

AMENDMENT TO H.R. 810
OFFERED BY MRS. JOHNSON OF CONNECTICUT

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**
2 **CURITY ACT; TABLE OF CONTENTS.**

3 (a) SHORT TITLE.—This Act may be cited as the “Medi-
4 care Regulatory and Contracting Reform Act of 2003”.

5 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as
6 otherwise specifically provided, whenever in this Act an amend-
7 ment is expressed in terms of an amendment to or repeal of
8 a section or other provision, the reference shall be considered
9 to be made to that section or other provision of the Social Se-
10 curity Act.

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

- Sec. 1. Short title; amendments to Social Security Act; table of contents.
- Sec. 2. Findings and construction.
- Sec. 3. Definitions.

TITLE I—REGULATORY REFORM

- Sec. 101. Issuance of regulations.
- Sec. 102. Compliance with changes in regulations and policies.
- Sec. 103. Reports and studies relating to regulatory reform.

TITLE II—CONTRACTING REFORM

- Sec. 201. Increased flexibility in medicare administration.
- Sec. 202. Requirements for information security for medicare administra-
tive contractors.

TITLE III—EDUCATION AND OUTREACH

- Sec. 301. Provider education and technical assistance.
- Sec. 302. Small provider technical assistance demonstration program.
- Sec. 303. Medicare Provider Ombudsman; Medicare Beneficiary Ombuds-
man.
- Sec. 304. Beneficiary outreach demonstration program.
- Sec. 305. Inclusion of additional information in notices to beneficiaries
about skilled nursing facility benefits.
- Sec. 306. Information on medicare-certified skilled nursing facilities in hos-
pital discharge plans.

TITLE IV—APPEALS AND RECOVERY

- Sec. 401. Transfer of responsibility for medicare appeals.
- Sec. 402. Process for expedited access to review.



- Sec. 403. Revisions to medicare appeals process.
 Sec. 404. Prepayment review.
 Sec. 405. Recovery of overpayments.
 Sec. 406. Provider enrollment process; right of appeal.
 Sec. 407. Process for correction of minor errors and omissions without pursuing appeals process.
 Sec. 408. Prior determination process for certain items and services; advance beneficiary notices.

TITLE V—MISCELLANEOUS PROVISIONS

- Sec. 501. Policy development regarding evaluation and management (E & M) documentation guidelines.
 Sec. 502. Improvement in oversight of technology and coverage.
 Sec. 503. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
 Sec. 504. EMTALA improvements.
 Sec. 505. Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group.
 Sec. 506. Authorizing use of arrangements to provide core hospice services in certain circumstances.
 Sec. 507. Application of OSHA bloodborne pathogens standard to certain hospitals.
 Sec. 508. BIPA-related technical amendments and corrections.
 Sec. 509. Conforming authority to waive a program exclusion.
 Sec. 510. Treatment of certain dental claims.
 Sec. 511. Furnishing hospitals with information to compute DSH formula.
 Sec. 512. Miscellaneous reports, studies, and publication requirements.

1 **SEC. 2. FINDINGS AND CONSTRUCTION.**

2 (a) **FINDINGS.**—Congress finds the following:

3 (1) The overwhelming majority of providers of services
 4 and suppliers in the United States are law-abiding persons
 5 who provide important health care services to patients each
 6 day.

7 (2) The Secretary of Health and Human Services
 8 should work to streamline paperwork requirements under
 9 the medicare program and communicate clearer instruc-
 10 tions to providers of services and suppliers so that they
 11 may spend more time caring for patients.

12 (b) **CONSTRUCTION.**—Nothing in this Act shall be
 13 construed—

14 (1) to compromise or affect existing legal remedies for
 15 addressing fraud or abuse, whether it be criminal prosecu-
 16 tion, civil enforcement, or administrative remedies, includ-
 17 ing under sections 3729 through 3733 of title 31, United
 18 States Code (known as the False Claims Act); or



1 (2) to prevent or impede the Department of Health
2 and Human Services in any way from its ongoing efforts
3 to eliminate waste, fraud, and abuse in the medicare pro-
4 gram.

5 Furthermore, the consolidation of medicare administrative con-
6 tracting set forth in this Act does not constitute consolidation
7 of the Federal Hospital Insurance Trust Fund and the Federal
8 Supplementary Medical Insurance Trust Fund or reflect any
9 position on that issue.

10 **SEC. 3. DEFINITIONS.**

11 (a) USE OF TERM SUPPLIER IN MEDICARE.—Section
12 1861 (42 U.S.C. 1395x) is amended by inserting after sub-
13 section (c) the following new subsection:

14 “Supplier

15 “(d) The term ‘supplier’ means, unless the context other-
16 wise requires, a physician or other practitioner, a facility, or
17 other entity (other than a provider of services) that furnishes
18 items or services under this title.”.

19 (b) OTHER TERMS USED IN ACT.—In this Act:

20 (1) BIPA.—The term “BIPA” means the Medicare,
21 Medicaid, and SCHIP Benefits Improvement and Protec-
22 tion Act of 2000, as enacted into law by section 1(a)(6) of
23 Public Law 106–554.

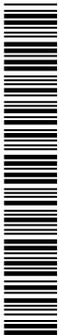
24 (2) SECRETARY.—The term “Secretary” means the
25 Secretary of Health and Human Services.

26 **TITLE I—REGULATORY REFORM**

27 **SEC. 101. ISSUANCE OF REGULATIONS.**

28 (a) LIMITATIONS ON NEW MATTER IN FINAL REGULA-
29 TIONS.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by
30 adding at the end the following new paragraph:

31 “(3) If the Secretary publishes a final regulation that in-
32 cludes a provision that is not a logical outgrowth of a pre-
33 viously published notice of proposed rulemaking or interim final
34 rule, such provision shall be treated as a proposed regulation
35 and shall not take effect until there is the further opportunity



1 for public comment and a publication of the provision again as
2 a final regulation.”.

3 (b) EFFECTIVE DATE.—The amendment made by sub-
4 section (a) shall apply to final regulations published on or after
5 the date of the enactment of this Act.

6 **SEC. 102. COMPLIANCE WITH CHANGES IN REGULA-**
7 **TIONS AND POLICIES.**

8 (a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE
9 CHANGES.—

10 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh),
11 as amended by section 101(a), is amended by adding at the
12 end the following new subsection:

13 “(e)(1)(A) A substantive change in regulations, manual in-
14 structions, interpretative rules, statements of policy, or guide-
15 lines of general applicability under this title shall not be applied
16 (by extrapolation or otherwise) retroactively to items and serv-
17 ices furnished before the effective date of the change, unless
18 the Secretary determines that—

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

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

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

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

28 (1) IN GENERAL.—Section 1871(e)(1), as added by
29 subsection (a), is amended by adding at the end the fol-
30 lowing:

31 “(B)(i) Except as provided in clause (ii), a substantive
32 change referred to in subparagraph (A) shall not become effec-
33 tive before the end of the 30-day period that begins on the date
34 that the Secretary has issued or published, as the case may be,
35 the substantive change.

36 “(ii) The Secretary may provide for such a substantive
37 change to take effect on a date that precedes the end of the



1 30-day period under clause (i) if the Secretary finds that waiv-
2 er of such 30-day period is necessary to comply with statutory
3 requirements or that the application of such 30-day period is
4 contrary to the public interest. If the Secretary provides for an
5 earlier effective date pursuant to this clause, the Secretary
6 shall include in the issuance or publication of the substantive
7 change a finding described in the first sentence, and a brief
8 statement of the reasons for such finding.

9 “(C) No action shall be taken against a provider of serv-
10 ices or supplier with respect to noncompliance with such a sub-
11 stantive change for items and services furnished before the ef-
12 fective date of such a change.”.

13 (2) EFFECTIVE DATE.—The amendment made by
14 paragraph (1) shall apply to compliance actions undertaken
15 on or after the date of the enactment of this Act.

16 (c) RELIANCE ON GUIDANCE.—

17 (1) IN GENERAL.—Section 1871(e), as added by sub-
18 section (a), is further amended by adding at the end the
19 following new paragraph:

20 “(2)(A) If—

21 “(i) a provider of services or supplier follows the writ-
22 ten guidance (which may be transmitted electronically) pro-
23 vided by the Secretary or by a medicare contractor (as de-
24 fined in section 1889(g)) acting within the scope of the
25 contractor’s contract authority, with respect to the fur-
26 nishing of items or services and submission of a claim for
27 benefits for such items or services with respect to such pro-
28 vider or supplier;

29 “(ii) the Secretary determines that the provider of
30 services or supplier has accurately presented the cir-
31 cumstances relating to such items, services, and claim to
32 the contractor in writing; and

33 “(iii) the guidance was in error;
34 the provider of services or supplier shall not be subject to any
35 sanction (including any penalty or requirement for repayment
36 of any amount) if the provider of services or supplier reason-
37 ably relied on such guidance.



1 “(B) Subparagraph (A) shall not be construed as pre-
2 venting the recoupment or repayment (without any additional
3 penalty) relating to an overpayment insofar as the overpayment
4 was solely the result of a clerical or technical operational
5 error.”.

6 (2) EFFECTIVE DATE.—The amendment made by
7 paragraph (1) shall take effect on the date of the enact-
8 ment of this Act but shall not apply to any sanction for
9 which notice was provided on or before the date of the en-
10 actment of this Act.

11 **SEC. 103. REPORTS AND STUDIES RELATING TO REGU-**
12 **LATORY REFORM.**

13 (a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

14 (1) STUDY.—The Comptroller General of the United
15 States shall conduct a study to determine the feasibility
16 and appropriateness of establishing in the Secretary au-
17 thority to provide legally binding advisory opinions on ap-
18 propriate interpretation and application of regulations to
19 carry out the medicare program under title XVIII of the
20 Social Security Act. Such study shall examine the appro-
21 priate timeframe for issuing such advisory opinions, as well
22 as the need for additional staff and funding to provide such
23 opinions.

24 (2) REPORT.—The Comptroller General shall submit
25 to Congress a report on the study conducted under para-
26 graph (1) by not later than one year after the date of the
27 enactment of this Act.

28 (b) REPORT ON LEGAL AND REGULATORY INCONSIST-
29 ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by
30 section 2(a), is amended by adding at the end the following new
31 subsection:

32 “(f)(1) Not later than 2 years after the date of the enact-
33 ment of this subsection, and every 2 years thereafter, the Sec-
34 retary shall submit to Congress a report with respect to the ad-
35 ministration of this title and areas of inconsistency or conflict
36 among the various provisions under law and regulation.



1 “(2) In preparing a report under paragraph (1), the Sec-
2 retary shall collect—

3 “(A) information from individuals entitled to benefits
4 under part A or enrolled under part B, or both, providers
5 of services, and suppliers and from the Medicare Bene-
6 ficiary Ombudsman and the Medicare Provider Ombuds-
7 man with respect to such areas of inconsistency and con-
8 flict; and

9 “(B) information from medicare contractors that
10 tracks the nature of written and telephone inquiries.

11 “(3) A report under paragraph (1) shall include a descrip-
12 tion of efforts by the Secretary to reduce such inconsistency or
13 conflicts, and recommendations for legislation or administrative
14 action that the Secretary determines appropriate to further re-
15 duce such inconsistency or conflicts.”.

16 **TITLE II—CONTRACTING REFORM**

17 **SEC. 201. INCREASED FLEXIBILITY IN MEDICARE AD-**
18 **MINISTRATION.**

19 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE AD-
20 MINISTRATION.—

21 (1) IN GENERAL.—Title XVIII is amended by insert-
22 ing after section 1874 the following new section:

23 “CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

24 “SEC. 1874A. (a) AUTHORITY.—

25 “(1) AUTHORITY TO ENTER INTO CONTRACTS.—The
26 Secretary may enter into contracts with any eligible entity
27 to serve as a medicare administrative contractor with re-
28 spect to the performance of any or all of the functions de-
29 scribed in paragraph (4) or parts of those functions (or, to
30 the extent provided in a contract, to secure performance
31 thereof by other entities).

32 “(2) ELIGIBILITY OF ENTITIES.—An entity is eligible
33 to enter into a contract with respect to the performance of
34 a particular function described in paragraph (4) only if—

35 “(A) the entity has demonstrated capability to
36 carry out such function;



1 “(B) the entity complies with such conflict of in-
2 terest standards as are generally applicable to Federal
3 acquisition and procurement;

4 “(C) the entity has sufficient assets to financially
5 support the performance of such function; and

6 “(D) the entity meets such other requirements as
7 the Secretary may impose.

8 “(3) MEDICARE ADMINISTRATIVE CONTRACTOR DE-
9 FINED.—For purposes of this title and title XI—

10 “(A) IN GENERAL.—The term ‘medicare adminis-
11 trative contractor’ means an agency, organization, or
12 other person with a contract under this section.

13 “(B) APPROPRIATE MEDICARE ADMINISTRATIVE
14 CONTRACTOR.—With respect to the performance of a
15 particular function in relation to an individual entitled
16 to benefits under part A or enrolled under part B, or
17 both, a specific provider of services or supplier (or class
18 of such providers of services or suppliers), the ‘appro-
19 priate’ medicare administrative contractor is the medi-
20 care administrative contractor that has a contract
21 under this section with respect to the performance of
22 that function in relation to that individual, provider of
23 services or supplier or class of provider of services or
24 supplier.

25 “(4) FUNCTIONS DESCRIBED.—The functions referred
26 to in paragraphs (1) and (2) are payment functions, pro-
27 vider services functions, and functions relating to services
28 furnished to individuals entitled to benefits under part A
29 or enrolled under part B, or both, as follows:

30 “(A) DETERMINATION OF PAYMENT AMOUNTS.—
31 Determining (subject to the provisions of section 1878
32 and to such review by the Secretary as may be provided
33 for by the contracts) the amount of the payments re-
34 quired pursuant to this title to be made to providers of
35 services, suppliers and individuals.

36 “(B) MAKING PAYMENTS.—Making payments de-
37 scribed in subparagraph (A) (including receipt, dis-



1 bursement, and accounting for funds in making such
2 payments).

3 “(C) BENEFICIARY EDUCATION AND ASSIST-
4 ANCE.—Providing education and outreach to individ-
5 uals entitled to benefits under part A or enrolled under
6 part B, or both, and providing assistance to those indi-
7 viduals with specific issues, concerns or problems.

8 “(D) PROVIDER CONSULTATIVE SERVICES.—Pro-
9 viding consultative services to institutions, agencies,
10 and other persons to enable them to establish and
11 maintain fiscal records necessary for purposes of this
12 title and otherwise to qualify as providers of services or
13 suppliers.

14 “(E) COMMUNICATION WITH PROVIDERS.—Com-
15 municating to providers of services and suppliers any
16 information or instructions furnished to the medicare
17 administrative contractor by the Secretary, and facili-
18 tating communication between such providers and sup-
19 pliers and the Secretary.

20 “(F) PROVIDER EDUCATION AND TECHNICAL AS-
21 SISTANCE.—Performing the functions relating to pro-
22 vider education, training, and technical assistance.

23 “(G) ADDITIONAL FUNCTIONS.—Performing such
24 other functions as are necessary to carry out the pur-
25 poses of this title.

26 “(5) RELATIONSHIP TO MIP CONTRACTS.—

27 “(A) NONDUPLICATION OF DUTIES.—In entering
28 into contracts under this section, the Secretary shall
29 assure that functions of medicare administrative con-
30 tractors in carrying out activities under parts A and B
31 do not duplicate activities carried out under the Medi-
32 care Integrity Program under section 1893. The pre-
33 vious sentence shall not apply with respect to the activ-
34 ity described in section 1893(b)(5) (relating to prior
35 authorization of certain items of durable medical equip-
36 ment under section 1834(a)(15)).



1 “(B) CONSTRUCTION.—An entity shall not be
2 treated as a medicare administrative contractor merely
3 by reason of having entered into a contract with the
4 Secretary under section 1893.

5 “(6) APPLICATION OF FEDERAL ACQUISITION REGULA-
6 TION.—Except to the extent inconsistent with a specific re-
7 quirement of this title, the Federal Acquisition Regulation
8 applies to contracts under this title.

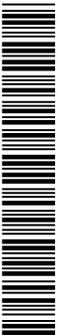
9 “(b) CONTRACTING REQUIREMENTS.—

10 “(1) USE OF COMPETITIVE PROCEDURES.—

11 “(A) IN GENERAL.—Except as provided in laws
12 with general applicability to Federal acquisition and
13 procurement or in subparagraph (B), the Secretary
14 shall use competitive procedures when entering into
15 contracts with medicare administrative contractors
16 under this section, taking into account performance
17 quality as well as price and other factors.

18 “(B) RENEWAL OF CONTRACTS.—The Secretary
19 may renew a contract with a medicare administrative
20 contractor under this section from term to term with-
21 out regard to section 5 of title 41, United States Code,
22 or any other provision of law requiring competition, if
23 the medicare administrative contractor has met or ex-
24 ceeded the performance requirements applicable with
25 respect to the contract and contractor, except that the
26 Secretary shall provide for the application of competi-
27 tive procedures under such a contract not less fre-
28 quently than once every five years.

29 “(C) TRANSFER OF FUNCTIONS.—The Secretary
30 may transfer functions among medicare administrative
31 contractors consistent with the provisions of this para-
32 graph. The Secretary shall ensure that performance
33 quality is considered in such transfers. The Secretary
34 shall provide public notice (whether in the Federal Reg-
35 ister or otherwise) of any such transfer (including a de-
36 scription of the functions so transferred, a description
37 of the providers of services and suppliers affected by



1 such transfer, and contact information for the contrac-
2 tors involved).

3 “(D) INCENTIVES FOR QUALITY.—The Secretary
4 shall provide incentives for medicare administrative
5 contractors to provide quality service and to promote
6 efficiency.

7 “(2) COMPLIANCE WITH REQUIREMENTS.—No con-
8 tract under this section shall be entered into with any
9 medicare administrative contractor unless the Secretary
10 finds that such medicare administrative contractor will per-
11 form its obligations under the contract efficiently and effec-
12 tively and will meet such requirements as to financial re-
13 sponsibility, legal authority, quality of services provided,
14 and other matters as the Secretary finds pertinent.

15 “(3) PERFORMANCE REQUIREMENTS.—

16 “(A) DEVELOPMENT OF SPECIFIC PERFORMANCE
17 REQUIREMENTS.—In developing contract performance
18 requirements, the Secretary shall develop performance
19 requirements applicable to functions described in sub-
20 section (a)(4).

