

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

# H. R. 4954

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize and reform payments and the regulatory structure of the Medicare Program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 18, 2002

Mrs. JOHNSON of Connecticut (for herself and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize and reform payments and the regulatory structure of the Medicare Program, and for other purposes.

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

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**  
4 **CURITY ACT; REFERENCES TO BIPA AND**  
5 **SECRETARY; TABLE OF CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the “Medi-  
7 care Modernization and Prescription Drug Act of 2002”.

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

7 (c) BIPA; SECRETARY.—In this Act:

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

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

14 (d) TABLE OF CONTENTS.—The table of contents of this  
 15 Act is as follows:

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

#### TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

##### “PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

“Sec. 1860A. Benefits; eligibility; enrollment; and coverage period.

“Sec. 1860B. Requirements for qualified prescription drug coverage.

“Sec. 1860C. Beneficiary protections for qualified prescription drug  
 coverage.

“Sec. 1860D. Requirements for prescription drug plan (PDP) spon-  
 sors; contracts; establishment of standards.

“Sec. 1860E. Process for beneficiaries to select qualified prescription  
 drug coverage.

“Sec. 1860F. Submission of bids.

“Sec. 1860G. Premium and cost-sharing subsidies for low-income indi-  
 viduals.

“Sec. 1860H. Subsidies for all medicare beneficiaries for qualified pre-  
 scription drug coverage.

“Sec. 1860I. Medicare Prescription Drug Trust Fund.

“Sec. 1860J. Definitions; treatment of references to provisions in part  
 C.

Sec. 102. Offering of qualified prescription drug coverage under the  
 Medicare+Choice program.

Sec. 103. Medicaid amendments.

Sec. 104. Medigap transition.

Sec. 105. Medicare prescription drug discount card endorsement program.

#### TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

##### Subtitle A—Medicare+Choice Revitalization

Sec. 201. Medicare+Choice improvements.

- Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
- Sec. 203. Avoiding duplicative State regulation.
- Sec. 204. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 205. Medicare MSAs.
- Sec. 206. Extension of reasonable cost and SHMO contracts.

#### Subtitle B—Medicare+Choice Competition Program

- Sec. 211. Medicare+Choice competition program.
- Sec. 212. Demonstration program for competitive-demonstration areas.
- Sec. 213. Conforming amendments.

### TITLE III—RURAL HEALTH CARE IMPROVEMENTS

- Sec. 301. Reference to full market basket increase for sole community hospitals.
- Sec. 302. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 303. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 304. More frequent update in weights used in hospital market basket.
- Sec. 305. Improvements to critical access hospital program.
- Sec. 306. Extension of temporary increase for home health services furnished in a rural area.
- Sec. 307. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.
- Sec. 308. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.
- Sec. 309. GAO study of geographic differences in payments for physicians' services.
- Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.

### TITLE IV—PROVISIONS RELATING TO PART A

#### Subtitle A—Inpatient Hospital Services

- Sec. 401. Revision of acute care hospital payment updates.
- Sec. 402. 2-year increase in level of adjustment for indirect costs of medical education (IME).
- Sec. 403. Recognition of new medical technologies under inpatient hospital PPS.
- Sec. 404. Phase-in of Federal rate for hospitals in Puerto Rico.
- Sec. 405. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 406. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 407. Reference to provision for more frequent updates in the weights used in hospital market basket.
- Sec. 408. Reference to provision making improvements to critical access hospital program for more frequent updates in the weights used in hospital market basket.

#### Subtitle B—Skilled Nursing Facility Services

- Sec. 411. Payment for covered skilled nursing facility services.

Subtitle C—Hospice

- Sec. 421. Coverage of hospice consultation services.
- Sec. 422. 10 percent increase in payment for hospice care furnished in a frontier area.
- Sec. 423. Rural hospice demonstration project.

Subtitle D—Other Provisions

- Sec. 431. Demonstration project for use of recovery audit contractors for part A services.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians’ Services

- Sec. 501. Revision of updates for physicians’ services.
- Sec. 502. Studies on access to physicians’ services.
- Sec. 503. MedPAC report on payment for physicians’ services.

Subtitle B—Other Services

- Sec. 511. Competitive acquisition of certain items and services.
- Sec. 512. Payment for ambulance services.
- Sec. 513. 1-year extension of moratorium on therapy caps; provisions relating to reports.
- Sec. 514. Accelerated implementation of 20 percent coinsurance for hospital outpatient department (OPD) services; other OPD provisions.
- Sec. 515. Coverage of an initial preventive physical examination.
- Sec. 516. Renal dialysis services.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.
- Sec. 602. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.
- Sec. 603. Update in home health services.
- Sec. 604. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
- Sec. 605. MedPAC study on medicare margins of home health agencies.

Subtitle B—Direct Graduate Medical Education

- Sec. 611. Extension of update limitation on high cost programs.
- Sec. 612. Redistribution of unused resident positions.

Subtitle C—Other Provisions

- Sec. 621. Modifications to Medicare Payment Advisory Commission (MedPAC).
- Sec. 622. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
- Sec. 623. Demonstration project for medical adult day care services.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

- Sec. 701. Establishment of Medicare Benefits Administration.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

- Sec. 801. Construction; definition of supplier.
- Sec. 802. Issuance of regulations.
- Sec. 803. Compliance with changes in regulations and policies.

Sec. 804. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

Sec. 811. Increased flexibility in medicare administration.

Sec. 812. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

Sec. 821. Provider education and technical assistance.

Sec. 822. Small provider technical assistance demonstration program.

Sec. 823. Medicare provider ombudsman; medicare beneficiary ombudsman.

Sec. 824. Beneficiary outreach demonstration program.

Subtitle D—Appeals and Recovery

Sec. 831. Transfer of responsibility for medicare appeals.

Sec. 832. Process for expedited access to review.

Sec. 833. Revisions to medicare appeals process.

Sec. 834. Prepayment review.

Sec. 835. Recovery of overpayments.

Sec. 836. Provider enrollment process; right of appeal.

Sec. 837. Process for correction of minor errors and omissions on claims without pursuing appeals process.

Sec. 838. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle E—Miscellaneous Provisions

Sec. 841. Policy development regarding evaluation and management (E & M) documentation guidelines.

Sec. 842. Improvement in oversight of technology and coverage.

Sec. 843. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.

Sec. 844. EMTALA improvements.

Sec. 845. Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group.

Sec. 846. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.

Sec. 847. Application of OSHA bloodborne pathogens standard to certain hospitals.

Sec. 848. BIPA-related technical amendments and corrections.

Sec. 849. Conforming authority to waive a program exclusion.

Sec. 850. Treatment of certain dental claims.

Sec. 851. Annual publication of list of national coverage determinations.

TITLE IX—MEDICAID, PUBLIC HEALTH, AND OTHER HEALTH PROVISIONS

Subtitle A—Medicaid Provisions

Sec. 901. National Bipartisan Commission on the Future of Medicaid.

Sec. 902. GAO study on medicaid drug payment system.

Subtitle B—Internet Pharmacies

Sec. 911. Findings.

Sec. 912. Amendment to Federal Food, Drug, and Cosmetic Act.

Sec. 913. Public education.

Sec. 914. Study regarding coordination of regulatory activities.

Sec. 915. Effective date.

Subtitle C—Promotion of Electronic Prescription

Sec. 921. Program of grants to health care providers to implement electronic prescription drug programs.

Subtitle D—Treatment of Rare Diseases

Sec. 931. NIH Office of Rare Diseases at National Institutes of Health.  
 Sec. 932. Rare disease regional centers of excellence.

Subtitle E—Other Provisions Relating to Drugs

Sec. 941. GAO study regarding direct-to-consumer advertising of prescription drugs.  
 Sec. 942. Certain health professions programs regarding practice of pharmacy.

“SUBPART 3—PHARMACIST WORKFORCE PROGRAMS

“Sec. 771. Public service announcements.  
 “Sec. 772. Demonstration project.  
 “Sec. 773. Information technology.  
 “Sec. 774. Authorization of appropriations.

TITLE X—HEALTH-CARE RELATED TAX PROVISIONS

Sec. 1001. Eligibility for Archer MSA’s extended to account holders of Medicare+Choice MSA’s.  
 Sec. 1002. Adjustment of employer contributions to Combined Benefit Fund to reflect medicare prescription drug subsidy payments.  
 Sec. 1003. Expansion of human clinical trials qualifying for orphan drug credit.

**TITLE I—MEDICARE  
 PRESCRIPTION DRUG BENEFIT**

**SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.**

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT  
 PROGRAM

**“SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT;  
 AND COVERAGE PERIOD.**

“(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

“(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j),

1 the individual may enroll in the plan and obtain coverage  
2 through such plan.

3 “(2) PRESCRIPTION DRUG PLAN.—If the individual is  
4 not enrolled in a Medicare+Choice plan that provides  
5 qualified prescription drug coverage, the individual may en-  
6 roll under this part in a prescription drug plan (as defined  
7 in section 1860J(a)(5)).

8 Such individuals shall have a choice of such plans under section  
9 1860E(d).

10 “(b) GENERAL ELECTION PROCEDURES.—

11 “(1) IN GENERAL.—An individual eligible to make an  
12 election under subsection (a) may elect to enroll in a pre-  
13 scription drug plan under this part, or elect the option of  
14 qualified prescription drug coverage under a  
15 Medicare+Choice plan under part C, and to change such  
16 election only in such manner and form as may be pre-  
17 scribed by regulations of the Administrator of the Medicare  
18 Benefits Administration (appointed under section 1808(b))  
19 (in this part referred to as the ‘Medicare Benefits Adminis-  
20 trator’) and only during an election period prescribed in or  
21 under this subsection.

22 “(2) ELECTION PERIODS.—

23 “(A) IN GENERAL.—Except as provided in this  
24 paragraph, the election periods under this subsection  
25 shall be the same as the coverage election periods  
26 under the Medicare+Choice program under section  
27 1851(e), including—

28 “(i) annual coordinated election periods; and

29 “(ii) special election periods.

30 In applying the last sentence of section 1851(e)(4) (re-  
31 lating to discontinuance of a Medicare+Choice election  
32 during the first year of eligibility) under this subpara-  
33 graph, in the case of an election described in such sec-  
34 tion in which the individual had elected or is provided  
35 qualified prescription drug coverage at the time of such  
36 first enrollment, the individual shall be permitted to en-  
37 roll in a prescription drug plan under this part at the

1 time of the election of coverage under the original fee-  
2 for-service plan.

3 “(B) INITIAL ELECTION PERIODS.—

4 “(i) INDIVIDUALS CURRENTLY COVERED.—In  
5 the case of an individual who is entitled to benefits  
6 under part A or enrolled under part B as of No-  
7 vember 1, 2004, there shall be an initial election  
8 period of 6 months beginning on that date.

9 “(ii) INDIVIDUAL COVERED IN FUTURE.—In  
10 the case of an individual who is first entitled to  
11 benefits under part A or enrolled under part B  
12 after such date, there shall be an initial election pe-  
13 riod which is the same as the initial enrollment pe-  
14 riod under section 1837(d).

15 “(C) ADDITIONAL SPECIAL ELECTION PERIODS.—  
16 The Administrator shall establish special election  
17 periods—

18 “(i) in cases of individuals who have and invol-  
19 untarily lose prescription drug coverage described  
20 in subsection (c)(2)(C);

21 “(ii) in cases described in section 1837(h) (re-  
22 lating to errors in enrollment), in the same manner  
23 as such section applies to part B;

24 “(iii) in the case of an individual who meets  
25 such exceptional conditions (including conditions  
26 provided under section 1851(e)(4)(D)) as the Ad-  
27 ministrator may provide; and

28 “(iv) in cases of individuals (as determined by  
29 the Administrator) who become eligible for pre-  
30 scription drug assistance under title XIX under  
31 section 1935(d).

32 “(c) GUARANTEED ISSUE; COMMUNITY RATING; AND  
33 NONDISCRIMINATION.—

34 “(1) GUARANTEED ISSUE.—

35 “(A) IN GENERAL.—An eligible individual who is  
36 eligible to elect qualified prescription drug coverage  
37 under a prescription drug plan or Medicare+Choice

1 plan at a time during which elections are accepted  
2 under this part with respect to the plan shall not be  
3 denied enrollment based on any health status-related  
4 factor (described in section 2702(a)(1) of the Public  
5 Health Service Act) or any other factor.

6 “(B) MEDICARE+CHOICE LIMITATIONS PER-  
7 MITTED.—The provisions of paragraphs (2) and (3)  
8 (other than subparagraph (C)(i), relating to default en-  
9 rollment) of section 1851(g) (relating to priority and  
10 limitation on termination of election) shall apply to  
11 PDP sponsors under this subsection.

12 “(2) COMMUNITY-RATED PREMIUM.—

13 “(A) IN GENERAL.—In the case of an individual  
14 who maintains (as determined under subparagraph (C))  
15 continuous prescription drug coverage since the date  
16 the individual first qualifies to elect prescription drug  
17 coverage under this part, a PDP sponsor or  
18 Medicare+Choice organization offering a prescription  
19 drug plan or Medicare+Choice plan that provides  
20 qualified prescription drug coverage and in which the  
21 individual is enrolled may not deny, limit, or condition  
22 the coverage or provision of covered prescription drug  
23 benefits or increase the premium under the plan based  
24 on any health status-related factor described in section  
25 2702(a)(1) of the Public Health Service Act or any  
26 other factor.

27 “(B) LATE ENROLLMENT PENALTY.—In the case  
28 of an individual who does not maintain such continuous  
29 prescription drug coverage (as described in subpara-  
30 graph (C)), a PDP sponsor or Medicare+Choice orga-  
31 nization may (notwithstanding any provision in this  
32 title) adjust the premium otherwise applicable or im-  
33 pose a pre-existing condition exclusion with respect to  
34 qualified prescription drug coverage in a manner that  
35 reflects additional actuarial risk involved. Such a risk  
36 shall be established through an appropriate actuarial

1 opinion of the type described in subparagraphs (A)  
2 through (C) of section 2103(c)(4).

3 “(C) CONTINUOUS PRESCRIPTION DRUG COV-  
4 ERAGE.—An individual is considered for purposes of  
5 this part to be maintaining continuous prescription  
6 drug coverage on and after the date the individual first  
7 qualifies to elect prescription drug coverage under this  
8 part if the individual establishes that as of such date  
9 the individual is covered under any of the following pre-  
10 scription drug coverage and before the date that is the  
11 last day of the 63-day period that begins on the date  
12 of termination of the particular prescription drug cov-  
13 erage involved (regardless of whether the individual  
14 subsequently obtains any of the following prescription  
15 drug coverage):

16 “(i) COVERAGE UNDER PRESCRIPTION DRUG  
17 PLAN OR MEDICARE+CHOICE PLAN.—Qualified  
18 prescription drug coverage under a prescription  
19 drug plan or under a Medicare+Choice plan.

20 “(ii) MEDICAID PRESCRIPTION DRUG COV-  
21 ERAGE.—Prescription drug coverage under a med-  
22 icaid plan under title XIX, including through the  
23 Program of All-inclusive Care for the Elderly  
24 (PACE) under section 1934, through a social  
25 health maintenance organization (referred to in  
26 section 4104(c) of the Balanced Budget Act of  
27 1997), or through a Medicare+Choice project that  
28 demonstrates the application of capitation payment  
29 rates for frail elderly medicare beneficiaries  
30 through the use of a interdisciplinary team and  
31 through the provision of primary care services to  
32 such beneficiaries by means of such a team at the  
33 nursing facility involved.

34 “(iii) PRESCRIPTION DRUG COVERAGE UNDER  
35 GROUP HEALTH PLAN.—Any outpatient prescrip-  
36 tion drug coverage under a group health plan, in-  
37 cluding a health benefits plan under the Federal

1 Employees Health Benefit Plan under chapter 89  
2 of title 5, United States Code, and a qualified re-  
3 tiree prescription drug plan as defined in section  
4 1860H(f)(1), but only if (subject to subparagraph  
5 (E)(ii)) the coverage provides benefits at least  
6 equivalent to the benefits under a qualified pre-  
7 scription drug plan.

8 “(iv) PRESCRIPTION DRUG COVERAGE UNDER  
9 CERTAIN MEDIGAP POLICIES.—Coverage under a  
10 medicare supplemental policy under section 1882  
11 that provides benefits for prescription drugs  
12 (whether or not such coverage conforms to the  
13 standards for packages of benefits under section  
14 1882(p)(1)), but only if the policy was in effect on  
15 January 1, 2005, and if (subject to subparagraph  
16 (E)(ii)) the coverage provides benefits at least  
17 equivalent to the benefits under a qualified pre-  
18 scription drug plan.

19 “(v) STATE PHARMACEUTICAL ASSISTANCE  
20 PROGRAM.—Coverage of prescription drugs under a  
21 State pharmaceutical assistance program, but only  
22 if (subject to subparagraph (E)(ii)) the coverage  
23 provides benefits at least equivalent to the benefits  
24 under a qualified prescription drug plan.

25 “(vi) VETERANS’ COVERAGE OF PRESCRIPTION  
26 DRUGS.—Coverage of prescription drugs for vet-  
27 erans under chapter 17 of title 38, United States  
28 Code, but only if (subject to subparagraph (E)(ii))  
29 the coverage provides benefits at least equivalent to  
30 the benefits under a qualified prescription drug  
31 plan.

