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Medicare Fee-for-Service Modifications and Medicaid Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House

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Summary

On June 27, 2003, the Senate passed the Prescription Drug and Medicare Improvement Act of 2003 by a vote of 76-21. Later that same evening, the House passed the Medicare Modernization and Prescription Drug Act of 2003 by a recorded vote of 216-215 with one voting present.

Each of the bills contain significant payment increases, certain payment reductions, expansion of covered benefits, establishment of demonstration projects, as well as new beneficiary cost-sharing provisions in the Medicare fee-for-service (FFS) program. Provisions affecting the Medicaid program are included as well. The majority of Medicare's FFS payment and benefit changes in S. 1 are in Title V and Title VI. Medicaid and other health-related provisions are also included in Title VI. In H.R. 1, comparable Medicare FFS changes are in Title III through Title VII; the Medicaid provisions in H.R. 1 are in Title X. Where applicable, selected provisions in other parts of the legislation that affect FFS Medicare are also included in the side-by-side comparison.

There are significant differences in many of the provisions contained in S. 1 and H.R. 1. Using changes to beneficiary cost-sharing amounts as an example, both bills increase beneficiary cost-sharing amounts in traditional Medicare in different fashions. Although both provide for annual increases in the Part B deductible amount that must be met before program payments will be made for covered Part B services, S. 1 would set the deductible amount at \$125 in 2006 with subsequent annual increases based on changes in the consumer price index for urban consumers (CPI-U) each year thereafter. H.R. 1 would increase the Part B deductible annually as well, but would do so beginning in 2004 off the current base of \$100 and would use the same percentage amount traditionally used to increase the Part B premium. This update would be the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund (rounded to the nearest dollar). S. 1 establishes beneficiary coinsurance and deductible requirements for clinical laboratory services; the House bill establishes a beneficiary copayment for each 60-day episode of home-health care.

This report provides a detailed side-by-side comparison of the fee-for service provisions of both bills. It will be updated as events warrant.

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Medicare Fee-for-Service Modifications and Medicaid Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House

On June 27, 2003, the Senate passed the Prescription Drug and Medicare Improvement Act of 2003 by a vote of 76-21. Later that same evening, the House passed the Medicare Modernization and Prescription Drug Act of 2003 by a recorded vote of 216-215 with one voting present.

Each of the bills contain significant payment increases, certain payment reductions, expansion of covered benefits, establishment of demonstration projects as well as new beneficiary cost-sharing provisions in the Medicare fee-for-service (FFS) program. Provisions affecting the Medicaid program are included also. The majority of Medicare's FFS payment and benefit changes in S. 1 are in Title IV and Title VI. Medicaid and other health-related provisions are also included in Title VI. Comparable Medicare FFS changes are in Title III through Title VII of H.R. 1; the Medicaid provisions in H.R. 1 are in Title X. Where applicable, selected provisions that affect FFS Medicare in other parts of the Senate and House legislation have been included in the following side-by-side comparison.

Several general points regarding the Medicare FFS modifications can be made:

- The actual monetary benefit accruing to the various providers, physicians, or suppliers will vary depending upon the specific structure of the payment adjustment; these payment adjustments are different in S. 1 and H.R. 1. Of course, the actual benefit accruing to any individual provider or physician will depend upon a myriad of unique circumstances, such as the characteristics of the provider or physician, including urban or rural location, as well as the amount and types of services provided to the Medicare beneficiaries who are served;
- Both bills have spending reductions for particular providers or suppliers. S. 1 would freeze certain durable medical equipment (DME) fee schedules. H.R. 1 proposes reductions in the updates for hospitals, ambulatory surgery centers, and home health services, and would also freeze per resident payment amounts for direct graduate education reimbursement to high cost hospitals. To some extent, however, reductions in either bill are counterbalanced by other payment changes that increase Medicare payments to particular subsets of the affected providers or suppliers.

- Both bills increase beneficiary cost-sharing amounts in traditional Medicare, but in different fashions and for different services. Both bills schedule annual increases in the Part B deductible amount that must be met before program payments will be made for covered Part B services. S. 1 sets the deductible amount at \$125 in 2006 and provides for annual increases based on changes in the consumer price index for urban consumers (CPI-U) each year thereafter. H.R. 1 would increase the Part B deductible annually as well, but would do so beginning in 2004 off the current base of \$100 and would use the same percentage amount traditionally used to increase the Part B premium. This update would be the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund (rounded to the nearest dollar). S. 1 establishes beneficiary coinsurance and deductible requirements for clinical laboratory services in most settings; H.R. 1 establishes a beneficiary copayment for each 60-day episode of home-health care at 1.5% of the national average payment rate per episode. Absent timely regulatory action, the copayment would be set at \$40.
- H.R. 1 provides for improved coverage of preventive services, including an initial preventive examination, and waives the deductible for certain cancer screening tests. S. 1 provides for increased Part B coverage of self-injected drugs.

The following general points can be made about the Medicaid provisions:

- Both bills temporarily increase states' disproportionate share hospital (DSH) allotments to erase the decline in these Medicaid amounts that occurred after a special rule for their calculation expired.
- S. 1 includes several other Medicaid provisions, including raising the floor on DSH allotments for "extremely low DSH states", increasing the federal matching share of certain Medicaid payments in the state of Hawaii, and allowing states to cover certain lawfully residing aliens under the Medicaid program.

This report contains a detailed side-by-side comparison of the relevant provisions of S. 1 and H.R. 1. Certain of the provisions have duplicate entries. For example, the home health deductible established in H.R. 1 is listed in as a home health provision and as a beneficiary cost-sharing provision.

Modifications to Fee-for-Service Medicare

Provisions Relating to Part A

Hospital Services.

Provisions	Current Law	S. 1	H.R. 1
Inpatient Prospective Payment System (IPPS) Hospitals			
Increase standardized amounts for small urban and rural hospitals in Medicare's inpatient hospital prospective payment system (IPPS)	<p>Medicare pays for inpatient services in acute hospitals in large urban areas using a standardized amount that is 1.6% larger than the standardized amount used to reimburse hospitals in other areas (both rural areas and smaller urban areas). PL.108-7 provided that all Medicare discharges from April 1, 2003, to December 31, 2003, will be paid on the basis of the large urban area amount.</p> <p>Under Medicare's IPPS, separate urban and rural standardized amounts are used for hospitals in Puerto Rico. These standardized amounts are currently a blend based on 25% of the national amount and 75% of the local amounts.</p>	<p>Section 401. Medicare would pay hospitals in rural and small urban areas in the fifty states using the standardized amount used to pay hospitals in large urban areas starting for discharges in FY2004. The Secretary would compute one standardized amount for hospitals in Puerto Rico equal to that for other areas. (There seems to be a drafting problem. There is no 1886(3)(D)(iii) in statute. If the reference is to 1886(3)(A)(iii), there will be one standardized amount which will be the other area standardized amount).</p>	<p>Section 402. Similar provision with respect to discharges in the fifty states. Two standardized amounts would still be used for hospitals in Puerto Rico; one federal amount would be used in the calculation of these 2 rates</p>
Increase payments to hospitals in areas with wage index values below one (by lowering Medicare's IPPS labor-related share which is the proportion of the standardized amount multiplied by the wage index).	<p>IPPS payments are adjusted, either increased or decreased as appropriate, by the hospital wage index of the area where the hospital is located or where it has been reassigned. Presently, approximately 71% of the standardized amount is adjusted by the area wage index.</p>	<p>Section 402. For cost reporting periods beginning October 1, 2004, the Secretary would be required to decrease the labor-related share to 62% of the standardized amount only if such change would result in higher total payments to the hospital. This provision would be applied without regard to certain budget neutrality requirements.</p>	<p>Section 416. Same provision except that the effective date is October 1, 2003.</p>
Increase Medicare IPPS payments for low-volume hospitals	<p>Medicare pays inpatient acute hospital services for each discharge from the hospital without regard for the number of beneficiaries</p>	<p>Section 403. The Secretary would be required to develop a graduated adjustment to Medicare's inpatient payment rates to account</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
	<p>discharged from any given hospital. Under certain circumstances, however, sole community hospitals (SCHs) and Medicare dependent hospitals with more than a 5% decline in total discharges from one period to the next may apply for an adjustment to their payment rates to partially account for higher costs associated with a drop in patient volume due to circumstances beyond its control.</p>	<p>for the higher unit costs associated with low-volume hospitals. Certain hospitals with fewer than 2,000 total discharges during the three most recent cost reporting periods would be eligible for up to a 25% increase in their Medicare payment amount starting with cost reports that begin during FY2005. Eligible hospitals would be located at least 15 miles from a similar hospital or those determined by the Secretary to be so located due to factors such as weather conditions, travel conditions, or travel time to the nearest alternative source of appropriate inpatient care. Certain budget neutrality requirements would not apply to this provision.</p>	
<p>Increase disproportionate share hospital (DSH) payments for small urban and rural hospitals</p>	<p>Medicare makes additional payments to certain acute hospitals that serve a large number of low-income Medicare and Medicaid patients. Although a SCH or rural referral center (RRC) can qualify for a higher DSH adjustment, generally, the DSH adjustment that a small urban or rural hospital can receive is limited to 5.25%. Large (100 beds and more) urban hospitals and large rural hospitals (500 beds and more) are eligible for a higher adjustment that can be significantly greater; the amount of the DSH adjustment received by these larger hospitals will depend upon its DSH percentage.</p>	<p>Section 404. Starting for discharges after October 1, 2004, a hospital that qualifies for a DSH adjustment when its DSH patient percentage exceeds the 15% DSH threshold would receive the DSH payments using the current formula that establishes the DSH adjustment for a large urban hospital.</p>	<p>Section 401. Starting for discharges after October 1, 2003, a hospital that is not a large urban hospital that qualifies for a DSH adjustment would receive its DSH payments using the current DSH adjustment formula for large urban hospitals, subject to a limit. The DSH adjustment for any of these hospitals, except for RRCs, would be capped at 10%.</p>
<p>Require MedPAC report on Medicare DSH adjustments</p>	<p>No provision</p>	<p>Section 404A. MedPAC would be required to conduct a study to determine (1) whether DSH payments should be made in the same manner as Medicare's graduate medical education payments; (2) the extent that hospitals receiving Medicaid DSH payments also receive Medicare DSH payments; and (3) whether uncompensated care costs should be</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
		added to the Medicare DSH formula. The report, including recommendations, would be due to Congress within 1 year from enactment.	
Exclude wage data of hospitals that convert to critical access hospitals (CAHs) from IPPS wage index	Certain qualified small hospitals are converting to CAHs. After conversion, these facilities are paid on a reasonable cost basis and are not paid under IPPS. Medicare's IPPS payments to acute hospitals are adjusted by the wage index of the area where the hospital is located or has been reassigned. Although the hospital wage index is recalculated annually, the wage index for any given fiscal year is based on data submitted as part of a hospital's cost report from 4 years previously. Presently wage data from hospitals that have converted to CAHs are included in the IPPS wage index calculation.	Section 405(e). The Secretary would be required to exclude wage data from hospitals that have converted to CAHs from the IPPS wage index calculation starting for cost reporting periods beginning January 1, 2004.	No provision.
Increase DSH for "Pickle" hospitals	Most DSH hospitals receive additional Medicare payments because they serve a disproportionate share of poor Medicare and Medicaid patients. A few urban hospitals receive DSH payments under an alternative Pickle formula. If a hospital receives at least 30% of its patient care revenue from indigent care funds, it will get a 35% increase in its Medicare operating payments. The Pickle hospitals receive a capital DSH adjustment of 14.16%, the amount that other non-Pickle hospitals with a 35% operating DSH adjustment would receive.	Section 420A. Hospitals that qualify for the DSH adjustment under the Pickle amendment would receive a DSH operating and capital adjustment of 40% for discharges beginning October 1, 2003.	No provision.

Provisions	Current Law	S. 1	H.R. 1
Increase payments for hospitals in Puerto Rico	Under Medicare's IPPS, separate standardized amounts are used to establish payments for discharges from short-term general hospitals in Puerto Rico. Balanced Budget Act of 1997 (BBA 97) provides for an adjustment of the Puerto Rico rates from blended amounts based on 25% of the national amounts and 75% of the local amounts to blended amounts based on a 50/50 split between national and local amounts.	Section 409. Hospitals in Puerto Rico would receive Medicare payments based on a 50/50 split between national and local amounts before October 1, 2004. These hospitals would receive Medicare payments based on 100% of the federal rate for discharges beginning October 1, 2004 and before October 1, 2009. The rate for hospitals in Puerto Rico would revert to a 50/50 split after October 1, 2009.	Section 503. Hospitals in Puerto Rico would receive Medicare payments based on a split between federal and local amounts before October 1, 2003. From FY2004 through FY2007, an increasing amount of the payment rate would be based on national rates as follows: during FY2004, payment would be 59% national and 41% local; this would change to 67% national and 33% local during FY2005 and 75% national and 25% local during FY2006 and subsequently.
Require GAO report on appropriateness of IPPS payments	No provision.	Section 413. Using the most current data, GAO would be required to report to Congress within 18 months of enactment on: (1) the appropriate level and distribution of IPPS Medicare payments to short-term general hospitals; and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs.	No provision.
Calculate wage indices for hospitals	IPPS hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification to a different area. If reclassification is granted, the new wage index will be used to calculating Medicare's payment for inpatient and outpatient services. The reclassification standards are established by regulation.	Section 419. The Secretary would be able to waive established reclassification criteria in calculating the wage index in a state when making payments for hospital discharges in FY2004.	No provision.
Update hospital market basket more frequently	IPPS standardized amounts are increased annually using an update factor which is determined in part by the projected increase in the hospital market basket (MB), an input price index which measures the average change in the price of goods and services hospitals purchased in order to furnish inpatient care. Centers for	No provision	Section 404. The Secretary would be required to revise the market basket cost weights to reflect the most currently available data and to establish a schedule for revising the weights more often than once every 5 years. The Secretary would be required to submit a report to Congress by October 1,

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Provisions	Current Law	S. 1	H.R. 1
	Medicare and Medicaid Services (CMS) revises the category weights, reevaluates the price proxies for such categories, and rebases the MB every 5 years.		2004 on the reasons for and the options considered in establishing such a schedule.
Reduce hospital update factor	Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected annual change in the hospital MB. Congress establishes the update for Medicare's IPSS for operating costs, often several years in advance. Currently, acute hospitals will receive the MB as an update for FY2004 and subsequently.	No provision.	Section 501. Acute hospitals would receive an operating update of the MB minus 0.4 percentage points for FY2004 through FY2006. The operating update would be the MB increase in FY2007 and subsequently.
Increase pass-through payments for new inpatient technology	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established that Medicare's IPPS should recognize the costs of new medical services and technologies beginning October 1, 2001. The additional hospital payments can be made by the means of new technology groups, an add-on payment, a payment adjustment, or other mechanism, but cannot be a separate fee schedule and must be budget neutral. CMS established that a technology that provided a substantial improvement to existing treatments would qualify for additional payments. The add-on payment for an eligible new technology would occur when the standard diagnosis related group (DRG) payment was inadequate. This threshold was established as one standard deviation above the mean standardized DRG; the add-on payment for new technology would be the lesser of: (a) 50% of the costs of the new technology; or (b) 50% of the amount by which the costs exceeded the standard DRG payment. However, if the new technology payments are estimated to exceed the budgeted target amount	No provision.	Section 502. New diagnosis and procedure codes would be added in April 1 of each year that would affect Medicare's IPPS starting the following October. The Secretary would not be able to deny new technology status because an item has been used prior to the 2-to-3 year period before it was issued a billing code. When establishing whether DRG payments are inadequate, the Secretary would be required to apply a threshold that is the lesser of 75% of the standardized amount (adjusted to reflect the difference between costs and charges) or 75% of one standard deviation for DRG involved. The Secretary would be required to provide additional regulatory guidance on the new technology criteria. The Secretary would be required to deem that a technology provides a substantial improvement on an existing treatment if it is designated under section 506 of the FDA Act, approved under certain sections of Title 21, designated for priority review, is an exempt medical device under section 520(m) of such Act, or receives expedited review under

Provisions	Current Law	S. 1	H.R. 1
	of 1% of the total operating inpatient payments, the add-on payments are reduced prospectively. CMS has proposed to reduce the threshold to 75% of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new service is assigned.		section 515(d)(5). Other requirements requiring the process for public input would be imposed. A preference for use of a DRG adjustment would be established. Add-on payments would be increased to the percentage that Medicare reimburses inpatient outlier cases. Funding for this new technology would no longer be budget neutral.
Increase hospitals' wage index values to reflect commuting patterns from higher wage index areas	Unlike other providers, IPPS hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for reassignment to another area. The MGCRB was created to determine whether a hospital should be redesignated to an area with which it has close proximity for purposes of using the other area's wage index. A hospital can establish proximity to the new area by documenting that at least 50% of its employees reside there. Other cost criteria must be met before a hospital will be reclassified. If reclassification is granted, the wage index for the new area will be used to calculate Medicare's payment for inpatient and outpatient services provided by the hospital.	No provision.	Section 504. The Secretary would be required to establish an application process and payment adjustment to recognize the commuting patterns of hospital employees. A hospital that qualified for such a payment adjustment would have average hourly wages that exceed the average wages of the area in which it is located and have at least 10% of its employees living in one or more areas that have higher wage index values. The process would be based on the MGCRB reclassification process and schedule with respect to data submitted. Such an adjustment would be effective for 3 years unless a hospital withdraws or elects to terminate its payment. It would also be exempt from certain budget neutrality requirements.
Permit hospitals with missing cost reports to be SCHs	SCHs are hospitals that, because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area, or are located more than 35 road miles from another hospital. An SCH receives the higher of the following payment rates: the current IPPS base payment rate, or its hospital-specific per discharge costs	No provision.	Section 414. Beginning January 1, 2004, a hospital would not be able to be denied treatment as a SCH or receive payment as a SCH because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data from at least one applicable base cost reporting period is available.