21 “(B) CONSULTATION.— In developing such re-
22 quirements, the Secretary may consult with providers
23 of services and suppliers, organizations representing in-
24 dividuals entitled to benefits under part A or enrolled
25 under part B, or both, and organizations and agencies
26 performing functions necessary to carry out the pur-
27 poses of this section with respect to such performance
28 requirements.

29 “(C) INCLUSION IN CONTRACTS.—All contractor
30 performance requirements shall be set forth in the con-
31 tract between the Secretary and the appropriate medi-
32 care administrative contractor. Such performance
33 requirements—

34 “(i) shall reflect the performance requirements
35 developed under subparagraph (A), but may in-
36 clude additional performance requirements;



1 “(ii) shall be used for evaluating contractor
2 performance under the contract; and

3 “(iii) shall be consistent with the written state-
4 ment of work provided under the contract.

5 “(4) INFORMATION REQUIREMENTS.—The Secretary
6 shall not enter into a contract with a medicare administra-
7 tive contractor under this section unless the contractor
8 agrees—

9 “(A) to furnish to the Secretary such timely infor-
10 mation and reports as the Secretary may find nec-
11 essary in performing his functions under this title; and

12 “(B) to maintain such records and afford such ac-
13 cess thereto as the Secretary finds necessary to assure
14 the correctness and verification of the information and
15 reports under subparagraph (A) and otherwise to carry
16 out the purposes of this title.

17 “(5) SURETY BOND.—A contract with a medicare ad-
18 ministrative contractor under this section may require the
19 medicare administrative contractor, and any of its officers
20 or employees certifying payments or disbursing funds pur-
21 suant to the contract, or otherwise participating in carrying
22 out the contract, to give surety bond to the United States
23 in such amount as the Secretary may deem appropriate.

24 “(c) TERMS AND CONDITIONS.—

25 “(1) IN GENERAL.—A contract with any medicare ad-
26 ministrative contractor under this section may contain such
27 terms and conditions as the Secretary finds necessary or
28 appropriate and may provide for advances of funds to the
29 medicare administrative contractor for the making of pay-
30 ments by it under subsection (a)(4)(B).

31 “(2) PROHIBITION ON MANDATES FOR CERTAIN DATA
32 COLLECTION.—The Secretary may not require, as a condi-
33 tion of entering into, or renewing, a contract under this
34 section, that the medicare administrative contractor match
35 data obtained other than in its activities under this title
36 with data used in the administration of this title for pur-



1 poses of identifying situations in which the provisions of
2 section 1862(b) may apply.

3 “(d) LIMITATION ON LIABILITY OF MEDICARE ADMINIS-
4 TRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

5 “(1) CERTIFYING OFFICER.—No individual designated
6 pursuant to a contract under this section as a certifying of-
7 ficer shall, in the absence of the reckless disregard of the
8 individual’s obligations or the intent by that individual to
9 defraud the United States, be liable with respect to any
10 payments certified by the individual under this section.

11 “(2) DISBURSING OFFICER.—No disbursing officer
12 shall, in the absence of the reckless disregard of the offi-
13 cer’s obligations or the intent by that officer to defraud the
14 United States, be liable with respect to any payment by
15 such officer under this section if it was based upon an au-
16 thorization (which meets the applicable requirements for
17 such internal controls established by the Comptroller Gen-
18 eral) of a certifying officer designated as provided in para-
19 graph (1) of this subsection.

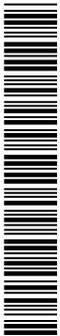
20 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE CON-
21 TRACTOR.—

22 “(A) IN GENERAL.—No medicare administrative con-
23 tractor shall be liable to the United States for a payment
24 by a certifying or disbursing officer unless, in connection
25 with such payment or in the supervision of or selection of
26 such officer, the medicare administrative contractor acted
27 with reckless disregard of its obligations under its medicare
28 administrative contract or with intent to defraud the
29 United States.

30 “(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing
31 in this subsection shall be construed to limit liability for
32 conduct that would constitute a violation of sections 3729
33 through 3731 of title 31, United States Code (commonly
34 known as the ‘False Claims Act’).

35 “(4) INDEMNIFICATION BY SECRETARY.—

36 “(A) IN GENERAL.—Subject to subparagraphs (B)
37 and (D), in the case of a medicare administrative con-

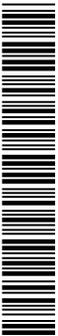


1 contractor (or a person who is a director, officer, or em-
2 ployee of such a contractor or who is engaged by the
3 contractor to participate directly in the claims adminis-
4 tration process) who is made a party to any judicial or
5 administrative proceeding arising from or relating di-
6 rectly to the claims administration process under this
7 title, the Secretary may, to the extent the Secretary de-
8 termines to be appropriate and as specified in the con-
9 tract with the contractor, indemnify the contractor and
10 such persons.

11 “(B) CONDITIONS.—The Secretary may not pro-
12 vide indemnification under subparagraph (A) insofar as
13 the liability for such costs arises directly from conduct
14 that is determined by the judicial proceeding or by the
15 Secretary to be criminal in nature, fraudulent, or
16 grossly negligent. If indemnification is provided by the
17 Secretary with respect to a contractor before a deter-
18 mination that such costs arose directly from such con-
19 duct, the contractor shall reimburse the Secretary for
20 costs of indemnification.

21 “(C) SCOPE OF INDEMNIFICATION.—Indemnifica-
22 tion by the Secretary under subparagraph (A) may in-
23 clude payment of judgments, settlements (subject to
24 subparagraph (D)), awards, and costs (including rea-
25 sonable legal expenses).

26 “(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A
27 contractor or other person described in subparagraph
28 (A) may not propose to negotiate a settlement or com-
29 promise of a proceeding described in such subpara-
30 graph without the prior written approval of the Sec-
31 retary to negotiate such settlement or compromise. Any
32 indemnification under subparagraph (A) with respect to
33 amounts paid under a settlement or compromise of a
34 proceeding described in such subparagraph are condi-
35 tioned upon prior written approval by the Secretary of
36 the final settlement or compromise.



1 “(E) CONSTRUCTION.—Nothing in this paragraph
2 shall be construed—

3 “(i) to change any common law immunity that
4 may be available to a medicare administrative con-
5 tractor or person described in subparagraph (A); or

6 “(ii) to permit the payment of costs not other-
7 wise allowable, reasonable, or allocable under the
8 Federal Acquisition Regulations.”.

9 (2) CONSIDERATION OF INCORPORATION OF CURRENT
10 LAW STANDARDS.—In developing contract performance re-
11 quirements under section 1874A(b) of the Social Security
12 Act, as inserted by paragraph (1), the Secretary shall con-
13 sider inclusion of the performance standards described in
14 sections 1816(f)(2) of such Act (relating to timely proc-
15 essing of reconsiderations and applications for exemptions)
16 and section 1842(b)(2)(B) of such Act (relating to timely
17 review of determinations and fair hearing requests), as
18 such sections were in effect before the date of the enact-
19 ment of this Act.

20 (b) CONFORMING AMENDMENTS TO SECTION 1816 (RE-
21 LATING TO FISCAL INTERMEDIARIES).—Section 1816 (42
22 U.S.C. 1395h) is amended as follows:

23 (1) The heading is amended to read as follows:
24 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

25 (2) Subsection (a) is amended to read as follows:

26 “(a) The administration of this part shall be conducted
27 through contracts with medicare administrative contractors
28 under section 1874A.”.

29 (3) Subsection (b) is repealed.

30 (4) Subsection (c) is amended—

31 (A) by striking paragraph (1); and

32 (B) in each of paragraphs (2)(A) and (3)(A), by
33 striking “agreement under this section” and inserting
34 “contract under section 1874A that provides for mak-
35 ing payments under this part”.

36 (5) Subsections (d) through (i) are repealed.

37 (6) Subsections (j) and (k) are each amended—



1 (A) by striking “An agreement with an agency or
2 organization under this section” and inserting “A con-
3 tract with a medicare administrative contractor under
4 section 1874A with respect to the administration of
5 this part”; and

6 (B) by striking “such agency or organization” and
7 inserting “such medicare administrative contractor”
8 each place it appears.

9 (7) Subsection (l) is repealed.

10 (c) CONFORMING AMENDMENTS TO SECTION 1842 (RE-
11 LATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is
12 amended as follows:

13 (1) The heading is amended to read as follows:
14 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

15 (2) Subsection (a) is amended to read as follows:

16 “(a) The administration of this part shall be conducted
17 through contracts with medicare administrative contractors
18 under section 1874A.”.

19 (3) Subsection (b) is amended—

20 (A) by striking paragraph (1);

21 (B) in paragraph (2)—

22 (i) by striking subparagraphs (A) and (B);

23 (ii) in subparagraph (C), by striking “car-
24 riers” and inserting “medicare administrative con-
25 tractors”; and

26 (iii) by striking subparagraphs (D) and (E);

27 (C) in paragraph (3)—

28 (i) in the matter before subparagraph (A), by
29 striking “Each such contract shall provide that the
30 carrier” and inserting “The Secretary”;

31 (ii) by striking “will” the first place it appears
32 in each of subparagraphs (A), (B), (F), (G), (H),
33 and (L) and inserting “shall”;

34 (iii) in subparagraph (B), in the matter before
35 clause (i), by striking “to the policyholders and
36 subscribers of the carrier” and inserting “to the



1 policyholders and subscribers of the medicare ad-
2 ministrative contractor”;

3 (iv) by striking subparagraphs (C), (D), and
4 (E);

5 (v) in subparagraph (H)—

6 (I) by striking “if it makes determinations
7 or payments with respect to physicians’ serv-
8 ices,” in the matter preceding clause (i); and

9 (II) by striking “carrier” and inserting
10 “medicare administrative contractor” in clause
11 (i);

12 (vi) by striking subparagraph (I);

13 (vii) in subparagraph (L), by striking the
14 semicolon and inserting a period;

15 (viii) in the first sentence, after subparagraph
16 (L), by striking “and shall contain” and all that
17 follows through the period; and

18 (ix) in the seventh sentence, by inserting
19 “medicare administrative contractor,” after “car-
20 rier,”; and

21 (D) by striking paragraph (5);

22 (E) in paragraph (6)(D)(iv), by striking “carrier”
23 and inserting “medicare administrative contractor”;
24 and

25 (F) in paragraph (7), by striking “the carrier”
26 and inserting “the Secretary” each place it appears.

27 (4) Subsection (c) is amended—

28 (A) by striking paragraph (1);

29 (B) in paragraph (2)(A), by striking “contract
30 under this section which provides for the disbursement
31 of funds, as described in subsection (a)(1)(B),” and in-
32 serting “contract under section 1874A that provides for
33 making payments under this part”;

34 (C) in paragraph (3)(A), by striking “subsection
35 (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;



1 (D) in paragraph (4), in the matter preceding sub-
2 paragraph (A), by striking “carrier” and inserting
3 “medicare administrative contractor”; and

4 (E) by striking paragraphs (5) and (6).

5 (5) Subsections (d), (e), and (f) are repealed.

6 (6) Subsection (g) is amended by striking “carrier or
7 carriers” and inserting “medicare administrative contractor
8 or contractors”.

9 (7) Subsection (h) is amended—

10 (A) in paragraph (2)—

11 (i) by striking “Each carrier having an agree-
12 ment with the Secretary under subsection (a)” and
13 inserting “The Secretary”; and

14 (ii) by striking “Each such carrier” and in-
15 sserting “The Secretary”;

16 (B) in paragraph (3)(A)—

17 (i) by striking “a carrier having an agreement
18 with the Secretary under subsection (a)” and in-
19 sserting “medicare administrative contractor having
20 a contract under section 1874A that provides for
21 making payments under this part”; and

22 (ii) by striking “such carrier” and inserting
23 “such contractor”;

24 (C) in paragraph (3)(B)—

25 (i) by striking “a carrier” and inserting “a
26 medicare administrative contractor” each place it
27 appears; and

28 (ii) by striking “the carrier” and inserting
29 “the contractor” each place it appears; and

30 (D) in paragraphs (5)(A) and (5)(B)(iii), by strik-
31 ing “carriers” and inserting “medicare administrative
32 contractors” each place it appears.

33 (8) Subsection (l) is amended—

34 (A) in paragraph (1)(A)(iii), by striking “carrier”
35 and inserting “medicare administrative contractor”;
36 and



1 (B) in paragraph (2), by striking “carrier” and in-
2 serting “medicare administrative contractor”.

3 (9) Subsection (p)(3)(A) is amended by striking “car-
4 rier” and inserting “medicare administrative contractor”.

5 (10) Subsection (q)(1)(A) is amended by striking “car-
6 rier”.

7 (d) EFFECTIVE DATE; TRANSITION RULE.—

8 (1) EFFECTIVE DATE.—

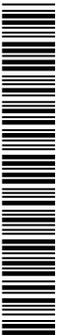
9 (A) IN GENERAL.—Except as otherwise provided
10 in this subsection, the amendments made by this sec-
11 tion shall take effect on October 1, 2005, and the Sec-
12 retary is authorized to take such steps before such date
13 as may be necessary to implement such amendments on
14 a timely basis.

15 (B) CONSTRUCTION FOR CURRENT CONTRACTS.—
16 Such amendments shall not apply to contracts in effect
17 before the date specified under subparagraph (A) that
18 continue to retain the terms and conditions in effect on
19 such date (except as otherwise provided under this Act,
20 other than under this section) until such date as the
21 contract is let out for competitive bidding under such
22 amendments.

23 (C) DEADLINE FOR COMPETITIVE BIDDING.—The
24 Secretary shall provide for the letting by competitive
25 bidding of all contracts for functions of medicare ad-
26 ministrative contractors for annual contract periods
27 that begin on or after October 1, 2010.

28 (D) WAIVER OF PROVIDER NOMINATION PROVI-
29 SIONS DURING TRANSITION.—During the period begin-
30 ning on the date of the enactment of this Act and be-
31 fore the date specified under subparagraph (A), the
32 Secretary may enter into new agreements under section
33 1816 of the Social Security Act (42 U.S.C. 1395h)
34 without regard to any of the provider nomination provi-
35 sions of such section.

36 (2) GENERAL TRANSITION RULES.—The Secretary
37 shall take such steps, consistent with paragraph (1)(B) and



1 (1)(C), as are necessary to provide for an appropriate tran-
2 sition from contracts under section 1816 and section 1842
3 of the Social Security Act (42 U.S.C. 1395h, 1395u) to
4 contracts under section 1874A, as added by subsection
5 (a)(1).

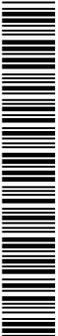
6 (3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS
7 UNDER CURRENT CONTRACTS AND AGREEMENTS AND
8 UNDER ROLLOVER CONTRACTS.—The provisions contained
9 in the exception in section 1893(d)(2) of the Social Secu-
10 rity Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply
11 notwithstanding the amendments made by this section, and
12 any reference in such provisions to an agreement or con-
13 tract shall be deemed to include a contract under section
14 1874A of such Act, as inserted by subsection (a)(1), that
15 continues the activities referred to in such provisions.

16 (e) REFERENCES.—On and after the effective date pro-
17 vided under subsection (d)(1), any reference to a fiscal inter-
18 mediary or carrier under title XI or XVIII of the Social Secu-
19 rity Act (or any regulation, manual instruction, interpretative
20 rule, statement of policy, or guideline issued to carry out such
21 titles) shall be deemed a reference to an appropriate medicare
22 administrative contractor (as provided under section 1874A of
23 the Social Security Act).

24 (f) REPORTS ON IMPLEMENTATION.—

25 (1) PLAN FOR IMPLEMENTATION.—By not later than
26 October 1, 2004, the Secretary shall submit a report to
27 Congress and the Comptroller General of the United States
28 that describes the plan for implementation of the amend-
29 ments made by this section. The Comptroller General shall
30 conduct an evaluation of such plan and shall submit to
31 Congress, not later than 6 months after the date the report
32 is received, a report on such evaluation and shall include
33 in such report such recommendations as the Comptroller
34 General deems appropriate.

35 (2) STATUS OF IMPLEMENTATION.—The Secretary
36 shall submit a report to Congress not later than October
37 1, 2008, that describes the status of implementation of



1 such amendments and that includes a description of the
2 following:

3 (A) The number of contracts that have been com-
4 petitively bid as of such date.

5 (B) The distribution of functions among contracts
6 and contractors.

7 (C) A timeline for complete transition to full com-
8 petition.

9 (D) A detailed description of how the Secretary
10 has modified oversight and management of medicare
11 contractors to adapt to full competition.

12 **SEC. 202. REQUIREMENTS FOR INFORMATION SECURITY**
13 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**
14 **TORS.**

15 (a) IN GENERAL.—Section 1874A, as added by section
16 201(a)(1), is amended by adding at the end the following new
17 subsection:

18 “(e) REQUIREMENTS FOR INFORMATION SECURITY.—

19 “(1) DEVELOPMENT OF INFORMATION SECURITY PRO-
20 GRAM.—A medicare administrative contractor that per-
21 forms the functions referred to in subparagraphs (A) and
22 (B) of subsection (a)(4) (relating to determining and mak-
23 ing payments) shall implement a contractor-wide informa-
24 tion security program to provide information security for
25 the operation and assets of the contractor with respect to
26 such functions under this title. An information security
27 program under this paragraph shall meet the requirements
28 for information security programs imposed on Federal
29 agencies under paragraphs (1) through (8) of section
30 3544(b) of title 44, United States Code (other than re-
31 quirements under paragraphs (2)(D)(i), (5)(A), and (5)(B)
32 of such section).

33 “(2) INDEPENDENT AUDITS.—

34 “(A) PERFORMANCE OF ANNUAL EVALUATIONS.—

35 Each year a medicare administrative contractor that
36 performs the functions referred to in subparagraphs
37 (A) and (B) of subsection (a)(4) (relating to deter-



1 mining and making payments) shall undergo an evalua-
 2 tion of the information security of the contractor with
 3 respect to such functions under this title. The evalua-
 4 tion shall—

5 “(i) be performed by an entity that meets such
 6 requirements for independence as the Inspector
 7 General of the Department of Health and Human
 8 Services may establish; and

9 “(ii) test the effectiveness of information secu-
 10 rity policies, procedures, and practices of a rep-
 11 resentative subset of the contractor’s information
 12 systems (as defined in section 3502(8) of title 44,
 13 United States Code) relating to such functions
 14 under this title and an assessment of compliance
 15 with the requirements of this subsection and re-
 16 lated information security policies, procedures,
 17 standards and guidelines, including policies and
 18 procedures as may be prescribed by the Director of
 19 the Office of Management and Budget and applica-
 20 ble information security standards promulgated
 21 under section 11331 of title 40, United States
 22 Code.