32 “(D) CERTIFICATION.—For purposes of carrying  
33 out this paragraph, the certifications of the type de-  
34 scribed in sections 2701(e) of the Public Health Service  
35 Act and in section 9801(e) of the Internal Revenue  
36 Code shall also include a statement for the period of

1 coverage of whether the individual involved had pre-  
2 scription drug coverage described in subparagraph (C).

3 “(E) DISCLOSURE.—

4 “(i) IN GENERAL.—Each entity that offers  
5 coverage of the type described in clause (iii), (iv),  
6 (v), or (vi) of subparagraph (C) shall provide for  
7 disclosure, consistent with standards established by  
8 the Administrator, of whether such coverage pro-  
9 vides benefits at least equivalent to the benefits  
10 under a qualified prescription drug plan.

11 “(ii) WAIVER OF LIMITATIONS.—An individual  
12 may apply to the Administrator to waive the re-  
13 quirement that coverage of such type provide bene-  
14 fits at least equivalent to the benefits under a  
15 qualified prescription drug plan, if the individual  
16 establishes that the individual was not adequately  
17 informed that such coverage did not provide such  
18 level of benefits.

19 “(F) CONSTRUCTION.—Nothing in this section  
20 shall be construed as preventing the disenrollment of  
21 an individual from a prescription drug plan or a  
22 Medicare+Choice plan based on the termination of an  
23 election described in section 1851(g)(3), including for  
24 non-payment of premiums or for other reasons speci-  
25 fied in subsection (d)(3), which takes into account a  
26 grace period described in section 1851(g)(3)(B)(i).

27 “(3) NONDISCRIMINATION.—A PDP sponsor offering  
28 a prescription drug plan shall not establish a service area  
29 in a manner that would discriminate based on health or  
30 economic status of potential enrollees.

31 “(d) EFFECTIVE DATE OF ELECTIONS.—

32 “(1) IN GENERAL.—Except as provided in this section,  
33 the Administrator shall provide that elections under sub-  
34 section (b) take effect at the same time as the Adminis-  
35 trator provides that similar elections under section 1851(e)  
36 take effect under section 1851(f).

1           “(2) NO ELECTION EFFECTIVE BEFORE 2005.—In no  
2 case shall any election take effect before January 1, 2005.

3           “(3) TERMINATION.—The Administrator shall provide  
4 for the termination of an election in the case of—

5                 “(A) termination of coverage under both part A  
6 and part B; and

7                 “(B) termination of elections described in section  
8 1851(g)(3) (including failure to pay required pre-  
9 miums).

10       **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRE-**  
11                                   **SCRIPTION DRUG COVERAGE.**

12           “(a) REQUIREMENTS.—

13                 “(1) IN GENERAL.—For purposes of this part and  
14 part C, the term ‘qualified prescription drug coverage’  
15 means either of the following:

16                 “(A) STANDARD COVERAGE WITH ACCESS TO NE-  
17 GOTIATED PRICES.—Standard coverage (as defined in  
18 subsection (b)) and access to negotiated prices under  
19 subsection (d).

20                 “(B) ACTUARIALLY EQUIVALENT COVERAGE WITH  
21 ACCESS TO NEGOTIATED PRICES.—Coverage of covered  
22 outpatient drugs which meets the alternative coverage  
23 requirements of subsection (c) and access to negotiated  
24 prices under subsection (d), but only if it is approved  
25 by the Administrator, as provided under subsection (c).

26           “(2) PERMITTING ADDITIONAL OUTPATIENT PRE-  
27 SCRPTION DRUG COVERAGE.—

28                 “(A) IN GENERAL.—Subject to subparagraph (B),  
29 nothing in this part shall be construed as preventing  
30 qualified prescription drug coverage from including cov-  
31 erage of covered outpatient drugs that exceeds the cov-  
32 erage required under paragraph (1), but any such addi-  
33 tional coverage shall be limited to coverage of covered  
34 outpatient drugs.

35                 “(B) DISAPPROVAL AUTHORITY.—The Adminis-  
36 trator shall review the offering of qualified prescription  
37 drug coverage under this part or part C. If the Admin-

1            istrator finds that, in the case of a qualified prescrip-  
2            tion drug coverage under a prescription drug plan or  
3            a Medicare+Choice plan, that the organization or spon-  
4            sor offering the coverage is engaged in activities in-  
5            tended to discourage enrollment of classes of eligible  
6            medicare beneficiaries obtaining coverage through the  
7            plan on the basis of their higher likelihood of utilizing  
8            prescription drug coverage, the Administrator may ter-  
9            minate the contract with the sponsor or organization  
10           under this part or part C.

11           “(3) APPLICATION OF SECONDARY PAYOR PROVI-  
12           SIONS.—The provisions of section 1852(a)(4) shall apply  
13           under this part in the same manner as they apply under  
14           part C.

15           “(b) STANDARD COVERAGE.—For purposes of this part,  
16           the ‘standard coverage’ is coverage of covered outpatient drugs  
17           (as defined in subsection (f)) that meets the following require-  
18           ments:

19           “(1) DEDUCTIBLE.—The coverage has an annual  
20           deductible—

21           “(A) for 2005, that is equal to \$250; or

22           “(B) for a subsequent year, that is equal to the  
23           amount specified under this paragraph for the previous  
24           year increased by the percentage specified in paragraph  
25           (5) for the year involved.

26           Any amount determined under subparagraph (B) that is  
27           not a multiple of \$10 shall be rounded to the nearest mul-  
28           tiple of \$10.

29           “(2) LIMITS ON COST-SHARING.—

30           “(A) IN GENERAL.—The coverage has cost-sharing  
31           (for costs above the annual deductible specified in para-  
32           graph (1) and up to the initial coverage limit under  
33           paragraph (3)) as follows:

34           “(i) FIRST COPAYMENT RANGE.—For costs  
35           above the annual deductible specified in paragraph  
36           (1) and up to amount specified in subparagraph  
37           (C), the cost-sharing—

1 “(I) is equal to 20 percent; or

2 “(II) is actuarially equivalent (using proc-  
3 esses established under subsection (e)) to an  
4 average expected payment of 20 percent of  
5 such costs.

6 “(ii) SECONDARY COPAYMENT RANGE.—For  
7 costs above the amount specified in subparagraph  
8 (C) and up to the initial coverage limit, the cost-  
9 sharing—

10 “(I) is equal to 50 percent; or

11 “(II) is actuarially consistent (using proc-  
12 esses established under subsection (e)) with an  
13 average expected payment of 50 percent of  
14 such costs.

15 “(B) USE OF TIERED COPAYMENTS.—Nothing in  
16 this part shall be construed as preventing a PDP spon-  
17 sor from applying tiered copayments, so long as such  
18 tiered copayments are consistent with subparagraph  
19 (A).

20 “(C) INITIAL COPAYMENT THRESHOLD.—The  
21 amount specified in this subparagraph—

22 “(i) for 2005, is equal to \$1,000; or

23 “(ii) for a subsequent year, is equal to the  
24 amount specified in this subparagraph for the pre-  
25 vious year, increased by the annual percentage in-  
26 crease described in paragraph (5) for the year in-  
27 volved.

28 Any amount determined under clause (ii) that is not a  
29 multiple of \$10 shall be rounded to the nearest mul-  
30 tiple of \$10.

31 “(3) INITIAL COVERAGE LIMIT.—Subject to paragraph  
32 (4), the coverage has an initial coverage limit on the max-  
33 imum costs that may be recognized for payment purposes  
34 (above the annual deductible)—

35 “(A) for 2005, that is equal to \$2,000; or

36 “(B) for a subsequent year, that is equal to the  
37 amount specified in this paragraph for the previous

1           year, increased by the annual percentage increase de-  
2           scribed in paragraph (5) for the year involved.

3           Any amount determined under subparagraph (B) that is  
4           not a multiple of \$25 shall be rounded to the nearest mul-  
5           tiple of \$25.

6           “(4) CATASTROPHIC PROTECTION.—

7           “(A) IN GENERAL.—Notwithstanding paragraph  
8           (3), the coverage provides benefits with no cost-sharing  
9           after the individual has incurred costs (as described in  
10          subparagraph (C)) for covered outpatient drugs in a  
11          year equal to the annual out-of-pocket threshold speci-  
12          fied in subparagraph (B).

13          “(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For  
14          purposes of this part, the ‘annual out-of-pocket thresh-  
15          old’ specified in this subparagraph—

16                  “(i) for 2005, is equal to \$4,500; or

17                  “(ii) for a subsequent year, is equal to the  
18                  amount specified in this subparagraph for the pre-  
19                  vious year, increased by the annual percentage in-  
20                  crease described in paragraph (5) for the year in-  
21                  volved.

22          Any amount determined under clause (ii) that is not a  
23          multiple of \$100 shall be rounded to the nearest mul-  
24          tiple of \$100.

25          “(C) APPLICATION.—In applying subparagraph  
26          (A)—

27                  “(i) incurred costs shall only include costs in-  
28                  curred for the annual deductible (described in para-  
29                  graph (1)), cost-sharing (described in paragraph  
30                  (2)), and amounts for which benefits are not pro-  
31                  vided because of the application of the initial cov-  
32                  erage limit described in paragraph (3); and

33                  “(ii) such costs shall be treated as incurred  
34                  only if they are paid by the individual, under sec-  
35                  tion 1860G, or under title XIX and the individual  
36                  is not reimbursed (through insurance or otherwise)  
37                  by another person for such costs.

1           “(5) ANNUAL PERCENTAGE INCREASE.—For purposes  
 2 of this part, the annual percentage increase specified in  
 3 this paragraph for a year is equal to the annual percentage  
 4 increase in average per capita aggregate expenditures for  
 5 covered outpatient drugs in the United States for medicare  
 6 beneficiaries, as determined by the Administrator for the  
 7 12-month period ending in July of the previous year.

8           “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A pre-  
 9 scription drug plan or Medicare+Choice plan may provide a  
 10 different prescription drug benefit design from the standard  
 11 coverage described in subsection (b) so long as the following re-  
 12 quirements are met and the plan applies for, and receives, the  
 13 approval of the Administrator for such benefit design:

14           “(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT  
 15 COVERAGE.—

16           “(A) ASSURING EQUIVALENT VALUE OF TOTAL  
 17 COVERAGE.—The actuarial value of the total coverage  
 18 (as determined under subsection (e)) is at least equal  
 19 to the actuarial value (as so determined) of standard  
 20 coverage.

21           “(B) ASSURING EQUIVALENT UNSUBSIDIZED  
 22 VALUE OF COVERAGE.—The unsubsidized value of the  
 23 coverage is at least equal to the unsubsidized value of  
 24 standard coverage. For purposes of this subparagraph,  
 25 the unsubsidized value of coverage is the amount by  
 26 which the actuarial value of the coverage (as deter-  
 27 mined under subsection (e)) exceeds the actuarial value  
 28 of the subsidy payments under section 1860H with re-  
 29 spect to such coverage.

30           “(C) ASSURING STANDARD PAYMENT FOR COSTS  
 31 AT INITIAL COVERAGE LIMIT.—The coverage is de-  
 32 signed, based upon an actuarially representative pat-  
 33 tern of utilization (as determined under subsection (e)),  
 34 to provide for the payment, with respect to costs in-  
 35 curred that are equal to the initial coverage limit under  
 36 subsection (b)(3), of an amount equal to at least the  
 37 sum of the following products:

1                   “(i) FIRST COPAYMENT RANGE.—The product  
2 of—

3                   “(I) the amount by which the initial co-  
4 payment threshold described in subsection  
5 (b)(2)(C) exceeds the deductible described in  
6 subsection (b)(1); and

7                   “(II) 100 percent minus the cost-sharing  
8 percentage specified in subsection  
9 (b)(2)(A)(i)(I).

10                  “(ii) SECONDARY COPAYMENT RANGE.—The  
11 product of—

12                  “(I) the amount by which the initial cov-  
13 erage limit described in subsection (b)(3) ex-  
14 ceeds the initial copayment threshold described  
15 in subsection (b)(2)(C); and

16                  “(II) 100 percent minus the cost-sharing  
17 percentage specified in subsection  
18 (b)(2)(A)(ii)(I).

19                  “(2) CATASTROPHIC PROTECTION.—The coverage pro-  
20 vides for beneficiaries the catastrophic protection described  
21 in subsection (b)(4).

22                  “(d) ACCESS TO NEGOTIATED PRICES.—

23                  “(1) IN GENERAL.—Under qualified prescription drug  
24 coverage offered by a PDP sponsor or a Medicare+Choice  
25 organization, the sponsor or organization shall provide  
26 beneficiaries with access to negotiated prices (including ap-  
27 plicable discounts) used for payment for covered outpatient  
28 drugs, regardless of the fact that no benefits may be pay-  
29 able under the coverage with respect to such drugs because  
30 of the application of cost-sharing or an initial coverage  
31 limit (described in subsection (b)(3)). Insofar as a State  
32 elects to provide medical assistance under title XIX for a  
33 drug based on the prices negotiated by a prescription drug  
34 plan under this part, the requirements of section 1927 shall  
35 not apply to such drugs.

36                  “(2) DISCLOSURE.—The PDP sponsor or  
37 Medicare+Choice organization shall disclose to the Admin-

1        istrator (in a manner specified by the Administrator) the  
2        extent to which discounts or rebates made available to the  
3        sponsor or organization by a manufacturer are passed  
4        through to enrollees through pharmacies and other dis-  
5        pensers or otherwise. The provisions of section  
6        1927(b)(3)(D) shall apply to information disclosed to the  
7        Administrator under this paragraph in the same manner as  
8        such provisions apply to information disclosed under such  
9        section.

10       “(e) ACTUARIAL VALUATION; DETERMINATION OF AN-  
11       NUAL PERCENTAGE INCREASES.—

12       “(1) PROCESSES.—For purposes of this section, the  
13       Administrator shall establish processes and methods—

14       “(A) for determining the actuarial valuation of  
15       prescription drug coverage, including—

16       “(i) an actuarial valuation of standard cov-  
17       erage and of the reinsurance subsidy payments  
18       under section 1860H;

19       “(ii) the use of generally accepted actuarial  
20       principles and methodologies; and

21       “(iii) applying the same methodology for de-  
22       terminations of alternative coverage under sub-  
23       section (c) as is used with respect to determina-  
24       tions of standard coverage under subsection (b);  
25       and

26       “(B) for determining annual percentage increases  
27       described in subsection (b)(5).

28       “(2) USE OF OUTSIDE ACTUARIES.—Under the proc-  
29       esses under paragraph (1)(A), PDP sponsors and  
30       Medicare+Choice organizations may use actuarial opinions  
31       certified by independent, qualified actuaries to establish ac-  
32       tuarial values.

33       “(f) COVERED OUTPATIENT DRUGS DEFINED.—

34       “(1) IN GENERAL.—Except as provided in this sub-  
35       section, for purposes of this part, the term ‘covered out-  
36       patient drug’ means—

1           “(A) a drug that may be dispensed only upon a  
2           prescription and that is described in subparagraph  
3           (A)(i) or (A)(ii) of section 1927(k)(2); or

4           “(B) a biological product described in clauses (i)  
5           through (iii) of subparagraph (B) of such section or in-  
6           sulin described in subparagraph (C) of such section,  
7           and such term includes a vaccine licensed under section  
8           351 of the Public Health Service Act and any use of a cov-  
9           ered outpatient drug for a medically accepted indication (as  
10          defined in section 1927(k)(6)).

11          “(2) EXCLUSIONS.—

12           “(A) IN GENERAL.—Such term does not include  
13           drugs or classes of drugs, or their medical uses, which  
14           may be excluded from coverage or otherwise restricted  
15           under section 1927(d)(2), other than subparagraph (E)  
16           thereof (relating to smoking cessation agents), or under  
17           section 1927(d)(3).

18           “(B) AVOIDANCE OF DUPLICATE COVERAGE.—A  
19           drug prescribed for an individual that would otherwise  
20           be a covered outpatient drug under this part shall not  
21           be so considered if payment for such drug is available  
22           under part A or B for an individual entitled to benefits  
23           under part A and enrolled under part B.

24           “(3) APPLICATION OF FORMULARY RESTRICTIONS.—A  
25           drug prescribed for an individual that would otherwise be  
26           a covered outpatient drug under this part shall not be so  
27           considered under a plan if the plan excludes the drug under  
28           a formulary and such exclusion is not successfully appealed  
29           under section 1860C(f)(2).

30           “(4) APPLICATION OF GENERAL EXCLUSION PROVI-  
31           SIONS.—A prescription drug plan or Medicare+Choice plan  
32           may exclude from qualified prescription drug coverage any  
33           covered outpatient drug—

34           “(A) for which payment would not be made if sec-  
35           tion 1862(a) applied to part D; or

36           “(B) which are not prescribed in accordance with  
37           the plan or this part.



1 basis, through an Internet website and in writing upon re-  
 2 quest, information on specific changes in its formulary.

3 “(4) CLAIMS INFORMATION.—Each PDP sponsor of-  
 4 fering a prescription drug plan must furnish to enrolled in-  
 5 dividuals in a form easily understandable to such individ-  
 6 uals an explanation of benefits (in accordance with section  
 7 1806(a) or in a comparable manner) and a notice of the  
 8 benefits in relation to initial coverage limit and annual out-  
 9 of-pocket threshold for the current year, whenever prescrip-  
 10 tion drug benefits are provided under this part (except that  
 11 such notice need not be provided more often than monthly).

