HR 4954

Medicare Modernization and Prescription Drug Act of 2002

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Sponsor

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Party: Republican • **State:** CT • **Chamber:** House

Cosponsors (32 total)

Cosponsor	Party / State	Role	Date Joined
Rep. Bilirakis, Michael [R-FL-9]	R · FL		Jun 18, 2002
Rep. Bass, Charles F. [R-NH-2]	R · NH		Jun 19, 2002
Rep. Boozman, John [R-AR-3]	R · AR		Jun 19, 2002
Rep. Bryant, Ed [R-TN-7]	R · TN		Jun 19, 2002
Rep. Crenshaw, Ander [R-FL-4]	R · FL		Jun 19, 2002
Rep. Davis, Jo Ann [R-VA-1]	R · VA		Jun 19, 2002
Rep. Dunn, Jennifer [R-WA-8]	R · WA		Jun 19, 2002
Rep. English, Phil [R-PA-21]	R · PA		Jun 19, 2002
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Rep. Goss, Porter J. [R-FL-14]	R · FL		Jun 19, 2002
Rep. Greenwood, James C. [R-PA-8]	R · PA		Jun 19, 2002
Rep. Keller, Ric [R-FL-8]	R · FL		Jun 19, 2002
Rep. Kennedy, Mark R. [R-MN-2]	R · MN		Jun 19, 2002
Rep. McInnis, Scott [R-CO-3]	R · CO		Jun 19, 2002
Rep. Pickering, Charles W. "Chip" [R-MS-3]	R · MS		Jun 19, 2002
Rep. Portman, Rob [R-OH-2]	R · OH		Jun 19, 2002
Rep. Ryan, Paul [R-WI-1]	R · WI		Jun 19, 2002
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Rep. Terry, Lee [R-NE-2]	R · NE		Jun 19, 2002
Rep. Thomas, William M. [R-CA-21]	R · CA		Jun 19, 2002
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Rep. Weller, Jerry [R-IL-11]	R · IL		Jun 19, 2002
Rep. Houghton, Amo [R-NY-31]	R · NY		Jun 25, 2002
Rep. Lewis, Ron [R-KY-2]	R · KY		Jun 25, 2002
Rep. Vitter, David [R-LA-1]	R · LA		Jun 25, 2002
Rep. Gekas, George W. [R-PA-17]	R · PA		Jun 26, 2002
Rep. McCrery, Jim [R-LA-4]	R · LA		Jun 26, 2002
Rep. Shimkus, John [R-IL-20]	R · IL		Jun 26, 2002

Committee Activity

Committee	Chamber	Activity	Date
Energy and Commerce Committee	House	Referred to	Jun 26, 2002
Ways and Means Committee	House	Reported By	Jun 27, 2002

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
107 HRES 465	Procedurally related	**Jun 27, 2002:** Motion to reconsider laid on the table Agreed to without objection.
107 HR 4988	Related bill	**Jun 26, 2002:** Reported by the Committee on Energy and Commerce. H. Rept. 107-542, Part I.

Summary (as of Jun 28, 2002)

Medicare Modernization and Prescription Drug Act of 2002 - **Title I: Medicare Prescription Drug Benefit** - Amends title XVIII (Medicare) of the Social Security Act (SSA) to add a new part D (Voluntary Prescription Drug Benefit Program) under which each individual who is entitled to benefits under Medicare part A (Hospital Insurance) or enrolled under Medicare part B (Supplemental Medical Insurance) is entitled to obtain qualified prescription drug coverage by electing to enroll: (1) in a plan that provides qualified prescription drug coverage under the Medicare+Choice program under SSA title XVIII part C (Medicare+Choice) (M+C); or (2) in a prescription drug plan (PDP) under part D if the individual is not enrolled in a M+C plan providing qualified prescription drug coverage.

Outlines standard coverage benefit packages for FY 2005. Includes for the standard package an annual deductible of $250, and requires insurers under such package to cover 80 percent of enrollees drug costs from $251 to $1,000, then 50 percent of such costs between $1,001 and the initial coverage limit of $2,000. Requires enrollees to cover all costs between $2,001 and $3,700, and Medicare to cover the entire cost once the beneficiary has reached the $3,700 catastrophic limit. Prescribes a formula for adjustment of the deductible and thresholds for years after 2005.