23 “(B) DEADLINE FOR INITIAL EVALUATION.—

24 “(i) NEW CONTRACTORS.—In the case of a
 25 medicare administrative contractor covered by this
 26 subsection that has not previously performed the
 27 functions referred to in subparagraphs (A) and (B)
 28 of subsection (a)(4) (relating to determining and
 29 making payments) as a fiscal intermediary or car-
 30 rier under section 1816 or 1842, the first inde-
 31 pendent evaluation conducted pursuant subpara-
 32 graph (A) shall be completed prior to commencing
 33 such functions.

34 “(ii) OTHER CONTRACTORS.—In the case of a
 35 medicare administrative contractor covered by this
 36 subsection that is not described in clause (i), the
 37 first independent evaluation conducted pursuant



1 subparagraph (A) shall be completed within 1 year
2 after the date the contractor commences functions
3 referred to in clause (i) under this section.

4 “(C) REPORTS ON EVALUATIONS.—

5 “(i) TO THE DEPARTMENT OF HEALTH AND
6 HUMAN SERVICES.—The results of independent
7 evaluations under subparagraph (A) shall be sub-
8 mitted promptly to the Inspector General of the
9 Department of Health and Human Services and to
10 the Secretary.

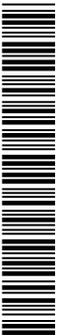
11 “(ii) TO CONGRESS.—The Inspector General
12 of Department of Health and Human Services shall
13 submit to Congress annual reports on the results of
14 such evaluations, including assessments of the
15 scope and sufficiency of such evaluations.

16 “(iii) AGENCY REPORTING.—The Secretary
17 shall address the results of such evaluations in re-
18 ports required under section 3544(c) of title 44,
19 United States Code.”.

20 (b) APPLICATION OF REQUIREMENTS TO FISCAL INTER-
21 MEDIARIES AND CARRIERS.—

22 (1) IN GENERAL.—The provisions of section
23 1874A(e)(2) of the Social Security Act (other than sub-
24 paragraph (B)), as added by subsection (a), shall apply to
25 each fiscal intermediary under section 1816 of the Social
26 Security Act (42 U.S.C. 1395h) and each carrier under
27 section 1842 of such Act (42 U.S.C. 1395u) in the same
28 manner as they apply to medicare administrative contrac-
29 tors under such provisions.

30 (2) DEADLINE FOR INITIAL EVALUATION.—In the case
31 of such a fiscal intermediary or carrier with an agreement
32 or contract under such respective section in effect as of the
33 date of the enactment of this Act, the first evaluation
34 under section 1874A(e)(2)(A) of the Social Security Act
35 (as added by subsection (a)), pursuant to paragraph (1),
36 shall be completed (and a report on the evaluation sub-



1 mitted to the Secretary) by not later than 1 year after such
2 date.

3 **TITLE III—EDUCATION AND** 4 **OUTREACH**

5 **SEC. 301. PROVIDER EDUCATION AND TECHNICAL AS-** 6 **SISTANCE.**

7 (a) COORDINATION OF EDUCATION FUNDING.—

8 (1) IN GENERAL.—The Social Security Act is amended
9 by inserting after section 1888 the following new section:
10 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

11 “SEC. 1889. (a) COORDINATION OF EDUCATION FUND-
12 ING.—The Secretary shall coordinate the educational activities
13 provided through medicare contractors (as defined in sub-
14 section (g), including under section 1893) in order to maximize
15 the effectiveness of Federal education efforts for providers of
16 services and suppliers.”.

17 (2) EFFECTIVE DATE.—The amendment made by
18 paragraph (1) shall take effect on the date of the enact-
19 ment of this Act.

20 (3) REPORT.—Not later than October 1, 2004, the
21 Secretary shall submit to Congress a report that includes
22 a description and evaluation of the steps taken to coordi-
23 nate the funding of provider education under section
24 1889(a) of the Social Security Act, as added by paragraph
25 (1).

26 (b) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-
27 ANCE.—

28 (1) IN GENERAL.—Section 1874A, as added by section
29 201(a)(1) and as amended by section 202(a), is amended
30 by adding at the end the following new subsection:

31 “(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-
32 ANCE IN PROVIDER EDUCATION AND OUTREACH.—The Sec-
33 retary shall use specific claims payment error rates or similar
34 methodology of medicare administrative contractors in the
35 processing or reviewing of medicare claims in order to give such
36 contractors an incentive to implement effective education and
37 outreach programs for providers of services and suppliers.”.



1 (2) APPLICATION TO FISCAL INTERMEDIARIES AND
2 CARRIERS.—The provisions of section 1874A(f) of the So-
3 cial Security Act, as added by paragraph (1), shall apply
4 to each fiscal intermediary under section 1816 of the Social
5 Security Act (42 U.S.C. 1395h) and each carrier under
6 section 1842 of such Act (42 U.S.C. 1395u) in the same
7 manner as they apply to medicare administrative contrac-
8 tors under such provisions.

9 (3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—
10 Not later than October 1, 2004, the Comptroller General
11 of the United States shall submit to Congress and to the
12 Secretary a report on the adequacy of the methodology
13 under section 1874A(f) of the Social Security Act, as added
14 by paragraph (1), and shall include in the report such rec-
15 ommendations as the Comptroller General determines ap-
16 propriate with respect to the methodology.

17 (4) REPORT ON USE OF METHODOLOGY IN ASSESSING
18 CONTRACTOR PERFORMANCE.—Not later than October 1,
19 2004, the Secretary shall submit to Congress a report that
20 describes how the Secretary intends to use such method-
21 ology in assessing medicare contractor performance in im-
22 plementing effective education and outreach programs, in-
23 cluding whether to use such methodology as a basis for per-
24 formance bonuses. The report shall include an analysis of
25 the sources of identified errors and potential changes in
26 systems of contractors and rules of the Secretary that could
27 reduce claims error rates.

28 (c) PROVISION OF ACCESS TO AND PROMPT RESPONSES
29 FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

30 (1) IN GENERAL.—Section 1874A, as added by section
31 201(a)(1) and as amended by section 202(a) and sub-
32 section (b), is further amended by adding at the end the
33 following new subsection:

34 “(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS
35 OF SERVICES AND SUPPLIERS.—

36 “(1) COMMUNICATION STRATEGY.—The Secretary
37 shall develop a strategy for communications with individ-



1 uals entitled to benefits under part A or enrolled under
2 part B, or both, and with providers of services and sup-
3 pliers under this title.

4 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each medi-
5 care administrative contractor shall, for those providers of
6 services and suppliers which submit claims to the con-
7 tractor for claims processing and for those individuals enti-
8 tled to benefits under part A or enrolled under part B, or
9 both, with respect to whom claims are submitted for claims
10 processing, provide general written responses (which may
11 be through electronic transmission) in a clear, concise, and
12 accurate manner to inquiries of providers of services, sup-
13 pliers and individuals entitled to benefits under part A or
14 enrolled under part B, or both, concerning the programs
15 under this title within 45 business days of the date of re-
16 ceipt of such inquiries.

17 “(3) RESPONSE TO TOLL-FREE LINES.—The Secretary
18 shall ensure that each medicare administrative contractor
19 shall provide, for those providers of services and suppliers
20 which submit claims to the contractor for claims processing
21 and for those individuals entitled to benefits under part A
22 or enrolled under part B, or both, with respect to whom
23 claims are submitted for claims processing, a toll-free tele-
24 phone number at which such individuals, providers of serv-
25 ices and suppliers may obtain information regarding billing,
26 coding, claims, coverage, and other appropriate information
27 under this title.

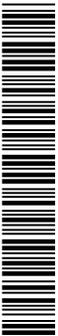
28 “(4) MONITORING OF CONTRACTOR RESPONSES.—

29 “(A) IN GENERAL.—Each medicare administrative
30 contractor shall, consistent with standards developed by
31 the Secretary under subparagraph (B)—

32 “(i) maintain a system for identifying who
33 provides the information referred to in paragraphs
34 (2) and (3); and

35 “(ii) monitor the accuracy, consistency, and
36 timeliness of the information so provided.

37 “(B) DEVELOPMENT OF STANDARDS.—



1 “(i) IN GENERAL.—The Secretary shall estab-
2 lish and make public standards to monitor the ac-
3 curacy, consistency, and timeliness of the informa-
4 tion provided in response to written and telephone
5 inquiries under this subsection. Such standards
6 shall be consistent with the performance require-
7 ments established under subsection (b)(3).

8 “(ii) EVALUATION.—In conducting evaluations
9 of individual medicare administrative contractors,
10 the Secretary shall take into account the results of
11 the monitoring conducted under subparagraph (A)
12 taking into account as performance requirements
13 the standards established under clause (i). The
14 Secretary shall, in consultation with organizations
15 representing providers of services, suppliers, and
16 individuals entitled to benefits under part A or en-
17 rolled under part B, or both, establish standards
18 relating to the accuracy, consistency, and timeliness
19 of the information so provided.

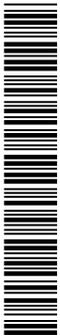
20 “(C) DIRECT MONITORING.—Nothing in this para-
21 graph shall be construed as preventing the Secretary
22 from directly monitoring the accuracy, consistency, and
23 timeliness of the information so provided.”.

24 (2) EFFECTIVE DATE.—The amendment made by
25 paragraph (1) shall take effect October 1, 2004.

26 (3) APPLICATION TO FISCAL INTERMEDIARIES AND
27 CARRIERS.—The provisions of section 1874A(g) of the So-
28 cial Security Act, as added by paragraph (1), shall apply
29 to each fiscal intermediary under section 1816 of the Social
30 Security Act (42 U.S.C. 1395h) and each carrier under
31 section 1842 of such Act (42 U.S.C. 1395u) in the same
32 manner as they apply to medicare administrative contrac-
33 tors under such provisions.

34 (d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

35 (1) IN GENERAL.—Section 1889, as added by sub-
36 section (a), is amended by adding at the end the following
37 new subsections:



1 “(b) ENHANCED EDUCATION AND TRAINING.—

2 “(1) ADDITIONAL RESOURCES.—There are authorized
3 to be appropriated to the Secretary (in appropriate part
4 from the Federal Hospital Insurance Trust Fund and the
5 Federal Supplementary Medical Insurance Trust Fund)
6 \$25,000,000 for each of fiscal years 2005 and 2006 and
7 such sums as may be necessary for succeeding fiscal years.

8 “(2) USE.—The funds made available under para-
9 graph (1) shall be used to increase the conduct by medicare
10 contractors of education and training of providers of serv-
11 ices and suppliers regarding billing, coding, and other ap-
12 propriate items and may also be used to improve the accu-
13 racy, consistency, and timeliness of contractor responses.

14 “(c) TAILORING EDUCATION AND TRAINING ACTIVITIES
15 FOR SMALL PROVIDERS OR SUPPLIERS.—

16 “(1) IN GENERAL.—Insofar as a medicare contractor
17 conducts education and training activities, it shall tailor
18 such activities to meet the special needs of small providers
19 of services or suppliers (as defined in paragraph (2)).

20 “(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—
21 In this subsection, the term ‘small provider of services or
22 supplier’ means—

23 “(A) a provider of services with fewer than 25 full-
24 time-equivalent employees; or

25 “(B) a supplier with fewer than 10 full-time-equiv-
26 alent employees.”.

27 (2) EFFECTIVE DATE.—The amendment made by
28 paragraph (1) shall take effect on October 1, 2004.

29 (e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

30 (1) IN GENERAL.—Section 1889, as added by sub-
31 section (a) and as amended by subsection (d), is further
32 amended by adding at the end the following new sub-
33 section:

34 “(d) INTERNET SITES; FAQs.—The Secretary, and each
35 medicare contractor insofar as it provides services (including
36 claims processing) for providers of services or suppliers, shall
37 maintain an Internet site which—



1 “(1) provides answers in an easily accessible format to
2 frequently asked questions, and

3 “(2) includes other published materials of the con-
4 tractor,

5 that relate to providers of services and suppliers under the pro-
6 grams under this title (and title XI insofar as it relates to such
7 programs).”.

8 (2) EFFECTIVE DATE.—The amendment made by
9 paragraph (1) shall take effect on October 1, 2004.

10 (f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

11 (1) IN GENERAL.—Section 1889, as added by sub-
12 section (a) and as amended by subsections (d) and (e), is
13 further amended by adding at the end the following new
14 subsections:

15 “(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION
16 PROGRAM ACTIVITIES.—A medicare contractor may not use a
17 record of attendance at (or failure to attend) educational activi-
18 ties or other information gathered during an educational pro-
19 gram conducted under this section or otherwise by the Sec-
20 retary to select or track providers of services or suppliers for
21 the purpose of conducting any type of audit or prepayment re-
22 view.

23 “(f) CONSTRUCTION.—Nothing in this section or section
24 1893(g) shall be construed as providing for disclosure by a
25 medicare contractor of information that would compromise
26 pending law enforcement activities or reveal findings of law en-
27 forcement-related audits.

28 “(g) DEFINITIONS.—For purposes of this section, the
29 term ‘medicare contractor’ includes the following:

30 “(1) A medicare administrative contractor with a con-
31 tract under section 1874A, including a fiscal intermediary
32 with a contract under section 1816 and a carrier with a
33 contract under section 1842.

34 “(2) An eligible entity with a contract under section
35 1893.

36 Such term does not include, with respect to activities of a spe-
37 cific provider of services or supplier an entity that has no au-



1 thority under this title or title IX with respect to such activities
2 and such provider of services or supplier.”.

3 (2) EFFECTIVE DATE.—The amendment made by
4 paragraph (1) shall take effect on the date of the enact-
5 ment of this Act.

6 **SEC. 302. SMALL PROVIDER TECHNICAL ASSISTANCE**
7 **DEMONSTRATION PROGRAM.**

8 (a) ESTABLISHMENT.—

9 (1) IN GENERAL.—The Secretary shall establish a
10 demonstration program (in this section referred to as the
11 “demonstration program”) under which technical assist-
12 ance described in paragraph (2) is made available, upon re-
13 quest and on a voluntary basis, to small providers of serv-
14 ices or suppliers in order to improve compliance with the
15 applicable requirements of the programs under medicare
16 program under title XVIII of the Social Security Act (in-
17 cluding provisions of title XI of such Act insofar as they
18 relate to such title and are not administered by the Office
19 of the Inspector General of the Department of Health and
20 Human Services).

21 (2) FORMS OF TECHNICAL ASSISTANCE.—The tech-
22 nical assistance described in this paragraph is—

23 (A) evaluation and recommendations regarding
24 billing and related systems; and

25 (B) information and assistance regarding policies
26 and procedures under the medicare program, including
27 coding and reimbursement.

28 (3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—
29 In this section, the term “small providers of services or
30 suppliers” means—

31 (A) a provider of services with fewer than 25 full-
32 time-equivalent employees; or

33 (B) a supplier with fewer than 10 full-time-equa-
34 lent employees.

35 (b) QUALIFICATION OF CONTRACTORS.—In conducting the
36 demonstration program, the Secretary shall enter into contracts
37 with qualified organizations (such as peer review organizations



1 or entities described in section 1889(g)(2) of the Social Secu-
2 rity Act, as inserted by section 5(f)(1)) with appropriate exper-
3 tise with billing systems of the full range of providers of serv-
4 ices and suppliers to provide the technical assistance. In award-
5 ing such contracts, the Secretary shall consider any prior inves-
6 tigations of the entity's work by the Inspector General of De-
7 partment of Health and Human Services or the Comptroller
8 General of the United States.

9 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The tech-
10 nical assistance provided under the demonstration program
11 shall include a direct and in-person examination of billing sys-
12 tems and internal controls of small providers of services or sup-
13 pliers to determine program compliance and to suggest more
14 efficient or effective means of achieving such compliance.

15 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS
16 IDENTIFIED AS CORRECTED.—The Secretary shall provide
17 that, absent evidence of fraud and notwithstanding any other
18 provision of law, any errors found in a compliance review for
19 a small provider of services or supplier that participates in the
20 demonstration program shall not be subject to recovery action
21 if the technical assistance personnel under the program deter-
22 mine that—

23 (1) the problem that is the subject of the compliance
24 review has been corrected to their satisfaction within 30
25 days of the date of the visit by such personnel to the small
26 provider of services or supplier; and

27 (2) such problem remains corrected for such period as
28 is appropriate.

29 The previous sentence applies only to claims filed as part of the
30 demonstration program and lasts only for the duration of such
31 program and only as long as the small provider of services or
32 supplier is a participant in such program.

33 (e) GAO EVALUATION.—Not later than 2 years after the
34 date of the date the demonstration program is first imple-
35 mented, the Comptroller General, in consultation with the In-
36 spector General of the Department of Health and Human Serv-
37 ices, shall conduct an evaluation of the demonstration program.



1 The evaluation shall include a determination of whether claims
2 error rates are reduced for small providers of services or sup-
3 pliers who participated in the program and the extent of im-
4 proper payments made as a result of the demonstration pro-
5 gram. The Comptroller General shall submit a report to the
6 Secretary and the Congress on such evaluation and shall in-
7 clude in such report recommendations regarding the continu-
8 ation or extension of the demonstration program.

9 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The pro-
10 vision of technical assistance to a small provider of services or
11 supplier under the demonstration program is conditioned upon
12 the small provider of services or supplier paying an amount es-
13 timated (and disclosed in advance of a provider’s or supplier’s
14 participation in the program) to be equal to 25 percent of the
15 cost of the technical assistance.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—There are au-
17 thorized to be appropriated to the Secretary (in appropriate
18 part from the Federal Hospital Insurance Trust Fund and the
19 Federal Supplementary Medical Insurance Trust Fund) to
20 carry out the demonstration program—

21 (1) for fiscal year 2005, \$1,000,000, and

22 (2) for fiscal year 2006, \$6,000,000.

