THE BENEFICIARY ACCESS TO CARE AND MEDICARE EQUITY ACT OF 2002

Total cost over 10 years: approximately $43 billion*

TITLE I – RURAL HEALTH CARE IMPROVEMENTS

(Approx. $12.8 billion over 10 years)

Sec. 101 Full standardized amount for rural and small urban hospitals by FY04 and thereafter.

Sec. 102 Wage index changes: labor-related share for hospitals with a wage index below 1.0 is 68% for FY03 through FY05; labor-relates share for hospitals with a wage index above 1.0 is held harmless (i.e. remains at current level of 71%).

Sec. 103 Medicare disproportionate share (DSH) payments: increases the maximum DSH adjustment for rural hospitals and urban hospitals with under 100 beds to 10% (phased-in over ten years).

Sec. 104 1-year extension of hold harmless from outpatient PPS for small rural hospitals.

Sec. 105 5% add-on for clinic and ER visits for small rural hospitals.

Sec. 106 2-year extension of reasonable cost payments for diagnostic lab tests in Sole Community Hospitals.

Sec. 107 Critical Access Hospital improvements:

(a) Reinstatement of periodic interim payments;
(b) Condition for application of special physician payment adjustment;
(c) Coverage of costs for certain emergency room on-call providers;
(d) Prohibition on retroactive recoupment;
(e) Increased flexibility for states with respect to certain frontier critical access hospitals;
(f) Permitting hospitals to allocate swing beds and acute care inpatient beds subject to a total limit of 25 beds;
(g) Provisions related to certain rural grants;
(h) Coordinated survey demonstration program.

*** Note: subtotals below do not sum to $42 billion due to Part B premium and Medicaid interactions and rounding. Part B premium and Medicaid interactions total approximately -$2.5 billion over 10 years.**

Sec. 108 Temporary relief for certain non-teaching hospital for FY03 through FY05 (same as House-passed provision).

Sec. 109 Physician work Geographic Practice Cost Index at 1.0 for CY03 through CY05, holding harmless those areas with work GPCIs over 1.0.

Sec. 110 Make existing Medicare Incentive Payment 10% bonus payments on claims by physicians serving patients in rural Health Professional Shortage Areas automatic, rather than requiring special coding on such claims.

Sec. 111 GAO study on geographic differences in physician payments.

Sec. 112 Extension of 10% rural add-on for home health through FY04.

Sec. 113 10% add-on for frontier hospice for CY03 through CY07.

Sec. 114 Exclude services provided by Rural Health Clinic-based practitioners from Skilled Nursing Facility consolidated billing.

Sec. 115 Rural Hospital Capital Loan Authorization.

TITLE II – PROVISIONS RELATING TO PART A

(Approx. $9.0 billion over 10 years)

Subtitle A – Inpatient Hospital Services

Sec. 201 FY03 inflation adjustment of market basket minus -0.25% for PPS hospitals; full market basket for Sole Community Hospitals.

Sec. 202 Update hospital market basket weights more frequently.

Sec. 203 IME Adjustment: 6.5% in FY03, 6.5% in FY04, 6.0% in FY05.

Sec. 204 Puerto Rico: 75%-25% Federal-Puerto Rico blend beginning in FY 03.

Sec. 205 Geriatric GME programs: certain geriatric residents do not count against caps.

Sec. 206 DSH increase for Pickle hospitals from 35% to 40%.

Subtitle B – Skilled Nursing Facility Services

Sec. 211 Increase to nursing component of RUGs:15% in FY03, 13% in FY04, 11% in FY05; increase in payment for AIDS patients cared for by SNFs; GAO study.

Sec. 212 Require collection of staffing data; require staffing measure in CMS quality initiative.

Subtitle C – Hospice

Sec. 221 Allow payment for hospice consultation services based on fee schedule set by Secretary; remove one-time limit set by House.

Sec. 222 Authorize use of arrangements with other hospice programs.

TITLE III – PROVISIONS RELATING TO PART B

(Approx. $10.0 billion over 10 years)

Subtitle A – Physicians' Services

Sec. 301 Physician payment increase (same as House-passed version); GAO study; MedPAC report.

Sec. 302 Extension of treatment of certain physician pathology services through FY05.

Subtitle B – Other Services

Sec. 311 Competitive bidding for DME: begin national phase-in CY03 for MSAs with over 500,000 people.

Sec. 312 2-year extension of moratorium on therapy caps.

Sec. 313 Acceleration of reduction of beneficiary copayment for hospital outpatient department services.

Sec. 314 End-Stage Renal Disease: Increase composite rate to 1.2% in CY03 and CY04; composite rate exceptions for pediatric facilities.

Sec. 315 Improved payment for certain mammography services.

Sec. 316 Waiver of Part B late enrollment penalty for certain military retirees and special enrollment period.

Sec. 317 Coverage of cholesterol and blood lipid screening.

Sec. 318 5% payment increase for rural ground ambulance services, 2% increase for urban ground ambulance services.

Sec. 319 Medical necessity criteria for air ambulance services under ambulance fee schedule.

Sec. 320 Improved payment for thin prep pap tests.

Sec. 321 Coverage of immunosuppressive drugs.

Sec. 322 Geriatric care assessment demonstration program.

Sec. 323 CMS study and recommendations to Congress on revisions to outpatient payment methodology for drugs, devices and biologicals.

TITLE IV – PROVISIONS RELATING TO PARTS A AND B

(Approx. $0.0 billion over 10 years)

Subtitle A – Home Health Services

Sec. 401 Eliminate 15% reduction in payments for home health services.

Sec. 402 Reduce inflation updates in FY03 through FY05; full market basket increases thereafter.

