.S.C. 1396u–3(c)) is amended—

(1) in paragraph (1)(E), by striking ''fiscal year 2002'' and inserting ''each of fiscal years 2002 through 2007''; and

(2) in paragraph (2)(A), by striking ''the sum of'' and all that follows through ''1902(a)(10)(E)(iv)(II) in the State; to'' and inserting ''twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if enacted on October 1, 2002.

SEC. 704. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if enacted on October 1, 2002.

SEC. 705. SCHIP ALLOTMENTS.

(a) CHANGES TO RULES FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF FISCAL YEAR 2000 AND SUBSEQUENT FISCAL YEAR ALLOTMENTS.—Section 2104(g) (42 U.S.C. 1397dd(g)) is amended—

(1) in the subsection heading—

(A) by striking ''AND'' after ''1998'' and inserting a comma; and

(B) by inserting '', 2000, AND SUBSEQUENT FISCAL YEAR'' after ''1999'';

(2) in paragraph (1)—

(A) in subparagraph (A)—

(i) in the matter preceding clause (i)—

(I) by inserting ''or for fiscal year 2000 by the end of fiscal year 2002, or allotments for fiscal year 2001 and subsequent fiscal years by the end of the last fiscal year for which such allotments are available under subsection (e), subject to paragraph (2)(C),'' after ''2001,''; and

(II) by striking ''1998 or 1999'' and inserting ''1998, 1999, 2000, or subsequent fiscal year'';

(ii) in clause (i)—

(I) in subclause (I), by striking ''or'' at the end;

(II) in subclause (II), by striking the period and inserting a semicolon; and

(III) by adding at the end the following:

''(III) subject to paragraph (2)(C), the fiscal year 2000 allotment, the amount by which the State's expenditures under this title in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b);

''(IV) subject to paragraph (2)(C), the fiscal year 2001 allotment, the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); or

''(V) subject to paragraph (2)(C), the allotment for any subsequent fiscal year, the amount by which the State's expenditures under this title in the period such allotment is available under subsection (e) exceeds the State's allotment for that fiscal year under subsection (b).''; and

(iii) in clause (ii), by striking ''1998 or 1999 allotment'' and inserting ''1998, 1999, 2000, or subsequent fiscal year allotment''; and

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking ''with respect to fiscal year 1998 or 1999'';

(ii) in clause (ii)—

(I) by inserting ''with respect to fiscal year 1998 or 1999,'' after ''subsection (e),''; and

(II) by striking ''2002; and'' and inserting ''2003;'';

(iii) by redesignating clause (iii) as clause (iv); and

(iv) by inserting after clause (ii), the following:

''(iii) notwithstanding subsection (e), with respect to fiscal year 2000 or any subsequent fiscal year, shall remain available for expenditure by the State through the end of the fiscal year in which the State is allotted a redistribution under this paragraph; and'';

(3) in paragraph (2)—

(A) in the paragraph heading, by striking ''1998 AND 1999'' and inserting ''1998, 1999, 2000, AND SUBSEQUENT FISCAL YEAR'';

(B) in subparagraph (A)—

(i) in clause (i), by striking ''2002'' and inserting ''2003'';

(ii) in clause (ii), by striking ''2002'' and inserting ''2003''; and

(iii) by adding at the end the following:

''(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, the amount

specified in subparagraph (B) for fiscal year 2000 for such State shall remain available for expenditure by the State through the end of fiscal year 2003.

''(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, the amount specified in subparagraph (B) for fiscal year 2001 for such State shall remain available for expenditure by the State through the end of fiscal year 2004.

''(v) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—Of the amounts allotted to a State pursuant to this section for any fiscal year after 2001, that were not expended by the State by the end of the last fiscal year such amounts are available under subsection (e), the amount specified in subparagraph (B) for that fiscal year for such State shall remain available for expenditure by the State through the end of the fiscal year following the last fiscal

year such amounts are available under subsection (e).'';

(C) in subparagraph (B), by striking ''The'' and inserting ''Subject to subparagraph (C), the'';

(D) by redesignating subparagraph (C) as subparagraph (D); and

(E) by inserting after subparagraph (B), the following:

''(C) FLOOR FOR ALLOTMENT FOR FISCAL YEAR 2000 OR ANY SUBSEQUENT FISCAL YEAR.—

''(i) IN GENERAL.—With respect to the allotments for each of fiscal years 2000 through 2003, if the total amounts that would otherwise be redistributed under paragraph (1) exceed 60 percent of the total amount available for redistribution under subsection (f) for the fiscal year, the amount remaining available for expenditure by the State under subparagraph (A) for such fiscal years shall be—

''(I) the amount equal to—

''(aa) the applicable percent (as determined under clause (ii))

of the total amount available for redistribution under subsection (f) from the allotments for the applicable fiscal year; multiplied by

''(II) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount available for redistribution under subsection (f) from the allotments for the fiscal year.