23 **SEC. 303. MEDICARE PROVIDER OMBUDSMAN; MEDI-**
24 **CARE BENEFICIARY OMBUDSMAN.**

25 (a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868
26 (42 U.S.C. 1395ee) is amended—

27 (1) by adding at the end of the heading the following:

28 “; MEDICARE PROVIDER OMBUDSMAN”;

29 (2) by inserting “PRACTICING PHYSICIANS ADVISORY
30 COUNCIL.—(1)” after “(a)”;

31 (3) in paragraph (1), as so redesignated under para-
32 graph (2), by striking “in this section” and inserting “in
33 this subsection”;

34 (4) by redesignating subsections (b) and (c) as para-
35 graphs (2) and (3), respectively; and

36 (5) by adding at the end the following new subsection:



1 “(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary
2 shall appoint within the Department of Health and Human
3 Services a Medicare Provider Ombudsman. The Ombudsman
4 shall—

5 “(1) provide assistance, on a confidential basis, to pro-
6 viders of services and suppliers with respect to complaints,
7 grievances, and requests for information concerning the
8 programs under this title (including provisions of title XI
9 insofar as they relate to this title and are not administered
10 by the Office of the Inspector General of the Department
11 of Health and Human Services) and in the resolution of
12 unclear or conflicting guidance given by the Secretary and
13 medicare contractors to such providers of services and sup-
14 pliers regarding such programs and provisions and require-
15 ments under this title and such provisions; and

16 “(2) submit recommendations to the Secretary for im-
17 provement in the administration of this title and such pro-
18 visions, including—

19 “(A) recommendations to respond to recurring
20 patterns of confusion in this title and such provisions
21 (including recommendations regarding suspending im-
22 position of sanctions where there is widespread confu-
23 sion in program administration), and

24 “(B) recommendations to provide for an appro-
25 priate and consistent response (including not providing
26 for audits) in cases of self-identified overpayments by
27 providers of services and suppliers.

28 The Ombudsman shall not serve as an advocate for any in-
29 creases in payments or new coverage of services, but may iden-
30 tify issues and problems in payment or coverage policies.”.

31 (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII
32 is amended by inserting after section 1806 the following new
33 section:

34 “MEDICARE BENEFICIARY OMBUDSMAN
35 “SEC. 1807. (a) IN GENERAL.—The Secretary shall ap-
36 point within the Department of Health and Human Services a
37 Medicare Beneficiary Ombudsman who shall have expertise and



1 experience in the fields of health care and education of (and
2 assistance to) individuals entitled to benefits under this title.

3 “(b) DUTIES.—The Medicare Beneficiary Ombudsman
4 shall—

5 “(1) receive complaints, grievances, and requests for
6 information submitted by individuals entitled to benefits
7 under part A or enrolled under part B, or both, with re-
8 spect to any aspect of the medicare program;

9 “(2) provide assistance with respect to complaints,
10 grievances, and requests referred to in paragraph (1),
11 including—

12 “(A) assistance in collecting relevant information
13 for such individuals, to seek an appeal of a decision or
14 determination made by a fiscal intermediary, carrier,
15 Medicare+Choice organization, or the Secretary; and

16 “(B) assistance to such individuals with any prob-
17 lems arising from disenrollment from a
18 Medicare+Choice plan under part C; and

19 “(3) submit annual reports to Congress and the Sec-
20 retary that describe the activities of the Office and that in-
21 clude such recommendations for improvement in the admin-
22 istration of this title as the Ombudsman determines appro-
23 priate.

24 The Ombudsman shall not serve as an advocate for any in-
25 creases in payments or new coverage of services, but may iden-
26 tify issues and problems in payment or coverage policies.

27 “(c) WORKING WITH HEALTH INSURANCE COUNSELING
28 PROGRAMS.—To the extent possible, the Ombudsman shall
29 work with health insurance counseling programs (receiving
30 funding under section 4360 of Omnibus Budget Reconciliation
31 Act of 1990) to facilitate the provision of information to indi-
32 viduals entitled to benefits under part A or enrolled under part
33 B, or both regarding Medicare+Choice plans and changes to
34 those plans. Nothing in this subsection shall preclude further
35 collaboration between the Ombudsman and such programs.”

36 (c) DEADLINE FOR APPOINTMENT.—The Secretary shall
37 appoint the Medicare Provider Ombudsman and the Medicare



1 Beneficiary Ombudsman, under the amendments made by sub-
2 sections (a) and (b), respectively, by not later than 1 year after
3 the date of the enactment of this Act.

4 (d) FUNDING.—There are authorized to be appropriated to
5 the Secretary (in appropriate part from the Federal Hospital
6 Insurance Trust Fund and the Federal Supplementary Medical
7 Insurance Trust Fund) to carry out the provisions of sub-
8 section (b) of section 1868 of the Social Security Act (relating
9 to the Medicare Provider Ombudsman), as added by subsection
10 (a)(5) and section 1807 of such Act (relating to the Medicare
11 Beneficiary Ombudsman), as added by subsection (b), such
12 sums as are necessary for fiscal year 2004 and each succeeding
13 fiscal year.

14 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-
15 MEDICARE).—

16 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE
17 HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—
18 Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by
19 adding at the end the following: “The Secretary shall pro-
20 vide, through the toll-free number 1-800-MEDICARE, for
21 a means by which individuals seeking information about, or
22 assistance with, such programs who phone such toll-free
23 number are transferred (without charge) to appropriate en-
24 tities for the provision of such information or assistance.
25 Such toll-free number shall be the toll-free number listed
26 for general information and assistance in the annual notice
27 under subsection (a) instead of the listing of numbers of
28 individual contractors.”.

29 (2) MONITORING ACCURACY.—

30 (A) STUDY.—The Comptroller General of the
31 United States shall conduct a study to monitor the ac-
32 curacy and consistency of information provided to indi-
33 viduals entitled to benefits under part A or enrolled
34 under part B, or both, through the toll-free number 1-
35 800-MEDICARE, including an assessment of whether
36 the information provided is sufficient to answer ques-
37 tions of such individuals. In conducting the study, the



1 Comptroller General shall examine the education and
2 training of the individuals providing information
3 through such number.

4 (B) REPORT.—Not later than 1 year after the
5 date of the enactment of this Act, the Comptroller Gen-
6 eral shall submit to Congress a report on the study
7 conducted under subparagraph (A).

8 **SEC. 304. BENEFICIARY OUTREACH DEMONSTRATION**
9 **PROGRAM.**

10 (a) IN GENERAL.—The Secretary shall establish a dem-
11 onstration program (in this section referred to as the “dem-
12 onstration program”) under which medicare specialists em-
13 ployed by the Department of Health and Human Services pro-
14 vide advice and assistance to individuals entitled to benefits
15 under part A of title XVIII of the Social Security Act, or en-
16 rolled under part B of such title, or both, regarding the medi-
17 care program at the location of existing local offices of the So-
18 cial Security Administration.

19 (b) LOCATIONS.—

20 (1) IN GENERAL.—The demonstration program shall
21 be conducted in at least 6 offices or areas. Subject to para-
22 graph (2), in selecting such offices and areas, the Secretary
23 shall provide preference for offices with a high volume of
24 visits by individuals referred to in subsection (a).

25 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—The
26 Secretary shall provide for the selection of at least 2 rural
27 areas to participate in the demonstration program. In con-
28 ducting the demonstration program in such rural areas, the
29 Secretary shall provide for medicare specialists to travel
30 among local offices in a rural area on a scheduled basis.

31 (c) DURATION.—The demonstration program shall be con-
32 ducted over a 3-year period.

33 (d) EVALUATION AND REPORT.—

34 (1) EVALUATION.—The Secretary shall provide for an
35 evaluation of the demonstration program. Such evaluation
36 shall include an analysis of—



1 (A) utilization of, and satisfaction of those individ-
2 uals referred to in subsection (a) with, the assistance
3 provided under the program; and

4 (B) the cost-effectiveness of providing beneficiary
5 assistance through out-stationing medicare specialists
6 at local offices of the Social Security Administration.

7 (2) REPORT.—The Secretary shall submit to Congress
8 a report on such evaluation and shall include in such report
9 recommendations regarding the feasibility of permanently
10 out-stationing medicare specialists at local offices of the So-
11 cial Security Administration.

12 **SEC. 305. INCLUSION OF ADDITIONAL INFORMATION IN**
13 **NOTICES TO BENEFICIARIES ABOUT**
14 **SKILLED NURSING FACILITY BENEFITS.**

15 (a) IN GENERAL.—The Secretary shall provide that in
16 medicare beneficiary notices provided (under section 1806(a) of
17 the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to
18 the provision of post-hospital extended care services under part
19 A of title XVIII of the Social Security Act, there shall be in-
20 cluded information on the number of days of coverage of such
21 services remaining under such part for the medicare beneficiary
22 and spell of illness involved.

23 (b) EFFECTIVE DATE.—Subsection (a) shall apply to no-
24 tices provided during calendar quarters beginning more than 6
25 months after the date of the enactment of this Act.

26 **SEC. 306. INFORMATION ON MEDICARE-CERTIFIED**
27 **SKILLED NURSING FACILITIES IN HOSPITAL**
28 **DISCHARGE PLANS.**

29 (a) AVAILABILITY OF DATA.—The Secretary shall publicly
30 provide information that enables hospital discharge planners,
31 medicare beneficiaries, and the public to identify skilled nursing
32 facilities that are participating in the medicare program.

33 (b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL
34 DISCHARGE PLANS.—

35 (1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C.
36 1395x(ee)(2)(D)) is amended—



1 (A) by striking “hospice services” and inserting
2 “hospice care and post-hospital extended care services”;
3 and

4 (B) by inserting before the period at the end the
5 following: “and, in the case of individuals who are like-
6 ly to need post-hospital extended care services, the
7 availability of such services through facilities that par-
8 ticipate in the program under this title and that serve
9 the area in which the patient resides”.

10 (2) EFFECTIVE DATE.—The amendments made by
11 paragraph (1) shall apply to discharge plans made on or
12 after such date as the Secretary shall specify, but not later
13 than 6 months after the date the Secretary provides for
14 availability of information under subsection (a).

15 **TITLE IV—APPEALS AND** 16 **RECOVERY**

17 **SEC. 401. TRANSFER OF RESPONSIBILITY FOR MEDI-** 18 **CARE APPEALS.**

19 (a) TRANSITION PLAN.—

20 (1) IN GENERAL.—Not later than October 1, 2004,
21 the Commissioner of Social Security and the Secretary
22 shall develop and transmit to Congress and the Comptroller
23 General of the United States a plan under which the func-
24 tions of administrative law judges responsible for hearing
25 cases under title XVIII of the Social Security Act (and re-
26 lated provisions in title XI of such Act) are transferred
27 from the responsibility of the Commissioner and the Social
28 Security Administration to the Secretary and the Depart-
29 ment of Health and Human Services.

30 (2) GAO EVALUATION.—The Comptroller General of
31 the United States shall evaluate the plan and, not later
32 than the date that is 6 months after the date on which the
33 plan is received by the Comptroller General, shall submit
34 to Congress a report on such evaluation.

35 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

36 (1) IN GENERAL.—Not earlier than July 1, 2005, and
37 not later than October 1, 2005, the Commissioner of Social



1 Security and the Secretary shall implement the transition
2 plan under subsection (a) and transfer the administrative
3 law judge functions described in such subsection from the
4 Social Security Administration to the Secretary.

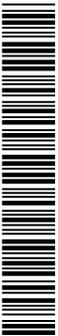
5 (2) ASSURING INDEPENDENCE OF JUDGES.—The Sec-
6 retary shall assure the independence of administrative law
7 judges performing the administrative law judge functions
8 transferred under paragraph (1) from the Centers for
9 Medicare & Medicaid Services and its contractors. In order
10 to assure such independence, the Secretary shall place such
11 judges in an administrative office that is organizationally
12 and functionally separate from such Centers.

13 (3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall
14 provide for an appropriate geographic distribution of ad-
15 ministrative law judges performing the administrative law
16 judge functions transferred under paragraph (1) through-
17 out the United States to ensure timely access to such
18 judges.

19 (4) HIRING AUTHORITY.—Subject to the amounts pro-
20 vided in advance in appropriations Act, the Secretary shall
21 have authority to hire administrative law judges to hear
22 such cases, giving priority to those judges with prior experi-
23 ence in handling medicare appeals and in a manner con-
24 sistent with paragraph (3), and to hire support staff for
25 such judges.

26 (5) FINANCING.—Amounts payable under law to the
27 Commissioner for administrative law judges performing the
28 administrative law judge functions transferred under para-
29 graph (1) from the Federal Hospital Insurance Trust Fund
30 and the Federal Supplementary Medical Insurance Trust
31 Fund shall become payable to the Secretary for the func-
32 tions so transferred.

33 (6) SHARED RESOURCES.—The Secretary shall enter
34 into such arrangements with the Commissioner as may be
35 appropriate with respect to transferred functions of admin-
36 istrative law judges to share office space, support staff, and



1 other resources, with appropriate reimbursement from the
2 Trust Funds described in paragraph (5).

3 (c) INCREASED FINANCIAL SUPPORT.—In addition to any
4 amounts otherwise appropriated, to ensure timely action on ap-
5 peals before administrative law judges and the Departmental
6 Appeals Board consistent with section 1869 of the Social Secu-
7 rity Act (as amended by section 521 of BIPA, 114 Stat.
8 2763A–534), there are authorized to be appropriated (in appro-
9 priate part from the Federal Hospital Insurance Trust Fund
10 and the Federal Supplementary Medical Insurance Trust
11 Fund) to the Secretary such sums as are necessary for fiscal
12 year 2005 and each subsequent fiscal year to—

13 (1) increase the number of administrative law judges
14 (and their staffs) under subsection (b)(4);

15 (2) improve education and training opportunities for
16 administrative law judges (and their staffs); and

17 (3) increase the staff of the Departmental Appeals
18 Board.

19 (d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i)
20 (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of
21 BIPA (114 Stat. 2763A–543), is amended by striking “of the
22 Social Security Administration”.

23 **SEC. 402. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

24 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section
25 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is
26 amended—

27 (1) in paragraph (1)(A), by inserting “, subject to
28 paragraph (2),” before “to judicial review of the Sec-
29 retary’s final decision”;

30 (2) in paragraph (1)(F)—

31 (A) by striking clause (ii);

32 (B) by striking “PROCEEDING” and all that follows
33 through “DETERMINATION” and inserting “DETER-
34 MINATIONS AND RECONSIDERATIONS”; and

35 (C) by redesignating subclauses (I) and (II) as
36 clauses (i) and (ii) and by moving the indentation of



1 such subclauses (and the matter that follows) 2 ems to
2 the left; and

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

4 “(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

5 “(A) IN GENERAL.—The Secretary shall establish
6 a process under which a provider of services or supplier
7 that furnishes an item or service or an individual enti-
8 tled to benefits under part A or enrolled under part B,
9 or both, who has filed an appeal under paragraph (1)
10 may obtain access to judicial review when a review
11 panel (described in subparagraph (D)), on its own mo-
12 tion or at the request of the appellant, determines that
13 no entity in the administrative appeals process has the
14 authority to decide the question of law or regulation
15 relevant to the matters in controversy and that there
16 is no material issue of fact in dispute. The appellant
17 may make such request only once with respect to a
18 question of law or regulation in a case of an appeal.

19 “(B) PROMPT DETERMINATIONS.—If, after or co-
20 incident with appropriately filing a request for an ad-
21 ministrative hearing, the appellant requests a deter-
22 mination by the appropriate review panel that no re-
23 view panel has the authority to decide the question of
24 law or regulations relevant to the matters in con-
25 troversy and that there is no material issue of fact in
26 dispute and if such request is accompanied by the doc-
27 uments and materials as the appropriate review panel
28 shall require for purposes of making such determina-
29 tion, such review panel shall make a determination on
30 the request in writing within 60 days after the date
31 such review panel receives the request and such accom-
32 panying documents and materials. Such a determina-
33 tion by such review panel shall be considered a final de-
34 cision and not subject to review by the Secretary.

35 “(C) ACCESS TO JUDICIAL REVIEW.—

36 “(i) IN GENERAL.—If the appropriate review
37 panel—



1 “(I) determines that there are no material
 2 issues of fact in dispute and that the only issue
 3 is one of law or regulation that no review panel
 4 has the authority to decide; or

5 “(II) fails to make such determination
 6 within the period provided under subparagraph
 7 (B);

8 then the appellant may bring a civil action as de-
 9 scribed in this subparagraph.

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

12 “(I) clause (i)(I), within 60 days of date
 13 of the determination described in such subpara-
 14 graph; or

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

18 “(iii) VENUE.—Such action shall be brought
 19 in the district court of the United States for the ju-
 20 dicial district in which the appellant is located (or,
 21 in the case of an action brought jointly by more
 22 than one applicant, the judicial district in which
 23 the greatest number of applicants are located) or in
 24 the district court for the District of Columbia.

25 “(iv) INTEREST ON AMOUNTS IN CON-
 26 TROVERSY.—Where a provider of services or sup-
 27 plier seeks judicial review pursuant to this para-
 28 graph, the amount in controversy shall be subject
 29 to annual interest beginning on the first day of the
 30 first month beginning after the 60-day period as
 31 determined pursuant to clause (ii) and equal to the
 32 rate of interest on obligations issued for purchase
 33 by the Federal Hospital Insurance Trust Fund and
 34 by the Federal Supplementary Medical Insurance
 35 Trust Fund for the month in which the civil action
 36 authorized under this paragraph is commenced, to
 37 be awarded by the reviewing court in favor of the



1 prevailing party. No interest awarded pursuant to
2 the preceding sentence shall be deemed income or
3 cost for the purposes of determining reimbursement
4 due providers of services or suppliers under this
5 Act.

6 “(D) REVIEW PANELS.—For purposes of this sub-
7 section, a ‘review panel’ is a panel consisting of 3 mem-
8 bers (who shall be administrative law judges, members
9 of the Departmental Appeals Board, or qualified indi-
10 viduals associated with a qualified independent con-
11 tractor (as defined in subsection (c)(2)) or with another
12 independent entity) designated by the Secretary for
13 purposes of making determinations under this para-
14 graph.”.