Provisions	Current Law	S. 1	H.R. 1
	from either FY 1982, 1987 or 1996 updated to the current year. The FY1996 base year option will be fully implemented beginning in FY2004.		
Provide hospitals with data on patient days for DSH adjustment	A hospital's DSH payments under IPPS are calculated using a formula that includes data on the number of total patient days as well as days provided to those eligible for Medicaid and to Medicare beneficiaries who receive Supplemental Security Income.	No provision.	Section 951. The Secretary would arrange to furnish necessary patient day information for the Medicare DSH computation for the current cost reporting year.
Permit adoption of new coding standard	The Secretary is required to rely on the recommendations from the National Committee on Vital and Health Statistics (NCVHS) before adopting health information standards and codes.	No provision.	Section 942(d). The new coding standards, International Classification of Diseases 10 th Revision (ICD-10) could be adopted within 1-year of enactment without receiving a recommendation from NCVHS.
Require GAO report on use of external data for IPPS payments	No provision.	No provision.	Section 942(c). GAO would study which external data can be collected in a shorter time frame by CMS to use in calculating IPPS payments. GAO could evaluate feasibility and appropriateness of using quarterly samples or special surveys and would include an analysis of whether other executive agencies are best suited to collect this information. The report would be due to Congress no later than October 1, 2004.

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Provisions	Current Law	S. 1	H.R. 1
Critical Access Hospital Services			
Eliminate 35-mile requirement for cost-based reimbursement of CAH ambulance services	Ambulance services provided by a CAH or provided by an entity that is owned or operated by a CAH is paid on a reasonable cost basis and not the ambulance fee schedule, if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.	Section 405(b). The requirement that the CAH or the related entity be the only ambulance provider within a 35-mile drive in order to receive reasonable cost reimbursement for the ambulance services would be dropped for services furnished beginning January 1, 2005.	Section 405(c). The 35-mile requirement would not apply to a provider or supplier of ambulance services who is a first responder to emergencies for services furnished after the first cost reporting period beginning after the date of enactment.
Expand payment for emergency room on-call providers	BIPA required the Secretary to include the costs of compensation (and related costs) of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the allowable, reasonable cost of outpatient CAH services.	Section 405(c). Reimbursement for on-call emergency room providers would be expanded to include physician assistants, nurse practitioners, and clinical nurse specialists as well as emergency room physicians for covered Medicare services provided beginning January 1, 2005.	Section 405(b). Same provision but would be effective January 1, 2004.
Increase critical access hospital (CAH) bed limit	A CAH is a limited service facility that must provide 24-hour emergency services and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. A CAH is limited to 15 acute-care beds, but can have an additional 10 swing beds that are set up for skilled nursing facility level care. While all 25 beds in a CAH can be used as swing beds, only 15 of the 25 can be used for acute care at any time.	Section 405(a) A CAH would be able to operate up to 25 swing beds or acute care beds, subject to the 96-hour average length of stay for acute care patients. The requirement that only 15 of the 25 beds be used for acute care at any time would be dropped. This provision would be effective for designations made beginning October 1, 2004.	Section 405(f). For designations beginning January 1, 2004, the Secretary would specify standards for establishing seasonal variations in a CAH's patient admissions that would justify a five-bed increase in the number of beds it can maintain (and still retain its classification as a CAH). CAHs with swing beds would be able to use up to 25 beds for acute care services as long as no more than 10 beds at any time are used for non-acute services. Those CAHs with swing beds that made this election would not be eligible for the five-bed seasonal adjustment. A CAH with swing beds that elects to operate 15 of its 25 beds as acute care beds would be eligible for the five-bed seasonal adjustment.

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Provisions	Current Law	S. 1	H.R. 1
<p>Authorize periodic interim payments for eligible CAHs</p>	<p>Eligible hospitals, skilled nursing facilities, and hospices which meet certain requirements receive Medicare periodic interim payments (PIP) every 2 weeks; these payments are based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made to account for any difference between the estimated PIP payment and the actual amount owed. A CAH is not eligible for PIP payments.</p>	<p>Section 405(d). Starting with payments made beginning January 1, 2005, an eligible CAH would be able to receive payments made on a PIP basis for inpatient services.</p>	<p>Section 405(d). Same provision but would be effective January 1, 2004. Also, the Secretary would be required to develop alternative methods based on the expenditures of the hospital for these PIP payments.</p>
<p>Exclude beds in distinct-part units from CAH bed count</p>	<p>Beds in distinct-part skilled nursing facility units do not count toward the CAH bed limit. Beds in distinct-part psychiatric or rehabilitation units operated by an entity seeking to become a CAH count toward the bed limit.</p>	<p>Section 405(g). The Secretary would not be able to count any beds in a distinct-part psychiatric or rehabilitation unit operated by the entity seeking to become a CAH for designations beginning October 1, 2003. The total number of beds in these distinct-part units would not be able to exceed 25. A CAH would be able to establish a such a distinct-part unit.</p>	<p>No provision.</p>
<p>Establish CAH improvement demonstration program</p>	<p>No provision.</p>	<p>Section 415. The Secretary would be required to establish a budget neutral 5-year CAH demonstration program in four areas including Kansas and Nebraska to test various methods to improve the CAH program. Services would be paid either on the basis of its reasonable costs (without regard to customary charges) or using the relevant PPS for those services. In this instance, reasonable cost reimbursement of capital would include a return on equity payment of 150% of the average rate of interest paid by the Hospital Insurance (HI) Trust Fund.</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
Modify CAHs' billing requirements for physician services	As specified by Balanced Budget Refinement Act of 1999 (BBRA), CAHs can elect to be paid for outpatient services using cost-based reimbursement for its facility fee and at 115% of the fee schedule for professional services otherwise included within its outpatient critical access hospital services for cost reporting periods starting October 1, 2000.	No provision.	Section 405(e). The Secretary would not be able to require that all physicians providing services in a CAH assign their billing rights to the entity in order for the CAH to be able to be paid on the basis of 115% of the fee schedule for the professional services provided by the physicians. However, a CAH would not receive such payment for any physician who did not assign billing rights to the CAH.
Increase CAH payments for inpatient, outpatient, and swing bed services	Generally, a CAH receives reasonable, cost-based reimbursement for care rendered to Medicare beneficiaries. CAHs may elect either a cost-based hospital outpatient service payment or an all-inclusive rate which is equal to a reasonable cost payment for facility services plus 115% of the fee schedule payment for professional services.	No provision.	Section 405(a). Beginning October 1, 2003, inpatient services, outpatient services, and covered skilled nursing facility services furnished in swing beds by a CAH would be reimbursed at 102% of reasonable costs of services furnished to Medicare beneficiaries.
Other Hospitals			
Create essential rural hospital category	Generally, a hospital designated as a CAH is exempt from IPPS and receives reasonable, cost-based reimbursement for care rendered to Medicare beneficiaries. Certain acute general hospitals receive special treatment under IPPS, particularly those facilities identified as isolated or essential hospitals primarily located in rural areas, including RRCs and SCHs.	No provision.	Section 403. The definition of CAH hospital and services would be amended to add an essential rural hospital. An eligible hospital would apply for such a classification, have more than 25 licensed acute care beds, and be located in a rural area as defined by IPPS. The Secretary would have to determine that the closure of this hospital would significantly diminish the ability of beneficiaries to obtain essential health care services based on certain criteria. Such hospitals would not be able to change such classification and would not be able to be treated as a SCH, Medicare dependent hospital or RRC under IPPS and would be

Provisions	Current Law	S. 1	H.R. 1
			reimbursed 102% of its reasonable costs for inpatient and outpatient services beginning October 1, 2004. Beneficiary cost-sharing amounts would not be affected and required billing for such services would not be waived.

Allied Health and Graduate Medical Education Payments.

Provisions	Current Law	S. 1	H.R. 1
Pay hospitals for training costs of psychologists	Medicare pays hospitals for its share of direct costs associated with approved hospital-based training programs for nurses and certain other allied health professionals including inhalation therapists, nurse anesthetists, occupational and physical therapists. Medicare does not pay for such costs associated with psychologists' training.	Section 408. Beginning October 1, 2004, Medicare would reimburse its share of the reasonable costs of approved education activities of psychologists under the allied health professional training provisions.	No provision.
Increase initial residency period for geriatricians	Medicare counts residents in their initial residency period (the lesser of the minimum number of years required for board eligibility in the physician's specialty or 5 years) as 1.0 FTE. Residents whose training has extended beyond their initial residency period count as 0.5 FTE. Geriatrics is a subspecialty of family practice, internal medicine and psychiatry. A 1-year fellowship is required for certification in geriatrics, following an initial residency in one of those three areas.	Section 410. The Secretary would be required to promulgate interim final regulations after notice and comment that would establish full GME payment for 2 years as a 2-year initial residency program for certain geriatric training programs effective for cost reporting periods beginning October 1, 2003.	No provision.
Increase indirect medical education (IME) payments	A hospital's IME payment is based on a percentage add-on to its IPPS rate that is established by a complicated curvilinear formula that currently provides a payment increase of approximately 5.5% for each 10% increase in the hospital's intern and resident-to-bed (IRB) ratio. The statutory formula is multiplied by a hospital's base payment rate for each Medicare discharge to determine the IME payments: 1.35	Section 418. The IME multiplier in FY2004 and in FY 2005 would be 1.36; the multiplier would be 1.355 in FY2006 and in subsequent years. This would provide an IME adjustment of 5.508% for each 10% increase in a hospital's IRB ratio for FY2004 and FY2005. This change has been projected to increase payments to teaching hospitals by \$300 million over 10 years.	No provision.

Provisions	Current Law	S. 1	H.R. 1
	<p>X [(1+ IRB)^{0.405} - 1]. The multiplier of 1.35 increases the level of the IME adjustment to the existing target level of 5.5%. Congress has periodically changed the multiplier to decrease or increase IME payments to teaching hospitals.</p>		
<p>Count residents in a non-provider setting; drop dentists and podiatrists from the 3-year rolling limit on IME payments</p>	<p>Medicare has different resident limits for the IME adjustment and direct medical education (DGME) payment. Generally, the resident counts for both IME and DGME payments are based on the number of residents in approved allopathic and osteopathic teaching programs reported by the hospital in calendar year 1996. The DGME limit may differ from the IME limit because in 1996 residents training in non-hospital sites were eligible for DGME payments but not for IME payments. Prior to BBA 1997, the number of residents that could be counted for IME purposes included only those in the hospital inpatient and outpatient departments. Effective October 1, 1997, under certain circumstances, a hospital may now count residents in non-hospital sites for the purposes of IME. Subject to these resident limits, a teaching hospital's IME and DGME payments are based on a 3-year rolling average of resident counts. The rolling average calculation includes podiatry and dental residents. CMS has proposed regulations that limit Medicare's medical education payments when existing residents are transferred from a non-hospital entity to a teaching hospital, particularly when the non-hospital entity has historically paid for the training costs without hospital funding.</p>	<p>Section 411. The Secretary would be required to reimburse teaching hospitals for residents in non-hospital locations, when hospitals incur all, or substantially all, the costs of the training in that site starting from the effective date of a written agreement between the hospital and the entity owning or operating the non-hospital site. The effective date of the written agreement would be determined according to generally accepted accounting principles. The Secretary would not be able to take into account the fact that the hospital costs incurred are lower than actual Medicare reimbursement. Starting with FY2005, dental and podiatric residents would be removed from the 3-year rolling average calculation for IME and DGME reimbursements.</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
Extend update limitation on high cost programs	“Hospitals with per resident amounts between 85% and 140% of the geographically-adjusted national average would continue to receive payments based on their hospital-specific per resident amounts updated for inflation.	No provision.	Section 711. Hospitals with per resident amounts above 140% of the geographically-adjusted national average amount would not get an update from FY2004 through FY2013.
Redistribute unused residency positions	Medicare has different resident limits for the IME adjustment and DGME payment. Generally, the resident counts for both IME and DGME payments are based on the number of residents in approved allopathic and osteopathic teaching programs that were reported by the hospital for the cost reporting period ending in calendar year 1996. The DGME resident limit is based on the unweighted resident counts. It may differ from the IME limit because in 1996 residents training in non-hospital sites were eligible for DGME payments but not for IME payments. Generally, a hospital’s IME adjustment and increased IPPS payments depends on a hospital’s teaching intensity as measured by the ratio of the number of interns and residents per bed. Medicare’s DGME payment to teaching hospitals is based on its updated cost per resident (subject to a locality adjustment and certain payment corridors), the weighted number of approved full-time equivalent (FTE) residents, and Medicare’s share of inpatient days in the hospital.	No provision.	Section 406. A teaching hospital’s total number of Medicare-reimbursed resident positions would be reduced by a portion of its unused residency slots for cost reporting periods starting January 1, 2004 if its resident reference level is less than its applicable resident limit. If so, the reduction would be equal to 75% of the difference between the hospital’s limit and its resident reference level upon the timely request for such an adjustment, for the cost reporting period that includes July 1, 2003. A hospital’s reference period would be the three most recent settled or submitted consecutive cost reporting periods on or before September 30, 2002. The need for an increase in the physician specialty and the location involved would be considered. Positions would be distributed to programs in rural areas and those not in large urban areas on a first-come-first-served basis. The hospital would have to demonstrate that the resident positions would be filled; not more than 25 positions would be given to any hospital. These hospitals would be reimbursed for DGME for the increase in resident positions at the locality-adjusted national average per resident amount. IME payments would also be affected. The Secretary would be required to submit a report to Congress, no later than July 1, 2005, on whether to extend the application deadline for increases in resident limits.

Skilled Nursing Facility (SNF) and Hospice Services.

Provisions	Current Law	S. 1	H.R. 1
Skilled Nursing Facility Services (SNF)			
Increase skilled nursing facility (SNF) payments for AIDS patients	Under PPS, SNFs are paid a daily rate that varies depending on the care needs of the beneficiary. There are 44 resource utilization groups (RUGs) used to adjust payment for care needs; each group reflects the intensity of services, such as skilled nursing care and/or various therapy and other services needed by a beneficiary.	No provision.	Section 511. Starting October 1, 2003, the per diem RUG payment for a SNF resident with acquired immune deficiency syndrome (AIDS) would be increased by 128%. This increase would not apply after such date when the Secretary certifies that the case-mix adjustment adequately compensates for the facility's increased costs associated with caring for a resident with AIDS.
Exclude certain clinic visits from skilled nursing facility (SNF) prospective payment system (PPS)	Under Medicare's PPS, SNFs are paid a predetermined amount to cover all services provided in a day, including the costs associated with room and board, nursing, therapy, and drugs; the daily payment varies depending upon a patient's therapy, nursing and special care needs as established by one of 44 RUGs. Certain services and items provided a SNF resident, such as physicians' services, specified ambulance services, specified chemotherapy items and services, and certain outpatient services provided by a Medicare-participating hospital or CAH, are excluded from the SNF-PPS and paid separately under Part B.	Section 429. Services provided by a rural health clinic (RHC) and a federally qualified health center (FQHC) after January 1, 2005 would be excluded from SNF-PPS if such services would have been excluded if furnished by a physician or practitioner who was not affiliated with a RHC or FQHC. Outpatient services that are beyond the general scope of SNF comprehensive care plans that are provided by an entity that is 100% owned as a joint venture by two Medicare-participating hospitals or critical access hospitals would be excluded from the SNF-PPS.	Section 408. Provision is limited to RHCs and FQHC services provided after January 1, 2004 and does not extend to outpatient services that are beyond the general scope of SNF comprehensive care plans.
Require background check on workers for certain Medicare and Medicaid health and long-term care providers	All nursing homes and home health agencies may access FBI records to conduct background checks for only those applicants who would provide direct patient care. Background checks may only be conducted in those states that choose to establish a mechanism for processing these requests. Most states have enacted laws that require or allow nursing homes and home health agencies to conduct these checks for certain categories of potential employees. The Attorney General may charge a fee of no greater	Section 636. Nursing homes, home health agencies, hospices and other entities providing long-term care services to Medicare and Medicaid beneficiaries would be required to initiate background checks when hiring non-licensed and licensed workers. States would be required to check state, and if appropriate, request the FBI to check criminal history records on behalf of providers that are required to conduct these background checks. Providers would be permitted to provisionally employ	No provision.