12 “(c) ACCESS TO COVERED BENEFITS.—

13 “(1) ASSURING PHARMACY ACCESS.—

14 “(A) IN GENERAL.—The PDP sponsor of the pre-  
 15 scription drug plan shall secure the participation in its  
 16 network of a sufficient number of pharmacies that dis-  
 17 pense (other than by mail order) drugs directly to pa-  
 18 tients to ensure convenient access (as determined by  
 19 the Administrator and including adequate emergency  
 20 access) for enrolled beneficiaries, in accordance with  
 21 standards established under section 1860D(e) that en-  
 22 sure such convenient access.

23 “(B) USE OF POINT-OF-SERVICE SYSTEM.—A  
 24 PDP sponsor shall establish an optional point-of-service  
 25 method of operation under which—

26 “(i) the plan provides access to any or all  
 27 pharmacies that are not participating pharmacies  
 28 in its network; and

29 “(ii) the plan may charge beneficiaries through  
 30 adjustments in premiums and copayments any ad-  
 31 ditional costs associated with the point-of-service  
 32 option.

33 The additional copayments so charged shall not count  
 34 toward the application of section 1860B(b).

35 “(2) USE OF STANDARDIZED TECHNOLOGY.—

36 “(A) IN GENERAL.—The PDP sponsor of a pre-  
 37 scription drug plan shall issue (and reissue, as appro-

1           priate) such a card (or other technology) that may be  
 2           used by an enrolled beneficiary to assure access to ne-  
 3           gotiated prices under section 1860B(d) for the pur-  
 4           chase of prescription drugs for which coverage is not  
 5           otherwise provided under the prescription drug plan.

6           “(B) STANDARDS.—

7           “(i) DEVELOPMENT.—The Administrator shall  
 8           provide for the development of national standards  
 9           relating to a standardized format for the card or  
 10          other technology referred to in subparagraph (A).  
 11          Such standards shall be compatible with standards  
 12          established under part C of title XI.

13          “(ii) APPLICATION OF ADVISORY TASK  
 14          FORCE.—The advisory task force established under  
 15          subsection (d)(3)(B)(ii) shall provide recommenda-  
 16          tions to the Administrator under such subsection  
 17          regarding the standards developed under clause (i).

18          “(3) REQUIREMENTS ON DEVELOPMENT AND APPLICA-  
 19          TION OF FORMULARIES.—If a PDP sponsor of a prescrip-  
 20          tion drug plan uses a formulary, the following requirements  
 21          must be met:

22          “(A) PHARMACY AND THERAPEUTIC (P&T) COM-  
 23          MITTEE.—The sponsor must establish a pharmacy and  
 24          therapeutic committee that develops and reviews the  
 25          formulary. Such committee shall include at least one  
 26          physician and at least one pharmacist both with exper-  
 27          tise in the care of elderly or disabled persons and a ma-  
 28          jority of its members shall consist of individuals who  
 29          are a physician or a pharmacist (or both).

30          “(B) FORMULARY DEVELOPMENT.—In developing  
 31          and reviewing the formulary, the committee shall base  
 32          clinical decisions on the strength of scientific evidence  
 33          and standards of practice, including assessing peer-re-  
 34          viewed medical literature, such as randomized clinical  
 35          trials, pharmacoeconomic studies, outcomes research  
 36          data, and such other information as the committee de-  
 37          termines to be appropriate.

1           “(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC  
2 CATEGORIES.—The formulary must include drugs with-  
3 in each therapeutic category and class of covered out-  
4 patient drugs (although not necessarily for all drugs  
5 within such categories and classes).

6           “(D) PROVIDER EDUCATION.—The committee  
7 shall establish policies and procedures to educate and  
8 inform health care providers concerning the formulary.

9           “(E) NOTICE BEFORE REMOVING DRUGS FROM  
10 FORMULARY.—Any removal of a drug from a formulary  
11 shall take effect only after appropriate notice is made  
12 available to beneficiaries and physicians.

13           “(F) GRIEVANCES AND APPEALS RELATING TO AP-  
14 PPLICATION OF FORMULARIES.—For provisions relating  
15 to grievances and appeals of coverage, see subsections  
16 (e) and (f).

17           “(d) COST AND UTILIZATION MANAGEMENT; QUALITY AS-  
18 SURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

19           “(1) IN GENERAL.—The PDP sponsor shall have in  
20 place with respect to covered outpatient drugs—

21           “(A) an effective cost and drug utilization man-  
22 agement program, including medically appropriate in-  
23 centives to use generic drugs and therapeutic inter-  
24 change, when appropriate;

25           “(B) quality assurance measures and systems to  
26 reduce medical errors and adverse drug interactions,  
27 including a medication therapy management program  
28 described in paragraph (2) and for years beginning  
29 with 2006, an electronic prescription program described  
30 in paragraph (3); and

31           “(C) a program to control fraud, abuse, and  
32 waste.

33           Nothing in this section shall be construed as impairing a  
34 PDP sponsor from applying cost management tools (includ-  
35 ing differential payments) under all methods of operation.

36           “(2) MEDICATION THERAPY MANAGEMENT PRO-  
37 GRAM.—

1           “(A) IN GENERAL.—A medication therapy man-  
2           agement program described in this paragraph is a pro-  
3           gram of drug therapy management and medication ad-  
4           ministration that is designed to assure, with respect to  
5           beneficiaries with chronic diseases (such as diabetes,  
6           asthma, hypertension, and congestive heart failure) or  
7           multiple prescriptions, that covered outpatient drugs  
8           under the prescription drug plan are appropriately used  
9           to achieve therapeutic goals and reduce the risk of ad-  
10          verse events, including adverse drug interactions.

11          “(B) ELEMENTS.—Such program may include—

12           “(i) enhanced beneficiary understanding of  
13           such appropriate use through beneficiary education,  
14           counseling, and other appropriate means;

15           “(ii) increased beneficiary adherence with pre-  
16           scription medication regimens through medication  
17           refill reminders, special packaging, and other ap-  
18           propriate means; and

19           “(iii) detection of patterns of overuse and  
20           underuse of prescription drugs.

21          “(C) DEVELOPMENT OF PROGRAM IN COOPERA-  
22          TION WITH LICENSED PHARMACISTS.—The program  
23          shall be developed in cooperation with licensed phar-  
24          macists and physicians.

25          “(D) CONSIDERATIONS IN PHARMACY FEES.—The  
26          PDP sponsor of a prescription drug program shall take  
27          into account, in establishing fees for pharmacists and  
28          others providing services under the medication therapy  
29          management program, the resources and time used in  
30          implementing the program.

31          “(3) ELECTRONIC PRESCRIPTION PROGRAM.—

32           “(A) IN GENERAL.—An electronic prescription  
33           drug program described in this paragraph is a program  
34           that includes at least the following components, con-  
35           sistent with national standards established under sub-  
36           paragraph (B):

1                   “(i) ELECTRONIC TRANSMITTAL OF PRESCRIP-  
 2                   TIONS.—Prescriptions are only received electroni-  
 3                   cally, except in emergency cases and other excep-  
 4                   tional circumstances recognized by the Adminis-  
 5                   trator.

6                   “(ii) PROVISION OF INFORMATION TO PRE-  
 7                   SCRIBING HEALTH CARE PROFESSIONAL.—The pro-  
 8                   gram provides, upon transmittal of a prescription  
 9                   by a prescribing health care professional, for trans-  
 10                  mittal by the pharmacist to the professional of in-  
 11                  formation that includes—

12                   “(I) information (to the extent available  
 13                   and feasible) on the drugs being prescribed for  
 14                   that patient and other information relating to  
 15                   the medical history or condition of the patient  
 16                   that may be relevant to the appropriate pre-  
 17                   scription for that patient;

18                   “(II) cost-effective alternatives (if any) for  
 19                   the use of the drug prescribed; and

20                   “(III) information on the drugs included  
 21                   in the applicable formulary.

22                  To the extent feasible, such program shall permit  
 23                  the prescribing health care professional to provide  
 24                  (and be provided) related information on an inter-  
 25                  active, real-time basis.

26                  “(B) STANDARDS.—

27                   “(i) DEVELOPMENT.—The Administrator shall  
 28                   provide for the development of national standards  
 29                   relating to the electronic prescription drug program  
 30                   described in subparagraph (A). Such standards  
 31                   shall be compatible with standards established  
 32                   under part C of title XI.

33                   “(ii) ADVISORY TASK FORCE.—In developing  
 34                   such standards and the standards described in sub-  
 35                   section (c)(2)(B)(i) the Administrator shall estab-  
 36                   lish a task force that includes representatives of  
 37                   physicians, hospitals, pharmacists, and technology

1 experts and representatives of the Departments of  
2 Veterans Affairs and Defense and other appro-  
3 priate Federal agencies to provide recommenda-  
4 tions to the Administrator on such standards, in-  
5 cluding recommendations relating to the following:

6 “(I) The range of available computerized  
7 prescribing software and hardware and their  
8 costs to develop and implement.

9 “(II) The extent to which such systems re-  
10 duce medication errors and can be readily im-  
11 plemented by physicians and hospitals.

12 “(III) Efforts to develop a common soft-  
13 ware platform for computerized prescribing.

14 “(IV) The cost of implementing such sys-  
15 tems in the range of hospital and physician of-  
16 fice settings, including hardware, software, and  
17 training costs.

18 “(V) Implementation issues as they relate  
19 to part C of title XI, and current Federal and  
20 State prescribing laws and regulations and  
21 their impact on implementation of computer-  
22 ized prescribing.

23 “(iii) DEADLINES.—

24 “(I) The Administrator shall constitute  
25 the task force under clause (ii) by not later  
26 than April 1, 2003.

27 “(II) Such task force shall submit rec-  
28 ommendations to Administrator by not later  
29 than January 1, 2004.

30 “(III) The Administrator shall develop and  
31 promulgate the national standards referred to  
32 in clause (ii) by not later than July 1, 2004.

33 “(C) REFERENCE TO AVAILABILITY OF GRANT  
34 FUNDS.—Grant funds are authorized under section  
35 3990 of the Public Health Service Act to provide as-  
36 sistance to health care providers in implementing elec-  
37 tronic prescription drug programs.

1           “(4) TREATMENT OF ACCREDITATION.—Section  
2 1852(e)(4) (relating to treatment of accreditation) shall  
3 apply to prescription drug plans under this part with re-  
4 spect to the following requirements, in the same manner as  
5 they apply to Medicare+Choice plans under part C with re-  
6 spect to the requirements described in a clause of section  
7 1852(e)(4)(B):

8           “(A) Paragraph (1) (including quality assurance),  
9 including medication therapy management program  
10 under paragraph (2).

11           “(B) Subsection (e)(1) (relating to access to cov-  
12 ered benefits).

13           “(C) Subsection (g) (relating to confidentiality and  
14 accuracy of enrollee records).

15           “(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL  
16 PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor  
17 shall provide that each pharmacy or other dispenser that  
18 arranges for the dispensing of a covered outpatient drug  
19 shall inform the beneficiary at the time of purchase of the  
20 drug of any differential between the price of the prescribed  
21 drug to the enrollee and the price of the lowest cost generic  
22 drug covered under the plan that is therapeutically equiva-  
23 lent and bioequivalent.

24           “(e) GRIEVANCE MECHANISM, COVERAGE DETERMINA-  
25 TIONS, AND RECONSIDERATIONS.—

26           “(1) IN GENERAL.—Each PDP sponsor shall provide  
27 meaningful procedures for hearing and resolving grievances  
28 between the organization (including any entity or individual  
29 through which the sponsor provides covered benefits) and  
30 enrollees with prescription drug plans of the sponsor under  
31 this part in accordance with section 1852(f).

32           “(2) APPLICATION OF COVERAGE DETERMINATION  
33 AND RECONSIDERATION PROVISIONS.—A PDP sponsor  
34 shall meet the requirements of paragraphs (1) through (3)  
35 of section 1852(g) with respect to covered benefits under  
36 the prescription drug plan it offers under this part in the  
37 same manner as such requirements apply to a

1 Medicare+Choice organization with respect to benefits it  
2 offers under a Medicare+Choice plan under part C.

3 “(3) REQUEST FOR REVIEW OF TIERED FORMULARY  
4 DETERMINATIONS.—In the case of a prescription drug plan  
5 offered by a PDP sponsor that provides for tiered cost-  
6 sharing for drugs included within a formulary and provides  
7 lower cost-sharing for preferred drugs included within the  
8 formulary, an individual who is enrolled in the plan may re-  
9 quest coverage of a nonpreferred drug under the terms ap-  
10 plicable for preferred drugs if the prescribing physician de-  
11 termines that the preferred drug for treatment of the same  
12 condition is not as effective for the individual or has ad-  
13 verse effects for the individual.

14 “(f) APPEALS.—

15 “(1) IN GENERAL.—Subject to paragraph (2), a PDP  
16 sponsor shall meet the requirements of paragraphs (4) and  
17 (5) of section 1852(g) with respect to drugs not included  
18 on any formulary in the same manner as such requirements  
19 apply to a Medicare+Choice organization with respect to  
20 benefits it offers under a Medicare+Choice plan under part  
21 C.

22 “(2) FORMULARY DETERMINATIONS.—An individual  
23 who is enrolled in a prescription drug plan offered by a  
24 PDP sponsor may appeal to obtain coverage for a covered  
25 outpatient drug that is not on a formulary of the sponsor  
26 if the prescribing physician determines that the formulary  
27 drug for treatment of the same condition is not as effective  
28 for the individual or has adverse effects for the individual.

29 “(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE  
30 RECORDS.—A PDP sponsor shall meet the requirements of sec-  
31 tion 1852(h) with respect to enrollees under this part in the  
32 same manner as such requirements apply to a  
33 Medicare+Choice organization with respect to enrollees under  
34 part C.

1 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**  
2 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**  
3 **LISHMENT OF STANDARDS.**

4 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a  
5 prescription drug plan shall meet the following requirements:

6 “(1) LICENSURE.—Subject to subsection (c), the spon-  
7 sor is organized and licensed under State law as a risk-  
8 bearing entity eligible to offer health insurance or health  
9 benefits coverage in each State in which it offers a pre-  
10 scription drug plan.

11 “(2) ASSUMPTION OF FINANCIAL RISK.—

12 “(A) IN GENERAL.—Subject to subparagraph (B)  
13 and section 1860E(d)(2), the entity assumes full finan-  
14 cial risk on a prospective basis for qualified prescrip-  
15 tion drug coverage that it offers under a prescription  
16 drug plan and that is not covered under section  
17 1860H.

18 “(B) REINSURANCE PERMITTED.—The entity may  
19 obtain insurance or make other arrangements for the  
20 cost of coverage provided to any enrolled member under  
21 this part.

22 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the  
23 case of a sponsor that is not described in paragraph (1),  
24 the sponsor shall meet solvency standards established by  
25 the Administrator under subsection (d).

26 “(b) CONTRACT REQUIREMENTS.—

27 “(1) IN GENERAL.—The Administrator shall not per-  
28 mit the election under section 1860A of a prescription drug  
29 plan offered by a PDP sponsor under this part, and the  
30 sponsor shall not be eligible for payments under section  
31 1860G or 1860H, unless the Administrator has entered  
32 into a contract under this subsection with the sponsor with  
33 respect to the offering of such plan. Such a contract with  
34 a sponsor may cover more than one prescription drug plan.  
35 Such contract shall provide that the sponsor agrees to com-  
36 ply with the applicable requirements and standards of this

1 part and the terms and conditions of payment as provided  
2 for in this part.

3 “(2) NEGOTIATION REGARDING TERMS AND CONDI-  
4 TIONS.—The Administrator shall have the same authority  
5 to negotiate the terms and conditions of prescription drug  
6 plans under this part as the Director of the Office of Per-  
7 sonnel Management has with respect to health benefits  
8 plans under chapter 89 of title 5, United States Code. In  
9 negotiating the terms and conditions regarding premiums  
10 for which information is submitted under section  
11 1860F(a)(2), the Administrator shall take into account the  
12 subsidy payments under section 1860H and the adjusted  
13 community rate (as defined in section 1854(f)(3)) for the  
14 benefits covered.

15 “(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE  
16 CONTRACT REQUIREMENTS.—The following provisions of  
17 section 1857 shall apply, subject to subsection (c)(5), to  
18 contracts under this section in the same manner as they  
19 apply to contracts under section 1857(a):

20 “(A) MINIMUM ENROLLMENT.—Paragraphs (1)  
21 and (3) of section 1857(b).

22 “(B) CONTRACT PERIOD AND EFFECTIVENESS.—  
23 Paragraphs (1) through (3) and (5) of section 1857(c).

24 “(C) PROTECTIONS AGAINST FRAUD AND BENE-  
25 FICIARY PROTECTIONS.—Section 1857(d).

26 “(D) ADDITIONAL CONTRACT TERMS.—Section  
27 1857(e); except that in applying section 1857(e)(2)  
28 under this part—

29 “(i) such section shall be applied separately to  
30 costs relating to this part (from costs under part  
31 C);

32 “(ii) in no case shall the amount of the fee es-  
33 tablished under this subparagraph for a plan ex-  
34 ceed 20 percent of the maximum amount of the fee  
35 that may be established under subparagraph (B) of  
36 such section; and

1                   “(iii) no fees shall be applied under this sub-  
2                   paragraph with respect to Medicare+Choice plans.

3                   “(E) INTERMEDIATE SANCTIONS.—Section  
4                   1857(g).

