

107<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 5729

To amend title XVIII of the Social Security Act to revise and improve payments to providers of services under the Medicare Program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 14, 2002

Mr. TANNER (for himself, Mr. BERRY, Mr. MATHESON, Mr. ROSS, Mr. STENHOLM, Mr. HILL, Mr. MOORE, Mr. PETERSON of Minnesota, Mr. TURNER, and Mr. FORD) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to revise and improve payments to providers of services under the Medicare Program, and for other purposes.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the  
 5 “Medicare Reimbursement Equity and Benefits Improve-  
 6 ment Act of 2002”.

7 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Ex-  
 8 cept as otherwise specifically provided, whenever in this  
 9 Act an amendment is expressed in terms of an amendment  
 10 to or repeal of a section or other provision, the reference  
 11 shall be considered to be made to that section or other  
 12 provision of the Social Security Act.

13 (c) **BIPA; SECRETARY.**—In this Act:

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

18 (2) **SECRETARY.**—The term “Secretary” means  
 19 the Secretary of Health and Human Services.

20 (d) **TABLE OF CONTENTS.**—The table of contents of  
 21 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

**TITLE I—RURAL HEALTH CARE IMPROVEMENTS**

Sec. 101. Reference to full market basket increase for sole community hospitals.

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

- Sec. 103. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 104. More frequent update in weights used in hospital market basket.
- Sec. 105. Improvements to critical access hospital program.
- Sec. 106. Extension of temporary increase for home health services furnished in a rural area.
- Sec. 107. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.
- Sec. 108. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.
- Sec. 109. GAO study of geographic differences in payments for physicians' services.
- Sec. 110. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 111. Relief for certain non-teaching hospitals.

## TITLE II—PROVISIONS RELATING TO PART A

### Subtitle A—Inpatient Hospital Services

- Sec. 201. Revision of acute care hospital payment updates.
- Sec. 202. 2-year increase in level of adjustment for indirect costs of medical education (IME).
- Sec. 203. Recognition of new medical technologies under inpatient hospital PPS.
- Sec. 204. Phase-in of Federal rate for hospitals in Puerto Rico.
- Sec. 205. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 206. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 207. Reference to provision for more frequent updates in the weights used in hospital market basket.
- Sec. 208. Reference to provision making improvements to critical access hospital program.
- Sec. 209. GAO study on improving the hospital wage index.

### Subtitle B—Skilled Nursing Facility Services

- Sec. 211. Payment for covered skilled nursing facility services.

### Subtitle C—Hospice

- Sec. 221. Coverage of hospice consultation services.
- Sec. 222. 10 percent increase in payment for hospice care furnished in a frontier area.
- Sec. 223. Rural hospice demonstration project.

## TITLE III—PROVISIONS RELATING TO PART B

### Subtitle A—Physicians' Services

- Sec. 301. Studies on access to physicians' services.

- Sec. 302. MedPAC report on payment for physicians' services.
- Sec. 303. 1-year extension of treatment of certain physician pathology services under medicare.
- Sec. 304. Physician fee schedule wage index revision.

#### Subtitle B—Other Services

- Sec. 311. Payment for ambulance services.
- Sec. 312. 2-year extension of moratorium on therapy caps; provisions relating to reports.
- Sec. 313. Coverage of an initial preventive physical examination.
- Sec. 314. Renal dialysis services.
- Sec. 315. Improved payment for certain mammography services.
- Sec. 316. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 317. Coverage of cholesterol and blood lipid screening.

### TITLE IV—PROVISIONS RELATING TO PARTS A AND B

#### Subtitle A—Home Health Services

- Sec. 401. Elimination of 15 percent reduction in payment rates under the prospective payment system.
- Sec. 402. Update in home health services.
- Sec. 403. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
- Sec. 404. MedPAC study on medicare margins of home health agencies.
- Sec. 405. Clarification of treatment of occasional absences in determining whether an individual is confined to the home.

#### Subtitle B—Direct Graduate Medical Education

- Sec. 411. Extension of update limitation on high cost programs.
- Sec. 412. Redistribution of unused resident positions.

#### Subtitle C—Other Provisions

- Sec. 421. Modifications to Medicare Payment Advisory Commission (MedPAC).
- Sec. 422. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
- Sec. 423. Demonstration project for medical adult day care services.
- Sec. 424. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

### TITLE V—MEDICARE+CHOICE REVITALIZATION

- Sec. 501. Medicare+Choice improvements.
- Sec. 502. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
- Sec. 503. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 504. Extension of reasonable cost and SHMO contracts.

### TITLE VI—MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

- Sec. 601. Disproportionate share hospital (DSH) payments.

1 **TITLE I—RURAL HEALTH CARE**  
2 **IMPROVEMENTS**

3 **SEC. 101. REFERENCE TO FULL MARKET BASKET INCREASE**  
4 **FOR SOLE COMMUNITY HOSPITALS.**

5 For provision eliminating any reduction from full  
6 market basket in the update for inpatient hospital services  
7 for sole community hospitals, see section 201.

8 **SEC. 102. ENHANCED DISPROPORTIONATE SHARE HOS-**  
9 **PITAL (DSH) TREATMENT FOR RURAL HOS-**  
10 **PITALS AND URBAN HOSPITALS WITH FEWER**  
11 **THAN 100 BEDS.**

12 (a) BLENDING OF PAYMENT AMOUNTS.—

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

16 “(xiv)(I) In the case of discharges in a fiscal year  
17 beginning on or after October 1, 2002, subject to sub-  
18 clause (II), there shall be substituted for the dispropor-  
19 tionate share adjustment percentage otherwise determined  
20 under clause (iv) (other than subclause (I)) or under  
21 clause (viii), (x), (xi), (xii), or (xiii), the old blend propor-  
22 tion (specified under subclause (III)) of the dispropor-  
23 tionate share adjustment percentage otherwise determined  
24 under the respective clause and 100 percent minus such  
25 old blend proportion of the disproportionate share adjust-

1 ment percentage determined under clause (vii) (relating  
2 to large, urban hospitals).

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

7 “(III) For purposes of subclause (I), the old blend  
8 proportion for fiscal year 2003 is 80 percent, for each sub-  
9 sequent year (through 2006) is the old blend proportion  
10 under this subclause for the previous year minus 20 per-  
11 centage points, and for each year beginning with 2007 is  
12 0 percent.”.

13 (2) CONFORMING AMENDMENTS.—Section  
14 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
15 amended—

16 (A) in each of subclauses (II), (III), (IV),  
17 (V), and (VI) of clause (iv), by inserting  
18 “subject to clause (xiv) and” before “for dis-  
19 charges occurring”;

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

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

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

4 **SEC. 103. 2-YEAR PHASED-IN INCREASE IN THE STANDARD-**  
5 **IZED AMOUNT IN RURAL AND SMALL URBAN**  
6 **AREAS TO ACHIEVE A SINGLE, UNIFORM**  
7 **STANDARDIZED AMOUNT.**

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

10 (1) by striking “(iv) For discharges” and in-  
11 sserting “(iv)(I) Subject to the succeeding provisions  
12 of this clause, for discharges”; and

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

15 “(II) For discharges occurring during fiscal  
16 year 2003, the average standardized amount for hos-  
17 pitals located other than in a large urban area shall  
18 be increased by  $\frac{1}{2}$  of the difference between the av-  
19 erage standardized amount determined under sub-  
20 clause (I) for hospitals located in large urban areas  
21 for such fiscal year and such amount determined  
22 (without regard to this subclause) for other hospitals  
23 for such fiscal year.

24 “(III) For discharges occurring in a fiscal year  
25 beginning with fiscal year 2004, the Secretary shall

1 compute an average standardized amount for hos-  
2 pitals located in any area within the United States  
3 and within each region equal to the average stand-  
4 arized amount computed for the previous fiscal  
5 year under this subparagraph for hospitals located  
6 in a large urban area (or, beginning with fiscal year  
7 2005, for hospitals located in any area) increased by  
8 the applicable percentage increase under subsection  
9 (b)(3)(B)(i).”.

10 **SEC. 104. MORE FREQUENT UPDATE IN WEIGHTS USED IN**  
11 **HOSPITAL MARKET BASKET.**

12 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After  
13 revising the weights used in the hospital market basket  
14 under section 1886(b)(3)(B)(iii) of the Social Security Act  
15 (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most cur-  
16 rent data available, the Secretary shall establish a fre-  
17 quency for revising such weights in such market basket  
18 to reflect the most current data available more frequently  
19 than once every 5 years.

20 (b) REPORT.—Not later than October 1, 2003, the  
21 Secretary shall submit a report to Congress on the fre-  
22 quency established under subsection (a), including an ex-  
23 planation of the reasons for, and options considered, in  
24 determining such frequency.

1 **SEC. 105. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**  
2 **PROGRAM.**

3 (a) REINSTATEMENT OF PERIODIC INTERIM PAY-  
4 MENT (PIP).—Section 1815(e)(2) (42 U.S.C.  
5 1395g(e)(2)) is amended—

6 (1) by striking “and” at the end of subpara-  
7 graph (C);

8 (2) by adding “and” at the end of subpara-  
9 graph (D); and

10 (3) by inserting after subparagraph (D) the fol-  
11 lowing new subparagraph:

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

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

17 “The Secretary may not require, as a condition for  
18 applying subparagraph (B) with respect to a critical  
19 access hospital, that each physician providing profes-  
20 sional services in the hospital must assign billing  
21 rights with respect to such services, except that such  
22 subparagraph shall not apply to those physicians  
23 who have not assigned such billing rights.”.

24 (c) FLEXIBILITY IN BED LIMITATION FOR HOS-  
25 PITALS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

1 (1) in subsection (c)(2)(B)(iii), by inserting  
2 “subject to paragraph (3)” after “(iii) provides”;

3 (2) by adding at the end of subsection (c) the  
4 following new paragraph:

5 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS  
6 FOR HOSPITALS WITH STRONG SEASONAL CENSUS  
7 FLUCTUATIONS.—

8 “(A) IN GENERAL.—Subject to subpara-  
9 graph (C), in the case of a hospital that dem-  
10 onstrates that it meets the standards estab-  
11 lished under subparagraph (B) and has not  
12 made the election described in subsection  
13 (f)(2)(A), the bed limitations otherwise applica-  
14 ble under paragraph (2)(B)(iii) and subsection  
15 (f) shall be increased by 5 beds.

16 “(B) STANDARDS.—The Secretary shall  
17 specify standards for determining whether a  
18 critical access hospital has sufficiently strong  
19 seasonal variations in patient admissions to jus-  
20 tify the increase in bed limitation provided  
21 under subparagraph (A).”; and

22 (3) in subsection (f)—

23 (A) by inserting “(1)” after “(f)”; and

24 (B) by adding at the end the following new  
25 paragraph:

1       “(2)(A) A hospital may elect to treat the reference  
2 in paragraph (1) to ‘15 beds’ as a reference to ‘25 beds’,  
3 but only if no more than 10 beds in the hospital are at  
4 any time used for non-acute care services. A hospital that  
5 makes such an election is not eligible for the increase pro-  
6 vided under subsection (c)(3)(A).

7       “(B) The limitations in numbers of beds under the  
8 first sentence of paragraph (1) are subject to adjustment  
9 under subsection (c)(3).”.

10       (d) 5-YEAR EXTENSION OF THE AUTHORIZATION  
11 FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section  
12 1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking  
13 “through 2002” and inserting “through 2007”.

14       (e) PROHIBITION OF RETROACTIVE RECOUPMENT.—  
15 The Secretary shall not recoup (or otherwise seek to re-  
16 cover) overpayments made for outpatient critical access  
17 hospital services under part B of title XVIII of the Social  
18 Security Act, for services furnished in cost reporting peri-  
19 ods that began before October 1, 2002, insofar as such  
20 overpayments are attributable to payment being based on  
21 80 percent of reasonable costs (instead of 100 percent of  
22 reasonable costs minus 20 percent of charges).

23       (f) EFFECTIVE DATES.—

1           (1) REINSTATEMENT OF PIP.—The amend-  
2           ments made by subsection (a) shall apply to pay-  
3           ments made on or after January 1, 2003.

4           (2) PHYSICIAN PAYMENT ADJUSTMENT CONDI-  
5           TION.—The amendment made by subsection (b)  
6           shall be effective as if included in the enactment of  
7           section 403(d) of the Medicare, Medicaid, and  
8           SCHIP Balanced Budget Refinement Act of 1999  
9           (113 Stat. 1501A–371).

10          (3) FLEXIBILITY IN BED LIMITATION.—The  
11          amendments made by subsection (c) shall apply to  
12          designations made on or after January 1, 2003, but  
13          shall not apply to critical access hospitals that were  
14          designated as of such date.