Provisions	Current Law	S. 1	H.R. 1
	<p>than \$50 per request to any nursing home or home health agency requesting the background check. Section 1819(c) and 1919(c) of the Social Security Act (SSA) requires the state to maintain a registry of nurse aides that includes information about their having completed training and competency evaluation programs and findings of neglect or abuse.</p>	<p>workers pending completion of the criminal background checks as long as they comply with supervisory requirements. Nursing homes that are found to have violated these requirements would face civil penalties of \$2,000 for a first-time violation and \$5,000 for subsequent violations within 5 years. Nursing homes that knowingly retain workers in violation of the requirements in this provision would face civil penalties of \$5,000 for a first-time violation and \$10,000 for subsequent violations within 5 years. Rules pertaining to allowable charges for conducting background checks and penalties for non-compliance would be specified. The nurse aide registry would be expanded to include non-licensed workers and renamed “employee registry.” Survey and certification agencies would investigate abuse and neglect allegations and misappropriation of resident property. Grants would be available to public or private non-profit entities to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities. \$10.2 million would be authorized to be appropriated for FY 2004.</p>	
Hospice Services			
<p>Permit hospices to provide core hospice services under arrangement</p>	<p>Medicare requires a hospice to provide certain core services directly. These core services include nursing care, medical social services, and counseling services.</p>	<p>Section 406. Beginning October 1, 2004, a hospice would be permitted to enter into arrangements with another hospice program to provide core service in extraordinary circumstances.</p>	<p>Section 946. Same provision.</p>

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Provisions	Current Law	S. 1	H.R. 1
Permit nurse practitioners, clinical nurse specialists, and physician assistants to attend hospice patients	Medicare covers hospice services to care for the terminal illness of the beneficiary. Reasonable and necessary medical and support services for the management of the terminal illness are furnished under a written plan-of-care established and periodically reviewed by the patient's attending physician and the hospice. The attending physician may be employed by the hospice and is identified by the beneficiary as having the most significant role in the determination and delivery of medical care to the beneficiary at the time that hospice care is elected.	Section 407. Beginning October 1, 2004, a terminally ill beneficiary under hospice care would be able to designate a physician assistant, nurse practitioner, or clinical nurse specialist (who is not an employee of the hospice program) as his or her attending physician. The written plan-of-care would be able to be established by these professionals who would be able to periodically review the beneficiary's written plan-of-care.	Section 409. Nurse practitioners would be permitted to be identified as a beneficiary's attending physician and would be able to establish and review the written plan-of-care as well as provide other services, but would not be able to certify that a beneficiary is terminally ill.
Pay for physician consultation services in certain instances	Current law authorizes coverage of hospice services, in lieu of certain other Medicare benefits, for terminally ill beneficiaries who elect such coverage. The hospice can be paid by Medicare only after the beneficiary has elected the hospice benefit.	No provision.	Section 512. As of January 1, 2004, Medicare would pay for a hospice-employed physician's consultation with a terminally ill beneficiary who has not elected the hospice benefit.
Establish rural hospice demonstration program	Medicare's hospice services are provided primarily in a patient's home to beneficiaries who are terminally ill and who elect such services. Medicare law prescribes that the aggregate number of days of inpatient care provided to Medicare beneficiaries who elect hospice care in any 12-month period cannot exceed 20% of the total number of days of hospice coverage provided to these persons.	No provision.	Section 418. The Secretary would establish a 5-year demonstration project in three hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. Those Medicare beneficiaries who lack an appropriate caregiver and are unable to receive home-based hospice care would be able to receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls. The facility would not be required to offer services outside of the home and the limit on the aggregate number of inpatient days provided to Medicare beneficiaries who elect hospice care would be waived.

Other Part A Provisions.

Provisions	Current Law	S. 1	H.R. 1
Make grants to States and certain rural hospitals	The Secretary is able to make grants for specified purposes to states or eligible small rural hospitals that apply for such awards. Funding for the Rural Hospital Flexibility Grant Program was \$25 million from 1999 through 2001; \$40 million in FY2002; and \$25 million in 2003. The authorization to award the grants expired in FY2002.	Section 405(f). Under this program, the Secretary would be able to award grants of up to \$50,000 to hospitals to assist eligible small rural hospitals in reducing medical errors and increasing patient safety under the new Small Rural Hospital Improvement Program. Appropriations of \$25 million each year from the Treasury from FY2004 through FY2008 would be authorized for this purpose. Appropriations of \$40 million each year from FY2004 through FY2008 from the HI Trust Fund for grants to states for specified purposes would be authorized. States that are awarded grants would be required to consult with the hospital associations and rural hospitals in the state.	Section 405(g). The authorization to award grants under the existing Rural Hospital Flexibility Program would be established from FY2004 through FY2008 from the Federal HI Trust Fund at amounts of up to \$25 million each year.
Establish health care infrastructure loan program	No provision	Section 608. A loan program would be established to improve the cancer-related health care infrastructure in states with a population of less than 3 million. In order to receive assistance, the applicant would be required to: (1) be engaged in cancer research; and (2) be designated as a cancer center for the National Cancer Institute (NCI) or be similarly designated by the state. \$49 million in budget authority would be authorized for July 1, 2004 through FY2008 to carry out the loan program, \$2 million for program administration.	No provision.
Establish capital infrastructure revolving loan program	The Public Health Services Act establishes a fund in the Treasury from which the Secretary of HHS can make loans or loan guarantees in the amounts that have been specified in appropriations acts from time to time. Under the Medicare Rural Hospital Flexibility Program established as part of Title XVIII, the Secretary may award grants to rural hospitals to cover the	Section 609. The Secretary would be able to make loans to any rural entity including rural health clinics, a medical facility with less than 50 beds in non-MSA counties or in rural census tracts of MSAs, rural referral centers or sole community hospitals for various purposes. An geographically reclassified entity would be eligible for these loans and loan guarantees. The	No provision.

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Provisions	Current Law	S. 1	H.R. 1
	<p>implementation costs associated with data systems needed to meet the BBA 97 requirements.</p>	<p>government's total exposure for this program would not exceed \$50 million per year and the principal amount of all loans directly made or guaranteed in any year is not to exceed \$250 million per year. In addition, rural providers could apply to receive \$50,000 planning grants to help assess capital and infrastructure needs. The grants awarded in any year would not exceed \$2.5 million. The program would expire after September 30, 2008.</p>	
<p>Establish rural community hospital demonstration program</p>	<p>No provision.</p>	<p>Section 414. The Secretary would be required to establish a 5-year rural community hospital (RCH) demonstration program in four areas including Kansas and Nebraska that will pay for acute inpatient services, outpatient services, and certain home health services in qualifying hospitals either on the basis of its reasonable costs (without regard to the amount of customary charges) or using the respective prospective payment systems for those services. In this instance, reasonable cost reimbursement of capital costs would include a return on equity payment of 150% of the average rate of interest paid by the HI Trust Fund. The project would be budget neutral. Certain limits on beneficiary cost-sharing would be imposed.</p>	<p>No provision.</p>

CRS-21

Provisions	Current Law	S. 1	H.R. 1
Ensure status as long-term hospitals for certain hospital-in-hospitals	A hospital-in-a-hospital is a long-term hospital that is physically located in an acute care hospital. CMS has established certain requirements for these entities to be excluded from the IPPS and be paid as a long-term hospital and exempted existing entities (those that were in existence on or before September 30, 1995) when these requirements were established. On May 19, 2003, CMS proposed that a grandfathered hospital-in-a hospital would only be exempt from the existing requirements if it continues to operate within the same terms and conditions that were in effect as of September 30, 1995.	Section 416. The Secretary would not be able to impose any special conditions on the operation, size, number of beds, or location of an existing long-term hospital in order to continue participating in Medicare or Medicaid or to continue being classified as a long-term hospital. The Secretary would not be able to adopt a proposed regulation that would implement such conditions or any revision to such regulation that have a comparable effect. [Duplicate provision is at Section 420B]	No provision.
Establish special treatment for certain entities	Unlike other providers, acute hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. Hospital reclassifications are established on a budget neutral basis so aggregate inpatient prospective payment system expenditures will not increase as a result. Aside from reclassifications through the MGCRB, hospitals have also been reclassified by law.	Section 417. Starting October 1, 2003, Iredell County and Rowan County, North Carolina would be deemed to be located in the Charlotte-Gastonia-Rock Hill, NC-SC Metropolitan Statistical Area for the purpose of Medicare's inpatient and outpatient acute hospital payments as well as SNF and home health payments. The Secretary would be required to adjust the wage index values of all hospitals in North Carolina to assure that aggregate payments for hospital inpatient operating costs are not greater than they would have been without such a change: also aggregate payments for SNF and home health services in North Carolina would not be greater than they would have been without such a change.	No provision.
Limit charges for contract health services provided to Indians by participating hospitals	The Indian Health Service (IHS) provides health care both directly, through tribes and tribal consortia, and through urban Indian organizations.	Section 412. The amendment would prohibit Medicare providers from charging the Indian Health Service more than the Medicare-established rates for inpatient hospital services.	No provision.
Pay interest on clerical error into HI Trust Fund	An incorrect amount of income was transferred into the HI Trust Fund in April 2001, because of a clerical error. An additional amount was transferred into the HI Trust Fund in December,	Section 623. After consultation with the Secretary of HHS, the Secretary of the Treasury would be required to transfer into the HI Trust fund an amount that would have been held by	Section 513. Same provision.

Provisions	Current Law	S. 1	H.R. 1
	2001 to correct for the principal amount associated with the error. Correction of the interest associated with the clerical error requires legislation.	that fund if the clerical error had not occurred within 120 days of enactment.	
Apply the Occupational Safety and Health Act of 1970 (OSHA) bloodborne pathogens standard to public hospitals	Section 1866 establishes certain conditions of participation that hospitals must meet in order to participate in Medicare.	No provision.	Section 947. As of July 1, 2004, public hospitals that are not otherwise subject to OSHA would be required to comply with the Bloodborne Pathogens standard under Section 1910.1030 of Title 29 of the <i>Code of Federal Regulations</i> . A hospital that fails to comply with the requirement would be subject to a civil monetary penalty, but would not be terminated from participating in Medicare.

Provisions Relating to Part B

Physician and Practitioner Services.

Provisions	Current Law	S. 1	H.R. 1
Establish floor on geographic adjustment for physician fee schedule	Medicare's payment for physicians' services under a fee schedule has three components: the relative value for the service, geographic adjustment factors and a conversion factor into a dollar amount. The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to the national average.	Section 421. For services furnished after January 1, 2004, the Secretary would be required to increase the value of any work geographic index that is below .980 to .980. The values for work index would be raised to 1.0 for services furnished in 2005, 2006, and 2007. The practice expense and malpractice geographic indices in low value localities areas would be raised to 1.00 for services furnished in 2005 until 2008.	Section 605(a). For services furnished after January 1, 2004 and before January 1, 2006, the Secretary would be required to increase the value of any work geographic index that is below 1.00. to 1.00 unless the Secretary determines, based on the subsequent GAO study which is due by September 1, 2004, that there is no sound economic rationale for such change.
Increase practice expense payments for certain specialists	The relative value associated with a particular physician service is the sum of three components one of which is practice expense. Practice expense includes both direct costs (such as a clinician's time and the medical supplies to provide a specific service to a patient) and indirect costs (such as rent and utilities). BBRA required the Secretary to establish a data	Section 432(b)(1). The Secretary would establish the practice expense relative values for the CY2004 fee schedule using the survey data from a physician specialty group as of January 1, 2003 if the data appropriately covers the practice expenses for oncology administration services. The Secretary would review and appropriately modify payments for the	Section 303(a) The Secretary would increase the practice expense relative values for the physician fee schedule in CY2005 using appropriate survey data on the expenses associated with drug administration provided by entities and organizations that are submitted by December 31, 2004. Using existing processes for coding considerations, the Secretary would

Provisions	Current Law	S. 1	H.R. 1
	collection process and standards for determining practice expense relative values as well as to use data collected or developed outside HHS, to the maximum extent practicable, consistent with sound data collection practices. The relative values are periodically reviewed and adjusted to account for various factors; changes that cause more than \$20 million in spending trigger a budget neutrality adjustment.	administration of more than one anti-cancer agent to a patient in a day. The resulting increase in spending would be exempt from the budget neutrality requirement. Also, the Secretary would change the non-physician work pool method so that associated payments are not inordinately reduced. These adjustments would not be implemented unless other outpatient drug pricing changes in the section are implemented.	evaluate existing codes for drug administration to ensure accurate reporting and billing for these services. Any resulting CY2005 payment increase would not be subject to budget neutrality provisions, would be exempt from administrative and judicial review, and would be treated as a change in law and regulation in the sustainable growth rate determination. Subsequent budget neutrality adjustments would be permitted. The same non-physician work pool methodology provision as in S. 1 is included.
Change Medicare Incentive Program	Physicians providing services in a health professional shortage area (HPSA) are entitled to an incentive payment from the Medicare program. This incentive payment is a 10% increase over the amount which would otherwise be paid under the physician fee schedule.	Section 422. The Secretary would be required to establish procedures to determine when a physician in a HPSA is eligible for a bonus payment. The Secretary would also be required to establish an ongoing education program, an ongoing study and submit annual reports. A GAO report would be required no later than 1 year from enactment.	Section 417. Same provision with respect to Secretary developing procedures to identify physicians eligible for bonus payments. Also, physicians in newly-created scarcity areas as well as other physicians would be eligible for an additional 5% increase in their fee schedule payment amounts. The Secretary would also be required to publish a list of all areas that qualify as a HPSA each year in the proposed and final rule implementing the physician fee schedule.
Revise reassignment provisions	Generally, beneficiaries are the parties who are entitled to receive Medicare payments under the Medicare statute. However, beneficiaries can assign these rights to participating physicians, suppliers, and other providers who directly provide the care and then submit claims for Medicare payment. Although Medicare permits physicians to reassign their right to payment to certain other entities, they cannot reassign their right to payment to staffing companies (entities that retain physicians on a contractual basis).	Section 434. Staffing companies (individuals or entities) would be able to submit claims to Medicare for physician services provided under contractual arrangement between the company and the physician, if the arrangement meets appropriate program integrity and other safeguards established by the Secretary.	Section 952. Same provision with some drafting differences.

Provisions	Current Law	S. 1	H.R. 1
Extend provision for separate payments of certain inpatient pathology services	In general, independent laboratories cannot directly bill for the technical component of pathology services provided to Medicare beneficiaries who are inpatients or outpatients of acute care hospitals. BIPA permitted certain independent laboratories with existing arrangements with acute hospitals to do so if the arrangement had been in effect as of July 22, 1999. The direct payments for these services apply to services furnished during a 2-year period starting on January 1, 2001 and ending December 31, 2002.	Section 435. Direct payments for the technical component for these pathology services would be made for services furnished during 2005.	Section 734. Similar provision except Medicare would make direct payments for the technical component of pathology services from 2004 through 2008. Would also specify that a change in hospital ownership would not affect these direct billing arrangements.
Pay Alaskan physicians based on Department of Veterans Affairs (VA) fee schedule	Physicians that provide services to Medicare beneficiaries are paid based on Medicare's physician fee schedule that is adjusted to account for geographic variations in practice expenses.	Section 450K. For 2004, physicians in Alaska would be paid 90% of the VA physician fee schedule used for FY2001. In 2005, this amount would be increased by the update amount for the Medicare physician fee schedule for 2005. If no VA fee schedule amount exists for a service, the payment amount would be an adjustment to the Medicare payment. The adjustment would equal 90% of the overall percentage difference between the two fee schedules weighted by the distribution of Medicare claims in 2001.	No provision.
Establish update to physician fee schedule	Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The law provides a specific formula for calculating the annual update to the conversion factor.	No provision.	Section 601. The update to the conversion factor for 2004 and 2005 would be not less than 1.5% and would be exempt from the budget neutrality adjustment.

Provisions	Current Law	S. 1	H.R. 1
Change the sustainable growth rate formula	<p>Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The law provides a specific formula for calculating the annual update to the conversion factor which regulates overall spending for physicians' services. Several factors enter into the calculation of the formula. One of those factors is the sustainable growth rate (SGR) which is essentially a target for Medicare spending growth in physicians' services. If expenditures exceed the target, the update for a future year is reduced. If expenditures are less than the target, the update is increased. The recent negative update adjustment factors reflect the application of the SGR system.</p>	<p>Section 464. The provision expresses a sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not prevent cuts in 2004 and following years that stem from the SGR formula. [Duplicate of Section 622]</p> <p>Section 629. The provision provides a sense of the Senate that the reductions in Medicare's physician fee schedule are destabilizing, primarily caused by the sustainable growth rate calculation, and that CMS should use its discretion to make certain exclusions and adjustments to the SGR calculation.</p>	<p>Section 601. The formula for calculating the sustainable growth rate would be modified. Starting with the SGR for 2003, the GDP factor would be based on the annual average change over the preceding 10 years (a 10-year rolling average). This calculation would replace the current GDP factor which measures the 1-year change from the preceding year.</p>
Require GAO report on physician compensation	No provision.	No provision.	<p>Section 953(a). No later than six months from enactment, GAO would report to Congress on the appropriateness of the updates in the conversion factor including the appropriateness of the SGR formula for 2002 and subsequently; the stability and the predictability of the updates; and alternatives to the SGR in the update. No later than 12 months from enactment, GAO would be required to report to Congress on all aspects of physician compensation for Medicare services. The report would review alternatives to the physician fee schedule.</p>

Provisions	Current Law	S. 1	H.R. 1
Extend Medicare's private contracting authority to dentists and podiatrists	Private contracting allows a physician and Medicare beneficiary not to submit a claim for a service which would otherwise be covered and paid for by Medicare. Under private contracting, physicians (not podiatrists or dentists) can bill patients at their discretion without being subject to upper payment limits specified by Medicare. If a physician decides to enter a private contract with a Medicare beneficiary, that physician must agree to forego any reimbursement by Medicare for all Medicare beneficiaries for 2 years.	No provision.	Section 604. Doctors of dental surgery or of dental medicine and doctors of podiatric medicine would be able to enter into private contracts with Medicare beneficiaries.
Require GAO report on geographic differences in physician payments	No provision.	Section 444. GAO would be required to study geographic differences in payment amounts in the physician fee schedule and report to Congress within 1 year of enactment.	Section 413. Same provision.
Require GAO report on beneficiary access to services including concierge care and impact of these mandatory fees and/or services on access	Periodic analyses by the Physician Payment Review Commission, and subsequently MedPAC, as well as CMS showed that access to physicians' services generally remained good for most beneficiaries through 1999. Detailed data is not available for a subsequent period; however, several surveys have showed a decline in the percentage of physicians accepting new Medicare patients.	Section 447. GAO would study concierge care provided to Medicare beneficiaries and its effect on their access to Medicare covered services and submit a report to Congress, including recommendations, no later than 12 months from enactment. In this instance, concierge care would be an arrangement where a physician or practitioner charges an individual a membership fee or other fee or requires the purchase of an item or service as a prerequisite for providing the care.	Section 602(a). GAO would be required to conduct a study on access of Medicare beneficiaries to physicians' services under Medicare including beneficiaries' use of services through an analysis of claims data and the extent to which physicians are not accepting new Medicare beneficiaries as patients.
Require Institute of Medicine (IOM) study on supply of physicians	No provision.	No provision.	Section 602(b). The Secretary would be required to request that IOM study the adequacy of the supply of physicians (including specialists) in the country and the factors that affect supply. The Secretary would be required to submit the results of the study in a report to Congress no later than 2 years from the date of enactment.