Establishes a competitive bidding process for negotiating the terms and conditions of PDP sponsors.

Provides for full premium subsidy and reduction of cost-sharing for individuals with incomes below 150 percent of the Federal poverty level. Contains subsidy payments for qualifying entities to promote the participation of PDP sponsors.

Creates in the Treasury the Medicare Prescription Drug Trust Fund for use in the new part D program.

(Sec. 104) Prohibits, effective January 1, 2005, the issuance of new Medicare supplemental (Medigap) policies with prescription drug coverage unless the policy replaces another policy with drug coverage. Makes such prohibition inapplicable to policies meeting new standards outlined in this Act. Guarantees issuance of a substitute Medigap policy for persons, enrolling in a PDP under part D, who at the time of such enrollment were enrolled in and terminated enrollment in a Medigap policy H, I, or J. Provides such guaranteed enrollment for any of the policy benefit packages A through G. Prohibits discrimination in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition and the imposition of an exclusion of benefits based on a pre-existing condition under such policy.

(Sec. 105) Directs the Secretary of Health and Human Services (HHS), or the Medicare Benefits Administrator, to: (1) establish for Medicare beneficiaries programs to endorse prescription drug discount card programs that meet specified requirements; (2) make available to Medicare beneficiaries information regarding such endorsed programs; and (3) provide for an appropriate transition and discontinuation of such program at the time prescription drug benefits first become available under part D.

Provides low-income Medicare beneficiaries with immediate assistance in the purchase of covered outpatient prescription drugs during the period before the program under part D becomes effective.

Directs the Comptroller General to conduct a study and report to the Congress on the effectiveness of the PDP program under part D.

Title II: Medicare+Choice Revitalization and Medicare+Choice Competition Program - **Subtitle A: Medicare+Choice Revitalization** - Amends SSA title XVIII part C to make changes to the M+C payment amounts for 2003 and 2004, revising calculation of the adjusted average per capita cost (AAPCC), the blend payment, and Medicare+Choice payment rates, including in such payment rates the costs of Department of Defense and Department of

Veterans Affairs military facility services to Medicare-eligible beneficiaries.

Directs: (1) the Medicare Payment Advisory Commission (MEDPAC) to conduct a study for a report to Congress on the method used for determining the AAPCC; and (2) the Secretary to submit to Congress a report on the impact of additional financing on the availability of M+C plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(Sec. 202) Extends permanently the M+C reporting deadline changes temporarily changed by the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 and makes the annual, coordinated election period temporarily changed by such Act permanent.

(Sec. 203) Makes Federal standards supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to M+C plans offered by M+C organizations.

(Sec. 204) Allows specialized M+C plans for special needs beneficiaries to be any type of coordinated care plan.

(Sec. 205) Makes permanent the current demonstration for coverage under M+C medical savings account (MSA) plans and eliminates the associated enrollment cap.

(Sec. 206) Allows a reasonable cost contract to be extended or renewed beyond December 31, 2004, if there were no coordinated care M+C plans in its service area.

Amends the Omnibus Budget Reconciliation Act of 1987 to extend the waivers permitting operation of the social health maintenance organization (SHMO) demonstration program through December 31, 2004. Provides that nothing prevents a SHMO from offering an M+C plan.

Subtitle B: Medicare+Choice Competition Program - Outlines a: (1) Medicare+Choice competition program allowing for the submission of bid amounts by Medicare+Choice organizations for the provision of all items and services; and (2) competitive-demonstration program under which Medicare+Choice areas are designated as competitive-demonstration areas.

Title III: Rural Health Care Improvements - Amends SSA title XVIII to provide that starting for discharges on or after October 1, 2002, hospitals (other than urban hospitals with a 100 or more beds or certain public hospitals) will receive payments based on a blend of their current disproportionate share (DSH) adjustment and the current DSH adjustment for large urban hospitals. Limits such new DSH adjustment at 10 percent for any hospital that is not classified as a rural referral center.