15 **SEC. 106. EXTENSION OF TEMPORARY INCREASE FOR**  
16                   **HOME HEALTH SERVICES FURNISHED IN A**  
17                   **RURAL AREA.**

18          (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.  
19 2763A–533) is amended—

20           (1) by striking “24-MONTH INCREASE BEGIN-  
21           NING APRIL 1, 2001” and inserting “IN GENERAL”;  
22           and

23           (2) by striking “April 1, 2003” and inserting  
24           “January 1, 2005”.

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

6 **SEC. 107. REFERENCE TO 10 PERCENT INCREASE IN PAY-**  
7 **MENT FOR HOSPICE CARE FURNISHED IN A**  
8 **FRONTIER AREA AND RURAL HOSPICE DEM-**  
9 **ONSTRATION PROJECT.**

10 For—

11 (1) provision of 10 percent increase in payment  
12 for hospice care furnished in a frontier area, see sec-  
13 tion 222; and

14 (2) provision of a rural hospice demonstration  
15 project, see section 223.

16 **SEC. 108. REFERENCE TO PRIORITY FOR HOSPITALS LO-**  
17 **CATED IN RURAL OR SMALL URBAN AREAS IN**  
18 **REDISTRIBUTION OF UNUSED GRADUATE**  
19 **MEDICAL EDUCATION RESIDENCIES.**

20 For provision providing priority for hospitals located  
21 in rural or small urban areas in redistribution of unused  
22 graduate medical education residencies, see section 412.

1 **SEC. 109. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN**  
2 **PAYMENTS FOR PHYSICIANS' SERVICES.**

3 (a) STUDY.—The Comptroller General of the United  
4 States shall conduct a study of differences in payment  
5 amounts under the physician fee schedule under section  
6 1848 of the Social Security Act (42 U.S.C. 1395w–4) for  
7 physicians' services in different geographic areas. Such  
8 study shall include—

9 (1) an assessment of the validity of the geo-  
10 graphic adjustment factors used for each component  
11 of the fee schedule;

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

14 (3) an evaluation of the methods used to deter-  
15 mine professional liability insurance costs used in  
16 computing the malpractice component, including a  
17 review of increases in professional liability insurance  
18 premiums and variation in such increases by State  
19 and physician specialty and methods used to update  
20 the geographic cost of practice index and relative  
21 weights for the malpractice component.

22 (b) REPORT.—Not later than 1 year after the date  
23 of the enactment of this Act, the Comptroller General shall  
24 submit to Congress a report on the study conducted under  
25 subsection (a). The report shall include recommendations  
26 regarding the use of more current data in computing geo-

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

4 **SEC. 110. PROVIDING SAFE HARBOR FOR CERTAIN COL-**  
5 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**  
6 **CALLY UNDERSERVED POPULATIONS.**

7 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
8 1320a–7(b)(3)), as amended by section 101(b)(2), is  
9 amended—

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

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

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

16 “(H) any remuneration between a public  
17 or nonprofit private health center entity de-  
18 scribed under clause (i) or (ii) of section  
19 1905(l)(2)(B) and any individual or entity pro-  
20 viding goods, items, services, donations or  
21 loans, or a combination thereof, to such health  
22 center entity pursuant to a contract, lease,  
23 grant, loan, or other agreement, if such agree-  
24 ment contributes to the ability of the health  
25 center entity to maintain or increase the avail-

1 ability, or enhance the quality, of services pro-  
2 vided to a medically underserved population  
3 served by the health center entity.”.

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

6 (1) ESTABLISHMENT.—

7 (A) IN GENERAL.—The Secretary of  
8 Health and Human Services (in this subsection  
9 referred to as the “Secretary”) shall establish,  
10 on an expedited basis, standards relating to the  
11 exception described in section 1128B(b)(3)(H)  
12 of the Social Security Act, as added by sub-  
13 section (a), for health center entity arrange-  
14 ments to the antikickback penalties.

15 (B) FACTORS TO CONSIDER.—The Sec-  
16 retary shall consider the following factors,  
17 among others, in establishing standards relating  
18 to the exception for health center entity ar-  
19 rangements under subparagraph (A):

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

1                   (ii) Whether the arrangement between  
2                   the health center entity and the other  
3                   party restricts or limits a patient's freedom  
4                   of choice.

5                   (iii) Whether the arrangement be-  
6                   tween the health center entity and the  
7                   other party protects a health care profes-  
8                   sional's independent medical judgment re-  
9                   garding medically appropriate treatment.

10                  The Secretary may also include other standards  
11                  and criteria that are consistent with the intent  
12                  of Congress in enacting the exception estab-  
13                  lished under this section.

14                  (2) INTERIM FINAL EFFECT.—No later than  
15                  180 days after the date of enactment of this Act, the  
16                  Secretary shall publish a rule in the Federal Reg-  
17                  ister consistent with the factors under paragraph  
18                  (1)(B). Such rule shall be effective and final imme-  
19                  diately on an interim basis, subject to such change  
20                  and revision, after public notice and opportunity (for  
21                  a period of not more than 60 days) for public com-  
22                  ment, as is consistent with this subsection.

1 **SEC. 111. RELIEF FOR CERTAIN NON-TEACHING HOS-**  
2 **PITALS.**

3 (a) IN GENERAL.—In the case of a non-teaching hos-  
4 pital that meets the condition of subsection (b), in each  
5 of fiscal years 2003, 2004, and 2005 the amount of pay-  
6 ment made to the hospital under section 1886(d) of the  
7 Social Security Act for discharges occurring during such  
8 fiscal year only shall be increased as though the applicable  
9 percentage increase (otherwise applicable to discharges oc-  
10 ccurring during such fiscal year under section  
11 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C.  
12 1395ww(b)(3)(B)(i)) had been increased by 5 percentage  
13 points. The previous sentence shall be applied for each  
14 such fiscal year separately without regard to its applica-  
15 tion in a previous fiscal year and shall not affect payment  
16 for discharges for any hospital occurring during a fiscal  
17 year after fiscal year 2005.

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

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

1 (a)(4) of such section) for all subsection (d) hos-  
2 pitals in such areas in such State with respect to  
3 such cost reporting periods; or

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

14 The amounts under paragraphs (1) and (2) shall be deter-  
15 mined by the Secretary of Health and Human Services  
16 based on data of the Medicare Payment Advisory Commis-  
17 sion.

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

19 (1) NON-TEACHING HOSPITAL.—The term  
20 “non-teaching hospital” means, for a cost reporting  
21 period, a subsection (d) hospital (as defined in sub-  
22 section (d)(1)(B) of section 1886 of the Social Secu-  
23 rity Act, 42 U.S.C. 1395ww) that is not receiving  
24 any additional payment under subsection (d)(5)(B)  
25 of such section or a payment under subsection (h)

1 of such section for discharges occurring during the  
2 period. A subsection (d) hospital that receives addi-  
3 tional payments under subsection (d)(5)(B) or (h) of  
4 such section shall, for purposes of this section, also  
5 be treated as a non-teaching hospital unless a chair-  
6 man of a department in the medical school with  
7 which the hospital is affiliated is serving or has been  
8 appointed as a clinical chief of service in the hos-  
9 pital.

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

14 **TITLE II—PROVISIONS**  
15 **RELATING TO PART A**  
16 **Subtitle A—Inpatient Hospital**  
17 **Services**

18 **SEC. 201. REVISION OF ACUTE CARE HOSPITAL PAYMENT**

19 **UPDATES.**

20 Subclause (XVIII) of section 1886(b)(3)(B)(i) (42  
21 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as fol-  
22 lows:

23 “(XVIII) for fiscal year 2003, the market bas-  
24 ket percentage increase for sole community hospitals

1 and such increase minus 0.25 percentage points for  
 2 other hospitals, and”.

3 **SEC. 202. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR**  
 4 **INDIRECT COSTS OF MEDICAL EDUCATION**  
 5 **(IME).**

6 Section 1886(d)(5)(B)(ii) (42 U.S.C.  
 7 1395ww(d)(5)(B)(ii)) is amended—

8 (1) in subclause (VI) by striking “and” at the  
 9 end;

10 (2) by redesignating subclause (VII) as sub-  
 11 clause (IX);

12 (3) in subclause (IX) as so redesignated, by  
 13 striking “2002” and inserting “2004”; and

14 (4) by inserting after subclause (VI) the fol-  
 15 lowing new subclause:

16 “(VII) during fiscal year 2003, ‘c’ is equal  
 17 to 1.47;

18 “(VIII) during fiscal year 2004, ‘c’ is  
 19 equal to 1.45; and”.

20 **SEC. 203. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**  
 21 **UNDER INPATIENT HOSPITAL PPS.**

22 (a) IMPROVING TIMELINESS OF DATA COLLEC-  
 23 TION.—Section 1886(d)(5)(K) (42 U.S.C.  
 24 1395ww(d)(5)(K)) is amended by adding at the end the  
 25 following new clause:

1       “(vii) Under the mechanism under this subpara-  
 2 graph, the Secretary shall provide for the addition of new  
 3 diagnosis and procedure codes in April 1 of each year, but  
 4 the addition of such codes shall not require the Secretary  
 5 to adjust the payment (or diagnosis-related group classi-  
 6 fication) under this subsection until the fiscal year that  
 7 begins after such date.”.

8       (b) ELIGIBILITY STANDARD.—

9               (1) MINIMUM PERIOD FOR RECOGNITION OF  
 10 NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi)  
 11 (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

12                       (A) by inserting “(I)” after “(vi)”; and

13                       (B) by adding at the end the following new  
 14 subclause:

15       “(II) Under such criteria, a service or technology  
 16 shall not be denied treatment as a new service or tech-  
 17 nology on the basis of the period of time in which the serv-  
 18 ice or technology has been in use if such period ends before  
 19 the end of the 2-to-3-year period that begins on the effec-  
 20 tive date of implementation of a code under ICD–9–CM  
 21 (or a successor coding methodology) that enables the iden-  
 22 tification of a significant sample of specific discharges in  
 23 which the service or technology has been used.”.

24               (2) ADJUSTMENT OF THRESHOLD.—Section  
 25 1886(d)(5)(K)(ii)(I)                       (42                       U.S.C.

1 1395ww(d)(5)(K)(ii)(I) is amended by inserting  
2 “(applying a threshold specified by the Secretary  
3 that is the lesser of 50 percent of the national aver-  
4 age standardized amount for operating costs of inpa-  
5 tient hospital services for all hospitals and all diag-  
6 nosis-related groups or one standard deviation for  
7 the diagnosis-related group involved)” after “is inad-  
8 equate”.

9 (3) CRITERION FOR SUBSTANTIAL IMPROVE-  
10 MENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C.  
11 1395ww(d)(5)(K)(vi)), as amended by paragraph  
12 (1), is further amended by adding at the end the fol-  
13 lowing subclause:

14 “(III) The Secretary shall by regulation provide for  
15 further clarification of the criteria applied to determine  
16 whether a new service or technology represents an advance  
17 in medical technology that substantially improves the diag-  
18 nosis or treatment of beneficiaries. Under such criteria,  
19 in determining whether a new service or technology rep-  
20 resents an advance in medical technology that substan-  
21 tially improves the diagnosis or treatment of beneficiaries,  
22 the Secretary shall deem a service or technology as meet-  
23 ing such requirement if the service or technology is a drug  
24 or biological that is designated under section 506 or 526  
25 of the Federal Food, Drug, and Cosmetic Act, approved

1 under section 314.510 or 601.41 of title 21, Code of Fed-  
2 eral Regulations, or designated for priority review when  
3 the marketing application for such drug or biological was  
4 filed or is a medical device for which an exemption has  
5 been granted under section 520(m) of such Act, or for  
6 which priority review has been provided under section  
7 515(d)(5) of such Act.”.

8 (4) PROCESS FOR PUBLIC INPUT.—Section  
9 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as  
10 amended by paragraph (1), is amended—

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

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

16 “(viii) The mechanism established pursuant to clause  
17 (i) shall be adjusted to provide, before publication of a  
18 proposed rule, for public input regarding whether a new  
19 service or technology not described in the second sentence  
20 of clause (vi)(III) represents an advance in medical tech-  
21 nology that substantially improves the diagnosis or treat-  
22 ment of beneficiaries as follows:

23 “(I) The Secretary shall make public and peri-  
24 odically update a list of all the services and tech-

1 nologies for which an application for additional pay-  
2 ment under this subparagraph is pending.

3 “(II) The Secretary shall accept comments, rec-  
4 ommendations, and data from the public regarding  
5 whether the service or technology represents a sub-  
6 stantial improvement.

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

16 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—  
17 Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is  
18 further amended by adding at the end the following new  
19 clause:

20 “(ix) Before establishing any add-on payment under  
21 this subparagraph with respect to a new technology, the  
22 Secretary shall seek to identify one or more diagnosis-re-  
23 lated groups associated with such technology, based on  
24 similar clinical or anatomical characteristics and the cost  
25 of the technology. Within such groups the Secretary shall

1 assign an eligible new technology into a diagnosis-related  
2 group where the average costs of care most closely approx-  
3 imate the costs of care of using the new technology. In  
4 such case, no add-on payment under this subparagraph  
5 shall be made with respect to such new technology and  
6 this clause shall not affect the application of paragraph  
7 (4)(C)(iii).”.