15 (b) APPLICATION TO PROVIDER AGREEMENT DETERMINA-
16 TIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is
17 amended—

18 (1) by inserting “(A)” after “(h)(1)”; and

19 (2) by adding at the end the following new subpara-
20 graph:

21 “(B) An institution or agency described in subparagraph
22 (A) that has filed for a hearing under subparagraph (A) shall
23 have expedited access to judicial review under this subpara-
24 graph in the same manner as providers of services, suppliers,
25 and individuals entitled to benefits under part A or enrolled
26 under part B, or both, may obtain expedited access to judicial
27 review under the process established under section 1869(b)(2).
28 Nothing in this subparagraph shall be construed to affect the
29 application of any remedy imposed under section 1819 during
30 the pendency of an appeal under this subparagraph.”.

31 (c) EFFECTIVE DATE.—The amendments made by this
32 section shall apply to appeals filed on or after October 1, 2004.

33 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREE-
34 MENT DETERMINATIONS.—

35 (1) TERMINATION AND CERTAIN OTHER IMMEDIATE
36 REMEDIES.—The Secretary shall develop and implement a
37 process to expedite proceedings under sections 1866(h) of



1 the Social Security Act (42 U.S.C. 1395cc(h)) in which the
2 remedy of termination of participation, or a remedy de-
3 scribed in clause (i) or (iii) of section 1819(h)(2)(B) of
4 such Act (42 U.S.C. 1395i-3(h)(2)(B)) which is applied on
5 an immediate basis, has been imposed. Under such process
6 priority shall be provided in cases of termination.

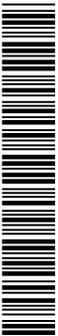
7 (2) INCREASED FINANCIAL SUPPORT.—In addition to
8 any amounts otherwise appropriated, to reduce by 50 per-
9 cent the average time for administrative determinations on
10 appeals under section 1866(h) of the Social Security Act
11 (42 U.S.C. 1395cc(h)), there are authorized to be appro-
12 priated (in appropriate part from the Federal Hospital In-
13 surance Trust Fund and the Federal Supplementary Med-
14 ical Insurance Trust Fund) to the Secretary such addi-
15 tional sums for fiscal year 2005 and each subsequent fiscal
16 year as may be necessary. The purposes for which such
17 amounts are available include increasing the number of ad-
18 ministrative law judges (and their staffs) and the appellate
19 level staff at the Departmental Appeals Board of the De-
20 partment of Health and Human Services and educating
21 such judges and staffs on long-term care issues.

22 **SEC. 403. REVISIONS TO MEDICARE APPEALS PROCESS.**

23 (a) REQUIRING FULL AND EARLY PRESENTATION OF EVI-
24 DENCE.—

25 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
26 1395ff(b)), as amended by BIPA and as amended by sec-
27 tion 402(a), is further amended by adding at the end the
28 following new paragraph:

29 “(3) REQUIRING FULL AND EARLY PRESENTATION OF
30 EVIDENCE BY PROVIDERS.—A provider of services or sup-
31 plier may not introduce evidence in any appeal under this
32 section that was not presented at the reconsideration con-
33 ducted by the qualified independent contractor under sub-
34 section (c), unless there is good cause which precluded the
35 introduction of such evidence at or before that reconsider-
36 ation.”.



1 (2) EFFECTIVE DATE.—The amendment made by
2 paragraph (1) shall take effect on October 1, 2004.

3 (b) USE OF PATIENTS' MEDICAL RECORDS.—Section
4 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended
5 by BIPA, is amended by inserting “(including the medical
6 records of the individual involved)” after “clinical experience”.

7 (c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—
8 (1) INITIAL DETERMINATIONS AND REDETERMINA-
9 TIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amend-
10 ed by BIPA, is amended by adding at the end the following
11 new paragraphs:

12 “(4) REQUIREMENTS OF NOTICE OF DETERMINA-
13 TIONS.—With respect to an initial determination insofar as
14 it results in a denial of a claim for benefits—

15 “(A) the written notice on the determination shall
16 include—

17 “(i) the reasons for the determination, includ-
18 ing whether a local medical review policy or a local
19 coverage determination was used;

20 “(ii) the procedures for obtaining additional
21 information concerning the determination, includ-
22 ing the information described in subparagraph (B);
23 and

24 “(iii) notification of the right to seek a rede-
25 termination or otherwise appeal the determination
26 and instructions on how to initiate such a redeter-
27 mination under this section; and

28 “(B) the person provided such notice may obtain,
29 upon request, the specific provision of the policy, man-
30 ual, or regulation used in making the determination.

31 “(5) REQUIREMENTS OF NOTICE OF REDETERMINA-
32 TIONS.—With respect to a redetermination insofar as it re-
33 sults in a denial of a claim for benefits—

34 “(A) the written notice on the redetermination
35 shall include—

36 “(i) the specific reasons for the redetermina-
37 tion;



1 “(ii) as appropriate, a summary of the clinical
2 or scientific evidence used in making the redeter-
3 mination;

4 “(iii) a description of the procedures for ob-
5 taining additional information concerning the rede-
6 termination; and

7 “(iv) notification of the right to appeal the re-
8 determination and instructions on how to initiate
9 such an appeal under this section;

10 “(B) such written notice shall be provided in
11 printed form and written in a manner calculated to be
12 understood by the individual entitled to benefits under
13 part A or enrolled under part B, or both; and

14 “(C) the person provided such notice may obtain,
15 upon request, information on the specific provision of
16 the policy, manual, or regulation used in making the
17 redetermination.”.

18 (2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42
19 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is
20 amended—

21 (A) by inserting “be written in a manner cal-
22 culated to be understood by the individual entitled to
23 benefits under part A or enrolled under part B, or
24 both, and shall include (to the extent appropriate)”
25 after “in writing, ”; and

26 (B) by inserting “and a notification of the right to
27 appeal such determination and instructions on how to
28 initiate such appeal under this section” after “such de-
29 cision,”.

30 (3) APPEALS.—Section 1869(d) (42 U.S.C.
31 1395ff(d)), as amended by BIPA, is amended—

32 (A) in the heading, by inserting “; NOTICE” after
33 “SECRETARY”; and

34 (B) by adding at the end the following new para-
35 graph:

36 “(4) NOTICE.—Notice of the decision of an adminis-
37 trative law judge shall be in writing in a manner calculated



1 to be understood by the individual entitled to benefits
2 under part A or enrolled under part B, or both, and shall
3 include—

4 “(A) the specific reasons for the determination (in-
5 cluding, to the extent appropriate, a summary of the
6 clinical or scientific evidence used in making the deter-
7 mination);

8 “(B) the procedures for obtaining additional infor-
9 mation concerning the decision; and

10 “(C) notification of the right to appeal the deci-
11 sion and instructions on how to initiate such an appeal
12 under this section.”.

13 (4) SUBMISSION OF RECORD FOR APPEAL.—Section
14 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking
15 “prepare” and inserting “submit” and by striking “with re-
16 spect to” and all that follows through “and relevant poli-
17 cies”.

18 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

19 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDE-
20 PENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C.
21 1395ff(c)(3)), as amended by BIPA, is amended—

22 (A) in subparagraph (A), by striking “sufficient
23 training and expertise in medical science and legal mat-
24 ters” and inserting “sufficient medical, legal, and other
25 expertise (including knowledge of the program under
26 this title) and sufficient staffing”; and

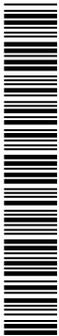
27 (B) by adding at the end the following new sub-
28 paragraph:

29 “(K) INDEPENDENCE REQUIREMENTS.—

30 “(i) IN GENERAL.—Subject to clause (ii), a
31 qualified independent contractor shall not conduct
32 any activities in a case unless the entity—

33 “(I) is not a related party (as defined in
34 subsection (g)(5));

35 “(II) does not have a material familial, fi-
36 nancial, or professional relationship with such a
37 party in relation to such case; and



1 “(III) does not otherwise have a conflict of
2 interest with such a party.

3 “(ii) EXCEPTION FOR REASONABLE COM-
4 PENSATION.—Nothing in clause (i) shall be con-
5 strued to prohibit receipt by a qualified inde-
6 pendent contractor of compensation from the Sec-
7 retary for the conduct of activities under this sec-
8 tion if the compensation is provided consistent with
9 clause (iii).

10 “(iii) LIMITATIONS ON ENTITY COMPENSA-
11 TION.—Compensation provided by the Secretary to
12 a qualified independent contractor in connection
13 with reviews under this section shall not be contin-
14 gent on any decision rendered by the contractor or
15 by any reviewing professional.”.

16 (2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—
17 Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is
18 amended—

19 (A) by amending subsection (c)(3)(D) to read as
20 follows:

21 “(D) QUALIFICATIONS FOR REVIEWERS.—The re-
22 quirements of subsection (g) shall be met (relating to
23 qualifications of reviewing professionals).”; and

24 (B) by adding at the end the following new sub-
25 section:

26 “(g) QUALIFICATIONS OF REVIEWERS.—

27 “(1) IN GENERAL.—In reviewing determinations under
28 this section, a qualified independent contractor shall assure
29 that—

30 “(A) each individual conducting a review shall
31 meet the qualifications of paragraph (2);

32 “(B) compensation provided by the contractor to
33 each such reviewer is consistent with paragraph (3);
34 and

35 “(C) in the case of a review by a panel described
36 in subsection (c)(3)(B) composed of physicians or other
37 health care professionals (each in this subsection re-



1 ferred to as a ‘reviewing professional’), a reviewing pro-
2 fessional meets the qualifications described in para-
3 graph (4) and, where a claim is regarding the fur-
4 nishing of treatment by a physician (allopathic or os-
5 teopathic) or the provision of items or services by a
6 physician (allopathic or osteopathic), a reviewing pro-
7 fessional shall be a physician (allopathic or osteo-
8 pathic).

9 “(2) INDEPENDENCE.—

10 “(A) IN GENERAL.—Subject to subparagraph (B),
11 each individual conducting a review in a case shall—

12 “(i) not be a related party (as defined in para-
13 graph (5));

14 “(ii) not have a material familial, financial, or
15 professional relationship with such a party in the
16 case under review; and

17 “(iii) not otherwise have a conflict of interest
18 with such a party.

19 “(B) EXCEPTION.—Nothing in subparagraph (A)
20 shall be construed to—

21 “(i) prohibit an individual, solely on the basis
22 of a participation agreement with a fiscal inter-
23 mediary, carrier, or other contractor, from serving
24 as a reviewing professional if—

25 “(I) the individual is not involved in the
26 provision of items or services in the case under
27 review;

28 “(II) the fact of such an agreement is dis-
29 closed to the Secretary and the individual enti-
30 tled to benefits under part A or enrolled under
31 part B, or both, (or authorized representative)
32 and neither party objects; and

33 “(III) the individual is not an employee of
34 the intermediary, carrier, or contractor and
35 does not provide services exclusively or pri-
36 marily to or on behalf of such intermediary,
37 carrier, or contractor;



1 “(ii) prohibit an individual who has staff privi-
 2 leges at the institution where the treatment in-
 3 volved takes place from serving as a reviewer mere-
 4 ly on the basis of having such staff privileges if the
 5 existence of such privileges is disclosed to the Sec-
 6 retary and such individual (or authorized represent-
 7 ative), and neither party objects; or

8 “(iii) prohibit receipt of compensation by a re-
 9 viewing professional from a contractor if the com-
 10 pensation is provided consistent with paragraph
 11 (3).

12 For purposes of this paragraph, the term ‘participation
 13 agreement’ means an agreement relating to the provi-
 14 sion of health care services by the individual and does
 15 not include the provision of services as a reviewer
 16 under this subsection.

17 “(3) LIMITATIONS ON REVIEWER COMPENSATION.—
 18 Compensation provided by a qualified independent con-
 19 tractor to a reviewer in connection with a review under this
 20 section shall not be contingent on the decision rendered by
 21 the reviewer.

22 “(4) LICENSURE AND EXPERTISE.—Each reviewing
 23 professional shall be—

24 “(A) a physician (allopathic or osteopathic) who is
 25 appropriately credentialed or licensed in one or more
 26 States to deliver health care services and has medical
 27 expertise in the field of practice that is appropriate for
 28 the items or services at issue; or

29 “(B) a health care professional who is legally au-
 30 thorized in one or more States (in accordance with
 31 State law or the State regulatory mechanism provided
 32 by State law) to furnish the health care items or serv-
 33 ices at issue and has medical expertise in the field of
 34 practice that is appropriate for such items or services.

35 “(5) RELATED PARTY DEFINED.—For purposes of this
 36 section, the term ‘related party’ means, with respect to a
 37 case under this title involving a specific individual entitled



1 to benefits under part A or enrolled under part B, or both,
2 any of the following:

3 “(A) The Secretary, the medicare administrative
4 contractor involved, or any fiduciary, officer, director,
5 or employee of the Department of Health and Human
6 Services, or of such contractor.

7 “(B) The individual (or authorized representative).

8 “(C) The health care professional that provides
9 the items or services involved in the case.

10 “(D) The institution at which the items or services
11 (or treatment) involved in the case are provided.

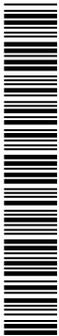
12 “(E) The manufacturer of any drug or other item
13 that is included in the items or services involved in the
14 case.

15 “(F) Any other party determined under any regu-
16 lations to have a substantial interest in the case in-
17 volved.”.

18 (3) REDUCING MINIMUM NUMBER OF QUALIFIED
19 INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42
20 U.S.C. 1395ff(c)(4)) is amended by striking “not fewer
21 than 12 qualified independent contractors under this sub-
22 section” and inserting “with a sufficient number of quali-
23 fied independent contractors (but not fewer than 4 such
24 contractors) to conduct reconsiderations consistent with the
25 timeframes applicable under this subsection”.

26 (4) EFFECTIVE DATE.—The amendments made by
27 paragraphs (1) and (2) shall be effective as if included in
28 the enactment of the respective provisions of subtitle C of
29 title V of BIPA, (114 Stat. 2763A–534).

30 (5) TRANSITION.—In applying section 1869(g) of the
31 Social Security Act (as added by paragraph (2)), any ref-
32 erence to a medicare administrative contractor shall be
33 deemed to include a reference to a fiscal intermediary
34 under section 1816 of the Social Security Act (42 U.S.C.
35 1395h) and a carrier under section 1842 of such Act (42
36 U.S.C. 1395u).



1 **SEC. 404. PREPAYMENT REVIEW.**

2 (a) IN GENERAL.—Section 1874A, as added by section
3 201(a)(1) and as amended by sections 202(b), 301(b)(1), and
4 301(e)(1), is further amended by adding at the end the fol-
5 lowing new subsection:

6 “(h) CONDUCT OF PREPAYMENT REVIEW.—

7 “(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

8 “(A) IN GENERAL.—A medicare administrative
9 contractor may conduct random prepayment review
10 only to develop a contractor-wide or program-wide
11 claims payment error rates or under such additional
12 circumstances as may be provided under regulations,
13 developed in consultation with providers of services and
14 suppliers.

15 “(B) USE OF STANDARD PROTOCOLS WHEN CON-
16 DUCTING PREPAYMENT REVIEWS.—When a medicare
17 administrative contractor conducts a random prepay-
18 ment review, the contractor may conduct such review
19 only in accordance with a standard protocol for random
20 prepayment audits developed by the Secretary.

21 “(C) CONSTRUCTION.—Nothing in this paragraph
22 shall be construed as preventing the denial of payments
23 for claims actually reviewed under a random prepay-
24 ment review.

25 “(D) RANDOM PREPAYMENT REVIEW.—For pur-
26 poses of this subsection, the term ‘random prepayment
27 review’ means a demand for the production of records
28 or documentation absent cause with respect to a claim.

29 “(2) LIMITATIONS ON NON-RANDOM PREPAYMENT RE-
30 VIEW.—

31 “(A) LIMITATIONS ON INITIATION OF NON-RAN-
32 DOM PREPAYMENT REVIEW.—A medicare administra-
33 tive contractor may not initiate non-random prepay-
34 ment review of a provider of services or supplier based
35 on the initial identification by that provider of services
36 or supplier of an improper billing practice unless there



1 is a likelihood of sustained or high level of payment
2 error (as defined in subsection (i)(3)(A)).

3 “(B) TERMINATION OF NON-RANDOM PREPAY-
4 MENT REVIEW.—The Secretary shall issue regulations
5 relating to the termination, including termination
6 dates, of non-random prepayment review. Such regula-
7 tions may vary such a termination date based upon the
8 differences in the circumstances triggering prepayment
9 review.”.

10 (b) EFFECTIVE DATE.—

11 (1) IN GENERAL.—Except as provided in this sub-
12 section, the amendment made by subsection (a) shall take
13 effect 1 year after the date of the enactment of this Act.

14 (2) DEADLINE FOR PROMULGATION OF CERTAIN REG-
15 ULATIONS.—The Secretary shall first issue regulations
16 under section 1874A(h) of the Social Security Act, as
17 added by subsection (a), by not later than 1 year after the
18 date of the enactment of this Act.

19 (3) APPLICATION OF STANDARD PROTOCOLS FOR RAN-
20 DOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of
21 the Social Security Act, as added by subsection (a), shall
22 apply to random prepayment reviews conducted on or after
23 such date (not later than 1 year after the date of the enact-
24 ment of this Act) as the Secretary shall specify.

25 (c) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-
26 RIERS.—The provisions of section 1874A(h) of the Social Secu-
27 rity Act, as added by subsection (a), shall apply to each fiscal
28 intermediary under section 1816 of the Social Security Act (42
29 U.S.C. 1395h) and each carrier under section 1842 of such Act
30 (42 U.S.C. 1395u) in the same manner as they apply to medi-
31 care administrative contractors under such provisions.

32 **SEC. 405. RECOVERY OF OVERPAYMENTS.**

33 (a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is
34 amended by adding at the end the following new subsection:

35 “(f) RECOVERY OF OVERPAYMENTS.—

36 “(1) USE OF REPAYMENT PLANS.—



1 “(A) IN GENERAL.—If the repayment, within 30
2 days by a provider of services or supplier, of an over-
3 payment under this title would constitute a hardship
4 (as defined in subparagraph (B)), subject to subpara-
5 graph (C), upon request of the provider of services or
6 supplier the Secretary shall enter into a plan with the
7 provider of services or supplier for the repayment
8 (through offset or otherwise) of such overpayment over
9 a period of at least 6 months but not longer than 3
10 years (or not longer than 5 years in the case of extreme
11 hardship, as determined by the Secretary). Interest
12 shall accrue on the balance through the period of re-
13 payment. Such plan shall meet terms and conditions
14 determined to be appropriate by the Secretary.