(Sec. 303) Provides that for discharges occurring: (1) during FY 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by half the difference between the average standardized amount for hospitals located in large urban areas for such fiscal year and such amount determined for other hospitals for such fiscal year; and (2) during FY 2004 and afterwards, the Secretary shall compute one standardized amount for all hospitals increased by the applicable percentage increase, and use this amount to pay all hospitals.

(Sec. 304) Directs the Secretary, after revising the market basket cost weights to reflect the most current data available, to establish a frequency for revising such weights in such market basket to reflect the most current data available more frequently than once every five years.

(Sec. 305) Revises the critical access hospital (CAH) program: (1) reinstating payments made on a periodic interim

payment basis for inpatient services starting with payments made on or after January 1, 2003; (2) prohibiting the Secretary from requiring as a condition for applying the special physician payment adjustment with respect to a CAH, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such condition shall not apply to those physicians who have not assigned such billing rights; (3) directing the Secretary to specify standards for determining whether a CAH has sufficiently strong seasonal variations in patient admissions to justify a five-bed increase in the number of inpatient acute beds it can maintain and still retain its classification as a CAH; and (4) extending the authorization of appropriations for the Medicare rural hospital flexibility program through FY 2007.

Prohibits the Secretary from recouping (or otherwise seeking to recover) overpayments made for outpatient critical access hospital services under Medicare part B for services furnished in cost reporting periods that began before October 1, 2002, insofar as such overpayments are attributable to payment being based on 80 percent of reasonable costs (instead of 100 percent of reasonable costs minus 20 percent of charges).

(Sec. 306) Amends the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BPIA) to extend through December 31, 2004, the ten percent additional payment for home health care furnished to beneficiaries residing in rural areas.

(Sec. 309) Directs the Comptroller General to conduct a study for a report to Congress on differences in payment amounts under the physician fee schedule for physicians' services in different geographic areas.

(Sec. 310) Amends SSA title XI to provide that any remuneration in the form of a contract, lease, grant, loan, or other agreement between a public or non-profit private health center and any individual or entity providing goods or services to the health center is not a violation of the anti-kickback statute if such agreement contributes to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population served by the health center.

(Sec. 311) Provides for a temporary adjustment for FY 2003 through 2005 for non-teaching hospitals in certain rural and urban areas where operating costs exceed operating payments.

Title IV: Provisions Relating to Part A - **Subtitle A: Inpatient Hospital Services** - Amends SSA title XVIII to: (1) set the hospital update factor at the market basket percentage increase minus .25 percentage points for all hospitals, except sole community hospitals which receive an update factor of the full market basket; (2) increase the level of adjustment for indirect costs of medical education in FY 2003 and FY 2004; (3) make changes to the mechanism to recognize the costs of new medical services or technologies, requiring, among other changes, for the Secretary to provide for the addition of new diagnosis and procedure codes in April 1 of each year that would not be required to affect Medicare's payment or diagnosis related group classification until the following fiscal year; and (4) provide for adjustment of the Federal rate for discharges from hospitals in Puerto Rico to a blended amount based on a 50-50 split between Federal and local amounts through October 1, 2003, with, from FY 2004 through 2007, an increasing amount of the payment rate based on Federal national rates, a decreasing amount on Puerto Rico local rates.

(Sec. 409) Directs the Comptroller General to conduct a study for a report to Congress on the improvements that can be made in the measurement of regional differences in hospital wages reflected in the hospital wage index.

Subtitle B: Skilled Nursing Facility Services - Amends BIPA and SSA title XVIII to modify payment for covered skilled nursing facility (SNF) services: (1) directing the Secretary to increase by 12, 11, and 8 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the

Federal Register by the Health Care Financing Administration on July 31, 2000, and as subsequently updated, effective for services furnished during FY 2003 through 2005; and (2) increase by 128 percent the resource utilization group payment for a SNF resident with acquired immune deficiency syndrome (AIDS).

Subtitle C: Hospice - Amends SSA title XVIII to provide for coverage of certain physicians' services for certain terminally ill individuals.

(Sec. 422) Increases by ten percent the payment rates for hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008.

(Sec. 423) Directs the Secretary to conduct, and to report to Congress on, a described demonstration project for the delivery of hospice care to Medicare beneficiaries in rural areas.

Subtitle D: Other Provisions - Directs the Secretary to conduct, and to report to Congress on, a described demonstration project to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under Medicare for services for which payment is made under Medicare part A.