Provisions	Current Law	S. 1	H.R. 1
Require MedPAC report on payment for physician services	No provision.	No provision.	Section 603. MedPAC would be required to report to Congress on the effects of refinements to the practice expense component of payments for physicians' services after full implementation of the resource-based payment in 2002.
Require consultative process before establishing new evaluation and management (E&M) codes	Initial E&M documentation guidelines were issued in 1995 with revisions issued in 1997; both remain in force today. Approximately 40% of Medicare payments for physician services are for services which are classified as evaluation and management services (i.e., physician visits). The Secretary stopped work on the current re-draft of E&M codes in order to reassess the entire effort.	Section 553. The Secretary, before making changes in documentation guidelines for, providing clinical examples of, or changing codes for reporting E&M physician services, would be required to ensure that the process used in developing the guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.	Section 941. The Secretary would be prohibited from implementing new E&M documentation guidelines unless the Secretary developed the guidelines in collaboration with practicing physicians; established a plan with goals; conducted pilot projects; established and implemented an education program on the use of the guidelines with appropriate outreach. Changes to E&M guidelines would reduce paperwork burden on physicians.
Pay for additional hospital out patient department (HOPD) mammography services using physician fee schedule	Screening mammography coverage includes the radiological procedure as well as the physician's interpretation of the results of the procedure. The usual Part B deductible is waived for tests. Payment is made under the physician fee schedule. Certain services paid under fee schedules or other payment systems are excluded from Medicare's HOPD-PPS. For diagnostic mammography services provided in an HOPD, the technical component of the fee is paid under the HOPD PPS.	Section 445. Unilateral and bilateral diagnostic mammography as well as screening mammography services would be paid for under the physician fee schedule beginning January 1, 2005.	Section 614. Same provision except effective date would be January 1, 2004.
Pay the physician for pharmacy management services	No provision.	No provision.	Section 303(g). The Secretary would be required to provide for separate payments in the physician fee schedule to cover the administration and acquisition costs associated with covered drugs and biologicals furnished by a contractor under the competitive acquisition program.

Hospital Outpatient Department (HOPD), Ambulatory Surgery Center (ASC), and Clinic Services.

Provisions	Current Law	S. 1	H.R. 1
Hospital Outpatient Department (HOPD) Services			
Extend hold-harmless provisions for small rural hospitals	The HOPD-PPS was implemented in August 2000 for most acute care hospitals. Under hold-harmless provisions, rural hospitals with no more than 100 beds are paid no less under this PPS system than they would have received under the prior reimbursement system for covered OPD services provided before January 1, 2004.	Section 423. The hold-harmless provisions governing OPD reimbursement for small rural hospitals would be re-established in 2006.	Section 407. The hold-harmless provision would be extended to January 1, 2006. The Secretary would be required to conduct a study to determine if the costs by ambulatory payment classification (APC) groups incurred by rural providers exceeds those costs incurred by urban providers and provide an appropriate payment adjustment to reflect the higher costs of rural providers by January 1, 2005.
Establish hold-harmless provision for sole community hospitals (SCH)	No provision.	Section 423. HOPD-PPS hold-harmless provisions would be extended to SCHs located in rural areas for services provided in 2006.	Section 407. The hold-harmless provisions would be extended to SCHs for 2004 and 2005.
Change hold-harmless provision for children's hospitals	HOPD-PPS contains a permanent hold-harmless for cancer hospitals and children's hospitals where payments to these hospitals cannot fall below what these hospitals would have received under the payment system in place before HOPD-PPS.	Section 450J. These provisions for children's hospitals would be modified so that those in Maryland (which has a Medicare waiver) that are paid less under HOPD-PPS than what would have been received under the prior system or using hospital's reasonable operating and capital costs receive additional payments after October 1, 2003.	No provision.
Increase HOPD payments to small rural hospitals	Under the HOPD-PPS, which was implemented in August, 2000, Medicare pays for covered services using a fee schedule based on APCs. Beneficiary copayments are established as a percentage of Medicare's fee schedule payment and differ by APC. Certain hospitals, including rural hospitals with no more than 100 beds, are protected, either on a temporary or on a permanent basis, from financial losses that result from implementation of HOPD-PPS under hold-harmless provisions.	Section 424. Medicare's fee schedule payments would be increased by 5% for covered outpatient clinic and emergency room visits that are provided by rural hospitals with up to 100 beds beginning January 1, 2005 and before January 1, 2008. Beneficiary copayment amounts would not be affected. The increased Medicare payments would not be considered when calculating a rural hospital's hold-harmless payment. Budget neutrality provisions for Medicare's HOPD-PPS would not apply. Finally, these increased payments would not	No provision.

Provisions	Current Law	S. 1	H.R. 1
		affect Medicare payments for covered outpatient services after January 1, 2008.	
Increase SCH payments for clinical diagnostic laboratory tests	Generally, hospitals that provide clinical diagnostic laboratory tests under Part B are reimbursed using a fee schedule. SCHs that provide some clinical diagnostic tests 24 hours a day qualify for a 2% increase in the amounts established in the outpatient laboratory fee schedule; no beneficiary cost-sharing amounts are imposed.	Section 427. SCHs that provide clinical diagnostic laboratory tests covered under Part B in 2005 and 2006 would be reimbursed their reasonable costs of furnishing the tests. No beneficiary cost-sharing amounts would apply to these services.	No provision.
Limit application of functional equivalence standards when determining a drug's eligibility for transitional pass through payments	Starting in 2003, CMS decided that a new anemia treatment for cancer patients was no longer eligible for pass-through payments, because it was functionally equivalent (although not structurally identical or therapeutically equivalent) to an existing treatment. The transitional pass-through rate for the drug was reduced to zero starting for services in 2003.	Section 437. The Secretary would not be able to apply this standard to a drug or biological for transitional pass-through payments under HOPD-PPS. This prohibition would apply, unless such a standard was made prior to enactment and only for the purposes of transitional pass-through payments. The Secretary would still be able to deem a particular drug as identical to another drug if the two products are pharmaceutically equivalent and bioequivalent, as determined by FDA.	Section 621(c). The Secretary would be prohibited from applying a “functional equivalence” standard or any similar standard in order to deem a particular drug or biological to be similar or functionally equivalent to another drug unless the Commissioner of FDA establishes such a standard and certifies that the two products are functionally equivalent. The Secretary would be able to implement this standard after meeting applicable rulemaking requirements. The provision prohibits the application of this standard to a drug or biological prior to June 13, 2003.
Establish new payment method for certain HOPD drugs and biologicals	Under HOPD-PPS, Medicare pays for covered outpatient drugs in one of three ways: (1) as a transitional pass-through payment; (2) as a separate APC payment; or (3) as packaged APC payment with other services. Transitional pass-through payments are extra payments to cover the incremental cost associated with certain medical devices, drugs and biologicals that are inputs to an existing service. The additional payment for a given item is established for 2 or 3 years and then the costs are incorporated into the APC relative weights. BBRA specified that pass-through payments would be made for current orphan	Section 436. A new payment method for certain HOPD drugs and biologicals would be established for 2005 and 2006. The drugs and biologicals would be those for which hospitals received transitional pass-through payments prior to January 1, 2005 that have been assigned to drug-specific APCs beginning the date of enactment. Or those that would have been paid in such a manner but for the application of this provision. Payments made under this provision would be exempt from the budget neutrality requirement in FY2005 and FY2006. In 2005, these drugs would be paid as follows: a single	Section 621(a). Starting for services furnished beginning January 1, 2004, certain covered OPD drugs would be paid no more than 95% of AWP or less than the transition percentage of the AWP from CY2004 through CY2006. In subsequent years, payment would be equal to average price for the drug in the area and year established by the competitive acquisition program under 1847A. The covered OPD drugs affected by this provision are radiopharmaceuticals and outpatient drugs that were paid on a pass-through basis on or before December 31, 2002. These would not include

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Provisions	Current Law	S. 1	H.R. 1
	<p>drugs; current cancer therapy drugs, biologicals, and brachytherapy; current radiopharmaceutical drugs and biological products; and new drugs and biological agents. Generally, CMS has established that a pass-through payment for an eligible drug is based on the difference between 95% of its average wholesale price and the portion of the otherwise applicable APC payment rate attributable to the existing drug, subject to a budget neutrality provision.</p>	<p>source or orphan product would be paid at 94% of the AWP existing on May 1, 2003; a multiple source drug would be paid at 91% of that existing average wholesale price (AWP); and a drug with generic versions would be paid at 71% of that existing AWP. Those items furnished as part of other OPD services would be paid using the same applicable percentage of the AWP that would have been determined on May 1, 2003 if such payment were to have been made on that date. For 2006, these payment amounts would be increased by CPI-U. A private non-profit organization under contract would determine the hospital acquisition, pharmacy services, and handling costs for each of the drugs paid in this fashion to set payments in 2007 and beyond. This analysis would be accurate within 3% of the true mean hospital acquisition and handling costs at a 95% confidence level; begin by January 1, 2005; and be updated annually. Starting January 1, 2006, a report would be due to Congress each year.</p>	<p>drugs for which pass-through payments are first made beginning January 1, 2003 or those drugs for which a temporary HCPCS code has not been assigned. Drugs for which a temporary HCPCS code has not been assigned would be reimbursed at 95% of the AWP. The transition percentage to AWP for sole-source drugs manufactured by one entity is 83% in CY2004, 77% in CY2005, and 71% in CY2006. The transition percentage to AWP for innovator multiple source drugs is 81.5% in CY2004, 75% in CY2005, and 68% in CY2006. The transition percentage to AWP for multiple source drugs with generic drug competitors is 46% in CY2004 through CY2006. The additional expenditures resulting from these provisions would not be subject to the budget neutrality requirement. Starting in CY2004, the Secretary would be required to lower the threshold for establishing a separate APC group for higher costs drugs from \$150 to \$50 per administration. These separate drug APC groups would not be eligible for outlier payments. Starting in CY2004, Medicare's transitional pass-through payments for drugs and biologicals covered under a competitive acquisition contract would reflect the amount paid under that contract, not 95% of AWP.</p>

Provisions	Current Law	S. 1	H.R. 1
Establish demonstration project to pay for brachytherapy devices separately from HOPD-PPS in S. 1; establish separate payments for such devices in H.R. 1	In Medicare's HOPD-PPS, current drugs and biologicals that have been in transitional pass-through status on or prior to January 1, 2000, were removed from that payment status effective January 1, 2003. CMS established separate APC payments for certain of these drugs. Other drugs such as brachytherapy seeds (radioactive isotopes used in cancer treatments) were packaged into payments for brachytherapy procedures.	Section 450A. The Secretary would be required to conduct a budget neutral, 3-year demonstration project that would exclude brachytherapy devices from the HOPD-PPS and make payment on the basis of the hospital's charges for each device, adjusted to cost. The Secretary would be required to create separate, additional groups of covered HOPD services for brachytherapy devices to reflect the number, isotope, and radioactive intensity of such devices.	Section 621(b). From 2004 through 2006, payments for brachytherapy devices would equal the hospital's charges adjusted to cost. The Secretary would be required to create separate APCs to pay for these devices that reflect the number, isotope, and radioactive intensity of such devices. This would include separate groups for palladium-103 and iodine-125 devices. GAO would submit a report to Congress on the appropriateness of such payments no later than January 1, 2005.
Require hospital acquisition study	No provision.	No provision.	Section 621(d). The Secretary would study the hospital acquisition costs related to covered outpatient drugs that cost \$50 per administration and more that are reimbursed under the HOPD-PPS.
Ambulatory Surgery Center Services (ASCs)			
Reduce ambulatory surgery center (ACS) update	Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ACS. From FY1998 through FY2002, the update was established as the CPI-U minus 2.0 percentage points, but not less than zero. In 2003 and subsequent years, the update is CPI-U.	No provision.	Section 625. The reduction in the update would be reestablished for FY 2004 - FY 2008. ASCs would get an increase calculated as the CPI-U minus 2.0 percentage points (but not less than zero) in each of the fiscal years from 2004 through 2008.
Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) Services			
Increase payments for rural health clinics	BBA 1997 extended the per visit payment limits that had existed for independent rural health clinics to provider-based rural health clinics (RHC) except for those clinics based in small rural hospitals with fewer than 50 beds. For services rendered from January 1, 2003 through February 28, 2003, the RHC upper payment limit is \$66.46, which reflects a 2.6% increase in 2002 payment limit as established by the 2002 Medicare Economic Index (MEI). For services	Section 428. The RHC upper payment would be increased to \$80.00 for calendar year 2005. The MEI applicable to primary care services would be used to increase the payment limit in subsequent years.	No provision.

Provisions	Current Law	S. 1	H.R. 1
	rendered from March 1, 2003 through December 31, 2003, the Medicare RHC upper payment limit is \$66.72, which reflects a 3.0% increase in the 2002 payment limit as established by the 2003 MEI. The 2002 MEI was used as an update for 3 months because of the delayed implementation.		
Establish conforming changes regarding federally qualified health centers (FQHCs)	Medicare pays FQHCs for their services on a reasonable cost basis.	Section 420. Medicare would exclude the costs incurred by a FQHC for providing services and receiving payments through a contract with a eligible entity operating a Medicare prescription drug plan.	No provision.
Increase payments to FQHCs and RHCs providing Medicare managed care services	Services provided by FQHCs and RHCs to Medicare enrollees are reimbursed at no more than 80% of the reasonable costs of providing such services less any beneficiary cost sharing amounts collected.	Section 615. FQHCs and RHCs would receive a wrap-around payment for the reasonable costs of care provided to Medicare managed care patients served at such centers. The provision would raise reimbursements to FQHCs and RHCs, so that when they are combined with Medicare+Choice payments and cost-sharing payments from beneficiaries, to 100% of the reasonable costs of providing such services.	No provision.

Covered Part B Outpatient Drugs (Not Provided by a HOPD).

Provisions	Current Law	S. 1	H.R. 1
Pay for existing outpatient drugs provided incident to a physician's services	"Although Medicare does not currently have an outpatient prescription drug benefit, it covers approximately 450 outpatient drugs and biologicals authorized by statute, including those: (1) that are covered if they are usually not self-administered and are provided incident to a physician's services; (2) those that are necessary for the effective use of covered durable medical equipment; (3) certain self-administered oral cancer and anti-nausea drugs (those with injectable equivalents; (4) erythropoietin (used to treat anemia); (5) immunosuppressive drugs after	Section 432(a). In 2004, existing drugs (available by April 1, 2003) would be paid the lower of the widely available market price or 85% of the listed AWP as of April 1, 2003 as subsequently increased by the CPI for medical care as of June. The Secretary would be required to determine whether the widely available market price is different from the AWP amounts using any HHS-IG or GAO report issued in 2000 and later as well as other data from purchaser, supplier and manufacturers. If different, the widely available market price	Section 303(b). Physicians who opt out of the competitive acquisition program (which is described subsequently) would be paid under a new, separate 1847B payment method. Subject to the beneficiary cost-sharing, non-generic drugs would be paid 112% of the applicable price in 2005 and 2006 and 100% of the price subsequently. The multiple source drug applicable price would be the reported volume-weighted average of the average sales price; the applicable price for a single source drug would be the lesser of the <i>manufacturer's average</i>

Provisions	Current Law	S. 1	H.R. 1
	<p>covered Medicare organ transplants; (6) hemophilia clotting factors; and (7) vaccines for influenza, pneumonia, and hepatitis B. Payments are based on 95% of the average wholesale price (AWP) published in industry reference publications. AWP does not account for discounts routinely offered to providers and physicians. Current Medicare payment rates are 95% of AWP for brand name drugs produced by a single manufacturer (or single source drugs). Medicare will pay 95% of the lower of (a) the median AWP of all generic drugs or (b) the lowest brand-name product AWP for drugs with two or more competing brand names (or multiple source drugs) or those drugs with available generic equivalents. Although Medicare uses the Healthcare Common Procedure Coding System (HCPCS) codes to pay for physician administered drugs, the AWP's are established for national drug codes (NDC) which provides data on chemical molecule, drug manufacturer, dosage, dosage form and package size.</p>	<p>would be treated as the AWP amount in 2004 and subsequently. However, if that difference is more than 15%, payments would be reduced in 15% increments of Medicare's prior year payment. This transition would not apply to those with generic versions in the market beginning 2004. After January 1, 2004, payments for covered vaccines would be equal to the AWP.</p>	<p><i>sales price (ASP)</i> for the NDC code or the reported <i>wholesale acquisition cost (WAC)</i>. Payments would not account for special packaging, labeling or identifiers on the dosage form or product or package. By April 1, 2004, the <i>ASP</i> would be calculated by NDC each calendar quarter by dividing a manufacturer's total sales by the units sold in that quarter with certain adjustments to account for volume discounts and other rebates. Certain sales would be exempt from the calculation. The <i>WAC</i> would be the manufacturer's list price to wholesalers or direct purchasers for the most recent available month, not including discounts or other price reductions, as reported in wholesale price guides or other pricing publications. Payment rates would be updated on a quarterly basis. Certain contractors would determine the payment amounts. Certain standards would define multiple and single source drugs and establish pharmaceutical equivalence. There would be no administrative or judicial review of the ASP.</p>
<p>Pay for new outpatient drugs provided incident to a physician's services</p>	<p>See above.</p>	<p>Section 432(a) continued. New drugs (available after April 1, 2003) would be paid based on the manufacturer's estimated price data. During the first and second years, the manufacturer would provide data on the actual market prices paid by physicians or suppliers which would be equal to the lesser of the AWP or the original estimate. Subsequently, payments would be equal to the lesser of the AWP or the widely available market price established for existing drugs. If no market price exists, the prior year's payment is increased by June's CPI for medical care. Other payment changes for the administration of drugs would be contingent on the implementation of these provisions.</p>	<p>Section 303(b) continued. New drugs. The Secretary would be able to disregard the average sales price during the first quarter of a new drug's sales if the price data is not sufficient to determine an average amount payable.</p>