8 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-  
9 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.  
10 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after  
11 “the estimated average cost of such service or technology”  
12 the following: “(based on the marginal rate applied to  
13 costs under subparagraph (A))”.

14 (e) EFFECTIVE DATE.—

15 (1) IN GENERAL.—The Secretary shall imple-  
16 ment the amendments made by this section so that  
17 they apply to classification for fiscal years beginning  
18 with fiscal year 2004.

19 (2) RECONSIDERATIONS OF APPLICATIONS FOR  
20 FISCAL YEAR 2003 THAT ARE DENIED.—In the case  
21 of an application for a classification of a medical  
22 service or technology as a new medical service or  
23 technology under section 1886(d)(5)(K) of the Social  
24 Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was  
25 filed for fiscal year 2003 and that is denied—

1 (A) the Secretary shall automatically re-  
2 consider the application as an application for  
3 fiscal year 2004 under the amendments made  
4 by this section; and

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

8 **SEC. 204. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN**  
9 **PUERTO RICO.**

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

12 (1) in subparagraph (A)—

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

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

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

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

5           “(i) between October 1, 1987, and September  
6 30, 1997, the applicable Puerto Rico percentage is  
7 75 percent and the applicable Federal percentage is  
8 25 percent;

9           “(ii) on or after October 1, 1997, and before  
10 October 1, 2003, the applicable Puerto Rico percent-  
11 age is 50 percent and the applicable Federal per-  
12 centage is 50 percent;

13           “(iii) during fiscal year 2004, the applicable  
14 Puerto Rico percentage is 45 percent and the appli-  
15 cable Federal percentage is 55 percent;

16           “(iv) during fiscal year 2005, the applicable  
17 Puerto Rico percentage is 40 percent and the appli-  
18 cable Federal percentage is 60 percent;

19           “(v) during fiscal year 2006, the applicable  
20 Puerto Rico percentage is 35 percent and the appli-  
21 cable Federal percentage is 65 percent;

22           “(vi) during fiscal year 2007, the applicable  
23 Puerto Rico percentage is 30 percent and the appli-  
24 cable Federal percentage is 70 percent; and

1           “(vii) on or after October 1, 2007, the applica-  
2           ble Puerto Rico percentage is 25 percent and the ap-  
3           plicable Federal percentage is 75 percent.”.

4 **SEC. 205. REFERENCE TO PROVISION RELATING TO EN-**  
5           **HANCED DISPROPORTIONATE SHARE HOS-**  
6           **PITAL (DSH) PAYMENTS FOR RURAL HOS-**  
7           **PITALS AND URBAN HOSPITALS WITH FEWER**  
8           **THAN 100 BEDS.**

9           For provision enhancing disproportionate share hos-  
10          pital (DSH) treatment for rural hospitals and urban hos-  
11          pitals with fewer than 100 beds, see section 102.

12 **SEC. 206. REFERENCE TO PROVISION RELATING TO 2-YEAR**  
13           **PHASED-IN INCREASE IN THE STANDARDIZED**  
14           **AMOUNT IN RURAL AND SMALL URBAN**  
15           **AREAS TO ACHIEVE A SINGLE, UNIFORM**  
16           **STANDARDIZED AMOUNT.**

17          For provision phasing in over a 2-year period an in-  
18          crease in the standardized amount for rural and small  
19          urban areas to achieve a single, uniform, standardized  
20          amount, see section 103.

1 **SEC. 207. REFERENCE TO PROVISION FOR MORE FRE-**  
2 **QUENT UPDATES IN THE WEIGHTS USED IN**  
3 **HOSPITAL MARKET BASKET.**

4 For provision providing for more frequent updates in  
5 the weights used in hospital market basket, see section  
6 104.

7 **SEC. 208. REFERENCE TO PROVISION MAKING IMPROVE-**  
8 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**  
9 **GRAM.**

10 For provision providing making improvements to crit-  
11 ical access hospital program, see section 105.

12 **SEC. 209. GAO STUDY ON IMPROVING THE HOSPITAL WAGE**  
13 **INDEX.**

14 (a) STUDY.—

15 (1) IN GENERAL.—The Comptroller General of  
16 the United States shall conduct a study on the im-  
17 provements that can be made in the measurement of  
18 regional differences in hospital wages reflected in the  
19 hospital wage index under section 1886(d) of the So-  
20 cial Security Act (42 U.S.C. 1395ww(d)).

21 (2) EXAMINATION OF USE OF METROPOLITAN  
22 STATISTICAL AREAS (MSAS).—The study shall spe-  
23 cifically examine the use of metropolitan statistical  
24 areas for purposes of computing and applying the  
25 wage index and whether the boundaries of such  
26 areas accurately reflect local labor markets. In addi-

1       tion, the study shall examine whether regional in-  
2       equities are created as a result of infrequent updates  
3       of such boundaries and policies of the Bureau of the  
4       Census relating to commuting criteria.

5           (3) WAGE DATA.—The study shall specifically  
6       examine the portions of the hospital cost reports re-  
7       lating to wages, and methods for improving the ac-  
8       curacy of the wage data and for reducing inequities  
9       resulting from differences among hospitals in the re-  
10      porting of wage data.

11       (b) CONSULTATION WITH OMB.—The Comptroller  
12      General shall consult with the Director of Office of Man-  
13      agement and Budget in conducting the study under sub-  
14      section (a)(2).

15       (c) REPORT.—Not later than May 1, 2003, the  
16      Comptroller General shall submit to Congress a report on  
17      the study conducted under subsection (a) and shall include  
18      in the report such recommendations as may be appropriate  
19      on—

20           (1) changes in the definition of labor market  
21      areas used for purposes of the area wage index  
22      under section 1886 of the Social Security Act; and

23           (2) improvements in methods for the collection  
24      of wage data.

1                   **Subtitle B—Skilled Nursing**  
2                   **Facility Services**

3   **SEC. 211. PAYMENT FOR COVERED SKILLED NURSING FA-**  
4                   **CILITY SERVICES.**

5           (a) TEMPORARY INCREASE IN NURSING COMPONENT  
6 OF PPS FEDERAL RATE.—Section 312(a) of BIPA is  
7 amended by adding at the end the following new sentence:  
8 “The Secretary of Health and Human Services shall in-  
9 crease by 12, 10, and 8 percent the nursing component  
10 of the case-mix adjusted Federal prospective payment rate  
11 specified in Tables 3 and 4 of the final rule published in  
12 the Federal Register by the Health Care Financing Ad-  
13 ministration on July 31, 2000 (65 Fed. Reg. 46770) and  
14 as subsequently updated under section 1888(e)(4)(E)(ii)  
15 of the Social Security Act (42 U.S.C.  
16 1395yy(e)(4)(E)(ii)), effective for services furnished dur-  
17 ing fiscal years 2003, 2004, and 2005, respectively.”.

18           (b) ADJUSTMENT TO RUGS FOR AIDS RESI-  
19 DENTS.—

20           (1) IN GENERAL.—Paragraph (12) of section  
21 1888(e) (42 U.S.C. 1395yy(e)) is amended to read  
22 as follows:

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

1           “(A) IN GENERAL.—Subject to subpara-  
 2 graph (B), in the case of a resident of a skilled  
 3 nursing facility who is afflicted with acquired  
 4 immune deficiency syndrome (AIDS), the per  
 5 diem amount of payment otherwise applicable  
 6 shall be increased by 128 percent to reflect in-  
 7 creased costs associated with such residents.

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

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

## 18                           **Subtitle C—Hospice**

### 19   **SEC. 221. COVERAGE OF HOSPICE CONSULTATION SERV-** 20                           **ICES.**

21           (a) COVERAGE OF HOSPICE CONSULTATION SERV-  
 22 ICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amend-  
 23 ed—

24           (1) by striking “and” at the end of paragraph

25           (3);

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

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

5           “(5) for individuals who are terminally ill, have  
6           not made an election under subsection (d)(1), and  
7           have not previously received services under this  
8           paragraph, services that are furnished by a physi-  
9           cian who is either the medical director or an em-  
10          ployee of a hospice program and that consist of—

11                   “(A) an evaluation of the individual’s need  
12                   for pain and symptom management;

13                   “(B) counseling the individual with respect  
14                   to end-of-life issues and care options; and

15                   “(C) advising the individual regarding ad-  
16                   vanced care planning.”.

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

20           “(4) The amount paid to a hospice program with re-  
21          spect to the services under section 1812(a)(5) for which  
22          payment may be made under this part shall be equal to  
23          an amount equivalent to the amount established for an  
24          office or other outpatient visit for evaluation and manage-  
25          ment associated with presenting problems of moderate se-

1 verity under the fee schedule established under section  
 2 1848(b), other than the portion of such amount attrib-  
 3 utable to the practice expense component.”.

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

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

11 **SEC. 222. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**  
 12 **PICE CARE FURNISHED IN A FRONTIER AREA.**

13 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.  
 14 1395f(i)(1)) is amended by adding at the end the following  
 15 new subparagraph:

16 “(D) With respect to hospice care furnished in a fron-  
 17 tier area on or after January 1, 2003, and before January  
 18 1, 2008, the payment rates otherwise established for such  
 19 care shall be increased by 10 percent. For purposes of this  
 20 subparagraph, the term ‘frontier area’ means a county in  
 21 which the population density is less than 7 persons per  
 22 square mile.”.

23 (b) REPORT ON COSTS.—Not later than January 1,  
 24 2007, the Comptroller General of the United States shall  
 25 submit to Congress a report on the costs of furnishing

1 hospice care in frontier areas. Such report shall include  
2 recommendations regarding the appropriateness of extend-  
3 ing, and modifying, the payment increase provided under  
4 the amendment made by subsection (a).

5 **SEC. 223. RURAL HOSPICE DEMONSTRATION PROJECT.**

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

15 (b) SCOPE OF PROJECT.—The Secretary shall con-  
16 duct the project under this section with respect to no more  
17 than 3 hospice programs over a period of not longer than  
18 5 years each.

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

21 (1) the hospice program shall comply with oth-  
22 erwise applicable requirements, except that it shall  
23 not be required to offer services outside of the home  
24 or to meet the requirements of section  
25 1861(dd)(2)(A)(iii) of the Social Security Act; and

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

4   The Secretary may require the program to comply with  
5   such additional quality assurance standards for its provi-  
6   sion of services in its facility as the Secretary deems ap-  
7   propriate.

8           (d) REPORT.—Upon completion of the project, the  
9   Secretary shall submit a report to Congress on the project  
10   and shall include in the report recommendations regarding  
11   extension of such project to hospice programs serving  
12   rural areas.

13                   **TITLE III—PROVISIONS**  
14                   **RELATING TO PART B**  
15           **Subtitle A—Physicians’ Services**

16   **SEC. 301. STUDIES ON ACCESS TO PHYSICIANS’ SERVICES.**

17           (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-  
18   CIANS’ SERVICES.—

19           (1) STUDY.—The Comptroller General of the  
20   United States shall conduct a study on access of  
21   medicare beneficiaries to physicians’ services under  
22   the medicare program. The study shall include—

23                   (A) an assessment of the use by bene-  
24   ficiaries of such services through an analysis of

1 claims submitted by physicians for such services  
2 under part B of the medicare program;

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

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

9 (2) REPORT.—Not later than 18 months after  
10 the date of the enactment of this Act, the Comp-  
11 troller General shall submit to Congress a report on  
12 the study conducted under paragraph (1). The re-  
13 port shall include a determination whether—

14 (A) data from claims submitted by physi-  
15 cians under part B of the medicare program in-  
16 dicate potential access problems for medicare  
17 beneficiaries in certain geographic areas; and

18 (B) access by medicare beneficiaries to  
19 physicians' services may have improved, re-  
20 mained constant, or deteriorated over time.

21 (b) STUDY AND REPORT ON SUPPLY OF PHYSI-  
22 CIANS.—

23 (1) STUDY.—The Secretary shall request the  
24 Institute of Medicine of the National Academy of  
25 Sciences to conduct a study on the adequacy of the

1 supply of physicians (including specialists) in the  
2 United States and the factors that affect such sup-  
3 ply.

4 (2) REPORT TO CONGRESS.—Not later than 2  
5 years after the date of enactment of this section, the  
6 Secretary shall submit to Congress a report on the  
7 results of the study described in paragraph (1), in-  
8 cluding any recommendations for legislation.