5                   “(F) PROCEDURES FOR TERMINATION.—Section  
6                   1857(h).

7                   “(4) RULES OF APPLICATION FOR INTERMEDIATE  
8                   SANCTIONS.—In applying paragraph (3)(E)—

9                   “(A) the reference in section 1857(g)(1)(B) to sec-  
10                  tion 1854 is deemed a reference to this part; and

11                  “(B) the reference in section 1857(g)(1)(F) to sec-  
12                  tion 1852(k)(2)(A)(ii) shall not be applied.

13                  “(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND  
14                  CHOICE.—

15                  “(1) IN GENERAL.—In the case of an entity that seeks  
16                  to offer a prescription drug plan in a State, the Adminis-  
17                  trator shall waive the requirement of subsection (a)(1) that  
18                  the entity be licensed in that State if the Administrator de-  
19                  termines, based on the application and other evidence pre-  
20                  sented to the Administrator, that any of the grounds for  
21                  approval of the application described in paragraph (2) has  
22                  been met.

23                  “(2) GROUNDS FOR APPROVAL.—The grounds for ap-  
24                  proval under this paragraph are the grounds for approval  
25                  described in subparagraph (B), (C), and (D) of section  
26                  1855(a)(2), and also include the application by a State of  
27                  any grounds other than those required under Federal law.

28                  “(3) APPLICATION OF WAIVER PROCEDURES.—With  
29                  respect to an application for a waiver (or a waiver granted)  
30                  under this subsection, the provisions of subparagraphs (E),  
31                  (F), and (G) of section 1855(a)(2) shall apply.

32                  “(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CON-  
33                  STITUTE CERTIFICATION.—The fact that an entity is li-  
34                  censed in accordance with subsection (a)(1) does not deem  
35                  the entity to meet other requirements imposed under this  
36                  part for a PDP sponsor.

1           “(5) REFERENCES TO CERTAIN PROVISIONS.—For  
2 purposes of this subsection, in applying provisions of sec-  
3 tion 1855(a)(2) under this subsection to prescription drug  
4 plans and PDP sponsors—

5           “(A) any reference to a waiver application under  
6 section 1855 shall be treated as a reference to a waiver  
7 application under paragraph (1); and

8           “(B) any reference to solvency standards shall be  
9 treated as a reference to solvency standards established  
10 under subsection (d).

11           “(d) SOLVENCY STANDARDS FOR NON-LICENSED SPON-  
12 SORS.—

13           “(1) ESTABLISHMENT.—The Administrator shall es-  
14 tablish, by not later than October 1, 2003, financial sol-  
15 vency and capital adequacy standards that an entity that  
16 does not meet the requirements of subsection (a)(1) must  
17 meet to qualify as a PDP sponsor under this part.

18           “(2) COMPLIANCE WITH STANDARDS.—Each PDP  
19 sponsor that is not licensed by a State under subsection  
20 (a)(1) and for which a waiver application has been ap-  
21 proved under subsection (c) shall meet solvency and capital  
22 adequacy standards established under paragraph (1). The  
23 Administrator shall establish certification procedures for  
24 such PDP sponsors with respect to such solvency standards  
25 in the manner described in section 1855(c)(2).

26           “(e) OTHER STANDARDS.—The Administrator shall estab-  
27 lish by regulation other standards (not described in subsection  
28 (d)) for PDP sponsors and plans consistent with, and to carry  
29 out, this part. The Administrator shall publish such regulations  
30 by October 1, 2003.

31           “(f) RELATION TO STATE LAWS.—

32           “(1) IN GENERAL.—The standards established under  
33 this part shall supersede any State law or regulation (other  
34 than State licensing laws or State laws relating to plan sol-  
35 vency, except as provided in subsection (d)) with respect to  
36 prescription drug plans which are offered by PDP sponsors  
37 under this part.

1           “(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM  
2 TAXES.—No State may impose a premium tax or similar  
3 tax with respect to premiums paid to PDP sponsors for  
4 prescription drug plans under this part, or with respect to  
5 any payments made to such a sponsor by the Administrator  
6 under this part.

7           **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**  
8                           **QUALIFIED PRESCRIPTION DRUG COV-**  
9                           **ERAGE.**

10           “(a) IN GENERAL.—The Administrator shall establish a  
11 process for the selection of the prescription drug plan or  
12 Medicare+Choice plan which offer qualified prescription drug  
13 coverage through which eligible individuals elect qualified pre-  
14 scription drug coverage under this part.

15           “(b) ELEMENTS.—Such process shall include the fol-  
16 lowing:

17           “(1) Annual, coordinated election periods, in which  
18 such individuals can change the qualifying plans through  
19 which they obtain coverage, in accordance with section  
20 1860A(b)(2).

21           “(2) Active dissemination of information to promote  
22 an informed selection among qualifying plans based upon  
23 price, quality, and other features, in the manner described  
24 in (and in coordination with) section 1851(d), including the  
25 provision of annual comparative information, maintenance  
26 of a toll-free hotline, and the use of non-Federal entities.

27           “(3) Coordination of elections through filing with a  
28 Medicare+Choice organization or a PDP sponsor, in the  
29 manner described in (and in coordination with) section  
30 1851(c)(2).

31           “(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING  
32 PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENE-  
33 FITS THROUGH THE PLAN.—An individual who is enrolled  
34 under a Medicare+Choice plan that offers qualified prescrip-  
35 tion drug coverage may only elect to receive qualified prescrip-  
36 tion drug coverage under this part through such plan.

1           “(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRE-  
2       SCRIPTION DRUG COVERAGE.—

3           “(1) CHOICE OF AT LEAST TWO PLANS IN EACH  
4       AREA.—

5           “(A) IN GENERAL.—The Administrator shall as-  
6       sure that each individual who is entitled to benefits  
7       under part A or enrolled under part B and who is re-  
8       siding in an area in the United States has available,  
9       consistent with subparagraph (B), a choice of enroll-  
10      ment in at least two qualifying plans (as defined in  
11      paragraph (5)) in the area in which the individual re-  
12      sides, at least one of which is a prescription drug plan.

13          “(B) REQUIREMENT FOR DIFFERENT PLAN SPON-  
14      SORS.—The requirement in subparagraph (A) is not  
15      satisfied with respect to an area if only one PDP spon-  
16      sor or Medicare+Choice organization offers all the  
17      qualifying plans in the area.

18          “(2) GUARANTEEING ACCESS TO COVERAGE.—In order  
19      to assure access under paragraph (1) and consistent with  
20      paragraph (3), the Administrator may provide financial in-  
21      centives (including partial underwriting of risk) for a PDP  
22      sponsor to expand the service area under an existing pre-  
23      scription drug plan to adjoining or additional areas or to  
24      establish such a plan (including offering such a plan on a  
25      regional or nationwide basis), but only so long as (and to  
26      the extent) necessary to assure the access guaranteed  
27      under paragraph (1).

28          “(3) LIMITATION ON AUTHORITY.—In exercising au-  
29      thority under this subsection, the Administrator—

30           “(A) shall not provide for the full underwriting of  
31      financial risk for any PDP sponsor;

32           “(B) shall not provide for any underwriting of fi-  
33      nancial risk for a public PDP sponsor with respect to  
34      the offering of a nationwide prescription drug plan; and

35           “(C) shall seek to maximize the assumption of fi-  
36      nancial risk by PDP sponsors or Medicare+Choice or-  
37      ganizations.

1           “(4) REPORTS.—The Administrator shall, in each an-  
 2           nual report to Congress under section 1808(f), include in-  
 3           formation on the exercise of authority under this sub-  
 4           section. The Administrator also shall include such rec-  
 5           ommendations as may be appropriate to minimize the exer-  
 6           cise of such authority, including minimizing the assumption  
 7           of financial risk.

8           “(5) QUALIFYING PLAN DEFINED.—For purposes of  
 9           this subsection, the term ‘qualifying plan’ means a pre-  
 10          scription drug plan or a Medicare+Choice plan that in-  
 11          cludes qualified prescription drug coverage.

12       **“SEC. 1860F. SUBMISSION OF BIDS.**

13          “(a) SUBMISSION OF BIDS AND RELATED INFORMA-  
 14          TION.—

15               “(1) IN GENERAL.—Each PDP sponsor shall submit  
 16               to the Administrator information of the type described in  
 17               paragraph (2) in the same manner as information is sub-  
 18               mitted by a Medicare+Choice organization under section  
 19               1854(a)(1).

20               “(2) TYPE OF INFORMATION.—The information de-  
 21               scribed in this paragraph is the following:

22                       “(A) Information on the qualified prescription  
 23                       drug coverage to be provided.

24                       “(B) Information on the actuarial value of the cov-  
 25                       erage.

26                       “(C) Information on the bid for the coverage, in-  
 27                       cluding an actuarial certification of—

28                               “(i) the actuarial basis for such bid;

29                               “(ii) the portion of such bid attributable to  
 30                               benefits in excess of standard coverage; and

31                               “(iii) the reduction in such bid resulting from  
 32                               the subsidy payments provided under section  
 33                               1860H.

34                       “(D) Such other information as the Administrator  
 35                       may require to carry out this part.

1           “(3) REVIEW.—The Administrator shall review the in-  
2           formation filed under paragraph (2) for the purpose of con-  
3           ducting negotiations under section 1860D(b)(2).

4           “(b) UNIFORM BID.—

5           “(1) IN GENERAL.—The bid for a prescription drug  
6           plan under this section may not vary among individuals en-  
7           rolled in the plan in the same service area.

8           “(2) CONSTRUCTION.—Nothing in paragraph (1) shall  
9           be construed as preventing the imposition of a late enroll-  
10          ment penalty under section 1860A(c)(2)(B).

11          “(c) COLLECTION.—

12          “(1) USE OF ELECTRONIC FUNDS TRANSFER MECHA-  
13          NISM OR, AT BENEFICIARY’S OPTION, WITHHOLDING FROM  
14          SOCIAL SECURITY PAYMENT.—In accordance with regula-  
15          tions, a PDP sponsor may encourage that enrollees under  
16          a plan make payment of the premium established by the  
17          plan under this part through an electronic funds transfer  
18          mechanism, such as automatic charges of an account at a  
19          financial institution or a credit or debit card account, or,  
20          at the option of an enrollee, through withholding from ben-  
21          efit payments in the manner provided under section 1840  
22          with respect to monthly premiums under section 1839. All  
23          such amounts shall be credited to the Medicare Prescrip-  
24          tion Drug Trust Fund.

25          “(2) OFFSETTING.—Reductions in premiums for cov-  
26          erage under parts A and B as a result of a selection of a  
27          Medicare+Choice plan may be used to reduce the premium  
28          otherwise imposed under paragraph (1).

29          “(3) PAYMENT OF PLANS.—PDP plans shall receive  
30          payment based on bid amounts in the same manner as  
31          Medicare+Choice organizations receive payment based on  
32          bid amounts under section 1853(a)(1)(A)(ii) except that  
33          such payment shall be made from the Medicare Prescrip-  
34          tion Drug Trust Fund.

35          “(d) ACCEPTANCE OF BENCHMARK AMOUNT AS FULL  
36          PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS IF NO  
37          STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

1           “(1) IN GENERAL.—If there is no standard prescrip-  
 2           tion drug coverage (as defined in paragraph (2)) offered in  
 3           an area, in the case of an individual who is eligible for a  
 4           premium subsidy under section 1860G and resides in the  
 5           area, the PDP sponsor of any prescription drug plan of-  
 6           fered in the area (and any Medicare+Choice organization  
 7           that offers qualified prescription drug coverage in the area)  
 8           shall accept the benchmark bid amount (under section  
 9           1860G(b)(2)) as payment in full for the premium charge  
 10          for qualified prescription drug coverage.

11           “(2) STANDARD PRESCRIPTION DRUG COVERAGE DE-  
 12          FINED.—For purposes of this subsection, the term ‘stand-  
 13          ard prescription drug coverage’ means qualified prescrip-  
 14          tion drug coverage that is standard coverage or that has  
 15          an actuarial value equivalent to the actuarial value for  
 16          standard coverage.

17          **“SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES**  
 18          **FOR LOW-INCOME INDIVIDUALS.**

19           “(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS  
 20          WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY  
 21          LEVEL.—

22           “(1) FULL PREMIUM SUBSIDY AND REDUCTION OF  
 23          COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 150  
 24          PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a  
 25          subsidy eligible individual (as defined in paragraph (4))  
 26          who is determined to have income that does not exceed 150  
 27          percent of the Federal poverty level, the individual is enti-  
 28          tled under this section—

29                   “(A) to an income-related premium subsidy equal  
 30                   to 100 percent of the amount described in subsection  
 31                   (b)(1); and

32                   “(B) subject to subsection (c), to the substitution  
 33                   for the beneficiary cost-sharing described in paragraphs  
 34                   (1) and (2) of section 1860B(b) (up to the initial cov-  
 35                   erage limit specified in paragraph (3) of such section)  
 36                   of amounts that do not exceed \$2 for a multiple source

1 or generic drug (as described in section 1927(k)(7)(A))  
 2 and \$5 for a non-preferred drug.

3 “(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUC-  
 4 TION OF COST-SHARING FOR INDIVIDUALS WITH INCOME  
 5 ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POV-  
 6 ERTY LEVEL.—In the case of a subsidy eligible individual  
 7 who is determined to have income that exceeds 150 per-  
 8 cent, but does not exceed 175 percent, of the Federal pov-  
 9 erty level, the individual is entitled under this section to—

10 “(A) an income-related premium subsidy deter-  
 11 mined on a linear sliding scale ranging from 100 per-  
 12 cent of the amount described in subsection (b)(1) for  
 13 individuals with incomes at 150 percent of such level  
 14 to 0 percent of such amount for individuals with in-  
 15 comes at 175 percent of such level; and

16 “(B) subject to subsection (c), to the substitution  
 17 for the beneficiary cost-sharing described in paragraphs  
 18 (1) and (2) of section 1860B(b) (up to the initial cov-  
 19 erage limit specified in paragraph (3) of such section)  
 20 of amounts that do not exceed \$2 for a multiple source  
 21 or generic drug (as described in section 1927(k)(7)(A))  
 22 and \$5 for a non-preferred drug.

23 “(3) CONSTRUCTION.—Nothing in this section shall be  
 24 construed as preventing a PDP sponsor from reducing to  
 25 0 the cost-sharing otherwise applicable to generic drugs.

26 “(4) DETERMINATION OF ELIGIBILITY.—

27 “(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—  
 28 For purposes of this section, subject to subparagraph  
 29 (D), the term ‘subsidy eligible individual’ means an in-  
 30 dividual who—

31 “(i) is eligible to elect, and has elected, to ob-  
 32 tain qualified prescription drug coverage under this  
 33 part;

34 “(ii) has income below 175 percent of the Fed-  
 35 eral poverty line; and

36 “(iii) meets the resources requirement de-  
 37 scribed in section 1905(p)(1)(C).

1           “(B) DETERMINATIONS.—The determination of  
2 whether an individual residing in a State is a subsidy  
3 eligible individual and the amount of such individual’s  
4 income shall be determined under the State medicaid  
5 plan for the State under section 1935(a). In the case  
6 of a State that does not operate such a medicaid plan  
7 (either under title XIX or under a statewide waiver  
8 granted under section 1115), such determination shall  
9 be made under arrangements made by the Adminis-  
10 trator.

11           “(C) INCOME DETERMINATIONS.—For purposes of  
12 applying this section—

13           “(i) income shall be determined in the manner  
14 described in section 1905(p)(1)(B); and

15           “(ii) the term ‘Federal poverty line’ means the  
16 official poverty line (as defined by the Office of  
17 Management and Budget, and revised annually in  
18 accordance with section 673(2) of the Omnibus  
19 Budget Reconciliation Act of 1981) applicable to a  
20 family of the size involved.

21           “(D) TREATMENT OF TERRITORIAL RESIDENTS.—  
22 In the case of an individual who is not a resident of  
23 the 50 States or the District of Columbia, the indi-  
24 vidual is not eligible to be a subsidy eligible individual  
25 but may be eligible for financial assistance with pre-  
26 scription drug expenses under section 1935(e).

27           “(E) TREATMENT OF CONFORMING MEDIGAP  
28 POLICIES.—For purposes of this section, the term  
29 ‘qualified prescription drug coverage’ includes a medi-  
30 care supplemental policy described in section  
31 1860H(b)(4).

32           “(5) INDEXING DOLLAR AMOUNTS.—

33           “(A) FOR 2006.—The dollar amounts applied  
34 under paragraphs (1)(B) and (2)(B) for 2006 shall be  
35 the dollar amounts specified in such paragraph in-  
36 creased by the annual percentage increase described in  
37 section 1860B(b)(5) for 2006.

1           “(B) FOR SUBSEQUENT YEARS.—The dollar  
2 amounts applied under paragraphs (1)(B) and (2)(B)  
3 for a year after 2006 shall be the amounts (under this  
4 paragraph) applied under paragraph (1)(B) or (2)(B)  
5 for the preceding year increased by the annual percent-  
6 age increase described in section 1860B(b)(5) (relating  
7 to growth in medicare prescription drug costs per bene-  
8 ficiary) for the year involved.