Provisions	Current Law	S. 1	H.R. 1
Establish competitive pricing program; establish alternative pricing method for physicians who elect not to participate in competitive bidding program	See above.	See above.	Section 303(b). Under new section 1847A, the Secretary would establish a competitive acquisition program to acquire and pay for covered outpatient drugs. Under this program, at least two contractors would be established in each competitive acquisition area (which would be defined as an appropriate geographic region) throughout the United States. Each year, a physician would be able to select a contractor who would deliver covered drugs and biologicals to the physician; as discussed above, a physician would be able to elect payment under the ASP payment methodology established by 1847B. Blood clotting factors, drugs and biologicals furnished as treatment for end-stage renal disease (ESRD), radiopharmaceuticals, and vaccines would not be considered covered drugs under the competitive acquisition program.
Establish contracting requirements for competitive acquisition program	No provision.	No provision.	Section 303(b). The 1847A program would have two drug categories: the oncology drugs which would be implemented by 2005 and the non-oncology drugs which would be implemented by 2006. Certain contractor selection and contracting requirements for the program would be established. Specifically, the Secretary would establish an annual selection process for a contractor in each area for each of the two categories of drugs. The Secretary may not award the 2-year contract to any entity that does not meet capacity, quality, service, financial performance, solvency standards, conduct standards or disclosure requirements (to reflect changes in reasonable, net acquisition costs) established by the Secretary. The Secretary would be able to limit the number of qualified entities in each category and area, but not below two. The Secretary

Provisions	Current Law	S. 1	H.R. 1
			<p>would be required to base selection on bid prices for covered drugs, bid prices for distribution of those drugs as well as other quality factors. As part of the awarded contract, the selected contractor would be required to disclose the reasonable, net acquisition costs regularly (but not more often than once a quarter) as specified by the Secretary. Contract offers could be rejected if the aggregate average bid price exceeds the ASP under the 1847B process. The amount of the bid price would be required to be the same for all portions of the area. The appropriate contractor, as selected by the physician, would supply covered drugs directly to the physician, except under the circumstances when a beneficiary is presently able to receive a drug at home or at other specified non-physician office settings where a beneficiary would be able to receive a covered drug directly. However, the contractor would not be able to deliver drugs to a physician without first receiving a prescription or other necessary, specified information. However, a prescription for each individual treatment would not be required from the physician. Adequate safeguards against fraud and abuse and consistent with safe drug practices, in order for a physician to maintain a supply of drugs that may be needed in emergency situations, would be established.</p>
<p>Pay separately for the administration of blood clotting factors</p>	<p>Medicare will pay for blood clotting factors for hemophilia patients who are competent to use such factors to control bleeding without medical supervision as well as the items related to the administration of such factors.</p>	<p>Section 432(b)(4). The Secretary would be required to review a GAO report and provide a separate payment for the administration of these factors. These payments in CY2004 would not exceed the amount that would have otherwise been expended. In CY2005 and subsequently, the separate payment amount would be updated by June's CPI for medical care.</p>	<p>Section 303(f). MedPAC would be required to submit to Congress specific recommendations with respect to payment for blood clotting factors and its administration in its 2004 annual report.</p>

Provisions	Current Law	S. 1	H.R. 1
Pay the physician a pharmacy dispensing fee	Medicare pays for certain outpatient prescription drugs and biologicals. For instance, Medicare pays a dispensing fee in conjunction with inhalation therapy drugs used in nebulizers. Medicare does not pay a dispensing fee to pharmacists or providers who supply oral drugs.	Section 432(b)(8). Medicare would pay a dispensing fee (less applicable cost-sharing amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. Medicare would be able to pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for other drugs and biologicals.	No provision.
Pay for discarded chemotherapy drugs	Medicare does not pay for chemotherapy drugs that are purchased by physicians, are not dispensed, and must be discarded.	Section 432(b)(9). The Secretary would be able to pay a physician for chemotherapy drugs that are purchased with a reasonable intent to administer to a Medicare beneficiary but which cannot be administered despite the physician's reasonable efforts and must be discarded. Payment amounts for all covered chemotherapy drugs could be increased, subject to a 1% cap. The beneficiary's cost-sharing amounts would not be affected.	No provision.
Cover intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home	Intravenous immune globulin (IVIG) is a blood product prepared from the pooled plasma of donors. It has been used to treat a variety of autoimmune diseases, including mucocutaneous blistering diseases. It has fewer side effects than steroids or immunosuppressive agents. Effective October 1, 2002, IVIG is covered for the treatment of certain conditions for certain subpopulations. IVIG for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short term therapy, but not as a maintenance therapy, for those who where conventional therapy has failed.	No provision.	Section 629. By January 1, 2004, IVIG for the treatment of primary immune deficiency diseases in the home would be included as a covered medical service, if a physician determines administration of the derivative in the patient's home is medically appropriate. This would not include items or services related to the administration of the derivative. Intravenous immune globulin would be paid at 80% of the lesser of actual charge or the payment amount.
Establish demonstration project to cover outpatient drugs	No provision.	No provision.	Section 631. The Secretary would conduct a 2-year demonstration project in three states covering more than 10,000 patients under Part

Provisions	Current Law	S. 1	H.R. 1
			B that would pay for drugs and biologicals that are prescribed as replacements for existing covered drugs that are furnished incident to a physician's professional service and which are not usually self-administered including oral anti-cancer chemotherapeutic agents. The project would not extend beyond December 31, 2005 and would not cost more than \$100 million.
Require GAO report on impact of drug provisions on beneficiary access to covered drugs	No provision.	Section 432(e). GAO would examine the impact of the drug provisions on the access of Medicare beneficiaries' to covered drugs and biologicals which would be due to Congress no later than January 1, 2006.	Section 303(e). Same provision except report would be due 2 years after the implementation of the competitive acquisition program (January 1, 2007).
Require HHS-IG reports on market prices for drugs	No provision.	Section 432(e). The HHS IG would be required to conduct one or more studies that compare the market prices to Medicare payments for drugs that represent the largest portion of Medicare spending on such items.	No provision.
Require study on non-oncology codes	No provision.	No provision.	Section 303(h). The Secretary would be required to submit a study to Congress within 1 year of enactment that examines the appropriateness of establishing and implementing separate codes for non-oncology infusions that address the level of complexity and resource consumption. If deemed appropriate, the Secretary would be able to implement appropriate changes in the payment methodology.
Self-Injected Drugs and Biologicals			
Pay for selected self-injected drugs and biologicals	Coverage of certain outpatient drugs and biologicals is authorized by statute. Under Medicare Part B, these items are covered if they are usually not self-administered and are provided	Section 450E. In 2004 and 2005, Medicare would cover FDA approved self-injected biologicals that are prescribed as complete replacements for currently covered drugs in	No provision.

Provisions	Current Law	S. 1	H.R. 1
	incident to a physician's services. Generally, Medicare will cover an outpatient drug as usually self-administered if it is delivered by intramuscular injection, but not if it is injected subcutaneously.	physicians' offices or as usually self-administered outpatient hospital services and other self-injected drugs that are used to treat multiple sclerosis.	

Covered Drugs and Services at a Dialysis Facility.

Provisions	Current Law	S. 1	H.R. 1
Establish the composite rate and payments for covered drugs and services in a dialysis facility	Dialysis facilities providing care to end stage renal disease (ESRD) beneficiaries receive a fixed prospectively determined payment amount (the composite rate) for each dialysis treatment, regardless of whether services are provided at the facility or in the patient's home. Medicare pays separately for erythropoietin (EPO) which is used to treat anemia for persons with chronic renal failure who are on dialysis. Congress has set Medicare's payment for EPO at \$10 per 1,000 units whether it is administered intravenously or subcutaneously in dialysis facilities or in patients' homes. Providers receive 95% of the AWP for separately billable injectable medications other than EPO administered during treatments at the facility.	Section 432(b)(5). In 2004 the composite rate would be increased so that the sum of these payments plus the payments for non-EPO drugs and biologicals billed separately equal payments that would have been made without enactment of the drug pricing provisions in this legislation. During 2005, the ESRD rate would be increased by 0.05% and further increased by 1.6%. During 2006, the rate would be increased by 0.05% and then further increased by 1.6%. During 2007 and subsequently, the ESRD rate of the previous year would be increased by 0.05%. In any year after 2004, the Secretary would be required to provide for additional increases in the composite rate to account for any payment reductions for separately administered drugs (but not EPO) in the same manner as in 2004. These payment amounts, methods or adjustments would not be subject to administrative or judicial review.	Section 623(c). The ESRD composite payment rate would increase by 1.6% for 2004.
Restore composite rate exception for pediatric facilities	Prior to BIPA, an increase in the composite rate would trigger an opportunity for ESRD facilities to request a rate exception in order to receive higher payments. BIPA required the Secretary to develop an new ESRD payment system and prohibited the granting of new exceptions with respect to applications received after July 1, 2001.	No provision	Section 623(b). The prohibition on exceptions would not apply to pediatric ESRD facilities as of October 1, 2002. Pediatric facilities would be defined as a renal facility with 50% of its patients under 18 years old.

Provisions	Current Law	S. 1	H.R. 1
Change requirements for existing end-stage renal disease demonstration project	The Secretary announced a demonstration project establishing a disease-management program that will allow organizations experienced with treating ESRD patients to develop financing and delivery approaches to better meet the needs of beneficiaries with ESRD.	No provision.	Section 623(a). The provision would require the Secretary to establish an advisory board for the ESRD disease management demonstration.

Durable Medical Equipment (DME) and Related Outpatient Drugs.

Provisions	Current Law	S. 1	H.R. 1
Pay for home infusion drugs	Medicare will cover outpatient prescription drugs and biologicals if they are necessary for the effective use of covered durable medical equipment (DME), including those drugs which must be put directly into the equipment such as tumor chemotherapy agents used with infusion pump (home infusion drugs).	Section 432(b)(6). The Secretary would be able to make separate payments for infusion drugs and biologicals furnished through covered DME beginning January 1, 2004 if such payments are determined to be appropriate. Total amount of payments for the infusion drugs in the year could not exceed the total amount of spending that would have occurred without enactment of this legislation.	Section 302. Infusion drugs would be covered under the competitive bidding project.
Pay for inhalation therapy	Medicare will cover outpatient prescription drugs and biologicals if they are necessary for the effective use of covered durable medical equipment (DME), including those drugs which must be put directly into the equipment such as respiratory drugs given through a nebulizer (inhalation drugs).	Section 432(b)(7). The Secretary would be able to increase payments for covered DME associated with inhalation drugs and biologicals and make separate payments, if appropriate, for those furnished through covered DME beginning January 1, 2004. The associated spending in any year would not exceed the 10% of the difference of the savings for these drugs attributed to this legislation.	Section 302. The competitive acquisition program would include drugs and supplies used in conjunction with DME, including inhalation therapy. Section 302. The competitive acquisition program would include drugs and supplies used in conjunction with DME, including inhalation therapy. Section 602(c). GAO would be required to conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program and submit the results of the study in a report to Congress no later than May 1, 2004.
Freeze DME and prosthetics and orthotics (PO) fee schedule payments under S. 1;	Medicare pays for DME and PO, using different fee schedules for each class of covered item that are subject to different floors and ceilings, calculated either on a state, regional, or national	Section 430. Medicare would not increase the DME fee schedule amounts in any of the years from 2004 through 2010 and would update the amounts by the CPI-U in each subsequent year.	Section 302. Competitive acquisition programs for durable medical equipment, medical supplies, items used in infusion, drugs and supplies used in conjunction with durable

Provisions	Current Law	S. 1	H.R. 1
Establish competitive bidding program under H.R. 1	basis. BBA 1997 amended Medicare law to freeze DME fee schedule allowances for 5 years, beginning in 1998. PO were subject to a 1% increase for 5 years, beginning in 1998. BBA 97 also required the Secretary to undertake a competitive bidding demonstration for DME which occurred at two sites: Polk County, Florida and San Antonio, Texas. Class III medical devices are devices that sustain or support life, are implanted, or present potential unreasonable risk (e.g., implantable infusion pumps and heart valve replacements) and are subject to premarket approval, the most stringent regulatory control.	Payments for orthotic devices that have not been custom-fabricated would be similarly affected. Class III medical devices would be exempt from the freeze in DME payments. Prosthetics, prosthetic devices, and custom-fabricated orthotics would be updated by the percentage change in the CPI-U.	medical equipment, medical supplies, home dialysis supplies, blood products, parental nutrition, and off-the-shelf orthotics (requiring minimal self-adjustment for appropriate use) would replace the fee schedule payments. Enteral nutrients and class III devices would not be covered by the program. Rural areas and areas with low population density within urban areas would be able to be exempt, unless a significant national market exists through mail order for a particular item or service. The programs would be phased-in over 3 years with at least one-third of the areas implemented in 2005 and two-thirds of the areas implemented in 2006. High-cost items and services would be required to be phased-in first. Certain requirements for the competitive acquisition program would be established. A Program Advisory and Oversight Committee would be established. The Secretary would be able to use this payment information to adjust the payment amounts for DME not in a competitive acquisition area. In this instance, the inherent reasonableness rule would not be applied.
Establish accreditation standards and process for DME suppliers	Medicare law requires DME suppliers to meet certain requirements in order to participate in the program. Medicare law does not authorize the Secretary to deem accreditation by an independent entity as a substitute for onsite inspection by CMS.	Section 430(c). DME companies and suppliers would be subject to an accreditation and quality assurance process. The Secretary would be required to designate independent accreditation organizations no later than 6 months from enactment after consultation with an expert outside advisory panel. The application of quality standards would be phased in over a 3-year period.	Section 302. The competitive bidding project would establish certain quality standards for DME products no later than July 1, 2004.
Cover total body orthotic management services for certain nursing home residents	Orthotics are rigid devices, or braces, which are applied to the outside of the body to support or restrict movement in a body part. Orthotics are covered Part B benefits when furnished in an	Section 450B. Medicare would pay for qualified total body orthotic management devices provided by qualified practitioners and suppliers no later than 60 days from enactment. These	No provision.

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Provisions	Current Law	S. 1	H.R. 1
	<p>institutional setting, such as in a hospital or skilled nursing facility, while durable medical equipment (DME) is not covered in those settings, because Medicare law requires that covered DME be appropriate for use in home.</p>	<p>medically prescribed devices would consist of custom fitted individual braces that are attached to a frame that is integral to the device for a full-time patient of a skilled nursing facility who requires such medical care.</p>	
<p>Pay for certain custom shoes for diabetic patients</p>	<p>Subject to specified limits and under certain circumstances, Medicare will pay for extra-depth shoes with inserts or custom molded shoes with inserts for an individual with severe diabetic foot disease. Diabetic shoes are neither considered DME nor orthotics, but a separate category of coverage under Medicare Part B.</p>	<p>No provision.</p>	<p>Section 626. As of January 1, 2004, diabetic shoes would be paid as is if they were considered to be a prosthetic or orthotic device. The Secretary or a carrier would be able to establish lower payment limits than these amounts if shoes and inserts of an appropriate quality are readily available at lower amounts. The Secretary would be required to establish a payment amount for an individual substituting modifications to the covered shoe that would assure that there is no net increase in Medicare expenditures.</p>

Ambulance Services.

Provisions	Current Law	S. 1	H.R. 1
Increase ambulance fee schedule	Traditionally, Medicare has paid suppliers of ambulance services on a reasonable charge basis and paid provider-based ambulances on a reasonable cost basis. BBA 1997 provided for a national fee schedule which was to be implemented in phases. The required fee schedule became effective April 1, 2002 with full implementation by January, 2006. In the transition period, a gradually decreasing portion of the payment is to be based on the prior payment methodology.	Section 425. Payments for ground ambulance services originating in a rural area or a rural census tract would be increased by 5% for services furnished January 1, 2005 through December 31, 2007. The fee schedule for other areas would be increased by 2%. These increased payments would not affect subsequent periods. The ambulance conversion factor would not be adjusted downward because of the evaluation of the prior year's conversion factor.	Section 410. The base rate for ground ambulance services that originate in a qualified rural area would be increased after January 1, 2004 by the average costs per trip for the base rate in the lowest quartile as compared to the average cost for the base rate in the highest quartile of all rural counties. A qualified rural county is a rural area (a county not assigned to a metropolitan statistical area) with a population density of Medicare beneficiaries in the lowest quartile of all rural counties.
Change ambulance fee schedule	In the transition period from 2002-2006, payment is based on a blend with a gradually increasing portion of the payment based on the fee schedule and a decreasing portion on the former payment method (of either reasonable costs for ambulance providers or reasonable charges for ambulance suppliers.) In 2003, the blend is 40% of the fee schedule and 60% of the cost or charge rates.	No provision.	Section 622. Payments would be incorporate a regional fee schedule, if that would result in a larger payment to the ambulance provider or supplier. The blended rate from 2004 through 2010 would incorporate a decreasing portion of the regional fee schedules calculated for each of nine census regions. Full phase-in to the existing fee schedule would occur by 2010. Medicare's payments for ground ambulance services would be increased by one quarter of the amount otherwise established for trips longer than 50 miles occurring beginning January 1, 2004 and before January 1 2009. A GAO report would be required.
Increase coverage for air ambulance services	Medicare pays for ambulance services under a fee schedule. Seven categories of ground ambulance services, ranging from basic life support to specialty care transport, and two categories of air ambulance services are established. Payment for ambulance services can only be made if other methods of transportation are contraindicated by the patient's medical conditions, but only to the extent provided in regulations.	Section 426. For services furnished beginning January 1, 2005, the regulations governing ambulance services would be required to ensure that air ambulance services be covered if: (1) the air ambulance service is medically necessary based on the health condition of the patient being transported at or immediately prior to the time of the transport service; and (2) the air ambulance service complies with the equipment and crew requirements established by the Secretary. These services would be a fixed wing or rotary wing air ambulance services.	No provision.