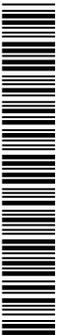
15 “(B) HARDSHIP.—

16 “(i) IN GENERAL.—For purposes of subpara-
17 graph (A), the repayment of an overpayment (or
18 overpayments) within 30 days is deemed to con-
19 stitute a hardship if—

20 “(I) in the case of a provider of services
21 that files cost reports, the aggregate amount of
22 the overpayments exceeds 10 percent of the
23 amount paid under this title to the provider of
24 services for the cost reporting period covered by
25 the most recently submitted cost report; or

26 “(II) in the case of another provider of
27 services or supplier, the aggregate amount of
28 the overpayments exceeds 10 percent of the
29 amount paid under this title to the provider of
30 services or supplier for the previous calendar
31 year.

32 “(ii) RULE OF APPLICATION.—The Secretary
33 shall establish rules for the application of this sub-
34 paragraph in the case of a provider of services or
35 supplier that was not paid under this title during
36 the previous year or was paid under this title only
37 during a portion of that year.



1 “(iii) TREATMENT OF PREVIOUS OVERPAY-
 2 MENTS.—If a provider of services or supplier has
 3 entered into a repayment plan under subparagraph
 4 (A) with respect to a specific overpayment amount,
 5 such payment amount under the repayment plan
 6 shall not be taken into account under clause (i)
 7 with respect to subsequent overpayment amounts.

8 “(C) EXCEPTIONS.—Subparagraph (A) shall not
 9 apply if—

10 “(i) the Secretary has reason to suspect that
 11 the provider of services or supplier may file for
 12 bankruptcy or otherwise cease to do business or
 13 discontinue participation in the program under this
 14 title; or

15 “(ii) there is an indication of fraud or abuse
 16 committed against the program.

17 “(D) IMMEDIATE COLLECTION IF VIOLATION OF
 18 REPAYMENT PLAN.—If a provider of services or sup-
 19 plier fails to make a payment in accordance with a re-
 20 payment plan under this paragraph, the Secretary may
 21 immediately seek to offset or otherwise recover the
 22 total balance outstanding (including applicable interest)
 23 under the repayment plan.

24 “(E) RELATION TO NO FAULT PROVISION.—Noth-
 25 ing in this paragraph shall be construed as affecting
 26 the application of section 1870(c) (relating to no ad-
 27 justment in the cases of certain overpayments).

28 “(2) LIMITATION ON RECOUPMENT.—

29 “(A) IN GENERAL.—In the case of a provider of
 30 services or supplier that is determined to have received
 31 an overpayment under this title and that seeks a recon-
 32 sideration by a qualified independent contractor on
 33 such determination under section 1869(b)(1), the Sec-
 34 retary may not take any action (or authorize any other
 35 person, including any medicare contractor, as defined
 36 in subparagraph (C)) to recoup the overpayment until
 37 the date the decision on the reconsideration has been



1 rendered. If the provisions of section 1869(b)(1) (pro-
2 viding for such a reconsideration by a qualified inde-
3 pendent contractor) are not in effect, in applying the
4 previous sentence any reference to such a reconsider-
5 ation shall be treated as a reference to a redetermina-
6 tion by the fiscal intermediary or carrier involved.

7 “(B) COLLECTION WITH INTEREST.—Insofar as
8 the determination on such appeal is against the pro-
9 vider of services or supplier, interest on the overpay-
10 ment shall accrue on and after the date of the original
11 notice of overpayment. Insofar as such determination
12 against the provider of services or supplier is later re-
13 versed, the Secretary shall provide for repayment of the
14 amount recouped plus interest at the same rate as
15 would apply under the previous sentence for the period
16 in which the amount was recouped.

17 “(C) MEDICARE CONTRACTOR DEFINED.—For
18 purposes of this subsection, the term ‘medicare con-
19 tractor’ has the meaning given such term in section
20 1889(g).

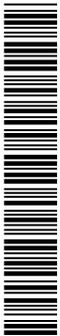
21 “(3) LIMITATION ON USE OF EXTRAPOLATION.—A
22 medicare contractor may not use extrapolation to determine
23 overpayment amounts to be recovered by recoupment, off-
24 set, or otherwise unless—

25 “(A) there is a sustained or high level of payment
26 error (as defined by the Secretary by regulation); or

27 “(B) documented educational intervention has
28 failed to correct the payment error (as determined by
29 the Secretary).

30 “(4) PROVISION OF SUPPORTING DOCUMENTATION.—
31 In the case of a provider of services or supplier with respect
32 to which amounts were previously overpaid, a medicare con-
33 tractor may request the periodic production of records or
34 supporting documentation for a limited sample of sub-
35 mitted claims to ensure that the previous practice is not
36 continuing.

37 “(5) CONSENT SETTLEMENT REFORMS.—



1 “(A) IN GENERAL.—The Secretary may use a con-
2 sent settlement (as defined in subparagraph (D)) to
3 settle a projected overpayment.

4 “(B) OPPORTUNITY TO SUBMIT ADDITIONAL IN-
5 FORMATION BEFORE CONSENT SETTLEMENT OFFER.—
6 Before offering a provider of services or supplier a con-
7 sent settlement, the Secretary shall—

8 “(i) communicate to the provider of services or
9 supplier—

10 “(I) that, based on a review of the medical
11 records requested by the Secretary, a prelimi-
12 nary evaluation of those records indicates that
13 there would be an overpayment;

14 “(II) the nature of the problems identified
15 in such evaluation; and

16 “(III) the steps that the provider of serv-
17 ices or supplier should take to address the
18 problems; and

19 “(ii) provide for a 45-day period during which
20 the provider of services or supplier may furnish ad-
21 ditional information concerning the medical records
22 for the claims that had been reviewed.

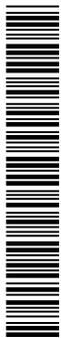
23 “(C) CONSENT SETTLEMENT OFFER.—The Sec-
24 retary shall review any additional information furnished
25 by the provider of services or supplier under subpara-
26 graph (B)(ii). Taking into consideration such informa-
27 tion, the Secretary shall determine if there still appears
28 to be an overpayment. If so, the Secretary—

29 “(i) shall provide notice of such determination
30 to the provider of services or supplier, including an
31 explanation of the reason for such determination;
32 and

33 “(ii) in order to resolve the overpayment, may
34 offer the provider of services or supplier—

35 “(I) the opportunity for a statistically
36 valid random sample; or

37 “(II) a consent settlement.



1 The opportunity provided under clause (ii)(I) does not
2 waive any appeal rights with respect to the alleged
3 overpayment involved.

4 “(D) CONSENT SETTLEMENT DEFINED.—For pur-
5 poses of this paragraph, the term ‘consent settlement’
6 means an agreement between the Secretary and a pro-
7 vider of services or supplier whereby both parties agree
8 to settle a projected overpayment based on less than a
9 statistically valid sample of claims and the provider of
10 services or supplier agrees not to appeal the claims in-
11 volved.

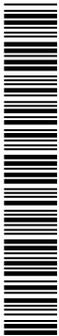
12 “(6) NOTICE OF OVER-UTILIZATION OF CODES.—The
13 Secretary shall establish, in consultation with organizations
14 representing the classes of providers of services and sup-
15 pliers, a process under which the Secretary provides for no-
16 tice to classes of providers of services and suppliers served
17 by the contractor in cases in which the contractor has iden-
18 tified that particular billing codes may be overutilized by
19 that class of providers of services or suppliers under the
20 programs under this title (or provisions of title XI insofar
21 as they relate to such programs).

22 “(7) PAYMENT AUDITS.—

23 “(A) WRITTEN NOTICE FOR POST-PAYMENT AU-
24 DITS.—Subject to subparagraph (C), if a medicare con-
25 tractor decides to conduct a post-payment audit of a
26 provider of services or supplier under this title, the con-
27 tractor shall provide the provider of services or supplier
28 with written notice (which may be in electronic form)
29 of the intent to conduct such an audit.

30 “(B) EXPLANATION OF FINDINGS FOR ALL AU-
31 DITS.—Subject to subparagraph (C), if a medicare con-
32 tractor audits a provider of services or supplier under
33 this title, the contractor shall—

34 “(i) give the provider of services or supplier a
35 full review and explanation of the findings of the
36 audit in a manner that is understandable to the



1 provider of services or supplier and permits the de-
2 velopment of an appropriate corrective action plan;

3 “(ii) inform the provider of services or supplier
4 of the appeal rights under this title as well as con-
5 sent settlement options (which are at the discretion
6 of the Secretary);

7 “(iii) give the provider of services or supplier
8 an opportunity to provide additional information to
9 the contractor; and

10 “(iv) take into account information provided,
11 on a timely basis, by the provider of services or
12 supplier under clause (iii).

13 “(C) EXCEPTION.—Subparagraphs (A) and (B)
14 shall not apply if the provision of notice or findings
15 would compromise pending law enforcement activities,
16 whether civil or criminal, or reveal findings of law en-
17 forcement-related audits.

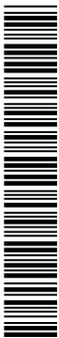
18 “(8) STANDARD METHODOLOGY FOR PROBE SAM-
19 PLING.—The Secretary shall establish a standard method-
20 ology for medicare contractors to use in selecting a sample
21 of claims for review in the case of an abnormal billing pat-
22 tern.”.

23 (b) EFFECTIVE DATES AND DEADLINES.—

24 (1) USE OF REPAYMENT PLANS.—Section 1893(f)(1)
25 of the Social Security Act, as added by subsection (a), shall
26 apply to requests for repayment plans made after the date
27 of the enactment of this Act.

28 (2) LIMITATION ON RECOUPMENT.—Section
29 1893(f)(2) of the Social Security Act, as added by sub-
30 section (a), shall apply to actions taken after the date of
31 the enactment of this Act.

32 (3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of
33 the Social Security Act, as added by subsection (a), shall
34 apply to statistically valid random samples initiated after
35 the date that is 1 year after the date of the enactment of
36 this Act.



1 (4) PROVISION OF SUPPORTING DOCUMENTATION.—
2 Section 1893(f)(4) of the Social Security Act, as added by
3 subsection (a), shall take effect on the date of the enact-
4 ment of this Act.

5 (5) CONSENT SETTLEMENT.—Section 1893(f)(5) of
6 the Social Security Act, as added by subsection (a), shall
7 apply to consent settlements entered into after the date of
8 the enactment of this Act.

9 (6) NOTICE OF OVERUTILIZATION.—Not later than 1
10 year after the date of the enactment of this Act, the Sec-
11 retary shall first establish the process for notice of over-
12 utilization of billing codes under section 1893A(f)(6) of the
13 Social Security Act, as added by subsection (a).

14 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of the
15 Social Security Act, as added by subsection (a), shall apply
16 to audits initiated after the date of the enactment of this
17 Act.

18 (8) STANDARD FOR ABNORMAL BILLING PATTERNS.—
19 Not later than 1 year after the date of the enactment of
20 this Act, the Secretary shall first establish a standard
21 methodology for selection of sample claims for abnormal
22 billing patterns under section 1893(f)(8) of the Social Se-
23 curity Act, as added by subsection (a).

24 **SEC. 406. PROVIDER ENROLLMENT PROCESS; RIGHT OF**
25 **APPEAL.**

26 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is
27 amended—

28 (1) by adding at the end of the heading the following:

29 “; ENROLLMENT PROCESSES”; and

30 (2) by adding at the end the following new subsection:

31 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERV-
32 ICES AND SUPPLIERS.—

33 “(1) ENROLLMENT PROCESS.—

34 “(A) IN GENERAL.—The Secretary shall establish
35 by regulation a process for the enrollment of providers
36 of services and suppliers under this title.



1 “(B) DEADLINES.—The Secretary shall establish
2 by regulation procedures under which there are dead-
3 lines for actions on applications for enrollment (and, if
4 applicable, renewal of enrollment). The Secretary shall
5 monitor the performance of medicare administrative
6 contractors in meeting the deadlines established under
7 this subparagraph.

8 “(C) CONSULTATION BEFORE CHANGING PRO-
9 VIDER ENROLLMENT FORMS.—The Secretary shall con-
10 sult with providers of services and suppliers before
11 making changes in the provider enrollment forms re-
12 quired of such providers and suppliers to be eligible to
13 submit claims for which payment may be made under
14 this title.

15 “(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-
16 RENEWAL.—A provider of services or supplier whose appli-
17 cation to enroll (or, if applicable, to renew enrollment)
18 under this title is denied may have a hearing and judicial
19 review of such denial under the procedures that apply
20 under subsection (h)(1)(A) to a provider of services that is
21 dissatisfied with a determination by the Secretary.”.

22 (b) EFFECTIVE DATES.—

23 (1) ENROLLMENT PROCESS.—The Secretary shall pro-
24 vide for the establishment of the enrollment process under
25 section 1866(j)(1) of the Social Security Act, as added by
26 subsection (a)(2), within 6 months after the date of the en-
27 actment of this Act.

28 (2) CONSULTATION.—Section 1866(j)(1)(C) of the So-
29 cial Security Act, as added by subsection (a)(2), shall apply
30 with respect to changes in provider enrollment forms made
31 on or after January 1, 2004.

32 (3) HEARING RIGHTS.—Section 1866(j)(2) of the So-
33 cial Security Act, as added by subsection (a)(2), shall apply
34 to denials occurring on or after such date (not later than
35 1 year after the date of the enactment of this Act) as the
36 Secretary specifies.



1 **SEC. 407. PROCESS FOR CORRECTION OF MINOR ER-**
2 **RORS AND OMISSIONS WITHOUT PURSUING**
3 **APPEALS PROCESS.**

4 (a) CLAIMS.—The Secretary shall develop, in consultation
5 with appropriate medicare contractors (as defined in section
6 1889(g) of the Social Security Act, as inserted by section
7 301(a)(1)) and representatives of providers of services and sup-
8 pliers, a process whereby, in the case of minor errors or omis-
9 sions (as defined by the Secretary) that are detected in the sub-
10 mission of claims under the programs under title XVIII of such
11 Act, a provider of services or supplier is given an opportunity
12 to correct such an error or omission without the need to initiate
13 an appeal. Such process shall include the ability to resubmit
14 corrected claims.

15 (b) PERMITTING USE OF CORRECTED AND SUPPLE-
16 MENTARY DATA.—

17 (1) IN GENERAL.—Section 1886(d)(10)(D)(vi) (42
18 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after
19 subclause (II) at the end the following:

20 “Notwithstanding subclause (I), a hospital may submit, and the
21 Secretary may accept upon verification, data that corrects or
22 supplements the data described in such subclause without re-
23 gard to whether the corrected or supplementary data relate to
24 a cost report that has been settled.”

25 (2) EFFECTIVE DATE.—The amendment made by
26 paragraph (1) shall apply to fiscal years beginning with fis-
27 cal year 2004.

28 (3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS
29 PERMITTED FOR FISCAL YEAR 2004.—

30 (A) IN GENERAL.—Notwithstanding any other
31 provision of law, a hospital may submit (or resubmit)
32 an application for a change described in section
33 1886(d)(10)(C)(i)(II) of the Social Security Act for fis-
34 cal year 2004 if the hospital demonstrates on a timely
35 basis to the satisfaction of the Secretary that the use
36 of corrected or supplementary data under the amend-



1 ment made by paragraph (1) would materially affect
2 the approval of such an application.

3 (B) APPLICATION OF BUDGET NEUTRALITY.—If
4 one or more hospital's applications are approved as a
5 result of paragraph (1) and subparagraph (A) for fiscal
6 year 2004, the Secretary shall make a proportional ad-
7 justment in the standardized amounts determined
8 under section 1886(d)(3) of the Social Security Act (42
9 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure
10 that approval of such applications does not result in
11 aggregate payments under section 1886(d) of such Act
12 that are greater or less than those that would otherwise
13 be made if paragraph (1) and subparagraph (A) did
14 not apply.

15 **SEC. 408. PRIOR DETERMINATION PROCESS FOR CER-**
16 **TAIN ITEMS AND SERVICES; ADVANCE BENE-**
17 **FICIARY NOTICES.**

18 (a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as
19 amended by sections 521 and 522 of BIPA and section
20 403(d)(2)(B), is further amended by adding at the end the fol-
21 lowing new subsection:

22 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN
23 ITEMS AND SERVICES.—

24 “(1) ESTABLISHMENT OF PROCESS.—

25 “(A) IN GENERAL.—With respect to a medicare
26 administrative contractor that has a contract under
27 section 1874A that provides for making payments
28 under this title with respect to eligible items and serv-
29 ices described in subparagraph (C), the Secretary shall
30 establish a prior determination process that meets the
31 requirements of this subsection and that shall be ap-
32 plied by such contractor in the case of eligible request-
33 ers.

34 “(B) ELIGIBLE REQUESTER.—For purposes of
35 this subsection, each of the following shall be an eligi-
36 ble requester:



1 “(i) A physician, but only with respect to eligi-
2 ble items and services for which the physician may
3 be paid directly.

4 “(ii) An individual entitled to benefits under
5 this title, but only with respect to an item or serv-
6 ice for which the individual receives, from the phy-
7 sician who may be paid directly for the item or
8 service, an advance beneficiary notice under section
9 1879(a) that payment may not be made (or may no
10 longer be made) for the item or service under this
11 title.

12 “(C) ELIGIBLE ITEMS AND SERVICES.—For pur-
13 poses of this subsection and subject to paragraph (2),
14 eligible items and services are items and services which
15 are physicians’ services (as defined in paragraph (4)(A)
16 of section 1848(f) for purposes of calculating the sus-
17 tainable growth rate under such section).

18 “(2) SECRETARIAL FLEXIBILITY.—The Secretary shall
19 establish by regulation reasonable limits on the categories
20 of eligible items and services for which a prior determina-
21 tion of coverage may be requested under this subsection. In
22 establishing such limits, the Secretary may consider the
23 dollar amount involved with respect to the item or service,
24 administrative costs and burdens, and other relevant fac-
25 tors.

26 “(3) REQUEST FOR PRIOR DETERMINATION.—

27 “(A) IN GENERAL.—Subject to paragraph (2),
28 under the process established under this subsection an
29 eligible requester may submit to the contractor a re-
30 quest for a determination, before the furnishing of an
31 eligible item or service involved as to whether the item
32 or service is covered under this title consistent with the
33 applicable requirements of section 1862(a)(1)(A) (relat-
34 ing to medical necessity).