''(ii) APPLICABLE PERCENT.—For purposes of clause (i)(I)(aa), the applicable percent is—

''(I) 40 percent, with respect to the allotments for each of fiscal years 2000 and 2001;

''(II) 30 percent, with respect to the allotment for fiscal year 2002; and

''(III) 20 percent, with respect to the allotment for fiscal year 2003.''; and

(4) in paragraph (3), by adding at the end the following: ''For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the

allotment for any fiscal year after 1999, the Secretary shall use the amount reported by the States not later than November 30 of the applicable calendar year on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.''.

(b) ESTABLISHMENT OF CASELOAD STABILIZATION POOL AND ADDITIONAL REDISTRIBUTION OF ALLOTMENTS.—Section 2104 (42 U.S.C. 1397dd) is amended by adding at the end the following:

''(h) REDISTRIBUTION OF CASELOAD STABILIZATION POOL AMOUNTS.—

''(1) ADDITIONAL REDISTRIBUTION TO STABILIZE CASELOADS.—

''(A) IN GENERAL.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall redistribute to an eligible State (as defined in subparagraph (B)) the amount available for redistribution to the State (as determined under subparagraph (C)) from the caseload stabilization pool established under paragraph (3).

''(B) DEFINITION OF ELIGIBLE STATE.—For purposes of subparagraph (A), an eligible State is a State whose total expenditures under this title through the end of the previous fiscal

year exceed the total allotments made available to the State under subsection (b) or (c) (not including amounts made available under subsection (f)) through the previous fiscal year.

''(C) AMOUNT OF ADDITIONAL REDISTRIBUTION.—For purposes of subparagraph (A), the amount available for redistribution to a State under subparagraph (A) is equal to—

''(i) the ratio of the State's allotment for the previous fiscal year under subsection (b) or (c) to the total allotments made available under such subsections to eligible States as defined under subparagraph (A) for the previous fiscal year; multiplied by

''(ii) the total amounts available in the caseload stabilization pool established under paragraph (3).

''(2) PERIOD OF AVAILABILITY.—Amounts redistributed under this subsection shall remain available for expenditure by the State through the end of the fiscal year in which the State receives any such amounts.

''(3) CASELOAD STABILIZATION POOL.—For purposes of making a redistribution under para-

graph (1), the Secretary shall establish a caseload stabilization pool that includes the following amounts:

"(A) Any amount made available to a State under subsection (g) but not expended within the periods required under paragraph (1)(B)(ii), (1)(B)(iii), or (2)(A) of that subsection.

"(B) Any amount made available to a State under this subsection but not expended within the period required under paragraph (2).".

(c) AUTHORITY FOR QUALIFYING STATES TO USE PORTION OF SCHIP FUNDS FOR MEDICAID EXPENDITURES.—Section 2105 (42 U.S.C. 1397ee) is amended by adding at the end the following:

"(g) AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.—

"(1) STATE OPTION.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, with respect to fiscal year 2003 and each fiscal year thereafter, a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of the amount allotted to the State under sub-

section (b) or (c) of section 2104 for the fiscal year (instead of for expenditures under this title) for payments for such fiscal year under title XIX in accordance with subparagraph (B).

''(B) PAYMENTS TO STATES.—

''(i) IN GENERAL.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the total amount of funds described with respect to the State in subparagraph (A), the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under title XIX for expenditures of the State for the fiscal year described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)) of such expenditures.

''(ii) EXPENDITURES DESCRIBED.—For purposes of clause (i), the expenditures described in this clause are expenditures for such fiscal years for providing medical assistance under title XIX to indi-

viduals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

''(2) QUALIFYING STATE.—In this subsection, the term 'qualifying State' means a State that—

''(A) as of March 31, 1997, has an income eligibility standard with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1902(a)(10)(A) that is at least 185 percent of the poverty line; and

''(B) satisfies the requirements described in paragraph (3).

''(3) REQUIREMENTS.—The requirements described in this paragraph are the following:

''(A) SCHIP INCOME ELIGIBILITY.—The State has a State child health plan that (whether implemented under title XIX or this title)—

''(i) as of January 1, 2001, has an income eligibility standard that is at least 200 percent of the poverty line;

''(ii) subject to subparagraph (B), does not limit the acceptance of applications for children; and

"(iii) provides benefits to all children in the State who apply for and meet eligibility standards on a statewide basis.

"(B) NO WAITING LIST IMPOSED.—With respect to children whose family income is at or below 200 percent of the poverty line, the State does not impose any numerical limitation, waiting list, or similar limitation on the eligibility of such children for child health assistance under such State plan.