Other Part B Services and Provisions.

Provisions	Current Law	S. 1	H.R. 1
Establish 1-year moratorium on therapy caps	BBA 97 established annual payment limits per beneficiary for all outpatient therapy services provided by non-hospital providers. The therapy caps are not yet being enforced. BIPA postponed implementation until January 1, 2003; the Secretary delayed enforcement until July 1, 2003 and, again more recently, until September 1, 2003.	No provision.	Section 624. Application of the therapy caps would be suspended in 2004. Provisions with respect to existing report requirements are included.
Cover routine costs associated with clinical trials	Currently, Medicare covers the routine costs of qualifying clinical trials without explicit statutory instruction. However, Medicare does not pay for certain aspects of the clinical trial including: the investigational item or service, items and services not used in the direct clinical management of the patient, and items and services customarily provided by the research sponsor free of charge for any enrollee in the trial.	Section 438. After January 1, 2005, the routine costs of care for Medicare beneficiaries participating in clinical trials would be covered by statute. The Secretary would not be required to modify the existing regulations. Total Medicare expenditures associated with this provision would not exceed specified limits that start at \$32 million in 2005 and increase gradually to \$50 million in 2013.	Section 733. The routine costs of care for Medicare beneficiaries participating in clinical trials that are conducted in accordance with an investigational device exemption approved under Section 530(g) of the Federal Food, Drug, and Cosmetic Act would be covered. Any clinical trial established on the date of enactment or after would be covered. Services provided on or after enactment would be covered.
Cover certain vision rehabilitation services	Medicare does not cover routine eye care or related services and will not pay for eyeglasses; most contact lenses; eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses; and most procedures performed to determine the refractive state of the eyes. A CMS program memorandum issued May 29, 2002, clarified that Medicare beneficiaries who are blind or visually impaired are eligible for physician-prescribed rehabilitation services from approved health care professionals on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning.	Section 446. Medicare Part B would cover vision rehabilitation services furnished to a beneficiary who is diagnosed with certain vision impairments. Covered services would be established by a plan of care developed by a qualified physician or qualified occupational therapist whose plan of care is periodically reviewed by a qualified physician. Medicare would pay for the services under the physician fee schedule.	No provision.

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Provisions	Current Law	S. 1	H.R. 1
Cover marriage counseling and family therapy	Medicare will cover services connected with the treatment of a mental, psychoneurotic, or personality disorder of an individual who is not an inpatient of a hospital at the time such expenses are incurred. The term "treatment" does not include brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by the physician. Family counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient's condition.	Section 448. Starting January 1, 2004, Medicare would cover marriage and family therapist services and mental health counselor services for the diagnosis and treatment of mental illness. Payment amounts would be 80% of the lesser of the actual charge or 75% of the amount paid to a psychologist. These services would be subject to assignment. Rural health clinics, federally qualified health centers, and hospice programs would be authorized to provide such services. Marriage and family therapists would be authorized to develop post hospital discharge plans for patients.	No provision.
Cover all Part B services provided by Indian hospitals and clinics	Medicare will cover specific Part B services provided by a hospital, skilled nursing facility, or ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization.	Section 450C. All Medicare Part B items and services provided by hospitals, skilled nursing facilities, or ambulatory care clinics operated by the Indian Health Service or by an Indian tribe or organization beginning October 1, 2004 would be reimbursed.	No provision.
Cover cardiovascular screening tests	Medicare covers a number of preventive services. However, it does not cover cardiovascular screening tests.	Section 450D. Beginning January 1, 2005, Medicare would cover cardiovascular diagnostic testing including tests for cholesterol levels, lipid levels of the blood, and other tests identified after consultation with appropriate organizations to establish the frequency and type of these screening tests which could occur no more often than once every 2 years.	Section 612. Medicare coverage of cholesterol and blood lipid screening would be authorized. The Secretary would be required to establish standards regarding the frequency and type of these screening tests, but not more often than once every 2 years.
Cover initial preventative physical examination	Medicare covers a number of preventive services. However, it does not cover routine physical examinations.	No provision.	Section 611. Medicare coverage of an initial preventative physical examination would be authorized and paid for using the physician fee schedule. No beneficiary cost-sharing would be imposed.

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Provisions	Current Law	S. 1	H.R. 1
Cover diabetes laboratory diagnostic tests	On July 1, 1998, Medicare began covering diabetes self-management training services. These educational and training services are provided on an outpatient basis by physicians or other certified providers who have experience in diabetes self-management training services.	No provision.	Section 630. Starting 90 days from enactment, diabetes screening tests and services would be included as a covered medical service for individuals at high-risk for developing diabetes.
Cover kidney disease education services	No provision.	Section 456. Kidney disease education services would be covered under Medicare. Starting January 1, 2004, these services would be paid using the physician fee schedule on an assignment-related basis (and thus prohibiting balance billing) outside the ESRD composite rate. The Secretary would be required to report to Congress by April 1, 2004.	No provision.
Increase providers eligible for payments for telehealth services	Medicare pays for telehealth services that are provided in specified “originating sites.” These originating sites are: physician or practitioner office, a critical access hospital, a rural health clinic, a Federally-qualified health center, or a hospital.	Section 450H. Other types of providers would be added to the list of originating sites that can bill Medicare for telehealth services. In addition, the Secretary would be required to encourage and facilitate the adoption of state provisions allowing for multi-state practitioner licensure across state boundaries.	No provision.
Prohibit private insurers from requiring prior Medicare processing of dental claims	The Medicare benefit does not include most dental services. Some insurers may require a claim denial from Medicare before accepting the dental claim for payment review, even if the service is not covered by Medicare.	Section 555. A group health plan providing supplemental or secondary coverage to Medicare beneficiaries would not be able to require dentists to obtain a claim denial from Medicare for non-covered dental services before paying the claim.	Section 950. Same provision.

Provisions Relating to Parts A and B

Home Health Services.

Provisions	Current Law	S. 1	H.R. 1
Increase for home health services furnished in a rural area	BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2-year period beginning April 1, 2001, through March 31, 2003. The temporary additional payment was not included in the base for determination of payment updates.	Section 451. A 5% increase in payments for home health care services furnished in a rural area would be provided during FY 2005 and FY2006 without regard to certain budget neutrality requirements. The temporary additional payment would not be considered when determining future home health payment amounts.	Section 411. A 5% additional payment for home health care services furnished in a rural area would be provided during 2004 and 2005 without regard to certain budget neutrality requirements.
Increase for home health services furnished in a rural area	BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2-year period beginning April 1, 2001, through March 31, 2003. Home health PPS is required to make payments for extraordinarily costly cases. The total amount of the outlier payment may not exceed 5% of the total payment estimated to be made for the fiscal year.	Section 459. A 10% additional payment for home health care services furnished in a rural area during FY2005 and FY2006 would be provided without regard to certain budget neutrality requirements. The total amount of outlier payments would be reduced to no more than 3% of total payments in FY 2004 and 4% for FYs 2005 and 2006. [Duplicate provision is at Section 451].	No provision.
Limit reduction in area wage adjustment factors under home health PPS	In calculating PPS payment, the portion of the base payment amount that is attributable to wages and wage-related costs is required to be adjusted for those costs. The Secretary is required to calculate an area wage adjustment factor that is actually used to adjust the base payment amount. The factors change annually as new wage data are reported and areas change in relative costliness.	Section 452. The provision would limit any reduction in the home health area wage adjustment factor for fiscal years 2005 and 2006. Any reduction could be no more than 3% less than the area wage adjustment factor applicable to home health services for the area in the previous year.	No provision.

Provisions	Current Law	S. 1	H.R. 1
Reduce update for home health services	Home health service payments are increased on a federal fiscal year basis that begins in October. The FY2004 statutory update will be the full increase in the market basket (MB) index.	No provision.	Section 701. Home health agency payments would be increased by the home health MB minus 0.4 percentage points for 2004 through 2006. The update for subsequent years would be the full MB increase. The provision would also change the time frame for the update from the federal fiscal year to a calendar year basis. The home health prospective payment rates would not increase for the October 1 through December 31, 2003 period.
Establish demonstration project to clarify definition of homebound	A Medicare beneficiary must be confined to the home (or homebound) in addition to other criteria in order to qualify for the home health benefit.	Section 450. A 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare would be established.	Section 704. Substantially similar provision, however, would also require beneficiaries to permanently need skilled nursing services (other than medication management) and the skilled nursing services would need to be provided on a daily basis or an attendant would be needed during the day to monitor and treat the beneficiary's medical condition.
Establish adult day care demonstration project	No provision.	Section 454. A demonstration would be established where a home health agency, directly or under arrangement with a medical adult day care facility, would provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home.	Section 732. Same provision.
Require MedPAC study on home health agency (HHA) margins	No provision.	No provision.	Section 703. MedPAC would study payment margins of HHAs paid under PPS to examine whether systematic differences in payment margins were related to differences in case mix, as measured by home health resource groups (HHRGs).

Provisions	Current Law	S. 1	H.R. 1
Require GAO report on flexibility in applying home health conditions of participation (COP) to patients who are not Medicare beneficiaries	No provision.	No provision.	Section 953(d). GAO would report to Congress on the implications if Medicare's COPs for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries, include an analysis of the potential impact of this flexibility on clinical operations and the recipients of such services and analyze methods for monitoring the quality of care provided to these recipients. The report would be due no later than 6 months after enactment.
Establish beneficiary cost-sharing for home health services	The home health benefit does not have any cost-sharing requirement.	No provision.	Section 702. A beneficiary copayment for each 60-day episode of care beginning January 1, 2004 would be established. The copayment amount would be 1.5% of the national average payment per episode in a calendar year, rounded to the nearest multiple of \$5. For 2004, the copayment would be \$40 unless otherwise calculated on a timely basis by the Secretary. Medicare payments would be reduced to reflect copayments. Qualified Medicare beneficiaries, beneficiaries dually eligible for Medicare and Medicaid, and beneficiaries receiving four or fewer home health visits in an episode of care would not face any cost-sharing requirements. Administrative and judicial review of the calculated copayment amounts would be prohibited.
Suspend OASIS requirement for non-Medicare, non-Medicaid patients	Medicare is required to monitor the quality of home health care and services for all patients as part of the survey process with a standardized, reproducible assessment instrument. OASIS is the instrument that is used.	Section 630. The requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients would be suspended until the Secretary reported to Congress on the benefits of these data.	Section 954. Same provision.

Chronic Care Improvement.

Provisions	Current Law	S. 1	H.R. 1
Cover chronic care improvement services under traditional fee-for-service	No provision.	Section 443. The Secretary would be required to establish a 5-year budget neutral demonstration program that uses qualified care management organizations to provide health risk assessment and care management services to high-risk Medicare beneficiaries including those with multiple sclerosis or other disabling chronic conditions, nursing home residents or those at risk for placement, or high-risk dual eligible beneficiaries.	Section 721. Specified chronic care improvement services would be provided to certain beneficiaries with chronic conditions as a Medicare benefit, not as a demonstration project.
Cover chronic care improvement services under Medicare Advantage and Enhanced fee-for-service	No provision.	Section 442. The Secretary would be required to establish a 3-year budget neutral demonstration program to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes before October 1, 2004. Six sites would be designated for the demonstration, three in urban areas and at least one in a rural area. One site would be required to be located in Arkansas. The Secretary would pay each principal care physician a monthly complex care management fee developed by the Secretary. The fee would be the full payment for all the functions performed.	Section 722. Comparable chronic care improvement services would be provided to beneficiaries in Medicare Advantage and Enhanced FFS as a Medicare benefit, not as a demonstration project.

Provisions	Current Law	S. 1	H.R. 1
Establish consumer-directed chronic outpatient services.	No provision. Medicare coverage requires that a beneficiary need medically necessary care. In general, Medicare pays the provider that delivers skilled health care services.	No provision.	Section 736. The Secretary would establish no fewer than three demonstration projects to evaluate method to improve the care and reduce the cost of care provided to Medicare beneficiaries with chronic conditions including methods that would permit beneficiaries to direct their own health care needs and services. The Secretary would establish the demonstrations located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate within 2 years of enactment. The Secretary would evaluate and submit reports to Congress on the cost and clinical effectiveness of the projects biannually beginning 2 years after their start.
Require Institute of Medicine (IOM) report related to chronic conditions	No provision.	No provision.	Section 723. The Secretary would contract with the IOM to study the barriers to effective integrated care improvement for Medicare beneficiaries with multiple or severe chronic conditions across settings and over time. The study would examine the statutory and regulatory barriers to coordinating care across settings for Medicare beneficiaries in transition from one setting to another.
Require MedPAC report related to chronic care improvement program	No provision.	No provision.	Section 724. MedPAC would evaluate the chronic care improvement program established in Section 721. The evaluation would include a description of the status of the implementation of the program, the quality of health care services provided to individuals participating in the program, and the cost savings attributed to the implementation of the program.

Medicare Secondary Payor (MSP).

Provisions	Current Law	S. 1	H.R. 1
Modify MSP provisions	In certain instances, Medicare is prohibited from making payment for a health care claim if payment is expected to be made promptly by a primary plan. The definition of a primary plan includes a workmen's compensation law or plan, under automobile or liability insurance (including a self-insured plan) or under no-fault insurance on behalf of a beneficiary.	Section 461. The provision would clarify that the Secretary could make a conditional payment if a primary plan did not make a prompt payment or could not have reasonably been expected to make a prompt payment (as determined by regulations). Payment would be contingent on reimbursement by the primary plan to the Medicare Trust Funds. An entity engaging in a business, trade, or profession would be deemed as having a self-insured plan if it carried its own risk. Failure to obtain insurance would be considered evidence of carrying risk.	Section 301. Same provision.
Extend MSP rules for individuals with end-stage renal disease (ESRD)	The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and, for 30 months, employer health plans for the ESRD population.	Section 450F. This provision would extend the limited time period that employer health plans are primary payer for beneficiaries with end-stage renal disease to 36 months.	No provision.
Revise Medicare secondary payor requirements for diagnostic laboratory services	In certain instances when a beneficiary has other insurance coverage, Medicare becomes the secondary insurance. An entity furnishing a Part B service is required to obtain information from the beneficiary on whether other insurance coverage is available.	No provision.	Section 943. The Secretary would not be able to require that a hospital obtain information on other insurance coverage for reference laboratory services, if the Secretary does not impose such requirements in the case of services furnished by independent laboratories.

Other Medicare A and B Provisions.

Provisions	Current Law	S. 1	H.R. 1
Establish self-referral exemption for certain arrangements in underserved areas	People who knowingly and willfully offer or pay a kickback, a bribe, or rebate to directly or indirectly induce referrals or the provision of services under a federal program may be subject to financial penalties and imprisonment. Certain exceptions or safe harbors that are not considered violations of the anti-kickback statute have been established.	No provision.	Section 412. Remuneration between a public or non-profit private health center and an entity providing goods or services to the health center would not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved

Provisions	Current Law	S. 1	H.R. 1
			population. The Secretary would be required to establish standards, on an expedited basis, related to this safe harbor.
Change self-referral provision as applied to specialty hospitals	Physicians are generally prohibited from referring Medicare patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Certain rural providers that provide substantially all of the designated health services to individuals residing in the rural area are also exempt from the self-referral restriction.	Section 453. The exception for physician investment and self-referral would not extend to specialty hospitals. In this instance, a specialty hospital would be one that is primarily or exclusively engaged in the cardiac, orthopedic, surgical care, or other specialized categories of patients or cases deemed appropriate. A specialty hospital would not include any hospital that is determined by the Secretary to be in operation before June 12, 2003, under development as of such date, with the same number of beds and physician investors as of such date. The Secretary would consider certain factors in determining whether a hospital is under development. The rural provider exception would be modified. These rural providers would not include specialty hospitals and the Secretary would determine, with respect to the entity, that such services would not be available in such area but for the ownership or investment interest.	Section 505. MedPAC would be required to conduct a study of specialty hospitals compared with other similar general acute hospitals and report to Congress, including recommendations, no later than 1 year from enactment.
Change in national coverage determination process to respond to changes in technology	No provision.	Section 458. The provision would establish the following time frame for national coverage determinations — 6 months when a technology assessment is not required and 9 months when a technology assessment is required and in which a clinical trial is not requested. After the 6- or 9-month period, the draft proposed decision would be available on the HHS website or by other means to provide a 30-day public comment period. The final decision on the request must be made 60 days following the end of the public comment period.	Section 733. Similar provision. The routine costs of care for Medicare beneficiaries participating in clinical trials that are conducted in accordance with an investigational device exemption approved under Section 530(g) of the Federal Food, Drug, and Cosmetic Act would be covered. Also, the Secretary would be required to implement revised procedures for the issuance of temporary national HCPCS codes by January 1, 2004.