9 **SEC. 302. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS'**  
10 **SERVICES.**

11 Not later than 1 year after the date of the enactment  
12 of this Act, the Medicare Payment Advisory Commission  
13 shall submit to Congress a report on the effect of refine-  
14 ments to the practice expense component of payments for  
15 physicians' services, after the transition to a full resource-  
16 based payment system in 2002, under section 1848 of the  
17 Social Security Act (42 U.S.C. 1395w-4). Such report  
18 shall examine the following matters by physician specialty:

19 (1) The effect of such refinements on payment  
20 for physicians' services.

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

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

1           (4) The effect of such refinements on access to  
2           care by medicare beneficiaries to physicians' serv-  
3           ices.

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

6 **SEC. 303. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN**  
7                           **PHYSICIAN PATHOLOGY SERVICES UNDER**  
8                           **MEDICARE.**

9           Section 542(c) of BIPA is amended by striking “2-  
10 year period” and inserting “3-year period”.

11 **SEC. 304. PHYSICIAN FEE SCHEDULE WAGE INDEX REVI-**  
12                           **SION.**

13           (a) INDEX REVISION.—

14           (1) IN GENERAL.—Subject to paragraph (2),  
15           notwithstanding any other provision of law, for pur-  
16           poses of payment under the physician fee schedule  
17           under section 1848 of the Social Security Act (42  
18           U.S.C. 1395w-4) for physicians' services furnished  
19           during 2004, in no case may the work geographic  
20           index otherwise calculated under subsection  
21           (e)(1)(A)(iii) of such section be less than 0.985.

22           (2) SECRETARIAL DISCRETION.—Paragraph (1)  
23           shall not take effect or be in force if the Secretary  
24           determines, taking into account the report of the  
25           Comptroller General under subsection (b)(2), that

1 there is no sound economic rationale for the imple-  
2 mentation of such paragraph.

3 (3) EXEMPTION FROM LIMITATION ON ANNUAL  
4 ADJUSTMENTS.—Any increase in expenditures at-  
5 tributable to paragraph (1) during 2004 shall not be  
6 taken into account in applying section  
7 1848(e)(2)(B)(ii)(II) of the Social Security Act (42  
8 U.S.C. 1395w-4(e)(2)(B)(ii)(II)) for that year.

9 (b) GAO REPORT.—

10 (1) EVALUATION.—As part of the study on geo-  
11 graphic differences in payments for physicians' serv-  
12 ices conducted under section 109, the Comptroller  
13 General shall evaluate the following:

14 (A) Whether there is a sound economic  
15 basis for the implementation of the adjustment  
16 under subsection (a)(1) in those areas in which  
17 the adjustment applies.

18 (B) The effect of such adjustment on phy-  
19 sician location and retention in areas affected  
20 by such adjustment, taking into account—

21 (i) differences in recruitment costs  
22 and retention rates for physicians, includ-  
23 ing specialists, between large urban areas  
24 and other areas; and

1 (ii) the mobility of physicians, includ-  
2 ing specialists, over the last decade.

3 (C) The appropriateness of establishing a  
4 floor of 1.0 for the work geographic index.

5 (2) REPORT.—By not later than September 1,  
6 2003, the Comptroller General shall submit to Con-  
7 gress and to the Secretary a report on the evaluation  
8 conducted under paragraph (1).

## 9 **Subtitle B—Other Services**

### 10 **SEC. 311. PAYMENT FOR AMBULANCE SERVICES.**

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

14 (1) in paragraph (2)(E), by inserting  
15 “consistent with paragraph (10)” after “in an effi-  
16 cient and fair manner”;

17 (2) by redesignating the paragraph (8) added  
18 by section 221(a) of BIPA as paragraph (9); and

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

21 “(10) PHASE-IN PROVIDING FLOOR USING  
22 BLEND OF FEE SCHEDULE AND REGIONAL FEE  
23 SCHEDULES.—In carrying out the phase-in under  
24 paragraph (2)(E) for each level of service furnished  
25 in a year before January 1, 2007, the portion of the

1 payment amount that is based on the fee schedule  
2 shall not be less than the following blended rate of  
3 the fee schedule under paragraph (1) and of a re-  
4 gional fee schedule for the region involved:

5 “(A) For 2003, the blended rate shall be  
6 based 20 percent on the fee schedule under  
7 paragraph (1) and 80 percent on the regional  
8 fee schedule.

9 “(B) For 2004, the blended rate shall be  
10 based 40 percent on the fee schedule under  
11 paragraph (1) and 60 percent on the regional  
12 fee schedule.

13 “(C) For 2005, the blended rate shall be  
14 based 60 percent on the fee schedule under  
15 paragraph (1) and 40 percent on the regional  
16 fee schedule.

17 “(D) For 2006, the blended rate shall be  
18 based 80 percent on the fee schedule under  
19 paragraph (1) and 20 percent on the regional  
20 fee schedule.

21 For purposes of this paragraph, the Secretary shall  
22 establish a regional fee schedule for each of the 9  
23 Census divisions using the methodology (used in es-  
24 tablishing the fee schedule under paragraph (1)) to  
25 calculate a regional conversion factor and a regional

1 mileage payment rate and using the same payment  
2 adjustments and the same relative value units as  
3 used in the fee schedule under such paragraph.”.

4 (b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG  
5 TRIPS.—Section 1834(l), as amended by subsection (a),  
6 is further amended by adding at the end the following new  
7 paragraph:

8 “(11) ADJUSTMENT IN PAYMENT FOR CERTAIN  
9 LONG TRIPS.—In the case of ground ambulance  
10 services furnished on or after January 1, 2003, and  
11 before January 1, 2008, regardless of where the  
12 transportation originates, the fee schedule estab-  
13 lished under this subsection shall provide that, with  
14 respect to the payment rate for mileage for a trip  
15 above 50 miles the per mile rate otherwise estab-  
16 lished shall be increased by  $\frac{1}{4}$  of the payment per  
17 mile otherwise applicable to such miles.”.

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

21 **SEC. 312. 2-YEAR EXTENSION OF MORATORIUM ON THER-**  
22 **APY CAPS; PROVISIONS RELATING TO RE-**  
23 **PORTS.**

24 (a) 2-YEAR EXTENSION OF MORATORIUM ON THER-  
25 APY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4))

1 is amended by striking “and 2002” and inserting “2002,  
2 2003, and 2004”.

3 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON  
4 PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY  
5 SERVICES.—Not later than December 31, 2002, the Sec-  
6 retary shall submit to Congress the reports required under  
7 section 4541(d)(2) of the Balanced Budget Act of 1997  
8 (relating to alternatives to a single annual dollar cap on  
9 outpatient therapy) and under section 221(d) of the Medi-  
10 care, Medicaid, and SCHIP Balanced Budget Refinement  
11 Act of 1999 (relating to utilization patterns for outpatient  
12 therapy).

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

15 (1) STUDY.—The Secretary shall request the  
16 Institute of Medicine of the National Academy of  
17 Sciences to identify conditions or diseases that  
18 should justify conducting an assessment of the need  
19 to waive the therapy caps under section 1833(g)(4)  
20 of the Social Security Act (42 U.S.C. 1395l(g)(4)).

21 (2) REPORTS TO CONGRESS.—Not later than  
22 September 1, 2003, the Secretary shall submit to  
23 Congress a preliminary report on the conditions and  
24 diseases identified under paragraph (1) and not later

1 than December 31, 2003, a final report on the con-  
2 ditions and diseases so identified.

3 (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL  
4 THERAPIST SERVICES.—

5 (1) STUDY.—The Comptroller General of the  
6 United States shall conduct a study on access to  
7 physical therapist services in States authorizing such  
8 services without a physician referral and in States  
9 that require such a physician referral. The study  
10 shall—

11 (A) examine the use of and referral pat-  
12 terns for physical therapist services for patients  
13 age 50 and older in States that authorize such  
14 services without a physician referral and in  
15 States that require such a physician referral;

16 (B) examine the use of and referral pat-  
17 terns for physical therapist services for patients  
18 who are medicare beneficiaries;

19 (C) examine the potential effect of prohib-  
20 iting a physician from referring patients to  
21 physical therapy services owned by the physi-  
22 cian and provided in the physician's office;

23 (D) examine the delivery of physical thera-  
24 pists' services within the facilities of Depart-  
25 ment of Defense; and

1           (E) analyze the potential impact on medi-  
2           care beneficiaries and on expenditures under  
3           the medicare program of eliminating the need  
4           for a physician referral and physician certifi-  
5           cation for physical therapist services under the  
6           medicare program.

7           (2) REPORT.—The Comptroller General shall  
8           submit to Congress a report on the study conducted  
9           under paragraph (1) by not later than 1 year after  
10          the date of the enactment of this Act.

11 **SEC. 313. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**  
12 **ICAL EXAMINATION.**

13          (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
14 1395x(s)(2)) is amended—

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

17           (2) in subparagraph (V), by inserting “and” at  
18           the end; and

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

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

23          (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
24 1395x) is amended by adding at the end the following new  
25          subsection:

1 “Initial Preventive Physical Examination

2 “(ww) The term ‘initial preventive physical examina-  
3 tion’ means physicians’ services consisting of a physical  
4 examination with the goal of health promotion and disease  
5 detection and includes items and services (excluding clin-  
6 ical laboratory tests), as determined by the Secretary, con-  
7 sistent with the recommendations of the United States  
8 Preventive Services Task Force.”.

9 (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

10 (1) DEDUCTIBLE.—The first sentence of sec-  
11 tion 1833(b) (42 U.S.C. 1395l(b)) is amended—

12 (A) by striking “and” before “(6)”, and

13 (B) by inserting before the period at the  
14 end the following: “, and (7) such deductible  
15 shall not apply with respect to an initial preven-  
16 tive physical examination (as defined in section  
17 1861(ww))”.

18 (2) COINSURANCE.—Section 1833(a)(1) (42  
19 U.S.C. 1395l(a)(1)) is amended—

20 (A) in clause (N), by inserting “(or 100  
21 percent in the case of an initial preventive phys-  
22 ical examination, as defined in section  
23 1861(ww))” after “80 percent”; and

24 (B) in clause (O), by inserting “(or 100  
25 percent in the case of an initial preventive phys-

1 ical examination, as defined in section  
2 1861(wv))” after “80 percent”.

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

6 (e) OTHER CONFORMING AMENDMENTS.—Section  
7 1862(a) (42 U.S.C. 1395y(a)) is amended—

8 (1) in paragraph (1)—

9 (A) by striking “and” at the end of sub-  
10 paragraph (H);

11 (B) by striking the semicolon at the end of  
12 subparagraph (I) and inserting “, and”; and

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

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

19 (2) in paragraph (7), by striking “or (H)” and  
20 inserting “(H), or (J)”.

21 (f) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to services furnished on or after  
23 January 1, 2004, but only for individuals whose coverage  
24 period begins on or after such date.

1 **SEC. 314. RENAL DIALYSIS SERVICES.**

2 (a) REPORT ON DIFFERENCES IN COSTS IN DIF-  
3 FERENT SETTINGS.—Not later than 1 year after the date  
4 of the enactment of this Act, the Comptroller General of  
5 the United States shall submit to Congress a report con-  
6 taining—

7 (1) an analysis of the differences in costs of  
8 providing renal dialysis services under the medicare  
9 program in home settings and in facility settings;

10 (2) an assessment of the percentage of overhead  
11 costs in home settings and in facility settings; and

12 (3) an evaluation of whether the charges for  
13 home dialysis supplies and equipment are reasonable  
14 and necessary.

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

17 (1) IN GENERAL.—Section 422(a)(2) of BIPA  
18 is amended—

19 (A) in subparagraph (A), by striking “and  
20 (C)” and inserting “, (C), and (D)”;

21 (B) in subparagraph (B), by striking “In  
22 the case” and inserting “Subject to subpara-  
23 graph (D), in the case”; and

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

1           “(D) INAPPLICABILITY TO PEDIATRIC FA-  
2           CILITIES.—Subparagraphs (A) and (B) shall  
3           not apply, as of October 1, 2002, to pediatric  
4           facilities that do not have an exception rate de-  
5           scribed in subparagraph (C) in effect on such  
6           date. For purposes of this subparagraph, the  
7           term ‘pediatric facility’ means a renal facility at  
8           least 50 percent of whose patients are individ-  
9           uals under 18 years of age.”.

10           (2) CONFORMING AMENDMENT.—The fourth  
11           sentence of section 1881(b)(7) (42 U.S.C.  
12           1395rr(b)(7)) is amended by striking “The Sec-  
13           retary” and inserting “Subject to section 422(a)(2)  
14           of the Medicare, Medicaid, and SCHIP Benefits Im-  
15           provement and Protection Act of 2000, the Sec-  
16           retary”.

17           (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE  
18           FOR SERVICES FURNISHED IN 2004.—Notwithstanding  
19           any other provision of law, with respect to payment under  
20           part B of title XVIII of the Social Security Act for renal  
21           dialysis services furnished in 2004, the composite payment  
22           rate otherwise established under section 1881(b)(7) of  
23           such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by  
24           1.2 percent.