"(C) ADDITIONAL REQUIREMENTS.—The State has implemented at least 4 of the following policies and procedures (relating to coverage of children under title XIX and this title):

"(i) UNIFORM, SIMPLIFIED APPLICATION FORM.—With respect to children who are eligible for medical assistance under section 1902(a)(10)(A), the State uses the same uniform, simplified application form (including, if applicable, permitting application other than in person) for purposes of establishing eligibility for benefits under title XIX and this title.

"(ii) ELIMINATION OF ASSET TEST.—The State does not apply any asset test for

eligibility under section 1902(l) or this title with respect to children.

''(iii) ADOPTION OF 12-MONTH CONTINUOUS ENROLLMENT.—The State provides that eligibility shall not be regularly redetermined more often than once every year under this title or for children described in section 1902(a)(10)(A).

''(iv) SAME VERIFICATION AND REDETERMINATION POLICIES; AUTOMATIC REASSESSMENT OF ELIGIBILITY.—With respect to children who are eligible for medical assistance under section 1902(a)(10)(A), the State provides for initial eligibility determinations and redeterminations of eligibility using the same verification policies (including with respect to face-to-face interviews), forms, and frequency as the State uses for such purposes under this title, and, as part of such redeterminations, provides for the automatic reassessment of the eligibility of such children for assistance under title XIX and this title.

''(v) OUTSTATIONING ENROLLMENT STAFF.—The State provides for the receipt

and initial processing of applications for benefits under this title and for children under title XIX at facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(l)(2)(B) consistent with section 1902(a)(55).''.

(d) GAO STUDY AND REPORT REGARDING EXPENDITURE OF SCHIP ALLOTMENTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study regarding the expenditure of State allotments under the State children's health insurance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) to determine, with respect to States that have not expended all of their allotment under that program for fiscal year 1998, 1999, or 2000, the reasons why the States have not expended such allotments and to identify any impediments in title XXI of such Act or under regulations implemented to carry out such title to the full expenditure of such allotments. As part of the study, the Comptroller General—

(A) shall evaluate—

(i) the methods used to redistribute unexpended allotments under title XXI of such Act as of the date of enactment of this Act;

(ii) the caseload stabilization pool established under section 2104(h) of the Social Security Act (as added by subsection (b)); and

(iii) the adequacy of the funding and resources for the State children's health insurance program under title XXI of such Act; and

(B) shall identify the potential benefits and problems with respect to the matters evaluated under subparagraph (A).

(2) REPORTS.—

(A) INTERIM REPORT.—Not later than October 1, 2004, the Comptroller General of the United States shall submit an interim report to Congress on the study conducted under paragraph (1).

(B) FINAL REPORT.—Not later than October 1, 2005, the Comptroller General of the United States shall submit a final report to Congress on the study conducted under para-

graph (1), along with such recommendations for legislative action as the Comptroller General determines appropriate.

(e) EFFECTIVE DATE.—This section and the amendments made by this section shall take effect as if enacted on October 1, 2002.

SEC. 706. IMPROVEMENT OF THE PROCESS FOR THE DEVELOPMENT AND IMPLEMENTATION OF MEDICAID AND SCHIP WAIVERS.

(a) IN GENERAL.—Section 1115 (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

''(d) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of title XIX or XXI in a State that would result in a nontrivial impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a 'medicaid waiver' and a 'SCHIP waiver', respectively,) the following shall apply:

''(1) The Secretary may not approve a proposal for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver unless the State requesting approval certifies that the following process was used to develop the proposal:

''(A) Prior to publication of the notice required under subparagraph (B), the State—

''(i) provided notice (which may have been accomplished by electronic mail) of the State's intent to develop the proposal to the medical care advisory committee established for the State for purposes of complying with section 1902(a)(4) and any individual or organization that requests such notice; and

''(ii) convened at least 1 meeting of such medical care advisory committee at which the proposal and any modifications of the proposal were considered and discussed.

''(B) At least 60 days prior to the date that the State submits the proposal to the Secretary, the State published for written comment (in accordance with the State's procedure for issuing regulations) a notice of the proposal that contains at least the following:

''(i) Information regarding how the public may submit comments to the State on the proposal.

''(ii) A statement of the State's projections regarding the likely effect and impact of the proposal on any individuals who are eligible for, or receiving, medical assistance, child health assistance, or other health benefits coverage under a State program under title XIX or XXI and the State's assumptions on which such projections are based.

''(iii) A statement of the State's projections regarding the likely effect and impact of the proposal on any providers or suppliers of items or services for which payment may be made under title XIX or XXI and the State's assumptions on which such projections are based.

''(C) Concurrent with the publication of the notice required under subparagraph (B), the State—

''(i) posted the proposal (and any modifications of the proposal) on the State's Internet website; and

''(ii) provided the notice (which may have been accomplished by electronic mail) to the medical care advisory committee re-

ferred to in subparagraph (A)(i) and to any individual or organization that requested such notice.