9           “(b) PREMIUM SUBSIDY AMOUNT.—

10           “(1) IN GENERAL.—The premium subsidy amount de-  
11 scribed in this subsection for an individual residing in an  
12 area is the benchmark bid amount (as defined in paragraph  
13 (2)) for qualified prescription drug coverage offered by the  
14 prescription drug plan or the Medicare+Choice plan in  
15 which the individual is enrolled.

16           “(2) BENCHMARK BID AMOUNT DEFINED.—For pur-  
17 poses of this subsection, the term ‘benchmark bid amount’  
18 means, with respect to qualified prescription drug coverage  
19 offered under—

20           “(A) a prescription drug plan that—

21           “(i) provides standard coverage (or alternative  
22 prescription drug coverage the actuarial value is  
23 equivalent to that of standard coverage), the bid  
24 amount for enrollment under the plan under this  
25 part (determined without regard to any subsidy  
26 under this section or any late enrollment penalty  
27 under section 1860A(c)(2)(B)); or

28           “(ii) provides alternative prescription drug  
29 coverage the actuarial value of which is greater  
30 than that of standard coverage, the bid amount de-  
31 scribed in clause (i) multiplied by the ratio of (I)  
32 the actuarial value of standard coverage, to (II) the  
33 actuarial value of the alternative coverage; or

34           “(B) a Medicare+Choice plan, the portion of the  
35 bid amount that is attributable to statutory drug bene-  
36 fits (described in section 1853(a)(1)(A)(ii)(II)).

37           “(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

1           “(1) IN GENERAL.—In applying subsections (a)(1)(B)  
2           and (a)(2)(B), nothing in this part shall be construed as  
3           preventing a plan or provider from waiving or reducing the  
4           amount of cost-sharing otherwise applicable.

5           “(2) LIMITATION ON CHARGES.—In the case of an in-  
6           dividual receiving cost-sharing subsidies under subsection  
7           (a)(1)(B) or (a)(2)(B), the PDP sponsor may not charge  
8           more than \$5 per prescription.

9           “(3) APPLICATION OF INDEXING RULES.—The provi-  
10          sions of subsection (a)(4) shall apply to the dollar amount  
11          specified in paragraph (2) in the same manner as they  
12          apply to the dollar amounts specified in subsections  
13          (a)(1)(B) and (a)(2)(B).

14          “(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Ad-  
15          ministrator shall provide a process whereby, in the case of an  
16          individual who is determined to be a subsidy eligible individual  
17          and who is enrolled in prescription drug plan or is enrolled in  
18          a Medicare+Choice plan under which qualified prescription  
19          drug coverage is provided—

20               “(1) the Administrator provides for a notification of  
21               the PDP sponsor or Medicare+Choice organization in-  
22               volved that the individual is eligible for a subsidy and the  
23               amount of the subsidy under subsection (a);

24               “(2) the sponsor or organization involved reduces the  
25               premiums or cost-sharing otherwise imposed by the amount  
26               of the applicable subsidy and submits to the Administrator  
27               information on the amount of such reduction; and

28               “(3) the Administrator periodically and on a timely  
29               basis reimburses the sponsor or organization for the  
30               amount of such reductions.

31          The reimbursement under paragraph (3) with respect to cost-  
32          sharing subsidies may be computed on a capitated basis, taking  
33          into account the actuarial value of the subsidies and with ap-  
34          propriate adjustments to reflect differences in the risks actually  
35          involved.

36          “(e) RELATION TO MEDICAID PROGRAM.—

1           “(1) IN GENERAL.—For provisions providing for eligi-  
2           bility determinations, and additional financing, under the  
3           medicaid program, see section 1935.

4           “(2) MEDICAID PROVIDING WRAP AROUND BENE-  
5           FITS.—The coverage provided under this part is primary  
6           payor to benefits for prescribed drugs provided under the  
7           medicaid program under title XIX.

8           “(3) COORDINATION.—The Administrator shall de-  
9           velop and implement a plan for the coordination of pre-  
10          scription drug benefits under this part with the benefits  
11          provided under the medicaid program under title XIX, with  
12          particular attention to insuring coordination of payments  
13          and prevention of fraud and abuse. In developing and im-  
14          plementing such plan, the Administrator shall involve the  
15          Secretary, the States, the data processing industry, phar-  
16          macists, and pharmaceutical manufacturers, and other ex-  
17          perts.

18       **“SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**  
19                               **FICIARIES FOR QUALIFIED PRESCRIPTION**  
20                               **DRUG COVERAGE.**

21          “(a) SUBSIDY PAYMENT.—In order to reduce premium  
22          levels applicable to qualified prescription drug coverage for all  
23          medicare beneficiaries, to reduce adverse selection among pre-  
24          scription drug plans and Medicare+Choice plans that provide  
25          qualified prescription drug coverage, and to promote the par-  
26          ticipation of PDP sponsors under this part, the Administrator  
27          shall provide in accordance with this section for payment to a  
28          qualifying entity (as defined in subsection (b)) of the following  
29          subsidies:

30               “(1) DIRECT SUBSIDY.—In the case of an individual  
31               enrolled in a prescription drug plan, Medicare+Choice  
32               plan, or qualified retiree prescription drug plan, a direct  
33               subsidy equal to a percentage (specified by the Adminis-  
34               trator consistent with subsection (d)(2)) of an amount  
35               equal to the actuarial value of the standard drug coverage  
36               provided under the respective plan.

1           “(2) SUBSIDY THROUGH REINSURANCE.—The reinsur-  
 2           ance payment amount (as defined in subsection (c)) for ex-  
 3           cess costs incurred in providing qualified prescription drug  
 4           coverage—

5                   “(A) for individuals enrolled with a prescription  
 6                   drug plan under this part;

7                   “(B) for individuals enrolled with a  
 8                   Medicare+Choice plan that provides qualified prescrip-  
 9                   tion drug coverage under part C; and

10                   “(C) for individuals who are enrolled in a qualified  
 11                   retiree prescription drug plan.

12 This section constitutes budget authority in advance of appro-  
 13 priations Acts and represents the obligation of the Adminis-  
 14 trator to provide for the payment of amounts provided under  
 15 this section.

16           “(b) QUALIFYING ENTITY DEFINED.—For purposes of  
 17 this section, the term ‘qualifying entity’ means any of the fol-  
 18 lowing that has entered into an agreement with the Adminis-  
 19 trator to provide the Administrator with such information as  
 20 may be required to carry out this section:

21                   “(1) A PDP sponsor offering a prescription drug plan  
 22                   under this part.

23                   “(2) A Medicare+Choice organization that provides  
 24                   qualified prescription drug coverage under a  
 25                   Medicare+Choice plan under part C.

26                   “(3) The sponsor of a qualified retiree prescription  
 27                   drug plan (as defined in subsection (f)).

28           “(c) REINSURANCE PAYMENT AMOUNT.—

29                   “(1) IN GENERAL.—Subject to subsection (d)(2) and  
 30                   paragraph (4), the reinsurance payment amount under this  
 31                   subsection for a qualifying covered individual (as defined in  
 32                   subsection (g)(1)) for a coverage year (as defined in sub-  
 33                   section (g)(2)) is equal to the sum of the following:

34                           “(A) For the portion of the individual’s gross cov-  
 35                           ered prescription drug costs (as defined in paragraph  
 36                           (3)) for the year that exceeds the initial copayment  
 37                           threshold specified in section 1860B(b)(2)(C), but does

1 not exceed the initial coverage limit specified in section  
2 1860B(b)(3), an amount equal to 30 percent of the al-  
3 lowable costs (as defined in paragraph (2)) attributable  
4 to such gross covered prescription drug costs.

5 “(B) For the portion of the individual’s gross cov-  
6 ered prescription drug costs for the year that exceeds  
7 the annual out-of-pocket threshold specified in  
8 1860B(b)(4)(B), an amount equal to 80 percent of the  
9 allowable costs attributable to such gross covered pre-  
10 scription drug costs.

11 “(2) ALLOWABLE COSTS.—For purposes of this sec-  
12 tion, the term ‘allowable costs’ means, with respect to gross  
13 covered prescription drug costs under a plan described in  
14 subsection (b) offered by a qualifying entity, the part of  
15 such costs that are actually paid (net of average percentage  
16 rebates) under the plan, but in no case more than the part  
17 of such costs that would have been paid under the plan if  
18 the prescription drug coverage under the plan were stand-  
19 ard coverage.

20 “(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—  
21 For purposes of this section, the term ‘gross covered pre-  
22 scription drug costs’ means, with respect to an enrollee  
23 with a qualifying entity under a plan described in sub-  
24 section (b) during a coverage year, the costs incurred under  
25 the plan (including costs attributable to administrative  
26 costs) for covered prescription drugs dispensed during the  
27 year, including costs relating to the deductible, whether  
28 paid by the enrollee or under the plan, regardless of wheth-  
29 er the coverage under the plan exceeds standard coverage  
30 and regardless of when the payment for such drugs is  
31 made.

32 “(4) INDEXING DOLLAR AMOUNTS.—

33 “(A) AMOUNTS FOR 2005.—The dollar amounts  
34 applied under paragraph (1) for 2005 shall be the dol-  
35 lar amounts specified in such paragraph.

36 “(B) FOR 2006.—The dollar amounts applied  
37 under paragraph (1) for 2006 shall be the dollar

1 amounts specified in such paragraph increased by the  
2 annual percentage increase described in section  
3 1860B(b)(5) for 2006.

4 “(C) FOR SUBSEQUENT YEARS.—The dollar  
5 amounts applied under paragraph (1) for a year after  
6 2006 shall be the amounts (under this paragraph) ap-  
7 plied under paragraph (1) for the preceding year in-  
8 creased by the annual percentage increase described in  
9 section 1860B(b)(5) (relating to growth in medicare  
10 prescription drug costs per beneficiary) for the year in-  
11 volved.

12 “(D) ROUNDING.—Any amount, determined under  
13 the preceding provisions of this paragraph for a year,  
14 which is not a multiple of \$10 shall be rounded to the  
15 nearest multiple of \$10.

16 “(d) ADJUSTMENT OF PAYMENTS.—

17 “(1) ESTIMATION OF PAYMENTS.—The Administrator  
18 shall estimate—

19 “(A) the total payments to be made (without re-  
20 gard to this subsection) during a year under this sec-  
21 tion; and

22 “(B) the total payments to be made by qualifying  
23 entities for standard coverage under plans described in  
24 subsection (b) during the year.

25 “(2) ADJUSTMENT.—The Administrator shall propor-  
26 tionally adjust the payments made under this section for a  
27 coverage year in such manner so that—

28 “(A) the total of the payments made for the year  
29 under this section is equal to 65 percent of the total  
30 payments described in paragraph (1)(B) during the  
31 year; and

32 “(B) the ratio of the total of the payments made  
33 for direct subsidies under subsection (a)(1) for the year  
34 to the total of the payments made for reinsurance sub-  
35 sidies for the year under subsection (a)(2) is equal to  
36 the ratio of 35 to 30.

1           “(3) RISK ADJUSTMENT.—To the extent the Adminis-  
2           trator determines it appropriate to avoid risk selection, the  
3           payments made for direct subsidies under subsection (a)(1)  
4           are subject to adjustment based upon risk factors specified  
5           by the Administrator.

6           “(e) PAYMENT METHODS.—

7           “(1) IN GENERAL.—Payments under this section shall  
8           be based on such a method as the Administrator deter-  
9           mines. The Administrator may establish a payment method  
10          by which interim payments of amounts under this section  
11          are made during a year based on the Administrator’s best  
12          estimate of amounts that will be payable after obtaining all  
13          of the information.

14          “(2) SOURCE OF PAYMENTS.—Payments under this  
15          section shall be made from the Medicare Prescription Drug  
16          Trust Fund.

17          “(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DE-  
18          FINED.—

19          “(1) IN GENERAL.—For purposes of this section, the  
20          term ‘qualified retiree prescription drug plan’ means em-  
21          ployment-based retiree health coverage (as defined in para-  
22          graph (3)(A)) if, with respect to an individual enrolled (or  
23          eligible to be enrolled) under this part who is covered under  
24          the plan, the following requirements are met:

25                  “(A) ASSURANCE.—The sponsor of the plan shall  
26                  annually attest, and provide such assurances as the Ad-  
27                  ministrator may require, that the coverage meets or ex-  
28                  ceeds the requirements for qualified prescription drug  
29                  coverage.

30                  “(B) AUDITS.—The sponsor (and the plan) shall  
31                  maintain, and afford the Administrator access to, such  
32                  records as the Administrator may require for purposes  
33                  of audits and other oversight activities necessary to en-  
34                  sure the adequacy of prescription drug coverage, and  
35                  the accuracy of payments made.

36                  “(C) PROVISION OF CERTIFICATION OF PRESCRIP-  
37                  TION DRUG COVERAGE.—The sponsor of the plan shall

1 provide for issuance of certifications of the type de-  
2 scribed in section 1860A(c)(2)(D).

3 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—No pay-  
4 ment shall be provided under this section with respect to  
5 an individual who is enrolled under a qualified retiree pre-  
6 scription drug plan unless the individual is—

7 “(A) enrolled under this part;

8 “(B) is covered under the plan; and

9 “(C) is eligible to obtain qualified prescription  
10 drug coverage under section 1860A but did not elect  
11 such coverage under this part (either through a pre-  
12 scription drug plan or through a Medicare+Choice  
13 plan).

14 “(3) DEFINITIONS.—As used in this section:

15 “(A) EMPLOYMENT-BASED RETIREE HEALTH COV-  
16 ERAGE.—The term ‘employment-based retiree health  
17 coverage’ means health insurance or other coverage of  
18 health care costs for individuals enrolled under this  
19 part (or for such individuals and their spouses and de-  
20 pendents) based on their status as former employees or  
21 labor union members.

22 “(B) SPONSOR.—The term ‘sponsor’ means a plan  
23 sponsor, as defined in section 3(16)(B) of the Em-  
24 ployee Retirement Income Security Act of 1974.

25 “(g) GENERAL DEFINITIONS.—For purposes of this sec-  
26 tion:

27 “(1) QUALIFYING COVERED INDIVIDUAL.—The term  
28 ‘qualifying covered individual’ means an individual who—

29 “(A) is enrolled with a prescription drug plan  
30 under this part;

31 “(B) is enrolled with a Medicare+Choice plan that  
32 provides qualified prescription drug coverage under  
33 part C; or

34 “(C) is enrolled for benefits under this title and is  
35 covered under a qualified retiree prescription drug plan.

36 “(2) COVERAGE YEAR.—The term ‘coverage year’  
37 means a calendar year in which covered outpatient drugs

1 are dispensed if a claim for payment is made under the  
2 plan for such drugs, regardless of when the claim is paid.

3 **“SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST**  
4 **FUND.**

5 “(a) IN GENERAL.—There is created on the books of the  
6 Treasury of the United States a trust fund to be known as the  
7 ‘Medicare Prescription Drug Trust Fund’ (in this section re-  
8 ferred to as the ‘Trust Fund’). The Trust Fund shall consist  
9 of such gifts and bequests as may be made as provided in sec-  
10 tion 201(i)(1), and such amounts as may be deposited in, or  
11 appropriated to, such fund as provided in this part. Except as  
12 otherwise provided in this section, the provisions of subsections  
13 (b) through (i) of section 1841 shall apply to the Trust Fund  
14 in the same manner as they apply to the Federal Supple-  
15 mentary Medical Insurance Trust Fund under such section.

16 “(b) PAYMENTS FROM TRUST FUND.—

17 “(1) IN GENERAL.—The Managing Trustee shall pay  
18 from time to time from the Trust Fund such amounts as  
19 the Administrator certifies are necessary to make—

20 “(A) payments under section 1860G (relating to  
21 low-income subsidy payments);

22 “(B) payments under section 1860H (relating to  
23 subsidy payments); and

24 “(C) payments with respect to administrative ex-  
25 penses under this part in accordance with section  
26 201(g).

27 “(2) TRANSFERS TO MEDICAID ACCOUNT FOR IN-  
28 CREASED ADMINISTRATIVE COSTS.—The Managing Trustee  
29 shall transfer from time to time from the Trust Fund to  
30 the Grants to States for Medicaid account amounts the Ad-  
31 ministrator certifies are attributable to increases in pay-  
32 ment resulting from the application of a higher Federal  
33 matching percentage under section 1935(b).

34 “(c) DEPOSITS INTO TRUST FUND.—

35 “(1) LOW-INCOME TRANSFER.—There is hereby trans-  
36 ferred to the Trust Fund, from amounts appropriated for  
37 Grants to States for Medicaid, amounts equivalent to the

1 aggregate amount of the reductions in payments under sec-  
 2 tion 1903(a)(1) attributable to the application of section  
 3 1935(c).

4 “(2) APPROPRIATIONS TO COVER GOVERNMENT CON-  
 5 TRIBUTIONS.—There are authorized to be appropriated  
 6 from time to time, out of any moneys in the Treasury not  
 7 otherwise appropriated, to the Trust Fund, an amount  
 8 equivalent to the amount of payments made from the Trust  
 9 Fund under subsection (b), reduced by the amount trans-  
 10 ferred to the Trust Fund under paragraph (1).

11 “(d) RELATION TO SOLVENCY REQUIREMENTS.—Any pro-  
 12 vision of law that relates to the solvency of the Trust Fund  
 13 under this part shall take into account the Trust Fund and  
 14 amounts receivable by, or payable from, the Trust Fund.