35 “(B) ACCOMPANYING DOCUMENTATION.—The Sec-
36 retary may require that the request be accompanied by
37 a description of the item or service, supporting docu-



1 mentation relating to the medical necessity for the item
2 or service, and any other appropriate documentation.
3 In the case of a request submitted by an eligible re-
4 quester who is described in paragraph (1)(B)(ii), the
5 Secretary may require that the request also be accom-
6 panied by a copy of the advance beneficiary notice in-
7 volved.

8 “(4) RESPONSE TO REQUEST.—

9 “(A) IN GENERAL.—Under such process, the con-
10 tractor shall provide the eligible requester with written
11 notice of a determination as to whether—

12 “(i) the item or service is so covered;

13 “(ii) the item or service is not so covered; or

14 “(iii) the contractor lacks sufficient informa-
15 tion to make a coverage determination.

16 If the contractor makes the determination described in
17 clause (iii), the contractor shall include in the notice a
18 description of the additional information required to
19 make the coverage determination.

20 “(B) DEADLINE TO RESPOND.—Such notice shall
21 be provided within the same time period as the time pe-
22 riod applicable to the contractor providing notice of ini-
23 tial determinations on a claim for benefits under sub-
24 section (a)(2)(A).

25 “(C) INFORMING BENEFICIARY IN CASE OF PHYSI-
26 CIAN REQUEST.—In the case of a request in which an
27 eligible requester is not the individual described in
28 paragraph (1)(B)(ii), the process shall provide that the
29 individual to whom the item or service is proposed to
30 be furnished shall be informed of any determination de-
31 scribed in clause (ii) (relating to a determination of
32 non-coverage) and the right (referred to in paragraph
33 (6)(B)) to obtain the item or service and have a claim
34 submitted for the item or service.

35 “(5) EFFECT OF DETERMINATIONS.—

36 “(A) BINDING NATURE OF POSITIVE DETERMINA-
37 TION.—If the contractor makes the determination de-



1 scribed in paragraph (4)(A)(i), such determination
2 shall be binding on the contractor in the absence of
3 fraud or evidence of misrepresentation of facts pre-
4 sented to the contractor.

5 “(B) NOTICE AND RIGHT TO REDETERMINATION
6 IN CASE OF A DENIAL.—

7 “(i) IN GENERAL.—If the contractor makes
8 the determination described in paragraph
9 (4)(A)(ii)—

10 “(I) the eligible requester has the right to
11 a redetermination by the contractor on the de-
12 termination that the item or service is not so
13 covered; and

14 “(II) the contractor shall include in notice
15 under paragraph (4)(A) a brief explanation of
16 the basis for the determination, including on
17 what national or local coverage or noncoverage
18 determination (if any) the determination is
19 based, and the right to such a redetermination.

20 “(ii) DEADLINE FOR REDETERMINATIONS.—
21 The contractor shall complete and provide notice of
22 such redetermination within the same time period
23 as the time period applicable to the contractor pro-
24 viding notice of redeterminations relating to a
25 claim for benefits under subsection (a)(3)(C)(ii).

26 “(6) LIMITATION ON FURTHER REVIEW.—

27 “(A) IN GENERAL.—Contractor determinations de-
28 scribed in paragraph (4)(A)(ii) or (4)(A)(iii) (and rede-
29 terminations made under paragraph (5)(B)), relating
30 to pre-service claims are not subject to further adminis-
31 trative appeal or judicial review under this section or
32 otherwise.

33 “(B) DECISION NOT TO SEEK PRIOR DETERMINA-
34 TION OR NEGATIVE DETERMINATION DOES NOT IMPACT
35 RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT,
36 OR APPEAL RIGHTS.—Nothing in this subsection shall



1 be construed as affecting the right of an individual
2 who—

3 “(i) decides not to seek a prior determination
4 under this subsection with respect to items or serv-
5 ices; or

6 “(ii) seeks such a determination and has re-
7 ceived a determination described in paragraph
8 (4)(A)(ii),

9 from receiving (and submitting a claim for) such items
10 services and from obtaining administrative or judicial
11 review respecting such claim under the other applicable
12 provisions of this section. Failure to seek a prior deter-
13 mination under this subsection with respect to items
14 and services shall not be taken into account in such ad-
15 ministrative or judicial review.

16 “(C) NO PRIOR DETERMINATION AFTER RECEIPT
17 OF SERVICES.—Once an individual is provided items
18 and services, there shall be no prior determination
19 under this subsection with respect to such items or
20 services.”.

21 (b) EFFECTIVE DATE; TRANSITION.—

22 (1) EFFECTIVE DATE.—The Secretary shall establish
23 the prior determination process under the amendment
24 made by subsection (a) in such a manner as to provide for
25 the acceptance of requests for determinations under such
26 process filed not later than 18 months after the date of the
27 enactment of this Act.

28 (2) TRANSITION.—During the period in which the
29 amendment made by subsection (a) has become effective
30 but contracts are not provided under section 1874A of the
31 Social Security Act with medicare administrative contrac-
32 tors, any reference in section 1869(g) of such Act (as
33 added by such amendment) to such a contractor is deemed
34 a reference to a fiscal intermediary or carrier with an
35 agreement under section 1816, or contract under section
36 1842, respectively, of such Act.



1 (3) LIMITATION ON APPLICATION TO SGR.—For pur-
2 poses of applying section 1848(f)(2)(D) of the Social Secu-
3 rity Act (42 U.S.C. 1395w-4(f)(2)(D)), the amendment
4 made by subsection (a) shall not be considered to be a
5 change in law or regulation.

6 (c) PROVISIONS RELATING TO ADVANCE BENEFICIARY
7 NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

8 (1) DATA COLLECTION.—The Secretary shall establish
9 a process for the collection of information on the instances
10 in which an advance beneficiary notice (as defined in para-
11 graph (4)) has been provided and on instances in which a
12 beneficiary indicates on such a notice that the beneficiary
13 does not intend to seek to have the item or service that is
14 the subject of the notice furnished.

15 (2) OUTREACH AND EDUCATION.—The Secretary shall
16 establish a program of outreach and education for bene-
17 ficiaries and providers of services and other persons on the
18 appropriate use of advance beneficiary notices and coverage
19 policies under the medicare program.

20 (3) GAO REPORT REPORT ON USE OF ADVANCE BENE-
21 FICIARY NOTICES.—Not later than 18 months after the
22 date on which section 1869(g) of the Social Security Act
23 (as added by subsection (a)) takes effect, the Comptroller
24 General of the United States shall submit to Congress a re-
25 port on the use of advance beneficiary notices under title
26 XVIII of such Act. Such report shall include information
27 concerning the providers of services and other persons that
28 have provided such notices and the response of beneficiaries
29 to such notices.

30 (4) GAO REPORT ON USE OF PRIOR DETERMINATION
31 PROCESS.—Not later than 18 months after the date on
32 which section 1869(g) of the Social Security Act (as added
33 by subsection (a)) takes effect, the Comptroller General of
34 the United States shall submit to Congress a report on the
35 use of the prior determination process under such section.
36 Such report shall include—



1 (A) information concerning the types of proce-
2 dures for which a prior determination has been sought,
3 determinations made under the process, and changes in
4 receipt of services resulting from the application of
5 such process; and

6 (B) an evaluation of whether the process was use-
7 ful for physicians (and other suppliers) and bene-
8 ficiaries, whether it was timely, and whether the
9 amount of information required was burdensome to
10 physicians and beneficiaries.

11 (5) ADVANCE BENEFICIARY NOTICE DEFINED.—In
12 this subsection, the term “advance beneficiary notice”
13 means a written notice provided under section 1879(a)
14 of the Social Security Act (42 U.S.C. 1395pp(a)) to an indi-
15 vidual entitled to benefits under part A or B of title XVIII
16 of such Act before items or services are furnished under
17 such part in cases where a provider of services or other
18 person that would furnish the item or service believes that
19 payment will not be made for some or all of such items or
20 services under such title.

21 **TITLE V—MISCELLANEOUS** 22 **PROVISIONS**

23 **SEC. 501. POLICY DEVELOPMENT REGARDING EVALUA-** 24 **TION AND MANAGEMENT (E & M) DOCU-** 25 **MENTATION GUIDELINES.**

26 (a) IN GENERAL.—The Secretary may not implement any
27 new documentation guidelines for evaluation and management
28 physician services under the title XVIII of the Social Security
29 Act on or after the date of the enactment of this Act unless
30 the Secretary—

31 (1) has developed the guidelines in collaboration with
32 practicing physicians (including both generalists and spe-
33 cialists) and provided for an assessment of the proposed
34 guidelines by the physician community;

35 (2) has established a plan that contains specific goals,
36 including a schedule, for improving the use of such guide-
37 lines;



1 (3) has conducted appropriate and representative pilot
2 projects under subsection (b) to test modifications to the
3 evaluation and management documentation guidelines;

4 (4) finds that the objectives described in subsection (c)
5 will be met in the implementation of such guidelines; and

6 (5) has established, and is implementing, a program to
7 educate physicians on the use of such guidelines and that
8 includes appropriate outreach.

9 The Secretary shall make changes to the manner in which ex-
10 isting evaluation and management documentation guidelines
11 are implemented to reduce paperwork burdens on physicians.

12 (b) PILOT PROJECTS TO TEST EVALUATION AND MAN-
13 AGEMENT DOCUMENTATION GUIDELINES.—

14 (1) IN GENERAL.—The Secretary shall conduct under
15 this subsection appropriate and representative pilot projects
16 to test new evaluation and management documentation
17 guidelines referred to in subsection (a).

18 (2) LENGTH AND CONSULTATION.—Each pilot project
19 under this subsection shall—

20 (A) be voluntary;

21 (B) be of sufficient length as determined by the
22 Secretary to allow for preparatory physician and medi-
23 care contractor education, analysis, and use and assess-
24 ment of potential evaluation and management guide-
25 lines; and

26 (C) be conducted, in development and throughout
27 the planning and operational stages of the project, in
28 consultation with practicing physicians (including both
29 generalists and specialists).

30 (3) RANGE OF PILOT PROJECTS.—Of the pilot projects
31 conducted under this subsection—

32 (A) at least one shall focus on a peer review meth-
33 od by physicians (not employed by a medicare con-
34 tractor) which evaluates medical record information for
35 claims submitted by physicians identified as statistical
36 outliers relative to definitions published in the Current



1 Procedures Terminology (CPT) code book of the Amer-
2 ican Medical Association;

3 (B) at least one shall focus on an alternative
4 method to detailed guidelines based on physician docu-
5 mentation of face to face encounter time with a patient;

6 (C) at least one shall be conducted for services
7 furnished in a rural area and at least one for services
8 furnished outside such an area; and

9 (D) at least one shall be conducted in a setting
10 where physicians bill under physicians' services in
11 teaching settings and at least one shall be conducted in
12 a setting other than a teaching setting.

13 (4) BANNING OF TARGETING OF PILOT PROJECT PAR-
14 TICIPANTS.—Data collected under this subsection shall not
15 be used as the basis for overpayment demands or post-pay-
16 ment audits. Such limitation applies only to claims filed as
17 part of the pilot project and lasts only for the duration of
18 the pilot project and only as long as the provider is a par-
19 ticipant in the pilot project.

20 (5) STUDY OF IMPACT.—Each pilot project shall ex-
21 amine the effect of the new evaluation and management
22 documentation guidelines on—

23 (A) different types of physician practices, includ-
24 ing those with fewer than 10 full-time-equivalent em-
25 ployees (including physicians); and

26 (B) the costs of physician compliance, including
27 education, implementation, auditing, and monitoring.

28 (6) PERIODIC REPORTS.—The Secretary shall submit
29 to Congress periodic reports on the pilot projects under this
30 subsection.

31 (c) OBJECTIVES FOR EVALUATION AND MANAGEMENT
32 GUIDELINES.—The objectives for modified evaluation and man-
33 agement documentation guidelines developed by the Secretary
34 shall be to—

35 (1) identify clinically relevant documentation needed to
36 code accurately and assess coding levels accurately;



1 (2) decrease the level of non-clinically pertinent and
2 burdensome documentation time and content in the physi-
3 cian's medical record;

4 (3) increase accuracy by reviewers; and

5 (4) educate both physicians and reviewers.

6 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOC-
7 UMENTATION FOR PHYSICIAN CLAIMS.—

8 (1) STUDY.—The Secretary shall carry out a study of
9 the matters described in paragraph (2).

10 (2) MATTERS DESCRIBED.—The matters referred to in
11 paragraph (1) are—

12 (A) the development of a simpler, alternative sys-
13 tem of requirements for documentation accompanying
14 claims for evaluation and management physician serv-
15 ices for which payment is made under title XVIII of
16 the Social Security Act; and

17 (B) consideration of systems other than current
18 coding and documentation requirements for payment
19 for such physician services.

20 (3) CONSULTATION WITH PRACTICING PHYSICIANS.—
21 In designing and carrying out the study under paragraph
22 (1), the Secretary shall consult with practicing physicians,
23 including physicians who are part of group practices and
24 including both generalists and specialists.

25 (4) APPLICATION OF HIPAA UNIFORM CODING RE-
26 QUIREMENTS.—In developing an alternative system under
27 paragraph (2), the Secretary shall consider requirements of
28 administrative simplification under part C of title XI of the
29 Social Security Act.

30 (5) REPORT TO CONGRESS.—(A) Not later than Octo-
31 ber 1, 2005, the Secretary shall submit to Congress a re-
32 port on the results of the study conducted under paragraph
33 (1).

34 (B) The Medicare Payment Advisory Commission shall
35 conduct an analysis of the results of the study included in
36 the report under subparagraph (A) and shall submit a re-
37 port on such analysis to Congress.



1 (e) STUDY ON APPROPRIATE CODING OF CERTAIN EX-
2 TENDED OFFICE VISITS.—The Secretary shall conduct a study
3 of the appropriateness of coding in cases of extended office vis-
4 its in which there is no diagnosis made. Not later than October
5 1, 2005, the Secretary shall submit a report to Congress on
6 such study and shall include recommendations on how to code
7 appropriately for such visits in a manner that takes into ac-
8 count the amount of time the physician spent with the patient.

9 (f) DEFINITIONS.—In this section—

10 (1) the term “rural area” has the meaning given that
11 term in section 1886(d)(2)(D) of the Social Security Act,
12 42 U.S.C. 1395ww(d)(2)(D); and

13 (2) the term “teaching settings” are those settings de-
14 scribed in section 415.150 of title 42, Code of Federal Reg-
15 ulations.

16 **SEC. 502. IMPROVEMENT IN OVERSIGHT OF TECH-**
17 **NOLOGY AND COVERAGE.**

18 (a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Sec-
19 tion 1868 (42 U.S.C. 1395ee), as amended by section 301(a),
20 is amended by adding at the end the following new subsection:

21 “(e) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

22 “(1) ESTABLISHMENT.—The Secretary shall establish
23 a Council for Technology and Innovation within the Cen-
24 ters for Medicare & Medicaid Services (in this section re-
25 ferred to as ‘CMS’).

26 “(2) COMPOSITION.—The Council shall be composed
27 of senior CMS staff and clinicians and shall be chaired by
28 the Executive Coordinator for Technology and Innovation
29 (appointed or designated under paragraph (4)).

30 “(3) DUTIES.—The Council shall coordinate the activi-
31 ties of coverage, coding, and payment processes under this
32 title with respect to new technologies and procedures, in-
33 cluding new drug therapies, and shall coordinate the ex-
34 change of information on new technologies between CMS
35 and other entities that make similar decisions.

36 “(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY
37 AND INNOVATION.—The Secretary shall appoint (or des-



1 ignate) a noncareer appointee (as defined in section
2 3132(a)(7) of title 5, United States Code) who shall serve
3 as the Executive Coordinator for Technology and Innova-
4 tion. Such executive coordinator shall report to the Admin-
5 istrator of CMS, shall chair the Council, shall oversee the
6 execution of its duties, and shall serve as a single point of
7 contact for outside groups and entities regarding the cov-
8 erage, coding, and payment processes under this title.”.

9 (b) METHODS FOR DETERMINING PAYMENT BASIS FOR
10 NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is
11 amended by adding at the end the following:

12 “(8)(A) The Secretary shall establish by regulation proce-
13 dures for determining the basis for, and amount of, payment
14 under this subsection for any clinical diagnostic laboratory test
15 with respect to which a new or substantially revised HCPCS
16 code is assigned on or after January 1, 2005 (in this para-
17 graph referred to as ‘new tests’).

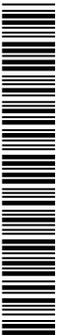
18 “(B) Determinations under subparagraph (A) shall be
19 made only after the Secretary—

20 “(i) makes available to the public (through an Internet
21 site and other appropriate mechanisms) a list that includes
22 any such test for which establishment of a payment amount
23 under this subsection is being considered for a year;

24 “(ii) on the same day such list is made available,
25 causes to have published in the Federal Register notice of
26 a meeting to receive comments and recommendations (and
27 data on which recommendations are based) from the public
28 on the appropriate basis under this subsection for estab-
29 lishing payment amounts for the tests on such list;

30 “(iii) not less than 30 days after publication of such
31 notice convenes a meeting, that includes representatives of
32 officials of the Centers for Medicare & Medicaid Services
33 involved in determining payment amounts, to receive such
34 comments and recommendations (and data on which the
35 recommendations are based);

36 “(iv) taking into account the comments and rec-
37 ommendations (and accompanying data) received at such



1 meeting, develops and makes available to the public
2 (through an Internet site and other appropriate mecha-
3 nisms) a list of proposed determinations with respect to the
4 appropriate basis for establishing a payment amount under
5 this subsection for each such code, together with an expla-
6 nation of the reasons for each such determination, the data
7 on which the determinations are based, and a request for
8 public written comments on the proposed determination;
9 and

10 “(v) taking into account the comments received during
11 the public comment period, develops and makes available to
12 the public (through an Internet site and other appropriate
13 mechanisms) a list of final determinations of the payment
14 amounts for such tests under this subsection, together with
15 the rationale for each such determination, the data on
16 which the determinations are based, and responses to com-
17 ments and suggestions received from the public.

18 “(C) Under the procedures established pursuant to sub-
19 paragraph (A), the Secretary shall—

20 “(i) set forth the criteria for making determinations
21 under subparagraph (A); and

22 “(ii) make available to the public the data (other than
23 proprietary data) considered in making such determina-
24 tions.