''(D) Not later than 30 days after publication of the notice required under subparagraph (B), the State convened at least 1 open meeting of the medical care advisory committee referred to in subparagraph (A)(i), at which the proposal and any modifications of the proposal were the primary items considered and discussed.

''(E) After publication of the notice required under subparagraph (B), the State—

''(i) held at least 2 public hearings on the proposal and any modifications of the proposal; and

''(ii) held the last such public hearing at least 15 days before the State submitted the proposal to the Secretary.

''(F) The State has a record of all public comments submitted in response to the notice required under subparagraph (B) or at any hearings or meetings required under this paragraph regarding the proposal.

''(2) A State shall include with any proposal submitted to the Secretary for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver the following:

''(A) A detailed description of the public notice and input process used to develop the proposal in accordance with the requirements of paragraph (1).

''(B) Copies of all notices required under paragraph (1).

''(C) The dates of all meetings and hearings required under paragraph (1).

''(D) A summary of the public comments received in response to the notices required under paragraph (1) or at any hearings or meetings required under that paragraph regarding the proposal and the State's response to the comments.

''(E) A certification that the State complied with any applicable notification requirements with respect to Indian tribes during the development of the proposal in accordance with paragraph (1).

''(3) The Secretary shall return to a State without action any proposal for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver that fails to satisfy the requirements of paragraphs (1) and (2).

''(4) With respect to all proposals for medicaid waivers, SCHIP waivers, or amendments to a previously approved medicaid waiver or SCHIP waiver received by the Secretary the following shall apply:

''(A) Each month the Secretary shall publish a notice in the Federal Register identifying all of the proposals for such waivers or amendments that were received by the Secretary during the preceding month.

''(B) The notice required under subparagraph (A) shall provide information regarding the method by which comments on the proposals will be received from the public.

''(C) Not later than 7 days after receipt of a proposal for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver, the Secretary shall—

''(i) provide notice (which may be accomplished by electronic mail) to any individual or organization that has requested such notification;

''(ii) publish on the Internet website of the Centers for Medicare & Medicaid Services a copy of the proposal, including any appendices or modifications of the proposal; and

''(iii) ensure that the information posted on the website is updated to accurately reflect the proposal.

''(D) The Secretary shall provide for a period of not less than 30 days from the later of the date of publication of the notice required under subparagraph (A) that first identifies receipt of the proposal or the date on which an Internet website containing the information required under subparagraph (C)(ii) with respect to the proposal is first published, in which written comments on the proposal may be submitted from all interested parties.

''(E) After the completion of the public comment period required under subparagraph (D), if the Secretary intends to approve the

proposal, as originally submitted or revised, the Secretary shall—

"(i) publish and post on the Internet website for the Centers for Medicare & Medicaid Services the proposed terms and conditions for such approval and updated versions of the statements required to be published by the State under clauses (ii) and (iii) of paragraph (1)(B);

"(ii) provide at least a 15-day period for the submission of written comments on such proposed terms and conditions and such statements; and

"(iii) retain, and make available upon request, all comments received concerning the proposal, the terms and conditions for approval of the proposal, or such statements.

"(F) In no event may the Secretary approve or deny a proposal for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver until the Secretary—

"(i) reviews and considers all comments submitted in response to the notices required under this paragraph; and

"(ii) considers the nature and impact of the proposal; and

"(iii) determines that the proposal—

"(I) is based on a reasonable hypothesis which the proposal is designed to test in a methodologically sound manner; and

"(II) will be evaluated on a yearly basis utilizing a sound methodology to determine whether the proposal has resulted in a change in access to health care or in health outcomes for any beneficiaries of medical assistance, child health assistance, or other health benefits coverage whose assistance or coverage would be altered as a result of the proposal.

"(G) Not later than 3 days after the approval of any proposal for a medicaid waiver, SCHIP waiver, or amendment to a previously approved medicaid waiver or SCHIP waiver, the Secretary shall post on the Internet website for

the Centers for Medicare & Medicaid Services the following:

''(i) The text of the approved medicaid waiver, SCHIP waiver, or amendment to a previously approved medicaid waiver or SCHIP waiver.

''(ii) A list identifying each provision of title XIX or XXI, and each regulation relating to either such title, for which compliance is waived under the approved waiver or amendment or for which costs that would otherwise not be permitted under the provision will be allowed.

''(iii) The terms and conditions for approval of the waiver or amendment.

''(v) The approval letter.

''(vi) The protocol for the waiver or amendment.

''(vii) The evaluation design for the waiver or amendment.

''(viii) The results of the evaluation of the waiver or amendment.

Any item required to be posted under this subparagraph that is not available within 3 days of the approval of the waiver or amendment shall

be posted as soon as the item becomes available.

''(H) Each month the Secretary shall publish a notice in the Federal Register that identifies any proposals for medicaid waivers, SCHIP waivers, or amendments to a previously approved medicaid waiver or SCHIP waiver that were approved, denied, or returned to the State without action during the preceding month.