1 **SEC. 315. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**  
2 **RAPHY SERVICES.**

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

9 (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For  
10 diagnostic mammography performed on or after January  
11 1, 2004, for which payment is made under the physician  
12 fee schedule under section 1848 of the Social Security Act  
13 (42 U.S.C. 1395w-4), the Secretary, based on the most  
14 recent cost data available, shall provide for an appropriate  
15 adjustment in the payment amount for the technical com-  
16 ponent of the diagnostic mammography.

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

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

23 (a) WAIVER OF PENALTY.—

24 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.  
25 1395r(b)) is amended by adding at the end the fol-  
26 lowing new sentence: “No increase in the premium

1 shall be effected for a month in the case of an indi-  
2 vidual who is 65 years of age or older, who enrolls  
3 under this part during 2001, 2002, or 2003, and  
4 who demonstrates to the Secretary before December  
5 31, 2003, that the individual is a covered beneficiary  
6 (as defined in section 1072(5) of title 10, United  
7 States Code). The Secretary of Health and Human  
8 Services shall consult with the Secretary of Defense  
9 in identifying individuals described in the previous  
10 sentence.”.

11 (2) EFFECTIVE DATE.—The amendment made  
12 by paragraph (1) shall apply to premiums for  
13 months beginning with January 2003. The Secretary  
14 of Health and Human Services shall establish a  
15 method for providing rebates of premium penalties  
16 paid for months on or after January 2003 for which  
17 a penalty does not apply under such amendment but  
18 for which a penalty was previously collected.

19 (b) MEDICARE PART B SPECIAL ENROLLMENT PE-  
20 RIOD.—

21 (1) IN GENERAL.—In the case of any individual  
22 who, as of the date of the enactment of this Act, is  
23 65 years of age or older, is eligible to enroll but is  
24 not enrolled under part B of title XVIII of the So-  
25 cial Security Act, and is a covered beneficiary (as

1 defined in section 1072(5) of title 10, United States  
2 Code), the Secretary of Health and Human Services  
3 shall provide for a special enrollment period during  
4 which the individual may enroll under such part.  
5 Such period shall begin as soon as possible after the  
6 date of the enactment of this Act and shall end on  
7 December 31, 2003.

8 (2) COVERAGE PERIOD.—In the case of an indi-  
9 vidual who enrolls during the special enrollment pe-  
10 riod provided under paragraph (1), the coverage pe-  
11 riod under part B of title XVIII of the Social Secu-  
12 rity Act shall begin on the first day of the month  
13 following the month in which the individual enrolls.

14 **SEC. 317. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**  
15 **SCREENING.**

16 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
17 1395x(s)(2)), as amended by section 313(a), is amended—

18 (1) in subparagraph (V), by striking “and” at  
19 the end;

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

22 (3) by adding at the end the following new sub-  
23 paragraph:

1                   “(X) cholesterol and other blood lipid  
2                   screening tests (as defined in subsection  
3                   (XX));”.

4           (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
5 1395x), as amended by section 313(b), is amended by add-  
6 ing at the end the following new subsection:

7           “Cholesterol and Other Blood Lipid Screening Test

8           “(xx)(1) The term ‘cholesterol and other blood lipid  
9 screening test’ means diagnostic testing of cholesterol and  
10 other lipid levels of the blood for the purpose of early de-  
11 tection of abnormal cholesterol and other lipid levels.

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

17           (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.  
18 1395y(a)(1)), as amended by section 313(e), is amend-  
19 ed—

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

22                   (2) by striking the semicolon at the end of sub-  
23 paragraph (J) and inserting “; and”; and

24                   (3) by adding at the end the following new sub-  
25 paragraph:

1           “(K) in the case of a cholesterol and other  
2 blood lipid screening test (as defined in section  
3 1861(xx)(1)), which is performed more frequently  
4 than is covered under section 1861(xx)(2).”.

5           (d) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to tests furnished on or after Janu-  
7 ary 1, 2004.

8                   **TITLE IV—PROVISIONS**  
9                   **RELATING TO PARTS A AND B**  
10                  **Subtitle A—Home Health Services**

11                  **SEC. 401. ELIMINATION OF 15 PERCENT REDUCTION IN**  
12                                   **PAYMENT RATES UNDER THE PROSPECTIVE**  
13                                   **PAYMENT SYSTEM.**

14           (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.  
15 1395fff(b)(3)(A)) is amended to read as follows:

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

20   “(i) Such amount (or amounts) shall  
21 initially be based on the most current au-  
22 dited cost report data available to the Sec-  
23 retary and shall be computed in a manner  
24 so that the total amounts payable under  
25 the system for fiscal year 2001 shall be

1 equal to the total amount that would have  
2 been made if the system had not been in  
3 effect and if section 1861(v)(1)(L)(ix) had  
4 not been enacted.

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

11 “(iii) For 2003, such amount (or  
12 amounts) shall be equal to the amount (or  
13 amounts) determined under this paragraph  
14 for fiscal year 2002, updated under sub-  
15 paragraph (B) for 2003.

16 “(iv) For 2004 and each subsequent  
17 year, such amount (or amounts) shall be  
18 equal to the amount (or amounts) deter-  
19 mined under this paragraph for the pre-  
20 vious year, updated under subparagraph  
21 (B).

22 Each such amount shall be standardized in a  
23 manner that eliminates the effect of variations  
24 in relative case mix and area wage adjustments  
25 among different home health agencies in a

1 budget neutral manner consistent with the case  
2 mix and wage level adjustments provided under  
3 paragraph (4)(A). Under the system, the Sec-  
4 retary may recognize regional differences or dif-  
5 ferences based upon whether or not the services  
6 or agency are in an urbanized area.”.

7 (b) EFFECTIVE DATE.—The amendment made by  
8 subsection (a) shall take effect as if included in the  
9 amendments made by section 501 of the Medicare, Med-  
10 icaid, and SCHIP Benefits Improvement and Protection  
11 Act of 2000 (as enacted into law by section 1(a)(6) of  
12 Public Law 106–554).

13 **SEC. 402. UPDATE IN HOME HEALTH SERVICES.**

14 (a) CHANGE TO CALENDAR YEAR UPDATE.—

15 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.  
16 1395fff(b)(3)) is amended—

17 (A) in paragraph (3)(B)(i)—

18 (i) by striking “each fiscal year  
19 (beginning with fiscal year 2002)” and in-  
20 sserting “fiscal year 2002 and for each sub-  
21 sequent year (beginning with 2003)”; and

22 (ii) by inserting “or year” after “the  
23 fiscal year”;

24 (B) in paragraph (3)(B)(ii)—

1 (i) in subclause (II), by striking  
2 “fiscal year” and inserting “year” and by  
3 redesignating such subclause as subclause  
4 (III); and

5 (ii) in subclause (I), by striking “each  
6 of fiscal years 2002 and 2003” and insert-  
7 ing the following: “fiscal year 2002, the  
8 home health market basket percentage in-  
9 crease (as defined in clause (iii)) minus 1.1  
10 percentage points;

11 “(II) 2003”;

12 (C) in paragraph (3)(B)(iii), by inserting  
13 “or year” after “fiscal year” each place it ap-  
14 pears;

15 (D) in paragraph (3)(B)(iv)—

16 (i) by inserting “or year” after “fiscal  
17 year” each place it appears; and

18 (ii) by inserting “or years” after  
19 “fiscal years”; and

20 (E) in paragraph (5), by inserting “or  
21 year” after “fiscal year”.

22 (2) TRANSITION RULE.—The standard prospec-  
23 tive payment amount (or amounts) under section  
24 1895(b)(3) of the Social Security Act for the cal-  
25 endar quarter beginning on October 1, 2002, shall

1 be such amount (or amounts) for the previous cal-  
2 endar quarter.

3 (b) CHANGES IN UPDATES FOR 2003, 2004, AND  
4 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C.  
5 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B),  
6 is amended—

7 (1) in subclause (II), by striking “the home  
8 health market basket percentage increase (as defined  
9 in clause (iii)) minus 1.1 percentage points” and in-  
10 sserting “2.0 percentage points”;

11 (2) by striking “or” at the end of subclause  
12 (II);

13 (3) by redesignating subclause (III) as sub-  
14 clause (V); and

15 (4) by inserting after subclause (II) the fol-  
16 lowing new subclause:

17 “(III) 2004, 1.1 percentage  
18 points;

19 “(IV) 2005, 2.7 percentage  
20 points; or”.

21 (c) PAYMENT ADJUSTMENT.—

22 (1) IN GENERAL.—Section 1895(b)(5) (42  
23 U.S.C. 1395fff(b)(5)) is amended by striking “5 per-  
24 cent” and inserting “3 percent”.

1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) shall apply to years beginning with  
3           2003.

4 **SEC. 403. OASIS TASK FORCE; SUSPENSION OF CERTAIN**  
5                   **OASIS DATA COLLECTION REQUIREMENTS**  
6                   **PENDING TASK FORCE SUBMITTAL OF RE-**  
7                   **PORT.**

8           (a) ESTABLISHMENT.—The Secretary of Health and  
9           Human Services shall establish and appoint a task force  
10          (to be known as the “OASIS Task Force”) to examine  
11          the data collection and reporting requirements under  
12          OASIS. For purposes of this section, the term “OASIS”  
13          means the Outcome and Assessment Information Set re-  
14          quired by reason of section 4602(e) of Balanced Budget  
15          Act of 1997 (42 U.S.C. 1395fff note).

16          (b) COMPOSITION.—The OASIS Task Force shall be  
17          composed of the following:

18               (1) Staff of the Centers for Medicare & Med-  
19               icaid Services with expertise in post-acute care.

20               (2) Representatives of home health agencies.

21               (3) Health care professionals and research and  
22               health care quality experts outside the Federal Gov-  
23               ernment with expertise in post-acute care.

24               (4) Advocates for individuals requiring home  
25               health services.

1 (c) DUTIES.—

2 (1) REVIEW AND RECOMMENDATIONS.—The  
3 OASIS Task Force shall review and make rec-  
4 ommendations to the Secretary regarding changes in  
5 OASIS to improve and simplify data collection for  
6 purposes of—

7 (A) assessing the quality of home health  
8 services; and

9 (B) providing consistency in classification  
10 of patients into home health resource groups  
11 (HHRGs) for payment under section 1895 of  
12 the Social Security Act (42 U.S.C. 1395fff).

13 (2) SPECIFIC ITEMS.—In conducting the review  
14 under paragraph (1), the OASIS Task Force shall  
15 specifically examine—

16 (A) the 41 outcome measures currently in  
17 use;

18 (B) the timing and frequency of data col-  
19 lection; and

20 (C) the collection of information on  
21 comorbidities and clinical indicators.

22 (3) REPORT.—The OASIS Task Force shall  
23 submit a report to the Secretary containing its find-  
24 ings and recommendations for changes in OASIS by

1 not later than 18 months after the date of the enact-  
2 ment of this Act.

3 (d) SUNSET.—The OASIS Task Force shall termi-  
4 nate 60 days after the date on which the report is sub-  
5 mitted under subsection (c)(2).

6 (e) NONAPPLICATION OF FACCA.—The provisions of  
7 the Federal Advisory Committee Act shall not apply to  
8 the OASIS Task Force.

9 (f) SUSPENSION OF OASIS REQUIREMENT FOR COL-  
10 LECTION OF DATA ON NON-MEDICARE AND NON-MED-  
11 ICAID PATIENTS PENDING TASK FORCE REPORT.—

12 (1) IN GENERAL.—During the period described  
13 in paragraph (2), the Secretary of Health and  
14 Human Services may not require, under section  
15 4602(e) of the Balanced Budget Act of 1997 or oth-  
16 erwise under OASIS, a home health agency to gath-  
17 er or submit information that relates to an indi-  
18 vidual who is not eligible for benefits under either  
19 title XVIII or title XIX of the Social Security Act.

20 (2) PERIOD OF SUSPENSION.—The period de-  
21 scribed in this paragraph—

22 (A) begins on January 1, 2003, and

23 (B) ends on the last day of the 2nd month  
24 beginning after the date the report is submitted  
25 under subsection (c)(2).

1 **SEC. 404. MEDPAC STUDY ON MEDICARE MARGINS OF**  
2 **HOME HEALTH AGENCIES.**

3 (a) **STUDY.**—The Medicare Payment Advisory Com-  
4 mission shall conduct a study of payment margins of home  
5 health agencies under the home health prospective pay-  
6 ment system under section 1895 of the Social Security Act  
7 (42 U.S.C. 1395fff). Such study shall examine whether  
8 systematic differences in payment margins are related to  
9 differences in case mix (as measured by home health re-  
10 source groups (HHRGs)) among such agencies. The study  
11 shall use the partial or full-year cost reports filed by home  
12 health agencies.