Provisions	Current Law	S. 1	H.R. 1
Publish annual list of national coverage determinations	No provision.	No provision.	Section 953(b). The Secretary would publish an annual list of national coverage determinations made under Medicare in the previous year. Information on how to get more information about the determinations would be included. The list would be published in an appropriate annual publication that is publically available.
Establish pancreatic islet cell transplant demonstration project	No explicit statutory authorization. Under existing authorities, Medicare covers the routine costs of qualifying clinical trials which includes items or services typically provided absent a clinical trial and items or services needed for the diagnosis or treatment of complications. Routine costs include items and services that are typically provided absent a clinical trial (such as conventional care) and needed for reasonable and necessary care (such as diagnosis or treatment of complications) that arises from the provision of an investigational item or service. Medicare does not pay for certain aspects of the clinical trial including: the investigational item or service, items and services not used in the direct clinical management of the patient, and items and services customarily provided by the research sponsor free of charge for any enrollee in the trial.	Section 462. The Secretary would be required to establish a 5-year demonstration project to pay for pancreatic islet cell transplantation and related items and services for Medicare beneficiaries who have type 1 diabetes and end-stage renal disease.	Section 735. Medicare would be required to pay the routine costs for items and services that beneficiaries receive as part of a clinical investigation of pancreatic islet cell transplants conducted by the National Institute of Health. The transplant would not be covered.
Establish funding for consumer ombudsman	The Omnibus Budget Reconciliation Act of 1990 established State Health Insurance Counseling Assistance grants to states to provide education and information to Medicare beneficiaries. Funding has been subject to annual appropriations.	Section 606. A Consumer Ombudsman Account would be established in the Medicare Trust Fund and \$1 for every Medicare beneficiary would be appropriated to the account from the Trust Fund beginning with fiscal year 2005. The account would be used to make grants to State Health Insurance Counseling Programs.	No provision.

Provisions	Current Law	S. 1	H.R. 1
<p>Increase funding for the Health Care Fraud and Abuse Control (HCFAC) Program and the Office of the Inspector General (OIG) in Health and Human Services</p>	<p>The Health Insurance Portability and Accountability Act of 1996 (HIPAA, PL.104-91) established the HCFAC Program which is administered by the HHS-OIG and the Department of Justice. Funds for the HCFAC program are appropriated from the Federal Hospital Insurance Trust Fund. HIPAA provided for annual increases of 15% in HCFAC funding through 2003, after which the appropriation for HCFAC and the amount earmarked for HHS-OIG remains the same. In FY2003 the available appropriation for HCFAC was \$240,558,320 of which \$150 million to \$160 million was available to the HHS-OIG.</p>	<p>Section 611. Additional appropriations to HCFAC would be authorized. In FY2004, the increase would be \$10 million over the FY2003 appropriation limit; in FY2005 the increase would be \$15 million over the FY2003 limit; in FY2006 the increase would be \$25 million above the FY2003 limit. Subsequent years' appropriations would be at the 2003 limit. The HHS-OIG earmarked appropriations would increase as well: to \$170 million in FY2004, \$175 million in FY2005, \$185 million in FY2006. In subsequent years, it would be not less than \$150 million and not more than \$160 million.</p>	<p>No provision.</p>
<p>Increase the civil monetary penalties in the False Claims Act</p>	<p>The False Claims Act imposes a liability on those who knowingly present or cause to be presented a false or fraudulent claim for payment by the government. In certain instances, the person may be liable for a civil penalty of not less than \$5,000 and not more than \$10,000, plus treble damages.</p>	<p>Section 612. For violations occurring beginning January 1, 2004, the minimum amount of the civil penalty would be increased from \$5,000 to \$7,500 and the maximum amount would increase from \$10,000 to \$15,000.</p>	<p>No provision.</p>
<p>Increase the civil monetary penalties (CMP) in the Social Security Act</p>	<p>OIG has the authority to impose CMPs on any person (including an organization or other entity, but not a beneficiary) who knowingly presents, or causes to be presented, to a state or federal government employee or agent, certain false or improper claims for medical or other items or services. CMPs may also be imposed for other fraudulent activities such as inflating charges or soliciting remuneration to influence the provision of services. Depending upon the violation, Section 1128A of the SSA authorizes CMPs up to \$10,000 for each item or service, up to \$15,000 for individuals who provide false or misleading information in certain instances, and up to \$50,000 per act in other instances as well as treble damages.</p>	<p>Section 613. The amount of penalties would be increased for violations that occur beginning January 1, 2004. Penalties that are limited to \$10,000 would be increased to \$12,500; those penalties that are limited to \$15,000 would be increased to \$18,750; and those that are limited to \$50,000 would be increased to \$62,500.</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
Require MedPAC to examine financial consequences associated with its recommendations and impose other reporting requirements	The Medicare Payment Advisory Commission is a 17-member body that reports and makes recommendations to Congress regarding Medicare payment policies. The Comptroller General is required to establish a public disclosure system for Commissioners to disclose financial and other potential conflicts of interest.	No provision.	Section 731. MedPAC would be required to examine the budgetary consequences of a recommendation and review the factors affecting the efficient provision of expenditures for services in different health care sectors. Two additional MedPAC reports would be submitted no later than June 1, 2004: the first would study the solvency and financial circumstances of hospitals and other Medicare providers, including uncompensated care accounted for by the treatment of illegal aliens; the second would address investments, capital financing and access to capital of hospitals participating under Medicare. Members of the Commission would be treated as employees of Congress for purposes of financial disclosure requirements.
Change Emergency Medical Treatment and Active Labor Act (EMTALA) requirements	Medicare participating hospitals that operate an emergency room (ER) are required to provide necessary screening and stabilization services to any patient who comes to an ER requesting examination or treatment for a medical condition, in order to determine whether an emergency medical situation exists. Hospitals found in violation of EMTALA may face civil money penalties and termination of their provider agreement.	No provision.	Section 944. For EMTALA-required services provided to a Medicare beneficiary, determinations about medical necessity would be required to be made on the basis of the information available to the treating physician or practitioner at the time the item or service was ordered or furnished and not on the patient's principal diagnosis. The Secretary would establish a procedure to notify hospitals and physicians when an EMTALA investigation is closed. Except where a delay would jeopardize the health and safety of individuals, the Secretary would be required to request a peer review organization (PRO) review before making a determination to terminate a hospital's Medicare participation because of an EMTALA violation. Other requirements would apply.

Provisions	Current Law	S. 1	H.R. 1
Establish an EMTALA technical advisory group	No explicit statutory instruction.	No provision.	Section 945. The Secretary would be required to establish a technical advisory group comprised of the CMS Administrator, the Inspector General of HHS, hospital, physician and patient representatives, CMS staff investigating EMTALA cases and a state survey office representative to review issues related to EMTALA.
Permit the Secretary to waive a program exclusion	The Secretary has the authority to waive exclusion from participation in any Federal health program when the provider is the sole source of care in a community, at the request of a state.	Section 544. The Secretary would be permitted to waive a program exclusion at the request of an administrator of a federal health care program (which includes state health care programs).	Section 949. Same provision.

Medicare Demonstration Projects and Studies.

Provisions	Current Law	S. 1	H.R. 1
Demonstration Projects			
Establish demonstration project to clarify definition of homebound	A Medicare beneficiary must be confined to the home (or homebound) in addition to other criteria in order to qualify for the home health benefit.	Section 450. The Secretary would establish a 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare.	Section 704. Same provision.
Establish health care quality demonstration projects	No provision.	Section 441. The Secretary would be required to establish a 5-year, budget neutral demonstration program that examines the health delivery factors which encourage the delivery of improved quality patient care.	No provision.
Establish adult day care demonstration projects	No provision.	Section 454. A demonstration project under which a home health agency, directly or under arrangement with a medical adult day care facility, would provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home would be established.	Section 732. Same provision.
Establish complex clinical care management	No provision.	Section 442. The Secretary would be required to establish a 3-year budget neutral demonstration program to promote continuity of	Section 721. Chronic care improvement services to certain beneficiaries with chronic conditions would be provided as a Medicare

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Provisions	Current Law	S. 1	H.R. 1
demonstration projects		care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes before October 1, 2004. Six sites would be designated for the demonstration, three in urban areas and at least one in a rural area. One site would be required to be located in Arkansas. The Secretary would pay each principal care physician a monthly management fee developed by the Secretary that would be the full payment for all the functions performed.	benefit, not a demonstration project.
Establish care coordination demonstration projects	No provision.	Section 443. The Secretary would be required to establish a 5-year, budget neutral demonstration program that uses qualified care management organizations to provide health risk assessment and care management services to high-risk Medicare beneficiaries including those with multiple sclerosis or other disabling chronic conditions, nursing home residents (or those at risk for placement), or high-risk, dual-eligible beneficiaries.	Section 722. Comparable services to beneficiaries in MedicareAdvantage and Enhanced FFS would be established as a Medicare benefit, not as a demonstration project.
Establish frontier extended stay clinic demonstration projects	No provision.	Section 457. The Secretary would conduct a demonstration project that would treat frontier extended stay clinics as a Medicare provider. A frontier extended stay clinic is one that is located in a community where the closest acute care hospital or critical access hospital is at least 75 miles away or is inaccessible by public road and is designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or patients who need monitoring and observation for a limited period of time. [Duplicate provision at Section 460].	No provision.

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Provisions	Current Law	S. 1	H.R. 1
Establish chiropractor demonstration projects	No specific provision with respect to a demonstration project. Medicare covers limited chiropractic services, specifically manual manipulation for correction of a dislocated or misaligned vertebra or subluxation.	Section 440. The Secretary would establish a 3-year budget neutral demonstration program at six sites to evaluate the feasibility and desirability of covering additional chiropractic services under the Medicare program. These projects may not be implemented before October 1, 2004. Voluntary participation by eligible beneficiaries would occur at six sites, equally split between rural and urban areas with one being a HPSA. Requirements would be waived. Reports would be required.	No provision.
Physical therapy services	No provision.	Section 449. The Secretary would be required to establish a budget neutral 3-year demonstration project in at least five states to examine the costs and patient satisfaction associated with allowing Medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and comprehensive outpatient rehabilitation facility (CORF) services. In this instance, the beneficiary would not be required to be under the care of or referred by a physician to receive physical therapy services.	Section 624. The GAO would be required to conduct a study of patient access to physical therapist services in states authorizing such services without a physician referral compared to that in states requiring such referral. The study would be due to Congress within 1 month of enactment.
Establish certified registered nurses as surgical first assistants demonstration projects	No provision.	Section 450I. The Secretary would be required to conduct a 3-year budget neutral demonstration in five states that would pay for “surgical first assisting services” to Medicare beneficiaries furnished by a certified registered nurse first assistant.	No provision.

Provisions	Current Law	S. 1	H.R. 1
Establish weight loss program demonstration projects	No provision regarding the demonstration. Medicare covers medical nutrition therapy services for beneficiaries with diabetes or a renal disease who (1) have not received diabetes outpatient self-management training services within a time period to be determined by the Secretary, (2) are not receiving maintenance dialysis, and (3) meet other criteria to be established by the Secretary. Nutrition therapy services are nutritional diagnostic, therapy, and counseling services for the purpose of disease management. The services must be provided by a registered dietitian or nutritional professional pursuant to a referral by a physician. Payment is based on the lower of actual charges or 85% of the physician fee schedule on an assignment-related basis.	Section 450L. The Secretary would be required to establish a demonstration project that would provide group weight loss management services for Medicare beneficiaries who are obese and have impaired glucose tolerance and who have been diagnosed and referred by a physician for assessment and treatment based on individual needs to a specific program or method that has demonstrated efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals. Services include current body weight measurement and recording of weight status at each meeting session; provision of a healthy eating plan; provision of an activity plan; provision of a behavior modification plan; and a weekly group support meeting.	No provision.
Extend the telehealth project at Columbia University consortium	BBA 1997 established a single 4-year demonstration project where an eligible health care provider telemedicine network would use high-capacity computer systems and medical informatics to improve primary care and prevent health complications in Medicare beneficiaries with diabetes mellitus.	No provision.	Section 415. The demonstration project would be extended for 4 years and total funding would be increased from \$30 million to \$60 million.
Extend the municipal demonstration projects	Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, the Municipal Health Service Demonstration projects will expire on December 31, 2004. The project is a multi-site demonstration intended to improve access to primary care services in underserved urban areas and to reduce the cost of health care. BBA 1997 authorized the Secretary to extend the project through December 31, 2000, but only with respect to persons who had received at least one service for the period of January 1, 1996-August 7, 1997 (the enactment date of BBA 97). Sites who wanted the demonstration project extended were required to submit plans for the orderly transition of participants to a non-demonstration	Section 618. Demonstration projects would be extended to December 31, 2006, for individuals who reside in the city in which the project is operated.	Section 236. Same provision, but would extend until December 31, 2009.

Provisions	Current Law	S. 1	H.R. 1
	health care delivery system. Subsequent legislation extended the project through December 31, 2004.		
Establish consumer directed chronic outpatient services demonstration projects	No provision. Medicare coverage requires that a beneficiary need medically necessary care. In general, Medicare pays the provider that delivers skilled health care services.	No provision.	Section 736. The Secretary would establish no fewer than three demonstration projects to evaluate method to improve the care and reduce the cost of care provided to Medicare beneficiaries with chronic conditions including methods that would permit beneficiaries to direct their own health care needs and services. The Secretary would establish the demonstrations located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate within 2 years of enactment. The Secretary would evaluate and submit reports to Congress on the cost and clinical effectiveness of the projects biannually beginning 2 years after their start.
Required Studies			
Require MedPAC study on HHA margins	No provision.	No provision.	Section 703. MedPAC would study payment margins of home health agencies paid under PPS to examine whether systematic differences in payment margins were related to differences in case mix, as measured by home health resource groups (HHRGs).
Require Institute of Medicine (IOM) report related to chronic conditions	No provision.	No provision.	Section 723. The Secretary would contract with the IOM to study the barriers to effective integrated care improvement for Medicare beneficiaries with multiple or severe chronic conditions across settings and over time. The study would examine the statutory and regulatory barriers to coordinating care across settings for Medicare beneficiaries in transition from one setting to another.

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Provisions	Current Law	S. 1	H.R. 1
Require MedPAC report related to chronic care improvement program	No provision.	No provision.	Section 724. MedPAC would evaluate the chronic care improvement program established in Section 721. The evaluation would include a description of the status of the implementation of the program, the quality of health care services provided to individuals participating in the program, and the cost savings attributed to the implementation of the program.
Require GAO study on impact of assets test on low-income beneficiaries	No provision.	“Section 607. GAO would determine the extent to which drug utilization and access to covered drugs differs between: (1) individuals who qualify for the transitional assistance prescription drug card program or for subsidies available to certain low-income beneficiaries and (2) individuals who <i>do not</i> qualify for these types of assistance solely because of an assets test to the income eligibility requirements of such individuals. The final report (including recommendations for legislation) would be due no later than September 30, 2007.	No provision.
Require MedPAC study on Medicare payments and efficiencies in the health care system	No provision.	Section 455. MedPAC would recommend to Congress ways to recognize and reward efficiencies and lower utilization of services created by the practice of medicine in historically efficient and low-cost areas. The recommendations would be made within established Medicare payment methodologies for hospitals and physicians.	No provision.

Beneficiary Issues: Cost-Sharing Amounts and Provision of Information

Provisions	Current Law	S. 1	H.R. 1
Beneficiary Cost-Sharing Amounts			
Establish beneficiary cost-sharing for clinical diagnostic services not provided by a sole community hospital	Medicare pays laboratories directly for laboratory services provided to ambulatory patients in an outpatient setting. Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are periodically updated. Assignment is mandatory. No beneficiary cost-sharing is imposed.	Section 431. Beginning January 1, 2004, Medicare would pay all clinical laboratories 80% of the applicable fee schedule amount. Hospital-based, physician office and independent laboratories would be able to charge beneficiaries a 20% coinsurance amount. The Medicare Part B deductible would apply to clinical diagnostic laboratory tests furnished across all settings. SCHs would be exempt from this provision. (see Section 427).	No provision.
Increase Part B deductible amount annually	Under Part B, Medicare generally pays 80% of the approved amount for covered services after the beneficiary pays an annual deductible of \$100. The Part B deductible has been \$100 since 1991.	Section 433. The Medicare Part B deductible would be set at \$100 through 2005 and then increased to \$125 in 2006. Effective January 1 of subsequent years, the deductible would be increased annually by the percentage change in the CPI-U for the previous year ending in June. The amount would be rounded to the nearest dollar.	Section 628. Starting January 1, 2004, the Medicare Part B deductible would be increased by the same percentage as the Part B premium increase. Specifically, the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund would be used as the update. The amount would be rounded to the nearest dollar.
Establish beneficiary cost-sharing for home health services	The home health benefit does not have any cost-sharing requirement.	No provision.	Section 702. A beneficiary copayment for each 60-day episode of care beginning January 1, 2004 would be established. The copayment amount would be 1.5% of the national average payment per episode in a calendar year, rounded to the nearest multiple of \$5. For 2004, the copayment would be \$40 unless otherwise calculated on a timely basis by the Secretary. Medicare payments would be reduced to reflect copayments. Qualified Medicare beneficiaries, beneficiaries dually eligible for Medicare and Medicaid, and beneficiaries receiving four or fewer home health visits in an episode of care would not

Provisions	Current Law	S. 1	H.R. 1
			face any cost-sharing requirements. Administrative and judicial review of the calculated copayment amounts would be prohibited.
Waive Part B enrollment fee for certain Medicare beneficiaries who are military retirees	A late enrollment penalty is required to be imposed on beneficiaries who do not enroll in Medicare part B upon becoming eligible for Medicare.	Section 439. Beginning January 2005, the late enrollment penalty would be waived for certain military retirees who enrolled in Part B during, 2002, 2003, 2004 or 2005 and a special enrollment period, beginning 1 year after enactment and ending December 31, 2005, would be provided.	Section 627. Similar provision, except that the waiver would apply beginning January 1, 2004, and the special enrollment period would begin as soon as possible after enactment and end December 31, 2004.
Waive deductible for colorectal cancer screening tests	Unless otherwise specified, Part B services are subject to beneficiary cost-sharing amounts, including an annual deductible and coinsurance amount.	No provision.	Section 613. The Part B deductible would be waived for colorectal cancer screening tests.
Provision of Information to Beneficiaries			
Include additional information in notices to beneficiaries about SNF and hospital benefits	Although the statute requires that beneficiaries receive a statement listing the items and services for which payment has been made, there is no explicit statutory instruction that requires the notice to include information about the number of days of coverage remaining in either the hospital or SNF benefit.	Section 551. Beneficiary notices for those beneficiaries in SNFs and hospital would be required to include information about the number of days of coverage remaining under the SNF benefit and the spell of illness involved.	Section 925. Similar provision. Would require information for beneficiaries in a SNF stay only.
Provide information on Medicare-certified SNF in hospital discharge plans	The hospital discharge planning process requires evaluation of a patient's likely need for post-hospital services including hospice and home care.	Section 552. The Secretary would be required to make information publically available regarding whether SNFs were participating in the Medicare program. Hospital discharge planning would be required to include evaluating a patient's need for SNF care.	Section 926. Same provision.