Title V: Provisions Relating to Part B - **Subtitle A: Physicians' Services** - Amends SSA title XVIII to revise updates for physicians' services for 2003 through 2005, making the update to the single conversion factor for 2003 two percent and providing for special rules for determining the update adjustment factors for 2004 and 2005, while providing for the use of a ten-year rolling average gross domestic product in setting updates, among other changes.

(Sec. 502) Directs the Comptroller General to conduct a study for a report to Congress: (1) examining the adequacy of current reimbursements for inhalation therapy under the Medicare program; and (2) concerning the access of Medicare beneficiaries to physicians' services under the Medicare program.

(Sec. 503) Mandates that MEDPAC submit to Congress a described report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002.

(Sec. 504) Amends BIPA to provide for a one-year extension of the continuation of separate billing and payment for the technical component of pathology services furnished by an independent laboratory.

(Sec. 505) Provides that, for purposes of payment under the physician fee schedule, for physicians' services furnished during 2004, in no case may the work geographic index otherwise calculated be less than 0.985 unless the Secretary determines, taking into account the report required of the Comptroller General by this Act for evaluation of matters concerning geographic adjustments, that there is no sound economic rationale for the implementation of such index revision.

Subtitle B: Other Services - Amends SSA title XVIII to replace provisions under Medicare part B for a limited number of demonstration projects for competitive acquisition of items and services with provisions for a permanent program for the establishment of programs for competitive acquisition of described items and services, including provisions for a demonstration project for application of competitive acquisition to clinical diagnostic laboratory tests.

(Sec. 512) Substitutes a new phase-in methodology for the ambulance fee schedule amount portion of the phase-in and lengthens the phase-in schedule, including in such methodology adjustment in payment for certain long trips.

(Sec. 513) Extends the moratorium on application of the therapy caps for an additional two years, through FY 2004.

Directs the Secretary to: (1) submit to Congress overdue reports required under the Balanced Budget Act of 1997 relating to alternatives to a single annual dollar cap on outpatient therapy and under the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 relating to utilization patterns for outpatient therapy; and (2) request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive therapy caps.

Requires the Comptroller General to conduct a study for a report to Congress on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral.

(Sec. 514) Provides for coverage of a free initial preventive physical examination.

(Sec. 515) Directs the Comptroller General to submit to Congress a report containing: (1) an analysis of the differences in costs of providing renal dialysis services under the Medicare program in home settings and in facility settings; (2) an assessment of the percentage of overhead costs in home settings and in facility settings; and (3) an evaluation of whether the charges for home dialysis supplies and equipment are reasonable and necessary.

Increases the composite rate 1.2 percent for renal dialysis services furnished in 2004.

Amends BIPA to specify that the prohibition on exceptions to the composite rate would not apply to pediatric facilities that, as of October 1, 2002, do not have an exception rate as of such date. Defines "pediatric facility" as a renal facility at least 50 percent of whose patients are individuals under 18 years of age.

(Sec. 516) Amends SSA title XVIII to exclude payment for screening mammography and unilateral and bilateral diagnostic mammography under the system for hospital outpatient services.

Provides that for diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule, the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(Sec. 517) Amends SSA title XVIII to waive the Medicare part B late enrollment penalty, beginning in January 2003, for certain military retirees who demonstrate to the Secretary before December 31, 2003, that they are covered beneficiaries.

Provides for creation of a special enrollment period through the end of 2003 to allow such covered beneficiaries to enroll under Medicare part B.

(Sec. 518) Provides coverage of cholesterol and other blood lipid screening tests.

Title VI: Provisions Relating to Parts A and B - **Subtitle A: Home Health Services** - Amends SSA title XVIII to: (1) eliminate the 15 percent reduction in payment rates under the prospective payment system; and (2) modify update provisions, changing to a calendar year update and increasing payments by two percent for 2003, by 1.1 percent for 2004, and by 2.7 percent for 2005.

Limits the total amount of outlier payments or payment adjustments for home health care in a fiscal year to no more than three percent of total projected payments, beginning in 2003.