15 **“SEC. 1860J. DEFINITIONS; TREATMENT OF REF-**  
 16 **ERENCES TO PROVISIONS IN PART C.**

17 “(a) DEFINITIONS.—For purposes of this part:

18 “(1) COVERED OUTPATIENT DRUGS.—The term ‘cov-  
 19 ered outpatient drugs’ is defined in section 1860B(f).

20 “(2) INITIAL COVERAGE LIMIT.—The term ‘initial cov-  
 21 erage limit’ means such limit as established under section  
 22 1860B(b)(3), or, in the case of coverage that is not stand-  
 23 ard coverage, the comparable limit (if any) established  
 24 under the coverage.

25 “(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—  
 26 The term ‘Medicare Prescription Drug Trust Fund’ means  
 27 the Trust Fund created under section 1860I(a).

28 “(4) PDP SPONSOR.—The term ‘PDP sponsor’ means  
 29 an entity that is certified under this part as meeting the  
 30 requirements and standards of this part for such a sponsor.

31 “(5) PRESCRIPTION DRUG PLAN.—The term ‘prescrip-  
 32 tion drug plan’ means health benefits coverage that—

33 “(A) is offered under a policy, contract, or plan by  
 34 a PDP sponsor pursuant to, and in accordance with, a  
 35 contract between the Administrator and the sponsor  
 36 under section 1860D(b);

1                   “(B) provides qualified prescription drug coverage;  
2                   and

3                   “(C) meets the applicable requirements of the sec-  
4                   tion 1860C for a prescription drug plan.

5                   “(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—  
6                   The term ‘qualified prescription drug coverage’ is defined  
7                   in section 1860B(a).

8                   “(7) STANDARD COVERAGE.—The term ‘standard cov-  
9                   erage’ is defined in section 1860B(b).

10                   “(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS  
11 UNDER THIS PART.—For purposes of applying provisions of  
12 part C under this part with respect to a prescription drug plan  
13 and a PDP sponsor, unless otherwise provided in this part such  
14 provisions shall be applied as if—

15                   “(1) any reference to a Medicare+Choice plan in-  
16                   cluded a reference to a prescription drug plan;

17                   “(2) any reference to a provider-sponsored organiza-  
18                   tion included a reference to a PDP sponsor;

19                   “(3) any reference to a contract under section 1857  
20                   included a reference to a contract under section 1860D(b);  
21                   and

22                   “(4) any reference to part C included a reference to  
23                   this part.”.

24                   (b) ADDITIONAL CONFORMING CHANGES.—

25                   (1) CONFORMING REFERENCES TO PREVIOUS PART  
26 D.—Any reference in law (in effect before the date of the  
27 enactment of this Act) to part D of title XVIII of the So-  
28 cial Security Act is deemed a reference to part E of such  
29 title (as in effect after such date).

30                   (2) CONFORMING AMENDMENT PERMITTING WAIVER  
31 OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C.  
32 1320a-7b(b)(3)) is amended—

33                   (A) by striking “and” at the end of subparagraph  
34 (E);

35                   (B) by striking the period at the end of subpara-  
36 graph (F) and inserting “; and”; and

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

3 “(G) the waiver or reduction of any cost-sharing im-  
4 posed under part D of title XVIII.”.

5 (3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not  
6 later than 6 months after the date of the enactment of this  
7 Act, the Secretary of Health and Human Services shall  
8 submit to the appropriate committees of Congress a legisla-  
9 tive proposal providing for such technical and conforming  
10 amendments in the law as are required by the provisions  
11 of this subtitle.

12 (c) STUDY ON TRANSITIONING PART B PRESCRIPTION  
13 DRUG COVERAGE.—Not later than January 1, 2004, the Medi-  
14 care Benefits Administrator shall submit a report to Congress  
15 that makes recommendations regarding methods for providing  
16 benefits under part D of title XVIII of the Social Security Act  
17 for outpatient prescription drugs for which benefits are pro-  
18 vided under part B of such title.

19 **SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION**  
20 **DRUG COVERAGE UNDER THE**  
21 **MEDICARE+CHOICE PROGRAM.**

22 (a) IN GENERAL.—Section 1851 (42 U.S.C. 1395w-21) is  
23 amended by adding at the end the following new subsection:

24 “(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—  
25 “(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COV-  
26 ERAGE.—

27 “(A) IN GENERAL.—A Medicare+Choice organiza-  
28 tion may not offer prescription drug coverage (other  
29 than that required under parts A and B) to an enrollee  
30 under a Medicare+Choice plan unless such drug cov-  
31 erage is at least qualified prescription drug coverage  
32 and unless the requirements of this subsection with re-  
33 spect to such coverage are met.

34 “(B) CONSTRUCTION.—Nothing in this subsection  
35 shall be construed as—

1 “(i) requiring a Medicare+Choice plan to in-  
2 clude coverage of qualified prescription drug cov-  
3 erage; or

4 “(ii) permitting a Medicare+Choice organiza-  
5 tion from providing such coverage to an individual  
6 who has not elected such coverage under section  
7 1860A(b).

8 For purposes of this part, an individual who has not  
9 elected qualified prescription drug coverage under sec-  
10 tion 1860A(b) shall be treated as being ineligible to en-  
11 roll in a Medicare+Choice plan under this part that of-  
12 fers such coverage.

13 “(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY  
14 PROTECTIONS.—With respect to the offering of qualified  
15 prescription drug coverage by a Medicare+Choice organiza-  
16 tion under a Medicare+Choice plan, the organization and  
17 plan shall meet the requirements of section 1860C, includ-  
18 ing requirements relating to information dissemination and  
19 grievance and appeals, in the same manner as they apply  
20 to a PDP sponsor and a prescription drug plan under part  
21 D and shall submit to the Administrator the information  
22 described in section 1860F(a)(2). The Administrator shall  
23 waive such requirements to the extent the Administrator  
24 determines that such requirements duplicate requirements  
25 otherwise applicable to the organization or plan under this  
26 part.

27 “(3) AVAILABILITY OF PREMIUM AND COST-SHARING  
28 SUBSIDIES FOR LOW-INCOME ENROLLEES AND DIRECT AND  
29 REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—  
30 For provisions—

31 “(A) providing premium and cost-sharing subsidies  
32 to low-income individuals receiving qualified prescrip-  
33 tion drug coverage through a Medicare+Choice plan,  
34 see section 1860G; and

35 “(B) providing a Medicare+Choice organization  
36 with direct and insurance subsidy payments for pro-

1           viding qualified prescription drug coverage under this  
2           part, see section 1860H.

3           “(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—  
4           Notwithstanding any other provision of this part, the an-  
5           nual, coordinated election period under subsection (e)(3)(B)  
6           for 2005 shall be the 6-month period beginning with No-  
7           vember 2004.

8           “(5) QUALIFIED PRESCRIPTION DRUG COVERAGE;  
9           STANDARD COVERAGE.—For purposes of this part, the  
10          terms ‘qualified prescription drug coverage’ and ‘standard  
11          coverage’ have the meanings given such terms in section  
12          1860B.”.

13          (b) CONFORMING AMENDMENTS.—Section 1851 (42  
14          U.S.C. 1395w–21) is amended—

15                 (1) in subsection (a)(1)—

16                         (A) by inserting “(other than qualified prescrip-  
17                         tion drug benefits)” after “benefits”;

18                         (B) by striking the period at the end of subpara-  
19                         graph (B) and inserting a comma; and

20                         (C) by adding after and below subparagraph (B)  
21                         the following:

22                                 “and may elect qualified prescription drug coverage in ac-  
23                                 cordance with section 1860A.”; and

24                         (2) in subsection (g)(1), by inserting “and section  
25                         1860A(c)(2)(B)” after “in this subsection”.

26          (c) EFFECTIVE DATE.—The amendments made by this  
27          section apply to coverage provided on or after January 1, 2005.

28          **SEC. 103. MEDICAID AMENDMENTS.**

29          (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME  
30          SUBSIDIES.—

31                 (1) REQUIREMENT.—Section 1902(a) (42 U.S.C.  
32                 1396a(a)) is amended—

33                         (A) by striking “and” at the end of paragraph  
34                         (64);

35                         (B) by striking the period at the end of paragraph  
36                         (65) and inserting “; and”; and

1 (C) by inserting after paragraph (65) the following  
2 new paragraph:

3 “(66) provide for making eligibility determinations  
4 under section 1935(a).”.

5 (2) NEW SECTION.—Title XIX is further amended—

6 (A) by redesignating section 1935 as section 1936;  
7 and

8 (B) by inserting after section 1934 the following  
9 new section:

10 “SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION  
11 DRUG BENEFIT

12 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY  
13 DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condi-  
14 tion of its State plan under this title under section 1902(a)(66)  
15 and receipt of any Federal financial assistance under section  
16 1903(a), a State shall—

17 “(1) make determinations of eligibility for premium  
18 and cost-sharing subsidies under (and in accordance with)  
19 section 1860G;

20 “(2) inform the Administrator of the Medicare Bene-  
21 fits Administration of such determinations in cases in  
22 which such eligibility is established; and

23 “(3) otherwise provide such Administrator with such  
24 information as may be required to carry out part D of title  
25 XVIII (including section 1860G).

26 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE  
27 COSTS.—

28 “(1) IN GENERAL.—The amounts expended by a State  
29 in carrying out subsection (a) are, subject to paragraph  
30 (2), expenditures reimbursable under the appropriate para-  
31 graph of section 1903(a); except that, notwithstanding any  
32 other provision of such section, the applicable Federal  
33 matching rates with respect to such expenditures under  
34 such section shall be increased as follows (but in no case  
35 shall the rate as so increased exceed 100 percent):

36 “(A) For expenditures attributable to costs in-  
37 curred during 2005, the otherwise applicable Federal

1 matching rate shall be increased by 10 percent of the  
 2 percentage otherwise payable (but for this subsection)  
 3 by the State.

4 “(B)(i) For expenditures attributable to costs in-  
 5 curred during 2006 and each subsequent year through  
 6 2013, the otherwise applicable Federal matching rate  
 7 shall be increased by the applicable percent (as defined  
 8 in clause (ii)) of the percentage otherwise payable (but  
 9 for this subsection) by the State.

10 “(ii) For purposes of clause (i), the ‘applicable  
 11 percent’ for—

12 “(I) 2006 is 20 percent; or

13 “(II) a subsequent year is the applicable per-  
 14 cent under this clause for the previous year in-  
 15 creased by 10 percentage points.

16 “(C) For expenditures attributable to costs in-  
 17 curred after 2013, the otherwise applicable Federal  
 18 matching rate shall be increased to 100 percent.

19 “(2) COORDINATION.—The State shall provide the Ad-  
 20 ministrator with such information as may be necessary to  
 21 properly allocate administrative expenditures described in  
 22 paragraph (1) that may otherwise be made for similar eligi-  
 23 bility determinations.”.

24 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RE-  
 25 SPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES  
 26 FOR DUALY ELIGIBLE INDIVIDUALS.—

27 (1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C.  
 28 1396b(a)(1)) is amended by inserting before the semicolon  
 29 the following: “, reduced by the amount computed under  
 30 section 1935(c)(1) for the State and the quarter”.

31 (2) AMOUNT DESCRIBED.—Section 1935, as inserted  
 32 by subsection (a)(2), is amended by adding at the end the  
 33 following new subsection:

34 “(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION  
 35 DRUG COSTS FOR DUALY-ELIGIBLE BENEFICIARIES.—

36 “(1) IN GENERAL.—For purposes of section  
 37 1903(a)(1), for a State that is one of the 50 States or the

1 District of Columbia for a calendar quarter in a year (be-  
 2 ginning with 2005) the amount computed under this sub-  
 3 section is equal to the product of the following:

4 “(A) MEDICARE SUBSIDIES.—The total amount of  
 5 payments made in the quarter under section 1860G  
 6 (relating to premium and cost-sharing prescription  
 7 drug subsidies for low-income medicare beneficiaries)  
 8 that are attributable to individuals who are residents of  
 9 the State and are entitled to benefits with respect to  
 10 prescribed drugs under the State plan under this title  
 11 (including such a plan operating under a waiver under  
 12 section 1115).

13 “(B) STATE MATCHING RATE.—A proportion com-  
 14 puted by subtracting from 100 percent the Federal  
 15 medical assistance percentage (as defined in section  
 16 1905(b)) applicable to the State and the quarter.

17 “(C) PHASE-OUT PROPORTION.—The phase-out  
 18 proportion (as defined in paragraph (2)) for the quar-  
 19 ter.

20 “(2) PHASE-OUT PROPORTION.—For purposes of para-  
 21 graph (1)(C), the ‘phase-out proportion’ for a calendar  
 22 quarter in—

23 “(A) 2005 is 90 percent;

24 “(B) a subsequent year before 2014, is the phase-  
 25 out proportion for calendar quarters in the previous  
 26 year decreased by 10 percentage points; or

27 “(C) a year after 2013 is 0 percent.”.

28 (c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—  
 29 Section 1935, as so inserted and amended, is further amended  
 30 by adding at the end the following new subsection:

31 “(d) ADDITIONAL PROVISIONS.—

32 “(1) MEDICAID AS SECONDARY PAYOR.—In the case of  
 33 an individual who is entitled to qualified prescription drug  
 34 coverage under a prescription drug plan under part D of  
 35 title XVIII (or under a Medicare+Choice plan under part  
 36 C of such title) and medical assistance for prescribed drugs  
 37 under this title, medical assistance shall continue to be pro-

1       vided under this title for prescribed drugs to the extent  
2       payment is not made under the prescription drug plan or  
3       the Medicare+Choice plan selected by the individual.

4           “(2) CONDITION.—A State may require, as a condition  
5       for the receipt of medical assistance under this title with  
6       respect to prescription drug benefits for an individual eligi-  
7       ble to obtain qualified prescription drug coverage described  
8       in paragraph (1), that the individual elect qualified pre-  
9       scription drug coverage under section 1860A.”.

10       (d) TREATMENT OF TERRITORIES.—

11           (1) IN GENERAL.—Section 1935, as so inserted and  
12       amended, is further amended—

13           (A) in subsection (a) in the matter preceding para-  
14       graph (1), by inserting “subject to subsection (e)” after  
15       “section 1903(a)”;

16           (B) in subsection (c)(1), by inserting “subject to  
17       subsection (e)” after “1903(a)(1)”; and

18           (C) by adding at the end the following new sub-  
19       section:

20       “(e) TREATMENT OF TERRITORIES.—

21           “(1) IN GENERAL.—In the case of a State, other than  
22       the 50 States and the District of Columbia—

23           “(A) the previous provisions of this section shall  
24       not apply to residents of such State; and

25           “(B) if the State establishes a plan described in  
26       paragraph (2) (for providing medical assistance with  
27       respect to the provision of prescription drugs to medi-  
28       care beneficiaries), the amount otherwise determined  
29       under section 1108(f) (as increased under section  
30       1108(g)) for the State shall be increased by the  
31       amount specified in paragraph (3).

32           “(2) PLAN.—The plan described in this paragraph is  
33       a plan that—

34           “(A) provides medical assistance with respect to  
35       the provision of covered outpatient drugs (as defined in  
36       section 1860B(f)) to low-income medicare beneficiaries;  
37       and

1           “(B) assures that additional amounts received by  
2 the State that are attributable to the operation of this  
3 subsection are used only for such assistance.

4           “(3) INCREASED AMOUNT.—

5           “(A) IN GENERAL.—The amount specified in this  
6 paragraph for a State for a year is equal to the product  
7 of—

8           “(i) the aggregate amount specified in sub-  
9 paragraph (B); and

10          “(ii) the amount specified in section  
11 1108(g)(1) for that State, divided by the sum of  
12 the amounts specified in such section for all such  
13 States.

14          “(B) AGGREGATE AMOUNT.—The aggregate  
15 amount specified in this subparagraph for—

16          “(i) 2005, is equal to \$20,000,000; or

17          “(ii) a subsequent year, is equal to the aggre-  
18 gate amount specified in this subparagraph for the  
19 previous year increased by annual percentage in-  
20 crease specified in section 1860B(b)(5) for the year  
21 involved.

22          “(4) REPORT.—The Administrator shall submit to  
23 Congress a report on the application of this subsection and  
24 may include in the report such recommendations as the Ad-  
25 ministrator deems appropriate.”.

26          (2) CONFORMING AMENDMENT.—Section 1108(f) (42  
27 U.S.C. 1308(f)) is amended by inserting “and section  
28 1935(e)(1)(B)” after “Subject to subsection (g)”.

29 **SEC. 104. MEDIGAP TRANSITION.**

30          (a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is  
31 amended by adding at the end the following new subsection:

32          “(v) COVERAGE OF PRESCRIPTION DRUGS.—

33          “(1) IN GENERAL.—Notwithstanding any other provi-  
34 sion of law, except as provided in paragraph (3) no new  
35 medicare supplemental policy that provides coverage of ex-  
36 penses for prescription drugs may be issued under this sec-  
37 tion on or after January 1, 2005, to an individual unless

1 it replaces a medicare supplemental policy that was issued  
2 to that individual and that provided some coverage of ex-  
3 penses for prescription drugs.