13 (b) **REPORT.**—Not later than 2 years after the date  
14 of the enactment of this Act, the Commission shall submit  
15 to Congress a report on the study under subsection (a).

16 **SEC. 405. CLARIFICATION OF TREATMENT OF OCCASIONAL**  
17 **ABSENCES IN DETERMINING WHETHER AN**  
18 **INDIVIDUAL IS CONFINED TO THE HOME.**

19 (a) **IN GENERAL.**—The penultimate sentence of sec-  
20 tion 1814(a) (42 U.S.C. 1395f(a) and the penultimate  
21 sentence of section 1835(a) (42 U.S.C. 1395n(a)) are each  
22 amended to read as follows: “Any other absence of an indi-  
23 vidual from the home shall not so disqualify the individual  
24 if the absence is infrequent or of relatively short duration,  
25 such as an occasional trip to the barber or a walk around  
26 the block, and is not inconsistent with the assessment un-

1 derlying the individual’s plan of care for home health serv-  
 2 ices.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
 4 subsection (a) shall take effect on the date of the enact-  
 5 ment of this Act.

## 6 **Subtitle B—Direct Graduate** 7 **Medical Education**

### 8 **SEC. 411. EXTENSION OF UPDATE LIMITATION ON HIGH** 9 **COST PROGRAMS.**

10 Section 1886(h)(2)(D)(iv) (42 U.S.C.

11 1395ww(h)(2)(D)(iv)) is amended—

12 (1) in subclause (I)—

13 (A) by striking “AND 2002” and inserting  
 14 “THROUGH 2012”;

15 (B) by striking “during fiscal year 2001 or  
 16 fiscal year 2002” and inserting “during the pe-  
 17 riod beginning with fiscal year 2001 and ending  
 18 with fiscal year 2012”; and

19 (C) by striking “subject to subclause  
 20 (III),”;

21 (2) by striking subclause (II); and

22 (3) in subclause (III)—

23 (A) by redesignating such subclause as  
 24 subclause (II); and

25 (B) by striking “or (II)”.

1 **SEC. 412. REDISTRIBUTION OF UNUSED RESIDENT POSI-**  
2 **TIONS.**

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

5 (1) in subparagraph (F)(i), by inserting  
6 “subject to subparagraph (I),” after “October 1,  
7 1997,”;

8 (2) in subparagraph (H)(i), by inserting  
9 “subject to subparagraph (I),” after “subparagraphs  
10 (F) and (G),”; and

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

13 “(I) REDISTRIBUTION OF UNUSED RESI-  
14 DENT POSITIONS.—

15 “(i) REDUCTION IN LIMIT BASED ON  
16 UNUSED POSITIONS.—

17 “(I) IN GENERAL.—If a hos-  
18 pital’s resident level (as defined in  
19 clause (iii)(I)) is less than the other-  
20 wise applicable resident limit (as de-  
21 fined in clause (iii)(II)) for each of  
22 the reference periods (as defined in  
23 subclause (II)), effective for cost re-  
24 porting periods beginning on or after  
25 January 1, 2003, the otherwise appli-  
26 cable resident limit shall be reduced

1 by 75 percent of the difference be-  
2 tween such limit and the reference  
3 resident level specified in subclause  
4 (III) (or subclause (IV) if applicable).

5 “(II) REFERENCE PERIODS DE-  
6 FINED.—In this clause, the term  
7 ‘reference periods’ means, for a hos-  
8 pital, the 3 most recent consecutive  
9 cost reporting periods of the hospital  
10 for which cost reports have been set-  
11 tled (or, if not, submitted) on or be-  
12 fore September 30, 2001.

13 “(III) REFERENCE RESIDENT  
14 LEVEL.—Subject to subclause (IV),  
15 the reference resident level specified in  
16 this subclause for a hospital is the  
17 highest resident level for the hospital  
18 during any of the reference periods.

19 “(IV) ADJUSTMENT PROCESS.—  
20 Upon the timely request of a hospital,  
21 the Secretary may adjust the ref-  
22 erence resident level for a hospital to  
23 be the resident level for the hospital  
24 for the cost reporting period that in-  
25 cludes July 1, 2002.

1 “(ii) REDISTRIBUTION.—

2 “(I) IN GENERAL.—The Sec-  
3 retary is authorized to increase the  
4 otherwise applicable resident limits for  
5 hospitals by an aggregate number es-  
6 timated by the Secretary that does  
7 not exceed the aggregate reduction in  
8 such limits attributable to clause (i)  
9 (without taking into account any ad-  
10 justment under subclause (IV) of such  
11 clause).

12 “(II) EFFECTIVE DATE.—No in-  
13 crease under subclause (I) shall be  
14 permitted or taken into account for a  
15 hospital for any portion of a cost re-  
16 porting period that occurs before July  
17 1, 2003, or before the date of the hos-  
18 pital’s application for an increase  
19 under this clause. No such increase  
20 shall be permitted for a hospital un-  
21 less the hospital has applied to the  
22 Secretary for such increase by Decem-  
23 ber 31, 2004.

24 “(III) CONSIDERATIONS IN RE-  
25 DISTRIBUTION.—In determining for

1 which hospitals the increase in the  
2 otherwise applicable resident limit is  
3 provided under subclause (I), the Sec-  
4 retary shall take into account the  
5 need for such an increase by specialty  
6 and location involved, consistent with  
7 subclause (IV).

8 “(IV) PRIORITY FOR RURAL AND  
9 SMALL URBAN AREAS.—In deter-  
10 mining for which hospitals and resi-  
11 dency training programs an increase  
12 in the otherwise applicable resident  
13 limit is provided under subclause (I),  
14 the Secretary shall first distribute the  
15 increase to programs of hospitals lo-  
16 cated in rural areas or in urban areas  
17 that are not large urban areas (as de-  
18 fined for purposes of subsection (d))  
19 on a first-come-first-served basis (as  
20 determined by the Secretary) based on  
21 a demonstration that the hospital will  
22 fill the positions made available under  
23 this clause and not to exceed an in-  
24 crease of 25 full-time equivalent posi-  
25 tions with respect to any hospital.

1                   “(V) APPLICATION OF LOCALITY  
2                   ADJUSTED NATIONAL AVERAGE PER  
3                   RESIDENT AMOUNT.—With respect to  
4                   additional residency positions in a  
5                   hospital attributable to the increase  
6                   provided under this clause, notwith-  
7                   standing any other provision of this  
8                   subsection, the approved FTE resi-  
9                   dent amount is deemed to be equal to  
10                  the locality adjusted national average  
11                  per resident amount computed under  
12                  subparagraph (E) for that hospital.

13                  “(VI) CONSTRUCTION.—Nothing  
14                  in this clause shall be construed as  
15                  permitting the redistribution of reduc-  
16                  tions in residency positions attrib-  
17                  utable to voluntary reduction pro-  
18                  grams under paragraph (6) or as af-  
19                  fecting the ability of a hospital to es-  
20                  tablish new medical residency training  
21                  programs under subparagraph (H).

22                  “(iii) RESIDENT LEVEL AND LIMIT  
23                  DEFINED.—In this subparagraph:

24                         “(I) RESIDENT LEVEL.—The  
25                         term ‘resident level’ means, with re-

1           spect to a hospital, the total number  
2           of full-time equivalent residents, be-  
3           fore the application of weighting fac-  
4           tors (as determined under this para-  
5           graph), in the fields of allopathic and  
6           osteopathic medicine for the hospital.

7                           “(II) OTHERWISE APPLICABLE  
8           RESIDENT       LIMIT.—The       term  
9           ‘otherwise applicable resident limit’  
10          means, with respect to a hospital, the  
11          limit otherwise applicable under sub-  
12          paragraphs (F)(i) and (H) on the  
13          resident level for the hospital deter-  
14          mined without regard to this subpara-  
15          graph.”.

16          (b) NO APPLICATION OF INCREASE TO IME.—Sec-  
17          tion 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is  
18          amended by adding at the end the following: “The provi-  
19          sions of clause (i) of subparagraph (I) of subsection (h)(4)  
20          shall apply with respect to the first sentence of this clause  
21          in the same manner as it applies with respect to subpara-  
22          graph (F) of such subsection, but the provisions of clause  
23          (ii) of such subparagraph shall not apply.”.

24          (c) REPORT ON EXTENSION OF APPLICATIONS  
25          UNDER REDISTRIBUTION PROGRAM.—Not later than July

1 1, 2004, the Secretary shall submit to Congress a report  
2 containing recommendations regarding whether to extend  
3 the deadline for applications for an increase in resident  
4 limits under section 1886(h)(4)(I)(ii)(II) of the Social Se-  
5 curity Act (as added by subsection (a)).

## 6 **Subtitle C—Other Provisions**

### 7 **SEC. 421. MODIFICATIONS TO MEDICARE PAYMENT ADVI-** 8 **SORY COMMISSION (MEDPAC).**

9 (a) **EXAMINATION OF BUDGET CONSEQUENCES.**—  
10 Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by  
11 adding at the end the following new paragraph:

12 “(8) **EXAMINATION OF BUDGET CON-**  
13 **SEQUENCES.**—Before making any recommendations,  
14 the Commission shall examine the budget con-  
15 sequences of such recommendations, directly or  
16 through consultation with appropriate expert enti-  
17 ties.”.

18 (b) **CONSIDERATION OF EFFICIENT PROVISION OF**  
19 **SERVICES.**—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–  
20 6(b)(2)(B)(i)) is amended by inserting “the efficient provi-  
21 sion of” after “expenditures for”.

22 (c) **ADDITIONAL REPORTS.**—

23 (1) **DATA NEEDS AND SOURCES.**—The Medicare  
24 Payment Advisory Commission shall conduct a  
25 study, and submit a report to Congress by not later

1 than June 1, 2003, on the need for current data,  
2 and sources of current data available, to determine  
3 the solvency and financial circumstances of hospitals  
4 and other medicare providers of services. The Com-  
5 mission shall examine data on uncompensated care,  
6 as well as the share of uncompensated care ac-  
7 counted for by the expenses for treating illegal  
8 aliens.

9 (2) USE OF TAX-RELATED RETURNS.—Using  
10 return information provided under Form 990 of the  
11 Internal Revenue Service, the Commission shall sub-  
12 mit to Congress, by not later than June 1, 2003, a  
13 report on the following:

14 (A) Investments and capital financing of  
15 hospitals participating under the medicare pro-  
16 gram and related foundations.

17 (B) Access to capital financing for private  
18 and for not-for-profit hospitals.

19 **SEC. 422. DEMONSTRATION PROJECT FOR DISEASE MAN-**  
20 **AGEMENT FOR CERTAIN MEDICARE BENE-**  
21 **FICIARIES WITH DIABETES.**

22 (a) IN GENERAL.—The Secretary of Health and  
23 Human Services shall conduct a demonstration project  
24 under this section (in this section referred to as the  
25 “project”) to demonstrate the impact on costs and health

1 outcomes of applying disease management to certain medi-  
2 care beneficiaries with diagnosed diabetes. In no case may  
3 the number of participants in the project exceed 30,000  
4 at any time.

5 (b) VOLUNTARY PARTICIPATION.—

6 (1) ELIGIBILITY.—Medicare beneficiaries are  
7 eligible to participate in the project only if—

8 (A) they are a member of a health dis-  
9 parity population (as defined in section  
10 485E(d) of the Public Health Service Act),  
11 such as Hispanics;

12 (B) they meet specific medical criteria  
13 demonstrating the appropriate diagnosis and  
14 the advanced nature of their disease;

15 (C) their physicians approve of participa-  
16 tion in the project; and

17 (D) they are not enrolled in a  
18 Medicare+Choice plan.

19 (2) BENEFITS.—A medicare beneficiary who is  
20 enrolled in the project shall be eligible—

21 (A) for disease management services re-  
22 lated to their diabetes; and

23 (B) for payment for all costs for prescrip-  
24 tion drugs without regard to whether or not  
25 they relate to the diabetes, except that the

1 project may provide for modest cost-sharing  
2 with respect to prescription drug coverage.

3 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-  
4 NIZATIONS.—

5 (1) IN GENERAL.—The Secretary of Health and  
6 Human Services shall carry out the project through  
7 contracts with up to three disease management orga-  
8 nizations. The Secretary shall not enter into such a  
9 contract with an organization unless the organiza-  
10 tion demonstrates that it can produce improved  
11 health outcomes and reduce aggregate medicare ex-  
12 penditures consistent with paragraph (2).

13 (2) CONTRACT PROVISIONS.—Under such con-  
14 tracts—

15 (A) such an organization shall be required  
16 to provide for prescription drug coverage de-  
17 scribed in subsection (b)(2)(B);

18 (B) such an organization shall be paid a  
19 fee negotiated and established by the Secretary  
20 in a manner so that (taking into account sav-  
21 ings in expenditures under parts A and B of  
22 the medicare program under title XVIII of the  
23 Social Security Act) there will be no net in-  
24 crease, and to the extent practicable, there will  
25 be a net reduction in expenditures under the

1 medicare program as a result of the project;  
2 and

3 (C) such an organization shall guarantee,  
4 through an appropriate arrangement with a re-  
5 insurance company or otherwise, the prohibition  
6 on net increases in expenditures described in  
7 subparagraph (B).