(Sec. 603) Directs the Secretary to establish and appoint a task force (the OASIS Task Force) to examine the data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required under the

Balanced Budget Act of 1997.

(Sec. 604) Directs MEDPAC to conduct a study for a report to Congress on payment margins of home health agencies under the home health prospective payment system.

(Sec. 605) Revises the treatment of occasional absences in determining whether an individual is confined to the home, giving examples of an occasional trip to the barber or a walk around the block as absences not disqualifying the individual from being determined to be confined to the home. Requires qualifying absences to not be inconsistent with the assessment underlying the individual's plan of care for home health services.

Subtitle B: Direct Graduate Medical Education - Amends SSA title XVIII to modify the adjustment in rate of increase for hospitals with full time equivalent approved amount above 140 percent of locality adjusted national average per resident amount, extending the applicable cost reporting period for such adjustment through FY 2012.

(Sec. 612) Requires the Secretary to determine if a hospital's resident level (the total number of full-time equivalent residents, before the application of weighting factors, in the fields of allopathic and osteopathic medicine for the hospital) is less than the otherwise applicable resident limit for each of the reference periods, effective for cost reporting periods beginning on or after January 1, 2003, and, if it is, 75 percent of the difference between such applicable resident limit and the reference resident level will be redistributed for other hospitals. Authorizes the Secretary to increase the otherwise applicable resident limit for any other hospital that has applied to the Secretary for such increase by not more than 25 positions. Requires the Secretary to take into account the need for such an increase by speciality and location involved, and to first distribute the increase to programs of hospitals located in rural and small urban areas on a first-come-first-served basis based on a demonstration that the hospital will fill the positions made available. Sets the application deadline for such increase at December 31, 2004. Provides that a hospital's indirect medical education (IME) limit would be treated in the same way as changes to the applicable resident limit except any resulting increase in resident counts would not affect a hospital's IME payments. Directs the Secretary to submit to Congress a report containing recommendations regarding whether to extend such application deadline.

Subtitle C: Other Provisions - Makes changes to MEDPAC, requiring it to: (1) examine the budget consequences of its recommendations prior to issuing such recommendations; (2) review the factors affecting expenditures for the efficient provision of services in different sectors; (3) conduct a study, and submit a report to Congress, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other Medicare providers of services; and (4) submit to Congress a report on investments and capital financing of hospitals participating under the Medicare program and related functions and access to capital financing for private and for not-for-profit hospitals.

(Sec. 622) Directs the Secretary to: (1) conduct a demonstration project to demonstrate the impact on costs and health outcomes of applying disease management to certain Medicare beneficiaries with diagnosed diabetes; and (2) establish within HHS a working group consisting of HHS employees to oversee the project.

Requires the Comptroller General to conduct a study that compares disease management programs under Medicare with such programs conducted in the private sector, for a report to Congress.

(Sec. 623) Mandates that the Secretary establish a demonstration project under which the Secretary shall permit a home health agency to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(Sec. 624) Directs the Secretary to issue final written guidance concerning the application of the prohibition in title VI of the Civil Rights Act of 1964 against national origin discrimination as it affects persons with limited English proficiency with respect to access to health care services under Medicare.

Title VII: Medicare Benefits Administration - Amends SSA title XVIII to establish within HHS the Medicare Benefits Administration, headed by the Medicare Benefits Administrator, to carry out Medicare parts C and D, and any duty provided for under such parts. Requires the Secretary to establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of Medicare beneficiaries; and the Medicare Policy Advisory Board to advise, consult with, and make recommendations to the Administrator.

Title VIII: Regulatory Reduction and Contracting Reform - **Subtitle A: Regulatory Reform** - Amends SSA title XVIII part E (Miscellaneous) (as redesignated by this Act) to require the Secretary to issue proposed or final regulations to carry out Medicare only on one business day of every month; but allows the Secretary to issue a proposed or final regulation on any other day if its issuance on another day is necessary to comply with requirements under law or if the limitation of issuance on the monthly date described is contrary to the public interest. Requires the Secretary to establish and publish on a regular timeline final regulations based on the previous publication of a proposed regulation or an interim final regulation.

(Sec. 803) Prohibits the retroactive application of a substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under Medicare to items and services furnished before the change's effective date, unless the Secretary determines that retroactive application is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest. Prohibits a substantive change from becoming effective until after the Secretary has issued or published it, except as provided for in this Act.