''(5) Any provision under title XIX or XXI, or under any regulation in effect that relates to either such title, that is not explicitly waived by the Secretary when the medicaid waiver, SCHIP waiver, or amendment is approved and identified in the list required under paragraph (4)(G)(ii), is not waived and a State shall continue to comply with any such requirement.''.

(b) CLARIFICATION OF LIMITATIONS OF WAIVER AUTHORITY.—

(1) SECTION 1115 WAIVERS.—Paragraphs (1) and (2) of section 1115(a) (42 U.S.C. 1315(a)) are each amended by inserting ''and only to the extent that waiving such requirements is likely to assist in promoting the objectives of the title in which such section is located,'' after ''as the case may be,''.

(2) EPSDT.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(13) Notwithstanding section 1115(a), with respect to any waiver, experimental, pilot, or demonstration project that involves the use of funds made available under this title, or an amendment to such a project that has been approved as of the date of enactment of this paragraph, the Secretary may not waive compliance with the requirements of subsection (a)(43) (relating to early and periodic screening, diagnostic, and treatment services as described in section 1905(r)).''.

(3) USE OF SCHIP FUNDS.—

(A) IN GENERAL.—Section 2107 (42 U.S.C. 1397gg) is amended by adding at the end the following:

''(f) LIMITATION OF WAIVER AUTHORITY.—Notwithstanding subsection (e)(2)(A) and section 1115(a), the Secretary may not approve a waiver, experimental, pilot, or demonstration project, or an amendment to such a project that has been approved as of the date of enactment of this subsection, that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to childless adults. For purposes of the preceding sentence, a caretaker rel-

ative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.''.

(B) CONFORMING AMENDMENT.—Section 2105(c)(1) (42 U.S.C. 1397ee(c)(1)) is amended by inserting before the period the following: ''and may not include coverage of childless adults. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.''.

(c) RULE OF CONSTRUCTION.—Nothing in this section or the amendments made by this section shall be construed to—

(1) authorize the waiver of any provision of title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) that is not otherwise authorized to be waived under such titles or under title XI of such Act (42 U.S.C. 1301 et seq.) as of the date of enactment of this Act; or

(2) imply congressional approval of any waiver, experimental, pilot, or demonstration project affecting the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act that has been approved as of such date of enactment.

(d) EFFECTIVE DATE.—This section and the amendments made by this section take effect on the date of enactment of this Act and apply to proposals to conduct a waiver, experimental, pilot, or demonstration project affecting the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act, and to any proposals to amend such projects, that are approved or extended on or after such date of enactment.

SEC. 707. TEMPORARY STATE FISCAL RELIEF.

(a) TEMPORARY INCREASE OF MEDICAID FMAP.—

(1) PERMITTING MAINTENANCE OF FISCAL YEAR 2002 FMAP FOR FISCAL YEAR 2003.—Notwithstanding any other provision of law, but subject to paragraphs (4) and (6), if the FMAP determined without regard to this subsection for a State for fiscal year 2003 is less than the FMAP as so determined for fiscal year 2002, the FMAP for the State for fiscal year 2002 shall be substituted for the State's FMAP for fiscal year 2003, before the application of this subsection.

(2) GENERAL 1.3 PERCENTAGE POINTS INCREASE FOR FISCAL YEAR 2003.—Notwithstanding any other provision of law, but subject to paragraphs (4), (5), and (6), for each State for fiscal year 2003,

the FMAP (taking into account the application of paragraph (1)) shall be increased by 1.3 percentage points.

(3) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—

(A) IN GENERAL.—Notwithstanding any other provision of law, but subject to paragraph (5) and subparagraph (B), with respect to fiscal year 2003, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) shall each be increased by an amount equal to 2.6 percent of such amounts.

(B) NO APPLICATION AFTER FISCAL YEAR 2003.—The amounts determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for fiscal year 2004 and each fiscal year thereafter shall be determined without regard to the increase under subparagraph (A) in such amounts for fiscal year 2003.

(4) SCOPE OF APPLICATION.—The increases in the FMAP for a State under this subsection shall apply only for purposes of title XIX of the Social Security Act and shall not apply with respect to—

(A) disproportionate share hospital payments described in section 1923 of such Act (42 U.S.C. 1396r–4); or

(B) payments under title IV or XXI of such Act (42 U.S.C. 601 et seq. and 1397aa et seq.).

(5) STATE ELIGIBILITY.—

(A) IN GENERAL.—Subject to subparagraph (B), a State is eligible for an increase in its FMAP under paragraph (2) or an increase in a cap amount under paragraph (3) only if the eligibility under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) is no more restrictive than the eligibility under such plan (or waiver) as in effect on January 1, 2002.