8 (3) PAYMENTS.—Payments to such organiza-  
9 tions shall be made in appropriate proportion from  
10 the Trust Funds established under title XVIII of the  
11 Social Security Act.

12 (d) APPLICATION OF MEDIGAP PROTECTIONS TO  
13 DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to  
14 paragraph (2), the provisions of section 1882(s)(3) (other  
15 than clauses (i) through (iv) of subparagraph (B)) and  
16 1882(s)(4) of the Social Security Act shall apply to enroll-  
17 ment (and termination of enrollment) in the demonstra-  
18 tion project under this section, in the same manner as they  
19 apply to enrollment (and termination of enrollment) with  
20 a Medicare+Choice organization in a Medicare+Choice  
21 plan.

22 (2) In applying paragraph (1)—

23 (A) any reference in clause (v) or (vi) of section  
24 1882(s)(3)(B) of such Act to 12 months is deemed

1 a reference to the period of the demonstration  
2 project; and

3 (B) the notification required under section  
4 1882(s)(3)(D) of such Act shall be provided in a  
5 manner specified by the Secretary of Health and  
6 Human Services.

7 (e) DURATION.—The project shall last for not longer  
8 than 3 years.

9 (f) WAIVER.—The Secretary of Health and Human  
10 Services shall waive such provisions of title XVIII of the  
11 Social Security Act as may be necessary to provide for  
12 payment for services under the project in accordance with  
13 subsection (e)(3).

14 (g) REPORT.—The Secretary of Health and Human  
15 Services shall submit to Congress an interim report on the  
16 project not later than 2 years after the date it is first im-  
17 plemented and a final report on the project not later than  
18 6 months after the date of its completion. Such reports  
19 shall include information on the impact of the project on  
20 costs and health outcomes and recommendations on the  
21 cost-effectiveness of extending or expanding the project.

22 (h) WORKING GROUP ON MEDICARE DISEASE MAN-  
23 AGEMENT PROGRAMS.—The Secretary shall establish  
24 within the Department of Health and Human Services a

1 working group consisting of employees of the Department  
2 to carry out the following:

3 (1) To oversee the project.

4 (2) To establish policy and criteria for medicare  
5 disease management programs within the Depart-  
6 ment, including the establishment of policy and cri-  
7 teria for such programs.

8 (3) To identify targeted medical conditions and  
9 targeted individuals.

10 (4) To select areas in which such programs are  
11 carried out.

12 (5) To monitor health outcomes under such  
13 programs.

14 (6) To measure the effectiveness of such pro-  
15 grams in meeting any budget neutrality require-  
16 ments.

17 (7) Otherwise to serve as a central focal point  
18 within the Department for dissemination of informa-  
19 tion on medicare disease management programs.

20 (i) GAO STUDY ON DISEASE MANAGEMENT PRO-  
21 GRAMS.—The Comptroller General of the United States  
22 shall conduct a study that compares disease management  
23 programs under title XVIII of the Social Security Act with  
24 such programs conducted in the private sector, including  
25 the prevalence of such programs and programs for case

1 management. The study shall identify the cost-effective-  
2 ness of such programs and any savings achieved by such  
3 programs. The Comptroller General shall submit a report  
4 on such study to Congress by not later than 18 months  
5 after the date of the enactment of this Act.

6 **SEC. 423. DEMONSTRATION PROJECT FOR MEDICAL ADULT**  
7 **DAY CARE SERVICES.**

8 (a) ESTABLISHMENT.—Subject to the succeeding  
9 provisions of this section, the Secretary of Health and  
10 Human Services shall establish a demonstration project  
11 (in this section referred to as the “demonstration project”)  
12 under which the Secretary shall, as part of a plan of an  
13 episode of care for home health services established for  
14 a medicare beneficiary, permit a home health agency, di-  
15 rectly or under arrangements with a medical adult day  
16 care facility, to provide medical adult day care services as  
17 a substitute for a portion of home health services that  
18 would otherwise be provided in the beneficiary’s home.

19 (b) PAYMENT.—

20 (1) IN GENERAL.—The amount of payment for  
21 an episode of care for home health services, a por-  
22 tion of which consists of substitute medical adult  
23 day care services, under the demonstration project  
24 shall be made at a rate equal to 95 percent of the  
25 amount that would otherwise apply for such home

1 health services under section 1895 of the Social Se-  
2 curity Act (42 U.S.C. 1395fff). In no case may a  
3 home health agency, or a medical adult day care fa-  
4 cility under arrangements with a home health agen-  
5 cy, separately charge a beneficiary for medical adult  
6 day care services furnished under the plan of care.

7 (2) BUDGET NEUTRALITY FOR DEMONSTRA-  
8 TION PROJECT.—Notwithstanding any other provi-  
9 sion of law, the Secretary shall provide for an appro-  
10 priate reduction in the aggregate amount of addi-  
11 tional payments made under section 1895 of the So-  
12 cial Security Act (42 U.S.C. 1395fff) to reflect any  
13 increase in amounts expended from the Trust Funds  
14 as a result of the demonstration project conducted  
15 under this section.

16 (c) DEMONSTRATION PROJECT SITES.—The project  
17 established under this section shall be conducted in not  
18 more than 5 States selected by the Secretary that license  
19 or certify providers of services that furnish medical adult  
20 day care services.

21 (d) DURATION.—The Secretary shall conduct the  
22 demonstration project for a period of 3 years.

23 (e) VOLUNTARY PARTICIPATION.—Participation of  
24 medicare beneficiaries in the demonstration project shall  
25 be voluntary. The total number of such beneficiaries that

1 may participate in the project at any given time may not  
2 exceed 15,000.

3 (f) PREFERENCE IN SELECTING AGENCIES.—In se-  
4 lecting home health agencies to participate under the dem-  
5 onstration project, the Secretary shall give preference to  
6 those agencies that are currently licensed or certified  
7 through common ownership and control to furnish medical  
8 adult day care services.

9 (g) WAIVER AUTHORITY.—The Secretary may waive  
10 such requirements of title XVIII of the Social Security Act  
11 as may be necessary for the purposes of carrying out the  
12 demonstration project, other than waiving the requirement  
13 that an individual be homebound in order to be eligible  
14 for benefits for home health services.

15 (h) EVALUATION AND REPORT.—The Secretary shall  
16 conduct an evaluation of the clinical and cost effectiveness  
17 of the demonstration project. Not later 30 months after  
18 the commencement of the project, the Secretary shall sub-  
19 mit to Congress a report on the evaluation, and shall in-  
20 clude in the report the following:

21 (1) An analysis of the patient outcomes and  
22 costs of furnishing care to the medicare beneficiaries  
23 participating in the project as compared to such out-  
24 comes and costs to beneficiaries receiving only home  
25 health services for the same health conditions.

1           (2) Such recommendations regarding the exten-  
2           sion, expansion, or termination of the project as the  
3           Secretary determines appropriate.

4           (i) DEFINITIONS.—In this section:

5           (1) HOME HEALTH AGENCY.—The term “home  
6           health agency” has the meaning given such term in  
7           section 1861(o) of the Social Security Act (42  
8           U.S.C. 1395x(o)).

9           (2) MEDICAL ADULT DAY CARE FACILITY.—The  
10          term “medical adult day care facility” means a facil-  
11          ity that—

12                 (A) has been licensed or certified by a  
13                 State to furnish medical adult day care services  
14                 in the State for a continuous 2-year period;

15                 (B) is engaged in providing skilled nursing  
16                 services and other therapeutic services directly  
17                 or under arrangement with a home health agen-  
18                 cy;

19                 (C) meets such standards established by  
20                 the Secretary to assure quality of care and such  
21                 other requirements as the Secretary finds nec-  
22                 essary in the interest of the health and safety  
23                 of individuals who are furnished services in the  
24                 facility; and

1 (D) provides medical adult day care serv-  
2 ices.

3 (3) MEDICAL ADULT DAY CARE SERVICES.—

4 The term “medical adult day care services” means—

5 (A) home health service items and services  
6 described in paragraphs (1) through (7) of sec-  
7 tion 1861(m) furnished in a medical adult day  
8 care facility;

9 (B) a program of supervised activities fur-  
10 nished in a group setting in the facility that—

11 (i) meet such criteria as the Secretary  
12 determines appropriate; and

13 (ii) is designed to promote physical  
14 and mental health of the individuals; and

15 (C) such other services as the Secretary  
16 may specify.

17 (4) MEDICARE BENEFICIARY.—The term  
18 “medicare beneficiary” means an individual entitled  
19 to benefits under part A of this title, enrolled under  
20 part B of this title, or both.

1 **SEC. 424. PUBLICATION ON FINAL WRITTEN GUIDANCE**  
2 **CONCERNING PROHIBITIONS AGAINST DIS-**  
3 **CRIMINATION BY NATIONAL ORIGIN WITH**  
4 **RESPECT TO HEALTH CARE SERVICES.**

5 Not later than January 1, 2003, the Secretary shall  
6 issue final written guidance concerning the application of  
7 the prohibition in title VI of the Civil Rights Act of 1964  
8 against national origin discrimination as it affects persons  
9 with limited English proficiency with respect to access to  
10 health care services under the medicare program.

11 **TITLE V—MEDICARE+CHOICE**  
12 **REVITALIZATION**

13 **SEC. 501. MEDICARE+CHOICE IMPROVEMENTS.**

14 (a) **EQUALIZING PAYMENTS BETWEEN FEE-FOR-**  
15 **SERVICE AND MEDICARE+CHOICE.—**

16 (1) **IN GENERAL.—**Section 1853(c)(1) (42  
17 U.S.C. 1395w-23(c)(1)) is amended by adding at  
18 the end the following:

19 “(D) **BASED ON 100 PERCENT OF FEE-**  
20 **FOR-SERVICE COSTS.—**

21 “(i) **IN GENERAL.—**For 2003 and  
22 2004, the adjusted average per capita cost  
23 for the year involved, determined under  
24 section 1876(a)(4) for the  
25 Medicare+Choice payment area for serv-  
26 ices covered under parts A and B for indi-

1 individuals entitled to benefits under part A  
2 and enrolled under part B who are not en-  
3 rolled in a Medicare+Choice plan under  
4 this part for the year, but adjusted to ex-  
5 clude costs attributable to payments under  
6 section 1886(h).

7 “(ii) INCLUSION OF COSTS OF VA AND  
8 DOD MILITARY FACILITY SERVICES TO  
9 MEDICARE-ELIGIBLE BENEFICIARIES.—In  
10 determining the adjusted average per cap-  
11 ita cost under clause (i) for a year, such  
12 cost shall be adjusted to include the Sec-  
13 retary’s estimate, on a per capita basis, of  
14 the amount of additional payments that  
15 would have been made in the area involved  
16 under this title if individuals entitled to  
17 benefits under this title had not received  
18 services from facilities of the Department  
19 of Veterans Affairs or the Department of  
20 Defense.”.

21 (2) CONFORMING AMENDMENT.—Such section  
22 is further amended, in the matter before subpara-  
23 graph (A), by striking “or (C)” and inserting “(C),  
24 or (D)”.

25 (b) REVISION OF BLEND.—

1           (1) REVISION OF NATIONAL AVERAGE USED IN  
2           CALCULATION           OF           BLEND.—Section  
3           1853(c)(4)(B)(i)(II)     (42     U.S.C.     1395w–  
4           23(c)(4)(B)(i)(II)) is amended by inserting “who  
5           (with respect to determinations for 2003 and for  
6           2004) are enrolled in a Medicare+Choice plan”  
7           after “the average number of medicare bene-  
8           ficiaries”.

9           (2) CHANGE IN BUDGET NEUTRALITY.—Section  
10          1853(c) (42 U.S.C. 1395w–23(c)) is amended—

11                   (A) in paragraph (1)(A), by inserting “(for  
12                   a year before 2003)” after “multiplied”; and

13                   (B) in paragraph (5), by inserting “(before  
14                   2003)” after “for each year”.

15          (c) REVISION IN MINIMUM PERCENTAGE INCREASE  
16          FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C.  
17          1395w–23(c)(1)(C)) is amended by striking clause (iv)  
18          and inserting the following:

19                           “(iv) For 2002, 102 percent of the  
20                           annual Medicare+Choice capitation rate  
21                           under this paragraph for the area for  
22                           2001.

23                           “(v) For 2003 and 2004, 103 percent  
24                           of the annual Medicare+Choice capitation

1 rate under this paragraph for the area for  
2 the previous year.