States that if a service provider or supplier reasonably relies on the written guidance of the Secretary or a Medicare contractor with respect to the furnishing of items or services and submission of a claim, and the Secretary determines that the provider or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing, and the guidance was in error, the provider or supplier shall not be subject to any sanction.

(Sec. 804) Directs the Comptroller General to study and report to Congress on the feasibility of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the Medicare program.

Subtitle B: Contracting Reform - Amends SSA title XVIII to authorize the Secretary to contract with an eligible entity to serve as a Medicare administrative contractor. Prescribes contract terms and conditions and performance requirements.

(Sec. 812) Outlines requirements for information security for Medicare administrative contractors and the general application of such requirements to fiscal intermediaries and carriers.

Subtitle C: Education and Outreach - Amends SSA title XVIII to require the Secretary to: (1) coordinate the educational activities provided through Medicare administrative contractors to maximize the effectiveness of Federal education efforts for service providers and suppliers; (2) develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of Medicare claims, in order to give them an incentive to implement effective education and outreach programs for service providers and suppliers; (3) develop a strategy for communications with individuals entitled to benefits under Medicare part A (Hospital Insurance) or enrolled under Medicare part B (Supplementary Medical Insurance), or both, and with service providers and suppliers under Medicare;

and (4) establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to inquiries of service providers, suppliers, and beneficiaries concerning the programs under Medicare.

(Sec. 822) Requires each Medicare administrative contractor, consistent with such standards, to maintain a system for identifying who provides such information and to monitor the accuracy, consistency, and timeliness of the information so provided.

Authorizes appropriations to the Secretary for FY 2004 and 2005 for improved provider education and training.

Requires: (1) a Medicare contractor that conducts education and training activities to tailor them to meet the special needs of small service providers or suppliers; and (2) the Secretary, and each Medicare contractor that provides services for service providers or suppliers, to maintain an Internet site which provides answers in an easily accessible format to frequently asked questions and includes other published materials of the contractor, that relate to service providers and suppliers under the programs under Medicare.

Prohibits a Medicare contractor from using a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under Medicare or otherwise by the Secretary to select or track service providers or suppliers for the purpose of conducting any type of audit or prepayment review.

(Sec. 822) Directs the Secretary to establish a demonstration program under which technical assistance is made available upon request to small service providers or suppliers to improve compliance with applicable Medicare requirements. Authorizes appropriations.

(Sec. 823) Amends SSA title XVIII to direct the Secretary to appoint within HHS a Medicare Provider Ombudsman and a Medicare Beneficiary Ombudsman to handle and provide assistance in resolving complaints and requests for information with respect to Medicare.

Authorizes appropriations.

Directs the Secretary to provide through a toll-free number (1-800-MEDICARE) for a means by which individuals seeking information about, or assistance with, Medicare programs are transferred to appropriate entities for the provision of such information or assistance.

Requires the Comptroller General to monitor and report to Congress on the accuracy and consistency of information provided to individuals entitled to benefits under Medicare part A or enrolled under Medicare part B, or both, through the toll-free number.

(Sec. 824) Directs the Secretary to establish a demonstration program under which HHS Medicare specialists provide advice and assistance to individuals entitled to benefits under Medicare part A, or enrolled under Medicare part B, or both, regarding the Medicare program at the location of existing local offices of the Social Security Administration.

Subtitle D: Appeals and Recovery - Requires the Commissioner of Social Security and the Secretary to develop and implement a plan under which the functions of administrative law judges responsible for hearing Medicare cases are transferred from the Social Security Administration to HHS.

(Sec. 832) Provides for increased financial support for administrative law judges and the Departmental Appeals Board.

(Sec. 833) Amends SSA title XVIII, as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, to revise the Medicare appeals process, providing for expedited access to judicial review of the Secretary's final decision in a hearing on an initial determination with respect to benefits under Medicare parts A or B, among other changes.

(Sec. 834) Authorizes Medicare administrative contractors to conduct random prepayment reviews only to develop contractor or program-wide claims payment error rates.