(B) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—A State that has restricted eligibility under its State plan under title XIX of the Social Security Act (including

any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after January 1, 2002, but prior to the date of enactment of this Act is eligible for an increase in its FMAP under paragraph (2) or an increase in a cap amount under paragraph (3) in the first calendar quarter (and subsequent calendar quarters) in which the State has reinstated eligibility that is no more restrictive than the eligibility under such plan (or waiver) as in effect on January 1, 2002.

(C) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) or (B) shall be construed as affecting a State's flexibility with respect to benefits offered under the State medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)).

(6) LIMITATION.—Notwithstanding paragraphs (1) and (2), the FMAP determined for a State under this section for fiscal year 2003 may not exceed 100 percent.

(7) DEFINITIONS.—In this subsection:

(A) FMAP.—The term ''FMAP'' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(B) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(8) REPEAL.—Effective as of October 1, 2003, this subsection is repealed.

(b) ADDITIONAL TEMPORARY STATE FISCAL RELIEF.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397–1397f) is amended by adding at the end the following:

''SEC. 2008. ADDITIONAL TEMPORARY GRANTS FOR STATE FISCAL RELIEF.

''(a) IN GENERAL.—For the purpose of providing State fiscal relief allotments to States under this section, there are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $1,000,000,000. Such funds shall be available for obligation by the State through June 30, 2003, and for expenditure by the State through September 30, 2003. This section constitutes budget authority in advance of appropriations Acts and

represents the obligation of the Federal Government to provide for the payment to States of amounts provided under this section.

"(b) ALLOTMENT.—Funds appropriated under subsection (a) shall be allotted by the Secretary among the States in accordance with the following table:

"State	Allotment (in dollars)
Alabama	$11,154,135
Alaska	$2,840,803
Amer. Samoa	$29,438
Arizona	$16,220,383
Arkansas	$9,163,338
California	$100,833,576
Colorado	$9,331,095
Connecticut	$13,994,165
Delaware	$2,767,146
District of Columbia	$4,059,080
Florida	$44,008,674
Georgia	$21,937,652
Guam	$45,247
Hawaii	$3,373,790
Idaho	$3,471,124
Illinois	$34,733,333
Indiana	$17,207,622
Iowa	$8,513,126
Kansas	$6,919,819
Kentucky	$14,548,137
Louisiana	$17,118,506
Maine	$5,979,575
Maryland	$14,684,167
Massachusetts	$34,248,540
Michigan	$29,836,794
Minnesota	$19,370,869
Mississippi	$12,153,821
Missouri	$20,314,882
Montana	$2,838,819
Nebraska	$5,613,219
Nevada	$3,808,574
New Hampshire	$3,550,440
New Jersey	$29,327,902
New Mexico	$7,255,647
New York	$157,469,433
North Carolina	$26,223,106
North Dakota	$1,874,707
N. Mariana Islands	$16,630
Ohio	$39,106,122
Oklahoma	$10,452,381
Oregon	$11,647,633
Pennsylvania	$53,862,604
Puerto Rico	$1,308,459
Rhode Island	$5,492,778
South Carolina	$12,652,401
South Dakota	$1,994,912
Tennessee	$27,222,837
Texas	$54,043,284
Utah	$4,254,036
Vermont	$2,655,179
Virgin Islands	$42,210
Virginia	$14,289,158
Washington	$20,884,225
West Virginia	$6,542,196
Wisconsin	$15,441,057
Wyoming	$1,271,214
Total	**$1,000,000,000**

''(c) USE OF FUNDS.—Funds appropriated under this section may be used by a State for services directed at the goals set forth in section 2001, subject to the requirements of this title.

''(d) PAYMENT TO STATES.—Not later than 30 days after amounts are appropriated under subsection (a), in addition to any payment made under section 2002 or 2007, the Secretary shall make a lump sum payment to a State of the total amount of the allotment for the State as specified in subsection (b).

''(e) DEFINITION.—For purposes of this section, the term 'State' means the 50 States, the District of Columbia, and the territories contained in the list under subsection (b).''.

(2) REPEAL.—Effective as of January 1, 2004, section 2008 of the Social Security Act, as added by paragraph (1), is repealed.

TITLE VIII—OTHER PROVISIONS

SEC. 801. INCREASE IN APPROPRIATIONS FOR SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)) is amended—

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

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

''(C) $150,000,000 for each of fiscal years 2004, 2005, and 2006.''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)) is amended—

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

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

''(C) $150,000,000 for each of fiscal years 2004, 2005, and 2006.''.

(c) EXTENSION OF FINAL REPORT ON GRANT PROGRAMS.—Section 4923(b)(2) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251), as amended by section 931(c) of BIPA (114 Stat. 2763A–585), is amended by striking ''2003'' and inserting ''2005''.

SEC. 802. DISREGARD OF CERTAIN PAYMENTS UNDER THE EMERGENCY SUPPLEMENTAL ACT, 2000 IN THE ADMINISTRATION OF FEDERAL PROGRAMS AND FEDERALLY ASSISTED PROGRAMS.