Provisions	Current Law	S. 1	H.R. 1
Require information on advance directives	Information about advance directives is required to be given to patients in hospitals, skilled nursing facilities, and served by home health agencies. The Secretary is required to provide Medicare beneficiaries annual information about Medicare benefits, limitations on payment, and a description of the limited benefits for long-term care. This information is provided to Medicare beneficiaries in the <i>Medicare and You</i> handbook that is mailed annually to all beneficiaries.	Section 616. The Secretary would be required to provide information on advance directives in the <i>Medicare and You</i> handbook. The information would be required to be presented in a separate section on advance directives and would include specific information about living wills and durable power of attorney for health care. The Secretary would further be required to note the inclusion of this information in the introductory letter that accompanies the handbook.	No provision.
Require OIG report on notices concerning use of hospital lifetime reserve days.	No provision.	No provision.	Section 953(d). The OIG would report to Congress on the extent to which hospitals provide notice to Medicare beneficiaries, in accordance with applicable requirements, before they use the 60 lifetime reserve days under the hospital benefit as well as the appropriateness and feasibility of hospitals providing a notice to beneficiaries before they exhaust the lifetime reserve days. The report would be due no later than 1 year after enactment.

Other Health-Related Studies, Commissions or Committees

Provisions	Current Law	S. 1	H.R. 1
Pay emergency health services provided to undocumented aliens	BBA 1997 provided \$25 million in funding for state emergency health services furnished to undocumented aliens for each of FY1998 through 2001. Funds were distributed among the 12 states with the highest number of undocumented aliens. In a fiscal year, each state's portion of the total funds available was based on its share of total undocumented aliens in all of the eligible states based on the estimates provided by the Immigration and Naturalization Service (INS).	Section 610. \$250 million in additional federal funding for emergency health services furnished to undocumented aliens would be appropriated for each year from FY2005-FY2008. Of this amount, \$167 million would be allocated among all states according to a specified formula, the remaining money would be distributed to the six states with the highest number of undocumented alien apprehensions for such fiscal year according to specified formulas. Other provisions would apply.	No provision.
Express sense of the Senate that Senate Finance should hold meeting to monitor the implementation of this legislation	No provision.	Section 617. The provision expresses a sense of the Senate that the Committee on Finance should hold at least four hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003. The first hearing should be held within 60 days after enactment of the Act, the remaining hearings should be held May 2004, October 2004, and May 2005.	No provision.
Require study on making prescription drug information accessible to the sight impaired	No provision.	Section 619. The Secretary would study how to make prescription drug information, including drug labels and usage instructions, accessible to blind and visually impaired individuals with a report due within 18 months of enactment.	No provision.
Establish Citizens' Health Care Working Group	No provision.	Section 620. The Secretary would use the Agency for Healthcare Research and Quality to establish a 25-member Citizens' Health Care Working Group. This group would be appointed by Congressional leaders to provide recommendations on ways to improve and strengthen health care coverage and the health care system.	No provision.

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Provisions	Current Law	S. 1	H.R. 1
Require GAO report on price controls in different countries	No provision.	Sections 621. GAO would study pharmaceutical price controls in France, Germany, Italy, Japan, the United Kingdom, and Canada and review their impact on consumers, including American consumers, as well as on medical innovations. [Duplicate of Section 634]	No provision.
Establish Safety Net Advisory Commission	No provision.	Section 624. The Safety Net Organizations and Patient Advisory Commission would be established to conduct an ongoing review of the health care safety net programs including Medicaid, the State Children's Health Insurance Program (SCHIP), and Maternal and Child Health Services Block Grant Programs, among other programs and payments. The appointment process would be similar to that for MedPAC. Annual reports would be required. [Duplicate of Section 635]	No provision.
Establish Committee on Drug Compounding	No provision.	Section 626. The Secretary would establish a committee on Drug Compounding within the FDA to ensure that patients are receiving necessary, safe, and accurate dosages of compounded drugs. Members would be appointed by the Secretary and would include representatives from associations, advocates and other interested parties. The Committee would submit a report with recommendations to improve and protect patient safety within 1 year of enactment whereupon the Committee would terminate.	No provision.

Provisions	Current Law	S. 1	H.R. 1
Express sense of Senate regarding structure of Medicare reform	No provision.	Section 627. The provision provides a sense of the Senate that Medicare reform should be developed according to nine principles. For instance, prescription drug coverage should be directed to those who need it most; should incorporate private sector market based elements; should cost no more than \$400 billion; and should preserve employer sponsored retiree plans among other things.	No provision.
Express sense of Senate regarding establishment of national lifestyle modification program	No provision.	Section 628. The provision provides a sense of the Senate that coronary disease is expensive, the Medicare Lifestyle Modification Program has been operating in 12 states as a demonstration program, and this program of behavior modification should be conducted on a national basis for those beneficiaries who elect to participate.	No provision.
Emphasize employer flexibility in providing health coverage for retirees	No provision.	Section 631. The provision would clarify that nothing in the newly-created Part D, which would add a new Medicare prescription drug benefit, would be construed as preventing employment-based retiree health coverage from providing coverage that was supplemental to benefits provided under a Medicare Prescription Drug Plan or a Medicare Advantage plan.	No provision.
Expand responsibilities of the Office of Rural Health Policy (ORHP) in HHS	ORHP advises the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the Medicare and Medicaid programs on the financial viability of small rural hospitals, the ability of rural areas to attract and retain physicians and other health professionals, and access to and the quality of health care in rural areas. In addition to advising the Secretary, the Office has other responsibilities including coordinating the activities within HHS that relate to rural health care.	Section 637. The list of explicit responsibilities of the Office is expanded to include administering grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.	No provision.

Medicaid Provisions

Provisions	Current Law	S. 1	H.R. 1
<p>Increase Medicaid Disproportionate Share Hospital (DSH) allotments</p>	<p>Hospitals that serve a large number of uninsured patients and Medicaid enrollees receive additional Medicaid disproportionate share hospital (DSH) payments. BBA 1997 capped the federal share of Medicaid DSH payments at specified amounts for each state for FY1998 through FY2002. For most states, those specified amounts declined over the 5-year period. A state's allotment for FY2003 and for later years is equal to its allotment for the previous year increased by the percentage change in CPI-U for the previous year. In addition, each state's DSH payment for FY2003 and subsequent years is limited to no more than 12% of spending for medical assistance in each state for that year. BIPA provided states with a temporary reprieve from the declining allotments by establishing a special rule for the calculation of DSH allotments for 2 years, raising allotments for FY2001 and for FY2002. The provision also clarified that the FY2003 allotments were to be calculated as specified above, using the lower, pre-BIPA levels for FY2002 in those calculations.</p>	<p>Section 601. The special DSH rule established by BIPA that raised DSH allotments, subject to the current law limit of 12% of spending for medical assistance, would be extended for FY2004 and FY2005. Allotments for FY2004 would be calculated to be equal to FY2004 allotments as established by BBA 1997 increased by the product of 0.50 and the difference between: (a) FY2002 allotments as established by BIPA 2000 increased by the percentage change in the CPI-U for each of fiscal years 2002 and 2003, and (b) FY2004 allotments as established by BBA 1997. Allotments for FY2005 would be calculated to be equal to FY2005 allotments as established by BBA 1997 increased by the product of 0.50; and the difference between: (a) FY2002 allotments as established by the BIPA 2000 increased by the percentage change in the CPI-U for each of fiscal years 2002, 2003, and 2004, and (b) FY2005 allotments as established by BBA 1997. For FY2006 and thereafter, DSH allotments would be calculated based on the previous years' amount as established by BBA 1997 and subject to the current law limit of 12% of spending for medical assistance increased by the CPI-U for the previous fiscal year. All allotments would be subject to the existing limit of 12% of medical assistance spending. A separate calculation of the DSH allotment for the District of Columbia for FY2004 would be specified.</p>	<p>Section 1001. Temporary increase in DSH allotments, subject to the current law limit of 12% of spending for medical assistance, would be established for FY2004 and for certain subsequent fiscal years. Allotments for FY2004 would be set at 120% of FY2003 allotments as under BIPA. Allotments for subsequent years would be equal to the allotments for FY 2004 unless the Secretary determines that the allotments as would have been calculated prior to the enactment of this bill would equal or exceed the FY 2004 amounts. For such fiscal years, allotments would be equal to allotments for the prior fiscal year increased by the CPI-U for the previous fiscal year.</p>
<p>Increase in floor for state with low DSH allotments</p>	<p>Extremely low DSH states are those states whose FY1999 federal and state DSH expenditures (as reported to CMS on August 31, 2000) are greater than zero but less than 1% of the state's total medical assistance expenditures during that fiscal</p>	<p>Section 602. Allotments for certain extremely low DSH states for FY2004 and FY2005 would be increased. For states with DSH expenditures for FY2000 (as reported to CMS as of August 31, 2003) that are greater than zero but less than</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
	<p>year. DSH allotments for the extremely low DSH states for FY2001 would be equal to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states would be equal to their allotment for the previous year, increased by the percentage change in the CPI-U for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.</p>	<p>3% of the state's total medical assistance expenditures during that fiscal year, the provision would raise the DSH allotments for FY2004 to 3% of the state's total amount of expenditures for such assistance during that fiscal year. States with DSH expenditures for FY2001 (as reported to CMS as of August 31, 2004) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year would have the DSH allotments for FY2005 equal to such state's DSH allotment for FY2004 increased by the percentage change in the CPI-U for FY2004. A special DSH allotment for Tennessee would be specified in FY2004 and FY2005 under certain circumstances.</p>	
<p>Increase DSH reporting requirements</p>	<p>BBA 1997 required each state to submit to the Secretary an annual report describing the disproportionate share payments made to each disproportionate share hospital (DSH) and the methodology used by the state for prioritizing payments to such hospitals.</p>	<p>Section 603. As a condition of receiving federal Medicaid payments for FY2004 and each fiscal year thereafter, the provision would require each state to submit to the Secretary an annual report (for the previous fiscal year) identifying each disproportionate share hospital that received a payment, the amount such hospital received, as well as other information the Secretary determines necessary to ensure the appropriateness of the DSH payments for the previous fiscal year.</p>	<p>No provision.</p>
<p>Exempt prices of drugs provided to certain safety net hospitals from Medicaid best price drug program</p>	<p>Medicaid drug rebates are calculated based on the difference between the Average Manufacturer's Price and the manufacturer's "best price". In determining a drug's best price, certain discounted prices and fee schedules are excluded. Discounted prices for outpatient drugs negotiated by the Office of Pharmacy Affairs (of HHS) with drug manufacturers on behalf of certain clinics and safety net providers are one example of such exclusion. Because of this exclusion, the discounts</p>	<p>Section 604. Effective October 1, 2003, the definition of "best price" for the purpose of calculating Medicaid drug rebates, would be modified to also exclude the discounted inpatient drug prices charged to certain public safety net hospitals. Those hospitals would also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination.</p>	<p>Section 1002. Same provision but would be effective on the date of enactment.</p>

Provisions	Current Law	S. 1	H.R. 1
	<p>available to safety net providers have no bearing on the calculation of Medicaid drug rebates which allows those providers to negotiate better rates with manufacturers — since Medicaid rebates will not change with the size of their negotiated discounts. Discounted prices for inpatient drugs for many safety net providers, however, are included in the Medicaid best price.</p>		
<p>Assist legal immigrants in Medicaid and SCHIP programs</p>	<p>“Qualified aliens” who entered the United States after the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, August 22, 1996) are not eligible to receive federally funded benefits under Medicaid or SCHIP for 5 years. Qualified aliens who entered the United States prior to the enactment of PRWORA are eligible for federally funded Medicaid coverage at state option, as are qualified aliens arriving after August 22, 1996 who have been present in the United States for more than 5 years. A person who executed an affidavit of support for an alien under Section 213A of the Immigration and Nationality Act (INA) is liable to reimburse the federal or state government for the public benefits received by the sponsored alien until the alien naturalizes or has accumulated 40 quarters of work. Section 213A was enacted as a part of PRWORA on August 22, 1996.</p>	<p>Section 605. The provision would lift the 5-year ban and would allow states the option to provide medical assistance to certain lawfully residing individuals under Medicaid (including under a waiver authorized by the Secretary) or SCHIP for any of fiscal years 2005 through 2007. Those eligible would include lawfully residing women during pregnancy and the 60-day period after delivery, and children otherwise eligible for Medicaid or SCHIP as defined by the state plan. States opting to provide coverage to such lawfully residing individuals under SCHIP must also provide coverage to such individuals under Medicaid. If services are provided under the Medicaid program, the alien’s sponsor would not be liable to reimburse the federal or state government for the cost of such services.</p>	<p>No provision.</p>
<p>Extend special DSH treatment for certain urban providers</p>	<p>Hospital-specific limits on DSH payments as well as overall state-wide DSH allotment have been established. DSH payments to hospitals are limited to some percentage of each hospital’s costs of providing inpatient and outpatient services to Medicaid and uninsured patients net of payments received from or on behalf of these patients (“unreimbursed costs”). DSH payments to public hospitals are limited to 100% of unreimbursed costs except in FY2003 and FY2004 when that</p>	<p>Section 625. DSH payments made to hospitals that are owned and operated by the state of Indiana and located in Marion County would be made without regard to the state’s DSH allotment limitation so long as those payment amounts, for FY2004 and each fiscal year thereafter do not exceed 175% of the “unreimbursed costs” of furnishing hospital services.</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
	<p>limit rises to 175% of unreimbursed costs. DSH payments to private hospitals are limited to 100% of these costs; certain public hospitals in California have a permanent DSH limit of 175%.</p>		
<p>Increase Medicaid payments for certain Hawaiian providers</p>	<p>The Medicaid program is jointly financed by the states and the federal government. The federal government share is based on each state's federal medical assistance percentage (FMAP). The FMAP for a state is calculated using a formula reflecting the state per capita income relative to the average U.S. per capita income. The formula is designed to give a higher FMAP to states with a per capita income below the U.S. average. No state can have an FMAP of less than 50% or more than 83%. Certain services including family planning are paid at alternative FMAP rate, as are administrative expenses. In addition, the law provides that services provided through an Indian Health Service facility operated by the Indian Health Service or an Indian tribe or tribal organization have an FMAP of 100%. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (JEGTRRA, P.L. 108-026) altered the statutory calculation of the FMAPs by providing a hold harmless for declines from the prior year for each state FMAP, and a temporary increase of 2.95 percentage points for the last two quarters of fiscal year 2003 and the first three quarters of fiscal year 2004. The calculated statutory FMAPs for Hawaii would be 58.77% for fiscal year 2003 and 58.90% for fiscal year 2004. The JEGTRRA changes result in an FMAP for Hawaii of 61.75% for the last two quarters of fiscal year 2003, and 61.85% for the first three quarters of fiscal year 2004. The FMAP for services provided to a Native Hawaiian is the same as for services provided to other Medicaid beneficiaries in Hawaii.</p>	<p>Section 632. For services provided to a Native Hawaiian by a federally qualified health center or a Native Hawaiian health care system, the FMAP would be 100%. Services qualifying for the 100% FMAP would include those provided by referral, and under contract or other arrangement between a health care provider and the federally qualified health center or Native Hawaiian health care system.</p>	<p>No provision.</p>

Provisions	Current Law	S. 1	H.R. 1
Extend special treatment for a specific provider	Medicaid payment for services provided by an institution for mental disease (IMD) may be made only for beneficiaries who are under age 21 or over 65. IMD means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. For two facilities in Michigan — Kent Community Hospital Complex and Saginaw Community Hospital — previous legislation has imposed a moratorium on determination of the facilities as IMDs through December 31, 2002.	Section 633. The moratorium on the determination of Saginaw Community Hospital as an IMD would be permanently extended as if included in BBA 1997.	No provision.

Miscellaneous Financial Provisions

Provisions	Current Law	S. 1	H.R. 1
Extend authority to collect Customs fees	The U.S. Customs Service, the federal government's oldest revenue collecting agency is responsible for regulating the movement of persons, carriers, merchandise, and commodities between the United States and other countries. Its authority to impose user fees for certain services will lapse on September 30, 2003.	Section 614. The authority would be extended until September 30, 2013.	No provision.

Provisions	Current Law	S. 1	H.R. 1
Require the Internal Revenue Service (IRS) to deposit certain receipts	The Secretary of the Treasury was granted the authority by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-286, the Treasury, Postal Service and General Government Appropriations Act of 1995 to establish new fees (if the fee is authorized by another law) or raise fees for services provided by the IRS to supplement appropriations made available to the IRS. The fees must be based on the costs of providing the specific services (to the persons paying the fees), and the Secretary must report quarterly to the Congress on the collection of such fees and how they are spent.	Section 450G. The Secretary of the Treasury must deposit any fees collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-286, the Treasury, Postal Service and General Government Appropriations Act of 1995 into the Treasury as miscellaneous receipts. The fees collected are only available to the IRS if authority is provided in advance in an appropriations Act.	No provision.