Prohibits Medicare administrative contractors from initiating non-random prepayment reviews of a service provider or supplier based on the initial identification by that service provider or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error.

Requires the Secretary to issue regulations relating to the termination of the non-random payment review.

(Sec. 835) Provides for the recovery of overpayments under the Medicare integrity program.

(Sec. 836) Directs the Secretary to establish by regulation a process for the enrollment of service providers and suppliers under Medicare.

(Sec. 837) Requires the Secretary to develop a process whereby, in the case of minor errors or omissions that are detected in the submission of claims under the programs under Medicare, a service provider or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal.

(Sec. 838) Provides that, with respect to a Medicare administrative contractor with a contract that provides for making Medicare payments for eligible items and services, the Secretary shall establish a prior determination process that meets specified requirements and that shall be applied by such contractor in the case of eligible requestors.

Requires the Secretary to establish a process for the collection of information on the instances in which: (1) an advance beneficiary notice has been provided; and (2) a beneficiary indicates on such a notice that he or she does not intend to seek or to have the item or service that is the subject of the notice furnished.

Requires the Secretary to establish a program of outreach and education for beneficiaries and service providers and other persons on the appropriate use of advance beneficiary notices and coverage policies under Medicare.

Requires the Comptroller General to report to Congress on the use of advance beneficiary notices and prior determination process under Medicare.

Subtitle E: Miscellaneous Provisions - Prohibits the Secretary from implementing any new documentation guidelines for evaluation and management physician services under Medicare unless the Secretary: (1) has developed the guidelines in collaboration with practicing physicians and provided for an assessment of the proposed guidelines by the physician community; (2) has established a plan that contains specific goals for improving the use of such guidelines; (3) has conducted appropriate and representative pilot projects to test modifications to the evaluation and management documentation guidelines; (4) finds that the objectives will be met in the implementation of such guidelines; and (5) has established, and is implementing, a program to educate physicians on the use of such guidelines.

(Sec. 841) Directs the Secretary to: (1) make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians; (2) conduct appropriate and representative pilot projects to test such new guidelines; (3) conduct a study and report to Congress on the development

of a simpler alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which Medicare payment is made, and consideration of systems other than current coding and documentation requirements for payment for such physician services; and (4) conduct a study and report to Congress on the appropriateness of coding in cases of extended office visits in which no diagnosis is made.

(Sec. 842) Provides for improved coordination between the Food and Drug Administration and the Centers for Medicare and Medicaid Services on Medicare (CMS) coverage of certain class III medical devices subject to premarket approval under the Federal Food, Drug, and Cosmetic Act, requiring the Secretary to ensure the appropriate sharing of information in the case of such devices.

Amends SSA title XVIII to direct the Secretary to establish a Council for Technology and Innovation within the Centers for Medicare and Medicaid Services to coordinate the activities of coverage, coding, and payment processes under Medicare with respect to new technologies and procedures, and to coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

Directs the Comptroller General to study and report to Congress on which external data can be collected in a shorter time frame by the CMS for use in computing payments for inpatient hospital services.

Requires the Secretary to arrange with the Institute of Medicine of the National Academy of Sciences for a study and report on local Medicare coverage determinations.

Directs the Secretary by regulation to establish procedures for determining the basis for, and amount of, Medicare payment for any clinical diagnostic laboratory test with respect to which a new or substantially revised Healthcare Common Procedure Coding System (HCPCS) code is assigned on or after January 1, 2003.

(Sec. 843) Provides for the treatment of hospitals for certain services under Medicare secondary payor requirements.

(Sec. 844) Amends SSA title XVIII to make changes with regard to Emergency Medical Treatment and Active Labor Act (EMTALA) matters, including requiring the Secretary to establish a procedure to notify hospitals and physicians when an investigation is closed.

(Sec. 845) Directs the Secretary to establish a Technical Advisory Group to review issues related to EMTALA and its implementation.

(Sec. 846) Amends SSA title XVIII to authorize a hospice program to enter into arrangements with another hospice program to provide core hospice services in certain circumstances.

(Sec. 847) Provides for the application of the Occupational Safety and Health Act of 1970 bloodborne pathogens standard to certain hospitals.

(Sec. 850) Provides for the treatment of certain dental claims under Medicare.