4 “(2) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN  
5 PRESCRIPTION DRUG COVERAGE UNDER PART D.—

6 “(A) IN GENERAL.—The issuer of a medicare sup-  
7 plemental policy—

8 “(i) may not deny or condition the issuance or  
9 effectiveness of a medicare supplemental policy that  
10 has a benefit package classified as ‘A’, ‘B’, ‘C’, ‘D’,  
11 ‘E’, ‘F’, or ‘G’ (under the standards established  
12 under subsection (p)(2)) and that is offered and is  
13 available for issuance to new enrollees by such  
14 issuer;

15 “(ii) may not discriminate in the pricing of  
16 such policy, because of health status, claims experi-  
17 ence, receipt of health care, or medical condition;  
18 and

19 “(iii) may not impose an exclusion of benefits  
20 based on a pre-existing condition under such policy,  
21 in the case of an individual described in subparagraph  
22 (B) who seeks to enroll under the policy not later than  
23 63 days after the date of the termination of enrollment  
24 described in such paragraph and who submits evidence  
25 of the date of termination or disenrollment along with  
26 the application for such medicare supplemental policy.

27 “(B) INDIVIDUAL COVERED.—An individual de-  
28 scribed in this subparagraph is an individual who—

29 “(i) enrolls in a prescription drug plan under  
30 part D; and

31 “(ii) at the time of such enrollment was en-  
32 rolled and terminates enrollment in a medicare sup-  
33 plemental policy which has a benefit package classi-  
34 fied as ‘H’, ‘I’, or ‘J’ under the standards referred  
35 to in subparagraph (A)(i) or terminates enrollment  
36 in a policy to which such standards do not apply  
37 but which provides benefits for prescription drugs.

1           “(C) ENFORCEMENT.—The provisions of para-  
2           graph (4) of subsection (s) shall apply with respect to  
3           the requirements of this paragraph in the same manner  
4           as they apply to the requirements of such subsection.

5           “(3) NEW STANDARDS.—In applying subsection  
6           (p)(1)(E) (including permitting the NAIC to revise its  
7           model regulations in response to changes in law) with re-  
8           spect to the change in benefits resulting from title I of the  
9           Medicare Modernization and Prescription Drug Act of  
10          2002, with respect to policies issued to individuals who are  
11          enrolled under part D, the changes in standards shall pro-  
12          vide for at least two benefit packages (other than the core  
13          benefit package) that may provide for coverage of cost-  
14          sharing with respect to qualified prescription drug coverage  
15          under such part, except that such coverage may not cover  
16          the prescription drug deductible under such part. Two ben-  
17          efit packages shall be consistent with the following:

18          “(A) FIRST NEW POLICY.—The policy described in  
19          this subparagraph has the following benefits, notwith-  
20          standing any other provision of this section relating to  
21          a core benefit package:

22                 “(i) Coverage of 50 percent of the cost-sharing  
23                 otherwise applicable, except coverage of 100 per-  
24                 cent of any cost-sharing otherwise applicable for  
25                 preventive benefits.

26                 “(ii) No coverage of the part B deductible.

27                 “(iii) Coverage for all hospital coinsurance for  
28                 long stays (as in the current core benefit package).

29                 “(iv) A limitation on annual out-of-pocket ex-  
30                 penditures to \$4,000 in 2005 (or, in a subsequent  
31                 year, to such limitation for the previous year in-  
32                 creased by an appropriate inflation adjustment  
33                 specified by the Secretary).

34          “(B) SECOND NEW POLICY.—The policy described  
35          in this subparagraph has the same benefits as the pol-  
36          icy described in subparagraph (A), except as follows:

1 “(i) Substitute ‘75 percent’ for ‘50 percent’ in  
2 clause (i) of such subparagraph.

3 “(ii) Substitute ‘\$2,000’ for ‘\$4,000’ in clause  
4 (iv) of such subparagraph.

5 “(4) CONSTRUCTION.—Any provision in this section or  
6 in a medicare supplemental policy relating to guaranteed  
7 renewability of coverage shall be deemed to have been met  
8 through the offering of other coverage under this sub-  
9 section.”.

10 **SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT**  
11 **CARD ENDORSEMENT PROGRAM.**

12 Title XVIII is amended by inserting after section 1806 the  
13 following new section:

14 “MEDICARE PRESCRIPTION DRUG DISCOUNT CARD  
15 ENDORSEMENT PROGRAM

16 “SEC. 1807. (a) IN GENERAL.—The Secretary (or the  
17 Medicare Benefits Administrator pursuant to section  
18 1808(c)(3)(C)) shall establish a program—

19 “(1) to endorse prescription drug discount card pro-  
20 grams that meet the requirements of this section; and

21 “(2) to make available to medicare beneficiaries infor-  
22 mation regarding such endorsed programs.

23 “(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary  
24 may not endorse a prescription drug discount card program  
25 under this section unless the program meets the following re-  
26 quirements:

27 “(1) SAVINGS TO MEDICARE BENEFICIARIES.—The  
28 program passes on to medicare beneficiaries who enroll in  
29 the program discounts on prescription drugs, including dis-  
30 counts negotiated with manufacturers.

31 “(2) PROHIBITION ON APPLICATION ONLY TO MAIL  
32 ORDER.—The program applies to drugs that are available  
33 other than solely through mail order.

34 “(3) BENEFICIARY SERVICES.—The program provides  
35 pharmaceutical support services, such as education and  
36 counseling, and services to prevent adverse drug inter-  
37 actions.

1           “(4) INFORMATION.—The program makes available to  
2 medicare beneficiaries through the Internet and otherwise  
3 information, including information on enrollment fees,  
4 prices charged to beneficiaries, and services offered under  
5 the program, that the Secretary identifies as being nec-  
6 essary to provide for informed choice by beneficiaries  
7 among endorsed programs.

8           “(5) DEMONSTRATED EXPERIENCE.—The entity oper-  
9 ating the program has demonstrated experience and exper-  
10 tise in operating such a program or a similar program.

11           “(6) QUALITY ASSURANCE.—The entity has in place  
12 adequate procedures for assuring quality service under the  
13 program.

14           “(7) ADDITIONAL BENEFICIARY PROTECTIONS.—The  
15 program meets such additional requirements as the Sec-  
16 retary identifies to protect and promote the interest of  
17 medicare beneficiaries, including requirements that ensure  
18 that beneficiaries are not charged more than the lower of  
19 the negotiated retail price or the usual and customary  
20 price.

21           “(c) PROGRAM OPERATION.—The Secretary shall operate  
22 the program under this section consistent with the following:

23           “(1) PROMOTION OF INFORMED CHOICE.—In order to  
24 promote informed choice among endorsed prescription drug  
25 discount card programs, the Secretary shall provide for the  
26 dissemination of information which compares the costs and  
27 benefits of such programs in a manner coordinated with  
28 the dissemination of educational information on  
29 Medicare+Choice plans under part C.

30           “(2) OVERSIGHT.—The Secretary shall provide appro-  
31 priate oversight to ensure compliance of endorsed programs  
32 with the requirements of this section, including verification  
33 of the discounts and services provided.

34           “(3) USE OF MEDICARE TOLL-FREE NUMBER.—The  
35 Secretary shall provide through the 1-800-medicare toll free  
36 telephone number for the receipt and response to inquiries

1 and complaints concerning the program and programs en-  
2 dored under this section.

3 “(4) DISQUALIFICATION FOR ABUSIVE PRACTICES.—  
4 The Secretary shall revoke the endorsement of a program  
5 that the Secretary determines no longer meets the require-  
6 ments of this section or that has engaged in false or mis-  
7 leading marketing practices.

8 “(5) ENROLLMENT PRACTICES.—A medicare bene-  
9 ficiary may not be enrolled in more than one endorsed pro-  
10 gram at any time.

11 “(d) TRANSITION.—The Secretary shall provide for an ap-  
12 propriate transition and discontinuation of the program under  
13 this section at the time prescription drug benefits first become  
14 available under part D.

15 “(e) AUTHORIZATION OF APPROPRIATIONS.—There are  
16 authorized to be appropriated such sums as may be necessary  
17 to carry out the program under this section.”.

18 **TITLE II—MEDICARE+CHOICE RE-**  
19 **VITALIZATION AND**  
20 **MEDICARE+CHOICE COMPETI-**  
21 **TION PROGRAM**

22 **Subtitle A—Medicare+Choice**  
23 **Revitalization**

24 **SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.**

25 (a) EQUALIZING PAYMENTS BETWEEN FEE-FOR-SERVICE  
26 AND MEDICARE+CHOICE.—

27 (1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C.  
28 1395w-23(c)(1)) is amended by adding at the end the fol-  
29 lowing:

30 “(D) BASED ON 100 PERCENT OF FEE-FOR-SERV-  
31 ICE COSTS.—

32 “(i) IN GENERAL.—For 2003 and 2004, the  
33 adjusted average per capita cost for the year in-  
34 volved, determined under section 1876(a)(4) for the  
35 Medicare+Choice payment area for services cov-  
36 ered under parts A and B for individuals entitled

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

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

18 (2) CONFORMING AMENDMENT.—Such section is fur-  
 19 ther amended, in the matter before subparagraph (A), by  
 20 striking “or (C)” and inserting “(C), or (D)”.

21 (b) REVISION OF BLEND.—

22 (1) REVISION OF NATIONAL AVERAGE USED IN CAL-  
 23 CULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42  
 24 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting  
 25 “who (with respect to determinations for 2003 and for  
 26 2004) are enrolled in a Medicare+Choice plan” after “the  
 27 average number of medicare beneficiaries”.

28 (2) CHANGE IN BUDGET NEUTRALITY.—Section  
 29 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

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

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

34 (c) REVISION IN MINIMUM PERCENTAGE INCREASE FOR  
 35 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–  
 36 23(c)(1)(C)) is amended by striking clause (iv) and inserting  
 37 the following:

1           “(iv) For 2002, 102 percent of the annual  
2 Medicare+Choice capitation rate under this para-  
3 graph for the area for 2001.

4           “(v) For 2003 and 2004, 103 percent of the  
5 annual Medicare+Choice capitation rate under this  
6 paragraph for the area for the previous year.

7           “(iv) For 2005 and each succeeding year, 102  
8 percent of the annual Medicare+Choice capitation  
9 rate under this paragraph for the area for the pre-  
10 vious year.”.

11           (d) INCLUSION OF COSTS OF DOD AND VA MILITARY FA-  
12 CILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN  
13 CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—  
14 Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)) is amended—

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

17           (2) by adding at the end the following new subpara-  
18 graph:

19           “(E) INCLUSION OF COSTS OF DOD AND VA MILI-  
20 TARY FACILITY SERVICES TO MEDICARE-ELIGIBLE  
21 BENEFICIARIES.—In determining the area-specific  
22 Medicare+Choice capitation rate under subparagraph  
23 (A) for a year (beginning with 2003), the annual per  
24 capita rate of payment for 1997 determined under sec-  
25 tion 1876(a)(1)(C) shall be adjusted to include in the  
26 rate the Secretary’s estimate, on a per capita basis, of  
27 the amount of additional payments that would have  
28 been made in the area involved under this title if indi-  
29 viduals entitled to benefits under this title had not re-  
30 ceived services from facilities of the Department of De-  
31 fense or the Department of Veterans Affairs.”.

32           (e) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE  
33 PAYMENT RATES.—Within 2 weeks after the date of the enact-  
34 ment of this Act, the Secretary shall determine, and shall an-  
35 nounce (in a manner intended to provide notice to interested  
36 parties) Medicare+Choice capitation rates under section 1853

1 of the Social Security Act (42 U.S.C. 1395w-23) for 2003, re-  
 2 vised in accordance with the provisions of this section.

3 (f) MEDPAC STUDY OF AAPCC.—

4 (1) STUDY.—The Medicare Payment Advisory Com-  
 5 mission shall conduct a study that assesses the method  
 6 used for determining the adjusted average per capita cost  
 7 (AAPCC) under section 1876(a)(4) of the Social Security  
 8 Act (42 U.S.C. 1395mm(a)(4)). Such study shall  
 9 examine—

10 (A) the bases for variation in such costs between  
 11 different areas, including differences in input prices,  
 12 utilization, and practice patterns;

13 (B) the appropriate geographic area for payment  
 14 under the Medicare+Choice program under part C of  
 15 title XVIII of such Act; and

16 (C) the accuracy of risk adjustment methods in re-  
 17 flecting differences in costs of providing care to dif-  
 18 ferent groups of beneficiaries served under such pro-  
 19 gram.

20 (2) REPORT.—Not later than 9 months after the date  
 21 of the enactment of this Act, the Commission shall submit  
 22 to Congress a report on the study conducted under para-  
 23 graph (1). Such report shall include recommendations re-  
 24 garding changes in the methods for computing the adjusted  
 25 average per capita cost among different areas.

26 **SEC. 202. MAKING PERMANENT CHANGE IN**  
 27 **MEDICARE+CHOICE REPORTING DEADLINES**  
 28 **AND ANNUAL, COORDINATED ELECTION PE-**  
 29 **RIOD.**

30 (a) CHANGE IN REPORTING DEADLINE.—Section  
 31 1854(a)(1) (42 U.S.C. 1395w-24(a)(1)), as amended by sec-  
 32 tion 532(b)(1) of the Public Health Security and Bioterrorism  
 33 Preparedness and Response Act of 2002, is amended by strik-  
 34 ing “2002, 2003, and 2004 (or July 1 of each other year)” and  
 35 inserting “2002 and each subsequent year (or July 1 of each  
 36 year before 2002)”.

1 (b) DELAY IN ANNUAL, COORDINATED ELECTION PE-  
 2 RIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)),  
 3 as amended by section 532(c)(1)(A) of the Public Health Secu-  
 4 rity and Bioterrorism Preparedness and Response Act of 2002,  
 5 is amended by striking “and after 2005, the month of Novem-  
 6 ber before such year and with respect to 2003, 2004, and  
 7 2005” and inserting “, the month of November before such  
 8 year and with respect to 2003 and any subsequent year”.

9 (c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Sec-  
 10 tion 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by  
 11 section 532(d)(1) of the Public Health Security and Bioter-  
 12 rorism Preparedness and Response Act of 2002, is amended by  
 13 striking “and after 2005 not later than March 1 before the cal-  
 14 endar year concerned and for 2004 and 2005” and inserting  
 15 “not later than March 1 before the calendar year concerned  
 16 and for 2004 and each subsequent year”.

17 (d) REQUIRING PROVISION OF AVAILABLE INFORMATION  
 18 COMPARING PLAN OPTIONS.—The first sentence of section  
 19 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amend-  
 20 ed by inserting before the period the following: “to the extent  
 21 such information is available at the time of preparation of ma-  
 22 terials for the mailing”.

23 **SEC. 203. AVOIDING DUPLICATIVE STATE REGULATION.**

24 (a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–  
 25 26(b)(3)) is amended to read as follows:

26 “(3) RELATION TO STATE LAWS.—The standards es-  
 27 tablished under this subsection shall supersede any State  
 28 law or regulation (other than State licensing laws or State  
 29 laws relating to plan solvency) with respect to  
 30 Medicare+Choice plans which are offered by  
 31 Medicare+Choice organizations under this part.”.

32 (b) EFFECTIVE DATE.—The amendment made by sub-  
 33 section (a) shall take effect on the date of the enactment of this  
 34 Act.

1 **SEC. 204. SPECIALIZED MEDICARE+CHOICE PLANS FOR**  
 2 **SPECIAL NEEDS BENEFICIARIES.**

3 (a) TREATMENT AS COORDINATED CARE PLAN.—Section  
 4 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by  
 5 adding at the end the following new sentence: “Specialized  
 6 Medicare+Choice plans for special needs beneficiaries (as de-  
 7 fined in section 1859(b)(4)) may be any type of coordinated  
 8 care plan.”.

9 (b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL  
 10 NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42  
 11 U.S.C. 1395w–29(b)) is amended by adding at the end the fol-  
 12 lowing new paragraph:

13 “(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR  
 14 SPECIAL NEEDS BENEFICIARIES.—

15 “(A) IN GENERAL.—The term ‘specialized  
 16 Medicare+Choice plan for special needs beneficiaries’  
 17 means a Medicare+Choice plan that exclusively serves  
 18 special needs beneficiaries (as defined in subparagraph  
 19 (B)).

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

23 “(i) is institutionalized (as defined by the Sec-  
 24 retary);

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

27 “(iii) meets such requirements as the Sec-  
 28 retary may determine would benefit from enroll-  
 29 ment in such a specialized Medicare+Choice plan  
 30 described in subparagraph (A) for individuals with  
 31 severe or disabling chronic conditions.”.

32 (c) RESTRICTION ON ENROLLMENT PERMITTED.—Section  
 33 1859 (42 U.S.C. 1395w–29) is amended by adding at the end  
 34 the following new subsection:

35 “(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED  
 36 MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENE-  
 37 FICIARIES.—In the case of a specialized Medicare+Choice plan

1 (as defined in subsection (b)(4)), notwithstanding any other  
 2 provision of this part and in accordance with regulations of the  
 3 Secretary and for periods before January 1, 2007, the plan  
 4 may restrict the enrollment of individuals under the plan to in-  
 5 dividuals who are within one or more classes of special needs  
 6 beneficiaries.”.

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

15 (e) EFFECTIVE DATES.—

16 (1) IN GENERAL.—The amendments made by sub-  
 17 sections (a), (b), and (c) shall take effect upon the date of  
 18 the enactment of this Act.

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

26 **SEC. 205. MEDICARE MSAS.**

27 (a) EXEMPTION FROM QUALITY ASSURANCE PROGRAM  
 28 REQUIREMENT.—

29 (1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C.  
 30 1395w-22(e)(1)) is amended by inserting “(other than  
 31 MSA plans)” after “Medicare+Choice plans”.