Subtitle B – Other Provisions

Sec. 411 Information technology demonstration project.

Sec. 412 Modifications to the Medicare Payment Advisory Commission.

Sec. 413 Requires CMS to maintain a carrier medical director and carrier advisory committee in every state to ensure access to the local coverage process.

TITLE V – MEDICARE+CHOICE AND RELATED PROVISIONS

(Approx. $2.3 billion over 10 years, including M+C interactions)

Sec. 501 Increase minimum updates to 4% in CY03 and 3% in CY04.

Sec. 502 Clarify Secretary's authority to disapprove certain cost-sharing.

Sec. 503 Extend cost contracts for 5 years.

Sec. 504 Extend the Social HMO Demonstration through 2006.

Sec. 505 Extend specialized plans for special needs beneficiaries for 5 years (Evercare).

Sec. 506 Extend 1% entry bonus for M+C for 2 years; bonus does not apply for private fee-for-service or demonstration plans.

Sec. 507 PACE technical fix regarding services furnished by non-contract providers.

Sec. 508 Reference to implementation of certain M+C provisions in 2003.

TITLE VI – MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

(Approx. $0.0 billion over 10 years)

Subtitle A – Regulatory Reform

Sec. 601 Require status report on interim final rules; limit effectiveness of interim final rules to 12 months with one extension permitted under certain circumstances.

Sec. 602 Requires only prospective compliance with regulation changes.

Sec. 603 Secretary report on legal and regulatory inconsistencies in Medicare.

Subtitle B – Appeals Process Reform

Sec. 611 Requires Secretary to submit detailed plan for transfer of responsibility for medicare appeals from SSA to HHS; GAO evaluation of plan.

Sec. 612 Allows expedited access to judicial review for Medicare appeals involving legal issues that the DAB does not have the authority to decide.

Sec. 613 Allows expedited appeals for certain provider agreement determinations, including terminations.

Sec. 614 Tightens eligibility requirements for QICs and reviewers; ensures notice and improved explanations on determination and redetermination decisions; delays implementation of Section 521 of BIPA for 14 months, but continues implementation of expedited redeterminations; expands CMS discretion on the number of QICs.

Sec. 615 Creates hearing rights in cases of denial or nonrenewal of enrollment agreements; requires consultation before CMS changes provider enrollment forms.

Sec. 616 Permits providers to appeal determinations relating to services rendered to an individual who subsequently dies if there is no other party available to appeal.

Sec. 617 Permits providers to seek appeal of local coverage decisions and to request development of local coverage decisions under certain circumstances.

Subtitle C – Contracting Reform

Sec. 621 Authorizes Medicare contractor reform beginning in October 2004.

Subtitle D – Education and Outreach Improvements

Sec. 631 New education and technical assistance requirements.

Sec. 632 Requires CMS and contractors to provide written responses to health care providers' and beneficiaries' questions within 45 days.

Sec. 633 Suspends penalties and interest payments for providers that have followed incorrect guidance.

Sec. 634 Creates new ombudsmen offices for health care providers and beneficiaries.

Sec. 635 Authorizes beneficiary outreach demonstration.

Subtitle E – Review, Recovery, and Enforcement Reform

Sec. 641 Requires CMS to establish standards for random prepayment audits.

Sec. 642 Requires CMS to enter into overpayment repayment plans. Prevents CMS from recovering overpayments until the second level of appeal is exhausted.

Sec. 643 Establishes a process for the correction of incomplete or missing data without pursuing the appeals process.

Sec. 644 Expands the current waiver of program exclusions in cases where the provider is a sole community physician or sole source of essential health care.

TITLE VII – MEDICAID-SCHIP

(Approx. $10.8 billion over 10 years)

Sec. 701 Extend Medicaid disproportionate share hospital (DSH) inflation updates (for 2001 and 2002) to 2003, 2004 and 2005 allotments; update District of Columbia DSH allotment.

Sec. 702 Raise cap from 1% to 3% for states classified as low Medicaid DSH in FY03 through FY05.

Sec. 703 Five year extension of QI-1 Program.

Sec. 704 Enable public safety net hospitals to access discount drug pricing for inpatient drugs.

Sec. 705 CHIP Redistribution: give states an additional year to spend expiring funds that would otherwise return to the Treasury; continue BIPA arrangement for SCHIP redistribution; establish caseload stabilization pool beginning in FY04; allow certain states to use a portion of unspent SCHIP funds to cover specified Medicaid beneficiaries; GAO study to evaluate program implementation and funding.

Sec. 706 Improvements to Section 1115 waiver process for Medicaid and State Children's Health Insurance Program (SCHIP) waiver.

Sec. 707 Increase the federal medical assistance percentage in Medicaid (FMAP) by

1.3% for 12 months for all states; "hold harmless" states scheduled to have a lower FMAP in FY03; $1 billion increase in Social Services Block Grant for FY03.

TITLE VIII – OTHER PROVISIONS

(Approx. $0.9 billion over 10 years)

Sec. 801 Extend funding for Special Diabetes Programs for FY04, FY05, and FY06 at $150 million per program per year.

Sec. 802 Disregard of certain payments under the Emergency Supplemental Act, 2000 in the administration of Federal programs and federally assisted programs.

Sec. 803 Create Safety Net Organizations and Patient Advisory Commission.

Sec. 804 Guidance on prohibitions against discrimination by national origin.

Sec. 805 Extend grants to hospitals for EMTALA treatment of undocumented aliens.

Sec. 806 Extend Medicare Municipal Health Services Demonstration for 1 year.

Sec. 807 Provides for delayed implementation of certain provisions.

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