(Sec. 851) Directs the Secretary to provide, in an appropriate annual publication to the public, a list of national Medicare coverage determinations made in the previous year, and information on how to get more information about them.

Title IX: Medicaid Provisions - Establishes the National Bipartisan Commission on the Future of Medicaid to: (1) review and analyze the long-term financial condition of the Medicaid program under SSA title XIX; (2) identify the factors that are causing, and the consequences of, increases in costs under the Medicaid program; (3) analyze potential policies that will

ensure both the financial integrity of the Medicaid program and the provision of appropriate benefits under such program; (4) make recommendations for establishing incentives and structures to promote enhanced efficiencies and ways of encouraging innovative State policies under the Medicaid program; (5) make recommendations for establishing the appropriate balance between benefits covered, payments to providers, State and Federal contributions and, where appropriate, recipient cost-sharing obligations; (6) make recommendations on the impact of promoting increased utilization of competitive, private enterprise models to contain program cost growth, through enhanced utilization of private plans, pharmacy benefit managers, and other methods currently being used to contain private sector health-care costs; (7) make recommendations on the financing of prescription drug benefits currently covered under Medicaid programs; (8) review and analyze such other matters relating to the Medicaid program as the Commission deems appropriate; and (9) analyze the impact of impending demographic changes upon Medicaid benefits.

(Sec. 902) Amends SSA title XIX to increase disproportionate share allotments for States for FY 2003 and beyond.

(Sec. 903) Creates the pharmacy assistance program under Medicaid to provide assistance to pharmacies in implementing the new prescription drug benefit under SSA title XVIII part D.

Actions Timeline

- **Jul 15, 2002:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 493.
- **Jul 10, 2002:** Read the first time. Placed on Senate Legislative Calendar under Read the First Time.
- **Jul 8, 2002:** Received in the Senate.
- **Jun 28, 2002:** Mr. Gephardt moved to recommit with instructions to Ways and Means and Energy and Commerce. (consideration: CR H4297-4320; text: CR H4297-4318)
- **Jun 28, 2002:** On motion to recommit with instructions Failed by recorded vote: 204 - 223 (Roll no. 281).
- **Jun 28, 2002:** Passed/agreed to in House: On passage Passed by recorded vote: 221 - 208 (Roll no. 282).(text: CR H4182-4269)
- **Jun 28, 2002:** Motion to reconsider laid on the table Agreed to without objection.
- **Jun 28, 2002:** On passage Passed by recorded vote: 221 - 208 (Roll no. 282). (text: CR H4182-4269)
- **Jun 27, 2002:** Rules Committee Resolution H. Res. 465 Reported to House. Rule provides for consideration of H.R. 4954 with 2 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Measure will be considered read. Bill is closed to amendments.
- **Jun 27, 2002:** Rule H. Res. 465 passed House.
- **Jun 27, 2002:** Considered under the provisions of rule H. Res. 465. (consideration: CR H4182-4320)
- **Jun 27, 2002:** Rule provides for consideration of H.R. 4954 with 2 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Measure will be considered read. Bill is closed to amendments.
- **Jun 27, 2002:** DEBATE - The House proceeded with two hours of debate on H.R. 4954.
- **Jun 26, 2002:** Referred to the Subcommittee on Health.
- **Jun 26, 2002:** Reported (Amended) by the Committee on Ways and Means. H. Rept. 107-539, Part I.
- **Jun 26, 2002:** Reported (Amended) by the Committee on Ways and Means. H. Rept. 107-539, Part I.
- **Jun 19, 2002:** Committee Consideration and Mark-up Session Held.
- **Jun 19, 2002:** Ordered to be Reported (Amended).
- **Jun 18, 2002:** Introduced in House
- **Jun 18, 2002:** Introduced in House
- **Jun 18, 2002:** Referred, pursuant to the order of the House of June 17, 2002, jointly to the Committees on Energy and Commerce and Ways and Means.
- **Jun 18, 2002:** Referred, pursuant to the order of the House of June 17, 2002, jointly to the Committees on Energy and Commerce and Ways and Means.
- **Jun 18, 2002:** Referred, pursuant to the order of the House of June 17, 2002, jointly to the Committees on Energy and Commerce and Ways and Means.