(a) IN GENERAL.—Chapter 2 of title II of the Emergency Supplemental Act, 2000 (Public Law 106–246; 114 Stat. 547) is amended by adding at the end the following new section:

''SEC. 2205. CERTAIN PAYMENTS DISREGARDED IN THE ADMINISTRATION OF FEDERAL PROGRAMS AND FEDERALLY ASSISTED PROGRAMS.—Any payment under this chapter with respect to west coast groundfish fishery shall not be taken into account as income or resources for purposes of determining the eligibility of such individual or any other individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of the Emergency Supplemental Act, 2000.

SEC. 803. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

''PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

''SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

''SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

''(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

''(1) REVIEW.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

''(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

''(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, the Beneficiary Ac-

cess to Care and Medicare Equity Act of 2002, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

''(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

''(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

''(E) supporting the development of new data systems where existing data are insufficient or inadequate;

''(F) developing criteria and indicators of impending core health care safety net failure;

''(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

''(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

''(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

''(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

''(ii) the degree to which these plans may be overburdened by adverse selection; and

''(iii) the degree to which emergency departments are used by enrollees of these plans; and

''(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

''(2) REPORTS.—

''(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2004), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

''(i) the health care needs of the uninsured; and

''(ii) the financial and infrastructure stability of the Nation's core health care safety net.

''(B) AGENDA AND ADDITIONAL REVIEWS.—

''(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

''(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional re-

views and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

"(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

"(II) If the Commission deems such additional reviews and reports appropriate.

"(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(3) DEFINITIONS.—In this section:

"(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

''(B) CORE HEALTH CARE SAFETY NET.—The term 'core health care safety net' means any health care provider that—

''(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

''(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

''(C) HEALTH CARE SAFETY NET PROGRAMS.—The term 'health care safety net programs' includes the following:

''(i) MEDICAID.—The medicaid program under title XIX.

"(ii) SCHIP.—The State children's health insurance program under title XXI.

"(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

"(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(l)(2)(B)) receives funds.

"(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

"(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

"(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the unin-

sured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

''(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

''(D) VULNERABLE POPULATIONS.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the 'Comptroller General'), in consultation with the appropriate committees of Congress.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net

research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety

net programs shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

''(i) four to serve a term of 1 year;

''(ii) four to serve a term of 2 years; and

''(iii) five to serve a term of 3 years.

''(B) VACANCIES.—

''(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

''(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall

be appointed only for the remainder of that term.

"(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

"(4) COMPENSATION.—

"(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

"(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

"(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

"(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

''(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of the duties of the

Commission under this section from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—

''(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

''(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

''(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.''.

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2003.

SEC. 804. PUBLICATION ON FINAL WRITTEN GUIDANCE CONCERNING PROHIBITIONS AGAINST DISCRIMINATION BY NATIONAL ORIGIN WITH RESPECT TO HEALTH CARE SERVICES.

Not later than January 1, 2003, the Secretary shall issue final written guidance concerning the application of the prohibition in title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) against national origin discrimination as it affects persons with limited English proficiency with respect to access to health care services under the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the SCHIP program under title XXI of such Act.

SEC. 805. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

Section 4723 of the Balanced Budget Act of 1997 (8 U.S.C. 1611 note) is amended to read as follows:

"SEC. 4723. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

''(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $48,000,000 for each of fiscal years 2003 and 2004, for the purpose of

making allotments under this section to States described in paragraph (1) or (2) of subsection (b).

''(b) STATE ALLOTMENTS.—

''(1) BASED ON HIGHEST NUMBER OF UNDOCUMENTED ALIENS.—

''(A) DETERMINATION OF ALLOTMENTS.—

''(i) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $32,000,000 of such amount to compute an allotment for each such fiscal year for each of the 17 States with the highest number of undocumented aliens.

''(ii) FORMULA.—The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year.

''(iii) AVAILABILITY OF FUNDS.—The amount of an allotment provided to a State under this paragraph for a fiscal year that

is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

''(B) DATA.—For purposes of subparagraph (A), the number of undocumented aliens in a State shall be determined based on estimates of the resident undocumented alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved).

''(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $16,000,000 of such amount to compute an allotment for each such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

''(B) DETERMINATION OF ALLOTMENTS.—The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments

under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year.

''(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

''(D) AVAILABILITY OF FUNDS.—The amount of an allotment provided to a State under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

''(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both such paragraphs for a fiscal year.

''(c) USE OF FUNDS.—The Secretary shall pay, from the allotments made for a State under paragraphs (1) and,

if applicable, (2) of subsection (b) for a fiscal year, to each State and directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, such amounts (subject to the total amount available from such allotments) as the State, local governments, hospitals, or providers demonstrate were incurred for the provision of such services during that fiscal year.