25 “(D) The Secretary may convene such further public meet-
26 ings to receive public comments on payment amounts for new
27 tests under this subsection as the Secretary deems appropriate.

28 “(E) For purposes of this paragraph:

29 “(i) The term ‘HCPCS’ refers to the Health Care Pro-
30 cedure Coding System.

31 “(ii) A code shall be considered to be ‘substantially re-
32 vised’ if there is a substantive change to the definition of
33 the test or procedure to which the code applies (such as a
34 new analyte or a new methodology for measuring an exist-
35 ing analyte-specific test).”



1 **SEC. 503. TREATMENT OF HOSPITALS FOR CERTAIN**
2 **SERVICES UNDER MEDICARE SECONDARY**
3 **PAYOR (MSP) PROVISIONS.**

4 (a) IN GENERAL.—The Secretary shall not require a hos-
5 pital (including a critical access hospital) to ask questions (or
6 obtain information) relating to the application of section
7 1862(b) of the Social Security Act (relating to medicare sec-
8 ondary payor provisions) in the case of reference laboratory
9 services described in subsection (b), if the Secretary does not
10 impose such requirement in the case of such services furnished
11 by an independent laboratory.

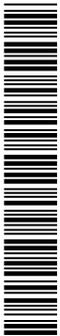
12 (b) REFERENCE LABORATORY SERVICES DESCRIBED.—
13 Reference laboratory services described in this subsection are
14 clinical laboratory diagnostic tests (or the interpretation of
15 such tests, or both) furnished without a face-to-face encounter
16 between the individual entitled to benefits under part A or en-
17 rolled under part B, or both, and the hospital involved and in
18 which the hospital submits a claim only for such test or inter-
19 pretation.

20 **SEC. 504. EMTALA IMPROVEMENTS.**

21 (a) PAYMENT FOR EMTALA-MANDATED SCREENING AND
22 STABILIZATION SERVICES.—

23 (1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is
24 amended by inserting after subsection (c) the following new
25 subsection:

26 “(d) For purposes of subsection (a)(1)(A), in the case of
27 any item or service that is required to be provided pursuant to
28 section 1867 to an individual who is entitled to benefits under
29 this title, determinations as to whether the item or service is
30 reasonable and necessary shall be made on the basis of the in-
31 formation available to the treating physician or practitioner (in-
32 cluding the patient’s presenting symptoms or complaint) at the
33 time the item or service was ordered or furnished by the physi-
34 cian or practitioner (and not on the patient’s principal diag-
35 nosis). When making such determinations with respect to such
36 an item or service, the Secretary shall not consider the fre-



1 quency with which the item or service was provided to the pa-
2 tient before or after the time of the admission or visit.”.

3 (2) EFFECTIVE DATE.—The amendment made by
4 paragraph (1) shall apply to items and services furnished
5 on or after January 1, 2004.

6 (b) NOTIFICATION OF PROVIDERS WHEN EMTALA IN-
7 VESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C.
8 1395dd(d)) is amended by adding at the end the following new
9 paragraph:

10 “(4) NOTICE UPON CLOSING AN INVESTIGATION.—The
11 Secretary shall establish a procedure to notify hospitals and
12 physicians when an investigation under this section is
13 closed.”.

14 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN
15 EMTALA CASES INVOLVING TERMINATION OF PARTICIPA-
16 TION.—

17 (1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C.
18 1395dd(d)(3)) is amended—

19 (A) in the first sentence, by inserting “or in termi-
20 nating a hospital’s participation under this title” after
21 “in imposing sanctions under paragraph (1)”; and

22 (B) by adding at the end the following new sen-
23 tences: “Except in the case in which a delay would
24 jeopardize the health or safety of individuals, the Sec-
25 retary shall also request such a review before making
26 a compliance determination as part of the process of
27 terminating a hospital’s participation under this title
28 for violations related to the appropriateness of a med-
29 ical screening examination, stabilizing treatment, or an
30 appropriate transfer as required by this section, and
31 shall provide a period of 5 days for such review. The
32 Secretary shall provide a copy of the organization’s re-
33 port to the hospital or physician consistent with con-
34 fidentiality requirements imposed on the organization
35 under such part B.”.



1 (2) EFFECTIVE DATE.—The amendments made by
2 paragraph (1) shall apply to terminations of participation
3 initiated on or after the date of the enactment of this Act.

4 **SEC. 505. EMERGENCY MEDICAL TREATMENT AND AC-**
5 **TIVE LABOR ACT (EMTALA) TECHNICAL AD-**
6 **VISORY GROUP.**

7 (a) ESTABLISHMENT.—The Secretary shall establish a
8 Technical Advisory Group (in this section referred to as the
9 “Advisory Group”) to review issues related to the Emergency
10 Medical Treatment and Labor Act (EMTALA) and its imple-
11 mentation. In this section, the term “EMTALA” refers to the
12 provisions of section 1867 of the Social Security Act (42 U.S.C.
13 1395dd).

14 (b) MEMBERSHIP.—The Advisory Group shall be com-
15 posed of 19 members, including the Administrator of the Cen-
16 ters for Medicare & Medicaid Services and the Inspector Gen-
17 eral of the Department of Health and Human Services and of
18 which—

19 (1) 4 shall be representatives of hospitals, including at
20 least one public hospital, that have experience with the ap-
21 plication of EMTALA and at least 2 of which have not
22 been cited for EMTALA violations;

23 (2) 7 shall be practicing physicians drawn from the
24 fields of emergency medicine, cardiology or cardiothoracic
25 surgery, orthopedic surgery, neurosurgery, pediatrics or a
26 pediatric subspecialty, obstetrics-gynecology, and psychi-
27 atry, with not more than one physician from any particular
28 field;

29 (3) 2 shall represent patients;

30 (4) 2 shall be staff involved in EMTALA investiga-
31 tions from different regional offices of the Centers for
32 Medicare & Medicaid Services; and

33 (5) 1 shall be from a State survey office involved in
34 EMTALA investigations and 1 shall be from a peer review
35 organization, both of whom shall be from areas other than
36 the regions represented under paragraph (4).



1 In selecting members described in paragraphs (1) through (3),
2 the Secretary shall consider qualified individuals nominated by
3 organizations representing providers and patients.

4 (c) GENERAL RESPONSIBILITIES.—The Advisory Group—

5 (1) shall review EMTALA regulations;

6 (2) may provide advice and recommendations to the
7 Secretary with respect to those regulations and their appli-
8 cation to hospitals and physicians;

9 (3) shall solicit comments and recommendations from
10 hospitals, physicians, and the public regarding the imple-
11 mentation of such regulations; and

12 (4) may disseminate information on the application of
13 such regulations to hospitals, physicians, and the public.

14 (d) ADMINISTRATIVE MATTERS.—

15 (1) CHAIRPERSON.—The members of the Advisory
16 Group shall elect a member to serve as chairperson of the
17 Advisory Group for the life of the Advisory Group.

18 (2) MEETINGS.—The Advisory Group shall first meet
19 at the direction of the Secretary. The Advisory Group shall
20 then meet twice per year and at such other times as the
21 Advisory Group may provide.

22 (e) TERMINATION.—The Advisory Group shall terminate
23 30 months after the date of its first meeting.

24 (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Sec-
25 retary shall establish the Advisory Group notwithstanding any
26 limitation that may apply to the number of advisory committees
27 that may be established (within the Department of Health and
28 Human Services or otherwise).

29 **SEC. 506. AUTHORIZING USE OF ARRANGEMENTS TO**
30 **PROVIDE CORE HOSPICE SERVICES IN CER-**
31 **TAIN CIRCUMSTANCES.**

32 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.
33 1395x(dd)(5)) is amended by adding at the end the following:

34 “(D) In extraordinary, exigent, or other non-routine cir-
35 cumstances, such as unanticipated periods of high patient
36 loads, staffing shortages due to illness or other events, or tem-
37 porary travel of a patient outside a hospice program’s service

1 area, a hospice program may enter into arrangements with an-
2 other hospice program for the provision by that other program
3 of services described in paragraph (2)(A)(ii)(I). The provisions
4 of paragraph (2)(A)(ii)(II) shall apply with respect to the serv-
5 ices provided under such arrangements.

6 “(E) A hospice program may provide services described in
7 paragraph (1)(A) other than directly by the program if the
8 services are highly specialized services of a registered profes-
9 sional nurse and are provided non-routinely and so infrequently
10 so that the provision of such services directly would be imprac-
11 ticable and prohibitively expensive.”.

12 (b) CONFORMING PAYMENT PROVISION.—Section 1814(i)
13 (42 U.S.C. 1395f(i)) is amended by adding at the end the fol-
14 lowing new paragraph:

15 “(4) In the case of hospice care provided by a hospice pro-
16 gram under arrangements under section 1861(dd)(5)(D) made
17 by another hospice program, the hospice program that made
18 the arrangements shall bill and be paid for the hospice care.”.

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

22 **SEC. 507. APPLICATION OF OSHA BLOODBORNE PATHO-**
23 **GENS STANDARD TO CERTAIN HOSPITALS.**

24 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is
25 amended—

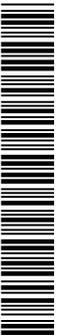
26 (1) in subsection (a)(1)—

27 (A) in subparagraph (R), by striking “and” at the
28 end;

29 (B) in subparagraph (S), by striking the period at
30 the end and inserting “, and”; and

31 (C) by inserting after subparagraph (S) the fol-
32 lowing new subparagraph:

33 “(T) in the case of hospitals that are not otherwise
34 subject to the Occupational Safety and Health Act of 1970,
35 to comply with the Bloodborne Pathogens standard under
36 section 1910.1030 of title 29 of the Code of Federal Regu-
37 lations (or as subsequently redesignated).”; and



1 (2) by adding at the end of subsection (b) the fol-
2 lowing new paragraph:

3 “(4)(A) A hospital that fails to comply with the require-
4 ment of subsection (a)(1)(T) (relating to the Bloodborne
5 Pathogens standard) is subject to a civil money penalty in an
6 amount described in subparagraph (B), but is not subject to
7 termination of an agreement under this section.

8 “(B) The amount referred to in subparagraph (A) is an
9 amount that is similar to the amount of civil penalties that may
10 be imposed under section 17 of the Occupational Safety and
11 Health Act of 1970 for a violation of the Bloodborne Pathogens
12 standard referred to in subsection (a)(1)(T) by a hospital that
13 is subject to the provisions of such Act.

14 “(C) A civil money penalty under this paragraph shall be
15 imposed and collected in the same manner as civil money pen-
16 alties under subsection (a) of section 1128A are imposed and
17 collected under that section.”

18 (b) EFFECTIVE DATE.—The amendments made by this
19 subsection (a) shall apply to hospitals as of July 1, 2004.

20 **SEC. 508. BIPA-RELATED TECHNICAL AMENDMENTS AND**
21 **CORRECTIONS.**

22 (a) TECHNICAL AMENDMENTS RELATING TO ADVISORY
23 COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of
24 section 1114 (42 U.S.C. 1314)—

25 (A) is transferred to section 1862 and added at the
26 end of such section; and

27 (B) is redesignated as subsection (j).

28 (2) Section 1862 (42 U.S.C. 1395y) is amended—

29 (A) in the last sentence of subsection (a), by striking
30 “established under section 1114(f)”; and

31 (B) in subsection (j), as so transferred and
32 redesignated—

33 (i) by striking “under subsection (f)”; and

34 (ii) by striking “section 1862(a)(1)” and inserting
35 “subsection (a)(1)”.



1 (b) TERMINOLOGY CORRECTIONS.—(1) Section
2 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by
3 section 521 of BIPA, is amended—

4 (A) in subclause (III), by striking “policy” and insert-
5 ing “determination”; and

6 (B) in subclause (IV), by striking “medical review
7 policies” and inserting “coverage determinations”.

8 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C))
9 is amended by striking “policy” and “POLICY” and inserting
10 “determination” each place it appears and “DETERMINATION”,
11 respectively.

12 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42
13 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is
14 amended—

15 (1) in subparagraph (A)(iv), by striking “subclause
16 (I), (II), or (III)” and inserting “clause (i), (ii), or (iii)”;

17 (2) in subparagraph (B), by striking “clause (i)(IV)”
18 and “clause (i)(III)” and inserting “subparagraph (A)(iv)”
19 and “subparagraph (A)(iii)”, respectively; and

20 (3) in subparagraph (C), by striking “clause (i)”,
21 “subclause (IV)” and “subparagraph (A)” and inserting
22 “subparagraph (A)”, “clause (iv)” and “paragraph
23 (1)(A)”, respectively each place it appears.

24 (d) OTHER CORRECTIONS.—Effective as if included in the
25 enactment of section 521(c) of BIPA, section 1154(e) (42
26 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

27 (e) EFFECTIVE DATE.—Except as otherwise provided, the
28 amendments made by this section shall be effective as if in-
29 cluded in the enactment of BIPA.

30 **SEC. 509. CONFORMING AUTHORITY TO WAIVE A PRO-**
31 **GRAM EXCLUSION.**

32 The first sentence of section 1128(c)(3)(B) (42 U.S.C.
33 1320a-7(c)(3)(B)) is amended to read as follows: “Subject to
34 subparagraph (G), in the case of an exclusion under subsection
35 (a), the minimum period of exclusion shall be not less than five
36 years, except that, upon the request of the administrator of a
37 Federal health care program (as defined in section 1128B(f))



1 who determines that the exclusion would impose a hardship on
2 individuals entitled to benefits under part A of title XVIII or
3 enrolled under part B of such title, or both, the Secretary may
4 waive the exclusion under subsection (a)(1), (a)(3), or (a)(4)
5 with respect to that program in the case of an individual or en-
6 tity that is the sole community physician or sole source of es-
7 sential specialized services in a community.”.

8 **SEC. 510. TREATMENT OF CERTAIN DENTAL CLAIMS.**

9 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is
10 amended by adding after subsection (g) the following new sub-
11 section:

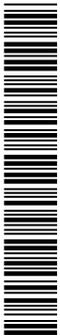
12 “(h)(1) Subject to paragraph (2), a group health plan (as
13 defined in subsection (a)(1)(A)(v)) providing supplemental or
14 secondary coverage to individuals also entitled to services under
15 this title shall not require a medicare claims determination
16 under this title for dental benefits specifically excluded under
17 subsection (a)(12) as a condition of making a claims deter-
18 mination for such benefits under the group health plan.

19 “(2) A group health plan may require a claims determina-
20 tion under this title in cases involving or appearing to involve
21 inpatient dental hospital services or dental services expressly
22 covered under this title pursuant to actions taken by the Sec-
23 retary.”.

24 (b) EFFECTIVE DATE.—The amendment made by sub-
25 section (a) shall take effect on the date that is 60 days after
26 the date of the enactment of this Act.

27 **SEC. 511. FURNISHING HOSPITALS WITH INFORMATION**
28 **TO COMPUTE DSH FORMULA.**

29 Beginning not later than 1 year after the date of the en-
30 actment of this Act, the Secretary shall furnish to subsection
31 (d) hospitals (as defined in section 1886(d)(1)(B) of the Social
32 Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary
33 for such hospitals to compute the number of patient days de-
34 scribed in subclause (II) of section 1886(d)(5)(F)(vi) of the So-
35 cial Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) used in
36 computing the disproportionate patient percentage under such
37 section for that hospital. Such data shall also be furnished to



1 other hospitals which would qualify for additional payments
2 under part A of title XVIII of the Social Security Act on the
3 basis of such data.

4 **SEC. 512. MISCELLANEOUS REPORTS, STUDIES, AND**
5 **PUBLICATION REQUIREMENTS.**

6 (a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

7 (1) SUSTAINABLE GROWTH RATE AND UPDATES.—

8 Not later than 6 months after the date of the enactment
9 of this Act, the Comptroller General of the United States
10 shall submit to Congress a report on the appropriateness
11 of the updates in the conversion factor under subsection
12 (d)(3) of section 1848 of the Social Security Act (42
13 U.S.C. 1395w-4), including the appropriateness of the sus-
14 tainable growth rate formula under subsection (f) of such
15 section for 2002 and succeeding years. Such report shall
16 examine the stability and predictability of such updates and
17 rate and alternatives for the use of such rate in the up-
18 dates.

19 (2) PHYSICIAN COMPENSATION GENERALLY.—Not

20 later than 12 months after the date of the enactment of
21 this Act, the Comptroller General shall submit to Congress
22 a report on all aspects of physician compensation for serv-
23 ices furnished under title XVIII of the Social Security Act,
24 and how those aspects interact and the effect on appro-
25 priate compensation for physician services. Such report
26 shall review alternatives for the physician fee schedule
27 under section 1848 of such title (42 U.S.C. 1395w-4).

28 (b) ANNUAL PUBLICATION OF LIST OF NATIONAL COV-

29 ERAGE DETERMINATIONS.—The Secretary shall provide, in an
30 appropriate annual publication available to the public, a list of
31 national coverage determinations made under title XVIII of the
32 Social Security Act in the previous year and information on
33 how to get more information with respect to such determina-
34 tions.

35 (c) GAO REPORT ON FLEXIBILITY IN APPLYING HOME
36 HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS WHO
37 ARE NOT MEDICARE BENEFICIARIES.—Not later than 6



1 months after the date of the enactment of this Act, the Comp-
2 troller General of the United States shall submit to Congress
3 a report on the implications if there were flexibility in the ap-
4 plication of the medicare conditions of participation for home
5 health agencies with respect to groups or types of patients who
6 are not medicare beneficiaries. The report shall include an
7 analysis of the potential impact of such flexible application on
8 clinical operations and the recipients of such services and an
9 analysis of methods for monitoring the quality of care provided
10 to such recipients.

11 (d) **OIG REPORT ON NOTICES RELATING TO USE OF**
12 **HOSPITAL LIFETIME RESERVE DAYS.**—Not later than 1 year
13 after the date of the enactment of this Act, the Inspector Gen-
14 eral of the Department of Health and Human Services shall
15 submit a report to Congress on—

16 (1) the extent to which hospitals provide notice to
17 medicare beneficiaries in accordance with applicable re-
18 quirements before they use the 60 lifetime reserve days de-
19 scribed in section 1812(a)(1) of the Social Security Act (42
20 U.S.C. 1395d(a)(1)); and

21 (2) the appropriateness and feasibility of hospitals pro-
22 viding a notice to such beneficiaries before they completely
23 exhaust such lifetime reserve days.