3 “(vi) For 2005 and each succeeding  
4 year, 102 percent of the annual  
5 Medicare+Choice capitation rate under  
6 this paragraph for the area for the pre-  
7 vious year.”.

8 (d) INCLUSION OF COSTS OF DOD AND VA MILI-  
9 TARY FACILITY SERVICES TO MEDICARE-ELIGIBLE  
10 BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE  
11 PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C.  
12 1395w-23(c)(3)) is amended—

13 (1) in subparagraph (A), by striking  
14 “subparagraph (B)” and inserting “subparagraphs  
15 (B) and (E)”, and

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

18 “(E) INCLUSION OF COSTS OF DOD AND  
19 VA MILITARY FACILITY SERVICES TO MEDICARE-  
20 ELIGIBLE BENEFICIARIES.—In determining the  
21 area-specific Medicare+Choice capitation rate  
22 under subparagraph (A) for a year (beginning  
23 with 2003), the annual per capita rate of pay-  
24 ment for 1997 determined under section  
25 1876(a)(1)(C) shall be adjusted to include in

1 the rate the Secretary's estimate, on a per cap-  
2 ita basis, of the amount of additional payments  
3 that would have been made in the area involved  
4 under this title if individuals entitled to benefits  
5 under this title had not received services from  
6 facilities of the Department of Defense or the  
7 Department of Veterans Affairs.”.

8 (e) ANNOUNCEMENT OF REVISED  
9 MEDICARE+CHOICE PAYMENT RATES.—Within 4 weeks  
10 after the date of the enactment of this Act, the Secretary  
11 shall determine, and shall announce (in a manner intended  
12 to provide notice to interested parties) Medicare+Choice  
13 capitation rates under section 1853 of the Social Security  
14 Act (42 U.S.C. 1395w-23) for 2003, revised in accordance  
15 with the provisions of this section.

16 (f) MEDPAC STUDY OF AAPCC.—

17 (1) STUDY.—The Medicare Payment Advisory  
18 Commission shall conduct a study that assesses the  
19 method used for determining the adjusted average  
20 per capita cost (AAPCC) under section 1876(a)(4)  
21 of the Social Security Act (42 U.S.C.  
22 1395mm(a)(4)). Such study shall examine—

23 (A) the bases for variation in such costs  
24 between different areas, including differences in  
25 input prices, utilization, and practice patterns;

1 (B) the appropriate geographic area for  
2 payment under the Medicare+Choice program  
3 under part C of title XVIII of such Act; and

4 (C) the accuracy of risk adjustment meth-  
5 ods in reflecting differences in costs of pro-  
6 viding care to different groups of beneficiaries  
7 served under such program.

8 (2) REPORT.—Not later than 9 months after  
9 the date of the enactment of this Act, the Commis-  
10 sion shall submit to Congress a report on the study  
11 conducted under paragraph (1). Such report shall  
12 include recommendations regarding changes in the  
13 methods for computing the adjusted average per  
14 capita cost among different areas.

15 (g) REPORT ON IMPACT OF INCREASED FINANCIAL  
16 ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later  
17 than July 1, 2003, the Secretary of Health and Human  
18 Services shall submit to Congress a report that describes  
19 the impact of additional financing provided under this Act  
20 and other Acts (including the Medicare, Medicaid, and  
21 SCHIP Balanced Budget Refinement Act of 1999 and  
22 BIPA) on the availability of Medicare+Choice plans in  
23 different areas and its impact on lowering premiums and  
24 increasing benefits under such plans.

1 **SEC. 502. MAKING PERMANENT CHANGE IN**  
2 **MEDICARE+CHOICE REPORTING DEADLINES**  
3 **AND ANNUAL, COORDINATED ELECTION PE-**  
4 **RIOD.**

5 (a) CHANGE IN REPORTING DEADLINE.—Section  
6 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by  
7 section 532(b)(1) of the Public Health Security and Bio-  
8 terrorism Preparedness and Response Act of 2002, is  
9 amended by striking “2002, 2003, and 2004 (or July 1  
10 of each other year)” and inserting “2002 and each subse-  
11 quent year (or July 1 of each year before 2002)”.

12 (b) DELAY IN ANNUAL, COORDINATED ELECTION  
13 PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–  
14 21(e)(3)(B)), as amended by section 532(c)(1)(A) of the  
15 Public Health Security and Bioterrorism Preparedness  
16 and Response Act of 2002, is amended by striking “and  
17 after 2005, the month of November before such year and  
18 with respect to 2003, 2004, and 2005” and inserting “,  
19 the month of November before such year and with respect  
20 to 2003 and any subsequent year”.

21 (c) ANNUAL ANNOUNCEMENT OF PAYMENT  
22 RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–  
23 23(b)(1)), as amended by section 532(d)(1) of the Public  
24 Health Security and Bioterrorism Preparedness and Re-  
25 sponse Act of 2002, is amended by striking “and after  
26 2005 not later than March 1 before the calendar year con-

1 cerned and for 2004 and 2005” and inserting “not later  
 2 than March 1 before the calendar year concerned and for  
 3 2004 and each subsequent year”.

4 (d) REQUIRING PROVISION OF AVAILABLE INFORMA-  
 5 TION COMPARING PLAN OPTIONS.—The first sentence of  
 6 section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w-  
 7 21(d)(2)(A)(ii)) is amended by inserting before the period  
 8 the following: “to the extent such information is available  
 9 at the time of preparation of materials for the mailing”.

10 **SEC. 503. SPECIALIZED MEDICARE+CHOICE PLANS FOR**  
 11 **SPECIAL NEEDS BENEFICIARIES.**

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

18 (b) SPECIALIZED MEDICARE+CHOICE PLAN FOR  
 19 SPECIAL NEEDS BENEFICIARIES DEFINED.—Section  
 20 1859(b) (42 U.S.C. 1395w-29(b)) is amended by adding  
 21 at the end the following new paragraph:

22 “(4) SPECIALIZED MEDICARE+CHOICE PLANS  
 23 FOR SPECIAL NEEDS BENEFICIARIES.—

24 “(A) IN GENERAL.—The term ‘specialized  
 25 Medicare+Choice plan for special needs bene-

1           ficiaries’ means a Medicare+Choice plan that  
2           exclusively serves special needs beneficiaries (as  
3           defined in subparagraph (B)).

4           “(B) SPECIAL NEEDS BENEFICIARY.—The  
5           term ‘special needs beneficiary’ means a  
6           Medicare+Choice eligible individual who—

7                   “(i) is institutionalized (as defined by  
8                   the Secretary);

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

11                  “(iii) meets such requirements as the  
12                  Secretary may determine would benefit  
13                  from enrollment in such a specialized  
14                  Medicare+Choice plan described in sub-  
15                  paragraph (A) for individuals with severe  
16                  or disabling chronic conditions.”.

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

20           “(f) RESTRICTION ON ENROLLMENT FOR SPECIAL-  
21           IZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS  
22           BENEFICIARIES.—In the case of a specialized  
23           Medicare+Choice plan (as defined in subsection (b)(4)),  
24           notwithstanding any other provision of this part and in  
25           accordance with regulations of the Secretary and for peri-

1 ods before January 1, 2007, the plan may restrict the en-  
2 rollment of individuals under the plan to individuals who  
3 are within one or more classes of special needs bene-  
4 ficiaries.”.

5 (d) REPORT TO CONGRESS.—Not later than Decem-  
6 ber 31, 2005, the Medicare Benefits Administrator shall  
7 submit to Congress a report that assesses the impact of  
8 specialized Medicare+Choice plans for special needs bene-  
9 ficiaries on the cost and quality of services provided to  
10 enrollees. Such report shall include an assessment of the  
11 costs and savings to the medicare program as a result of  
12 amendments made by subsections (a), (b), and (c).

13 (e) EFFECTIVE DATES.—

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

17 (2) DEADLINE FOR ISSUANCE OF REQUIRE-  
18 MENTS FOR SPECIAL NEEDS BENEFICIARIES; TRAN-  
19 SITION.—No later than 6 months after the date of  
20 the enactment of this Act, the Secretary of Health  
21 and Human Services shall issue final regulations to  
22 establish requirements for special needs beneficiaries  
23 under section 1859(b)(4)(B)(iii) of the Social Secu-  
24 rity Act, as added by subsection (b).

1 **SEC. 504. EXTENSION OF REASONABLE COST AND SHMO**  
2 **CONTRACTS.**

3 (a) REASONABLE COST CONTRACTS.—

4 (1) IN GENERAL.—Section 1876(h)(5)(C) (42  
5 U.S.C. 1395mm(h)(5)(C)) is amended—

6 (A) by inserting “(i)” after “(C)”;

7 (B) by inserting before the period the fol-  
8 lowing: “, except (subject to clause (ii)) in the  
9 case of a contract for an area which is not cov-  
10 ered in the service area of 1 or more coordi-  
11 nated care Medicare+Choice plans under part  
12 C”; and

13 (C) by adding at the end the following new  
14 clause:

15 “(ii) In the case in which—

16 “(I) a reasonable cost reimbursement contract  
17 includes an area in its service area as of a date that  
18 is after December 31, 2003;

19 “(II) such area is no longer included in such  
20 service area after such date by reason of the oper-  
21 ation of clause (i) because of the inclusion of such  
22 area within the service area of a Medicare+Choice  
23 plan; and

24 “(III) all Medicare+Choice plans subsequently  
25 terminate coverage in such area; such reasonable  
26 cost reimbursement contract may be extended and

1 renewed to cover such area (so long as it is not in-  
2 cluded in the service area of any Medicare+Choice  
3 plan).”.

4 (2) STUDY.—The Medicare Benefits Adminis-  
5 trator shall conduct a study of an appropriate tran-  
6 sition for plans offered under reasonable cost con-  
7 tracts under section 1876 of the Social Security Act  
8 on and after January 1, 2005. Such a transition  
9 may take into account whether there are one or  
10 more coordinated care Medicare+Choice plans being  
11 offered in the areas involved. Not later than Feb-  
12 ruary 1, 2004, the Administrator shall submit to  
13 Congress a report on such study and shall include  
14 recommendations regarding any changes in the  
15 amendment made by paragraph (1) as the Adminis-  
16 trator determines to be appropriate.

17 (b) EXTENSION OF SOCIAL HEALTH MAINTENANCE  
18 ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

19 (1) IN GENERAL.—Section 4018(b)(1) of the  
20 Omnibus Budget Reconciliation Act of 1987 is  
21 amended by striking “the date that is 30 months  
22 after the date that the Secretary submits to Con-  
23 gress the report described in section 4014(e) of the  
24 Balanced Budget Act of 1997” and inserting  
25 “December 31, 2004”.

1           (2) SHMOs OFFERING MEDICARE+CHOICE  
 2 PLANS.—Nothing in such section 4018 shall be con-  
 3 strued as preventing a social health maintenance or-  
 4 ganization from offering a Medicare+Choice plan  
 5 under part C of title XVIII of the Social Security  
 6 Act.

7 **TITLE VI—MEDICAID DIS-**  
 8 **PROPORTIONATE SHARE**  
 9 **HOSPITAL (DSH) PAYMENTS**

10 **SEC. 601. DISPROPORTIONATE SHARE HOSPITAL (DSH)**  
 11 **PAYMENTS.**

12 Section 1923(f)(3) (42 U.S.C. 1396r-4(f)(3)) is  
 13 amended—

14           (1) in subparagraph (A), by amending subpara-  
 15 graph (A) to read as follows:

16           “(A) IN GENERAL.—The DSH allotment  
 17 for any State—

18           “(i) for fiscal year 2003 is equal to  
 19 the DSH allotment for the State for fiscal  
 20 year 2001 under the table in paragraph  
 21 (2), without regard to paragraph (4), in-  
 22 creased, subject to subparagraph (B) and  
 23 paragraph (5), by the percentage change in  
 24 the consumer price index for all urban con-

1 consumers (all items; U.S. city average), for  
2 fiscal year 2001; and

3 “(ii) for each succeeding fiscal year is  
4 equal to the DSH allotment for the State  
5 for the previous fiscal year under this sub-  
6 paragraph increased, subject to subpara-  
7 graph (B) and paragraph (5), by 1.7 per-  
8 cent or, in the case of fiscal years begin-  
9 ning with the fiscal year specified in sub-  
10 paragraph (C) for that State, the percent-  
11 age change in the consumer price index for  
12 all urban consumers (all items; U.S. city  
13 average), for the previous fiscal year.”; and

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

16 “(C) FISCAL YEAR SPECIFIED.—For pur-  
17 poses of subparagraph (A)(ii), the fiscal year  
18 specified in this subparagraph for a State is the  
19 first fiscal year for which the Secretary esti-  
20 mates that the DSH allotment for that State  
21 will equal (or no longer exceed) the DSH allot-  
22 ment for that State under the law as in effect  
23 before the date of the enactment of this sub-  
24 paragraph.”.

○