''(d) DEFINITIONS.—In this section:

''(1) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

''(2) PROVIDER.—The term 'provider' includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

''(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(4) STATE.—The term 'State' means the 50 States and the District of Columbia.

''(e) ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of amounts provided under this section.''.

SEC. 806. EXTENSION OF MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, section 4017 of the Balance Budget Act of 1997 (111 Stat. 345, section 534 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–390), and section 633 of BIPA (114 Stat. 2763A–568), is amended by striking ''December 31, 2004'' and inserting ''December 31, 2005''.

SEC. 807. DELAYED IMPLEMENTATION OF CERTAIN PROVISIONS.

(a) AUTHORITY TO DELAY IMPLEMENTATION OF CERTAIN FEE-FOR-SERVICE PAYMENT CHANGES.—

(1) IN GENERAL.—If the Secretary determines that it is not administratively feasible to implement a covered payment change on the date otherwise applicable, notwithstanding any other provision of this Act and in order to comply with Congressional intent, the Secretary may delay the implementation of such change in accordance with subsection (b).

(2) COVERED PAYMENT CHANGE DEFINED.—For purposes of this section, the term ''covered payment change'' means a provision contained in titles I through IV of this Act that—

(A) changes the amount of payment made for an item or service furnished under the medicare program; and

(B) has an effective date during the period beginning on October 1, 2002, and ending on March 31, 2003.

(b) RULES FOR DELAYED IMPLEMENTATION.—

(1) PERIOD OF DELAY.—In the case of a covered payment change in which medicare payment rates change on a—

(A) fiscal year basis (or a cost reporting period basis that relates to a fiscal year), the Secretary may delay the implementation of the change until such time as the Secretary deter-

mines to be appropriate, but in no case later than April 1, 2003; or

(B) calendar year basis (or a cost reporting period basis that relates to a calendar year), the Secretary may delay the implementation of the change until such time as the Secretary determines to be appropriate, but in no case later than July 1, 2003.

(2) TEMPORARY ADJUSTMENT FOR REMAINDER OF FISCAL YEAR OR CALENDAR YEAR 2003 TO EFFECT FULL RATE CHANGE.—If the Secretary delays implementation of a covered payment change under paragraph (1), the Secretary shall make such adjustment to the amount of payments affected by such change, for the portion of fiscal year 2003 (or, in the case of a delay under paragraph (1)(B), calendar year 2003) after the date of the delayed implementation, in such manner as the Secretary estimates will ensure that the total payments so affected (for a type of service) with respect to such fiscal or calendar year, respectively, is the same as would have been made if this section had not been enacted.

(3) NO EFFECT ON PAYMENTS FOR SUBSEQUENT PAYMENT PERIODS.—The application of paragraphs (1) and (2) shall not affect payment

rates and shall not be taken into account in calculating payment amounts for services furnished for periods after September 30, 2003 (or, in the case of a delay under paragraph (1)(B), December 31, 2003).

(c) IMPLEMENTATION OF MEDICARE+CHOICE PROVISIONS.—

(1) TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES.—In order to comply with Congressional intent, the provisions of section 604 of BIPA (114 Stat. 2763A–555) shall apply to the provisions of title V of this Act for 2003 in the same manner as the provisions of such section applied to the provisions of BIPA for 2001.

(2) SPECIAL RULE FOR MEDICARE+CHOICE PAYMENT RATES IN 2003.—

(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by sections 501 and 506, for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2003, the annual Medicare+Choice capitation rate for a Medicare+Choice payment area shall be calculated, the new entry bonus amount under section 1853(i) under such Act

(42 U.S.C. 1395w–23(i)) shall be determined, and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, as if such amendments had not been enacted.

(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by sections 501 and 506, for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for March through February 2003, the annual Medicare+Choice capitation rate for a Medicare+Choice payment area shall be calculated, the new entry bonus amount under section 1853(i) under such Act (42 U.S.C. 1395w–23(i)) shall be determined, and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2003 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

(C) CONSTRUCTION.—Subparagraph (A) shall not be taken into account in computing

such capitation rate for 2004 and subsequent years.

(3) PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.—If a Medicare+Choice organization offering a Medicare+Choice plan revises its submission of the information described in section 1854(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) for a plan pursuant to the application of paragraph (1), and such revision results in reduced beneficiary premiums, reduced beneficiary cost-sharing, or enhanced benefits under the plan, then by not later than the date that is 3 weeks after the Secretary approves such submission, the Medicare+Choice organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

(d) ADMINISTRATION OF PROVISIONS.—

(1) NO RULEMAKING OR NOTICE REQUIRED.—The Secretary may carry out the authority under this section by program memorandum or otherwise and is not required to prescribe regulations or to provide notice in the Federal Register in order to carry out such authority.

(2) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or 1878 of the Social Security Act, or otherwise of any determination made by the Secretary under this section or the application of the payment rates determined under this section.