32 (2) CONFORMING AMENDMENTS.—Section 1852 (42  
 33 U.S.C. 1395w-22) is amended—

34 (A) in subsection (c)(1)(I), by inserting before the  
 35 period at the end the following: “if required under such  
 36 section”; and

1 (B) in subparagraphs (A) and (B) of subsection  
 2 (e)(2), by striking “, a non-network MSA plan,” and  
 3 “, NON-NETWORK MSA PLANS,” each place it appears.

4 (b) MAKING PROGRAM PERMANENT AND ELIMINATING  
 5 CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is  
 6 amended—

7 (1) in the heading of subparagraph (A), by striking  
 8 “ON A DEMONSTRATION BASIS”;

9 (2) by striking the first sentence of subparagraph (A);  
 10 and

11 (3) by striking the second sentence of subparagraph  
 12 (C).

13 (c) APPLYING LIMITATIONS ON BALANCE BILLING.—Sec-  
 14 tion 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by in-  
 15 serting “or with an organization offering a MSA plan” after  
 16 “section 1851(a)(2)(A)”.

17 (d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A)  
 18 (42 U.S.C. 1395w–21(e)(5)(A)) is amended—

19 (1) by adding “or” at the end of clause (i);

20 (2) by striking “, or” at the end of clause (ii) and in-  
 21 serting a semicolon; and

22 (3) by striking clause (iii).

23 **SEC. 206. EXTENSION OF REASONABLE COST AND SHMO**  
 24 **CONTRACTS.**

25 (a) REASONABLE COST CONTRACTS.—

26 (1) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C.  
 27 1395mm(h)(5)(C)) is amended—

28 (A) by inserting “(i)” after “(C)”;

29 (B) by inserting before the period the following: “,  
 30 except (subject to clause (ii)) in the case of a contract  
 31 for an area which is not covered in the service area of  
 32 1 or more coordinated care Medicare+Choice plans  
 33 under part C”; and

34 (C) by adding at the end the following new clause:  
 35 “(ii) In the case in which—

1           “(I) a reasonable cost reimbursement contract includes  
2           an area in its service area as of a date that is after Decem-  
3           ber 31, 2003;

4           “(II) such area is no longer included in such service  
5           area after such date by reason of the operation of clause  
6           (i) because of the inclusion of such area within the service  
7           area of a Medicare+Choice plan; and

8           “(III) all Medicare+Choice plans subsequently termi-  
9           nate coverage in such area;

10          such reasonable cost reimbursement contract may be extended  
11          and renewed to cover such area (so long as it is not included  
12          in the service area of any Medicare+Choice plan).”.

13           (2) STUDY.—The Medicare Benefits Administrator  
14          shall conduct a study of an appropriate transition for plans  
15          offered under reasonable cost contracts under section 1876  
16          of the Social Security Act on and after January 1, 2005.  
17          Such a transition may take into account whether there are  
18          one or more coordinated care Medicare+Choice plans being  
19          offered in the areas involved. Not later than February 1,  
20          2004, the Administrator shall submit to Congress a report  
21          on such study and shall include recommendations regarding  
22          any changes in the amendment made by paragraph (1) as  
23          the Administrator determines to be appropriate.

24           (b) EXTENSION OF SOCIAL HEALTH MAINTENANCE OR-  
25          GANIZATION (SHMO) DEMONSTRATION PROJECT.—

26           (1) IN GENERAL.—Section 4018(b)(1) of the Omnibus  
27          Budget Reconciliation Act of 1987 is amended by striking  
28          “the date that is 30 months after the date that the Sec-  
29          retary submits to Congress the report described in section  
30          4014(c) of the Balanced Budget Act of 1997” and insert-  
31          ing “December 31, 2004”.

32           (2) SHMOS OFFERING MEDICARE+CHOICE PLANS.—  
33          Nothing in such section 4018 shall be construed as pre-  
34          venting a social health maintenance organization from of-  
35          fering a Medicare+Choice plan under part C of title XVIII  
36          of the Social Security Act.

## Subtitle B—Medicare+Choice Competition Program

### SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.

(a) SUBMISSION OF BID AMOUNTS.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(1) by amending the heading to read as follows:

“SUBMISSION OF BID AMOUNTS”;

(2) in subsection (a)(1)(A)—

(A) by striking “(A)” and inserting “(A)(i) if the following year is before 2005,”; and

(B) by inserting before the semicolon at the end the following: “ or (ii) if the following year is 2005 or later, the information described in paragraph (6)(A)”;

and

(3) by adding at the end of subsection (a) the following:

“(6) SUBMISSION OF BID AMOUNTS BY MEDICARE+CHOICE ORGANIZATIONS.—

“(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

“(i) The monthly aggregate bid amount for provision of all items and services under this part and the actuarial basis for determining such amount.

“(ii) The proportions of such bid amount that are attributable to—

“(I) the provision of statutory non-drug benefits (such portion referred to in this part as the ‘unadjusted non-drug monthly bid amount’);

“(II) the provision of statutory prescription drug benefits; and

“(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

1                   “(iii) Such additional information as the Ad-  
 2                   ministrator may require to verify the actuarial  
 3                   bases described in clauses (i) and (ii).

4                   “(B) STATUTORY BENEFITS DEFINED.—For pur-  
 5                   poses of this part:

6                   “(i) The term ‘statutory non-drug benefits’  
 7                   means benefits under parts A and B.

8                   “(ii) The term ‘statutory prescription drug  
 9                   benefits’ means benefits under part D.

10                  “(iii) The term ‘statutory benefits’ means stat-  
 11                  utory prescription drug benefits and statutory non-  
 12                  drug benefits.

13                  “(C) ACCEPTANCE AND NEGOTIATION OF BID  
 14                  AMOUNTS.—The Administrator has the authority to ne-  
 15                  gotiate regarding monthly bid amounts submitted  
 16                  under subparagraph (A) (and the proportion described  
 17                  in subparagraph (A)(ii)). The Administrator may reject  
 18                  such a bid amount or proportion if the Administrator  
 19                  determines that such amount or proportion is not sup-  
 20                  ported by the actuarial bases provided under subpara-  
 21                  graph (A).”.

22                  (b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN  
 23                  PLANS.—

24                   (1) IN GENERAL.—Section 1854(b) (42 U.S.C.  
 25                   1395w-24(b)) is amended—

26                   (A) by adding at the end of paragraph (1) the fol-  
 27                   lowing new subparagraph:

28                   “(C) BENEFICIARY REBATE RULE.—

29                   “(i) REQUIREMENT.—The Medicare+Choice  
 30                   plan shall provide to the enrollee a monthly rebate  
 31                   equal to 75 percent of the average per capita sav-  
 32                   ings (if any) described in paragraph (3) applicable  
 33                   to the plan and year involved.

34                   “(iii) FORM OF REBATE.—A rebate required  
 35                   under this subparagraph shall be provided—

36                   “(I) through the crediting of the amount  
 37                   of the rebate towards the Medicare+Choice

1 monthly supplementary beneficiary premium or  
 2 the premium imposed for prescription drug cov-  
 3 erage under part D;

4 “(II) through a direct monthly payment  
 5 (through electronic funds transfer or other-  
 6 wise); or

7 “(III) through other means approved by  
 8 the Medicare Benefits Administrator,  
 9 or any combination thereof.”; and

10 (B) by adding at the end the following new para-  
 11 graph:

12 “(3) COMPUTATION OF AVERAGE PER CAPITA MONTH-  
 13 LY SAVINGS.—For purposes of paragraph (1)(C)(i), the av-  
 14 erage per capita monthly savings referred to in such para-  
 15 graph for a Medicare+Choice plan and year is computed  
 16 as follows:

17 “(A) DETERMINATION OF STATE-WIDE AVERAGE  
 18 RISK ADJUSTMENT.—

19 “(i) IN GENERAL.—The Medicare Benefits Ad-  
 20 ministrator shall determine, at the same time rates  
 21 are promulgated under section 1853(b)(1) (begin-  
 22 ning with 2005), for each State the average of the  
 23 risk adjustment factors to be applied to enrollees  
 24 under section 1853(a)(1)(A) in that State. In the  
 25 case of a State in which a Medicare+Choice plan  
 26 was offered in the previous year, the Administrator  
 27 may compute such average based upon risk adjust-  
 28 ment factors applied in that State in a previous  
 29 year.

30 “(ii) TREATMENT OF NEW STATES.—In the  
 31 case of a State in which no Medicare+Choice plan  
 32 was offered in the previous year, the Administrator  
 33 shall estimate such average. In making such esti-  
 34 mate, the Administrator may use average risk ad-  
 35 justment factors applied to comparable States or  
 36 applied on a national basis.

1           “(B) DETERMINATION OF RISK ADJUSTED BENCH-  
2           MARK AND RISK-ADJUSTED BID.—For each  
3           Medicare+Choice plan offered in a State, the Adminis-  
4           trator shall—

5                   “(i) adjust the fee-for-service area-specific  
6                   non-drug benchmark amount by the applicable av-  
7                   erage risk adjustment factor computed under sub-  
8                   paragraph (A); and

9                   “(ii) adjust the unadjusted non-drug monthly  
10                  bid amount by such applicable average risk adjust-  
11                  ment factor.

12           “(C) DETERMINATION OF AVERAGE PER CAPITA  
13           MONTHLY SAVINGS.—The average per capita monthly  
14           savings described in this subparagraph is equal to the  
15           amount (if any) by which—

16                   “(i) the risk-adjusted benchmark amount com-  
17                   puted under subparagraph (B)(i), exceeds

18                   “(ii) the risk-adjusted bid computed under  
19                   subparagraph (B)(ii).

20           “(D) AUTHORITY TO DETERMINE RISK ADJUST-  
21           MENT FOR AREAS OTHER THAN STATES.—The Admin-  
22           istrator may provide for the determination and applica-  
23           tion of risk adjustment factors under this paragraph on  
24           the basis of areas other than States.”.

25           (2) COMPUTATION OF FEE-FOR-SERVICE AREA-SPE-  
26           CIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C.  
27           1395w-23) is amended by adding at the end the following  
28           new subsection:

29                   “(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC  
30           NON-DRUG BENCHMARK AMOUNT.—For purposes of this part,  
31           the term ‘fee-for-service area-specific non-drug benchmark  
32           amount’ means, with respect to a Medicare+Choice payment  
33           area for a month in a year, an amount equal to the greater  
34           of the following (but in no case less than  $\frac{1}{12}$  of the rate com-  
35           puted under subsection (c)(1), without regard to subparagraph  
36           (A), for the year):

1           “(1) BASED ON 100 PERCENT OF FEE-FOR-SERVICE  
 2 COSTS IN THE AREA.—An amount equal to  $\frac{1}{12}$  of 100 per-  
 3 cent (for 2005 through 2007, or 95 percent for 2008 and  
 4 years thereafter) of the adjusted average per capita cost for  
 5 the year involved, determined under section 1876(a)(4) for  
 6 the Medicare+Choice payment area, for the area and the  
 7 year involved, for services covered under parts A and B for  
 8 individuals entitled to benefits under part A and enrolled  
 9 under part B who are not enrolled in a Medicare+Choice  
 10 plan under this part for the year, and adjusted to exclude  
 11 from such cost the amount the Medicare Benefits Adminis-  
 12 trator estimates is payable for costs described in subclauses  
 13 (I) and (II) of subsection (c)(3)(C)(i) for the year involved  
 14 and also adjusted in the manner described in subsection  
 15 (c)(1)(D)(ii) (relating to inclusion of costs of VA and DOD  
 16 military facility services to medicare-eligible beneficiaries).

17           “(2) MINIMUM MONTHLY AMOUNT.—The minimum  
 18 amount specified in this paragraph is the amount specified  
 19 in subsection (c)(1)(B)(iv) for the year involved.”.

20           (c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

21           (1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C.  
 22 1395w-23) is amended by striking “in an amount” and all  
 23 that follows and inserting the following: “in an amount de-  
 24 termined as follows:

25                   “(i) PAYMENT BEFORE 2005.—For years be-  
 26 fore 2005, the payment amount shall be equal to  
 27  $\frac{1}{12}$  of the annual Medicare+Choice capitation rate  
 28 (as calculated under subsection (c)) with respect to  
 29 that individual for that area, reduced by the  
 30 amount of any reduction elected under section  
 31 1854(f)(1)(E) and adjusted under clause (iii).

32                   “(ii) PAYMENT FOR STATUTORY NON-DRUG  
 33 BENEFITS BEGINNING WITH 2005.—For years be-  
 34 ginning with 2005—

35                           “(I) PLANS WITH BIDS BELOW BENCH-  
 36 MARK.—In the case of a plan for which there  
 37 are average per capita monthly savings de-

1                   scribed in section 1854(b)(3)(C), the payment  
 2                   under this subsection is equal to the  
 3                   unadjusted non-drug monthly bid amount, ad-  
 4                   justed under clause (iii), plus the amount of  
 5                   the monthly rebate computed under section  
 6                   1854(b)(1)(C)(i) for that plan and year.

7                   “(II) PLANS WITH BIDS AT OR ABOVE  
 8                   BENCHMARK.—In the case of a plan for which  
 9                   there are no average per capita monthly sav-  
 10                  ings described in section 1854(b)(3)(C), the  
 11                  payment amount under this subsection is equal  
 12                  to the fee-for-service area-specific non-drug  
 13                  benchmark amount, adjusted under clause (iii).

14                 “(iii) DEMOGRAPHIC ADJUSTMENT, INCLUD-  
 15                 ING ADJUSTMENT FOR HEALTH STATUS.—The Ad-  
 16                 ministrator shall adjust the payment amount under  
 17                 clause (i), the unadjusted non-drug monthly bid  
 18                 amount under clause (ii)(I), and the fee-for-service  
 19                 area-specific non-drug benchmark amount under  
 20                 clause (ii)(II) for such risk factors as age, disability  
 21                 status, gender, institutional status, and such other  
 22                 factors as the Administrator determines to be ap-  
 23                 propriate, including adjustment for health status  
 24                 under paragraph (3), so as to ensure actuarial  
 25                 equivalence. The Administrator may add to, mod-  
 26                 ify, or substitute for such adjustment factors if  
 27                 such changes will improve the determination of ac-  
 28                 tuarial equivalence.

29                 “(iv) REFERENCE TO SUBSIDY PAYMENT FOR  
 30                 STATUTORY DRUG BENEFITS.—In the case in which  
 31                 an enrollee is enrolled under part D, the  
 32                 Medicare+Choice organization also is entitled to a  
 33                 subsidy payment amount under section 1860H.”.

34                 (d) CONFORMING AMENDMENTS.—

35                 (1) PROTECTION AGAINST BENEFICIARY SELECTION.—  
 36                 Section 1852(b)(1)(A) (42 U.S.C. 1395w-22(b)(1)(A)) is  
 37                 amended by adding at the end the following: “The Admin-

1        istrator shall not approve a plan of an organization if the  
 2        Administrator determines that the benefits are designed to  
 3        substantially discourage enrollment by certain  
 4        Medicare+Choice eligible individuals with the organiza-  
 5        tion.”.

6            (2) CONFORMING AMENDMENT TO PREMIUM TERMI-  
 7        NOLOGY.—Subparagraphs (A) and (B) of section  
 8        1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) are amended to  
 9        read as follows:

10            “(A) MEDICARE+CHOICE MONTHLY BASIC BENE-  
 11        FICIARY PREMIUM.—The term ‘Medicare+Choice  
 12        monthly basic beneficiary premium’ means, with re-  
 13        spect to a Medicare+Choice plan—

14            “(i) described in section 1853(a)(1)(A)(ii)(I)  
 15        (relating to plans providing rebates), zero; or

16            “(ii) described in section 1853(a)(1)(A)(ii)(II),  
 17        the amount (if any) by which the unadjusted non-  
 18        drug monthly bid amount exceeds the fee-for-serv-  
 19        ice area-specific non-drug benchmark amount.

20            “(B) MEDICARE+CHOICE MONTHLY SUPPLE-  
 21        MENTAL BENEFICIARY PREMIUM.—The term  
 22        ‘Medicare+Choice monthly supplemental beneficiary  
 23        premium’ means, with respect to a Medicare+Choice  
 24        plan, the portion of the aggregate monthly bid amount  
 25        submitted under clause (i) of subsection (a)(6)(A) for  
 26        the year that is attributable under such section to the  
 27        provision of nonstatutory benefits.”.

28            (3) REQUIREMENT FOR UNIFORM BID AMOUNTS.—  
 29        Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended to  
 30        read as follows:

31            “(c) UNIFORM BID AMOUNTS.—The Medicare+Choice  
 32        monthly bid amount submitted under subsection (a)(6) of a  
 33        Medicare+Choice organization under this part may not vary  
 34        among individuals enrolled in the plan.”.

35            (4) PERMITTING BENEFICIARY REBATES.—

36            (A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–  
 37        21(h)(4)(A)) is amended by inserting “except as pro-

1           vided under section 1854(b)(1)(C)” after “or other-  
2           wise”.

3           (B) Section 1854(d) (42 U.S.C. 1395w-24(d)) is  
4           amended by inserting “, except as provided under sub-  
5           section (b)(1)(C),” after “and may not provide”.

6           (e) EFFECTIVE DATE.—The amendments made by this  
7           section shall apply to payments and premiums for months be-  
8           ginning with January 2005.

9           **SEC. 212. DEMONSTRATION PROGRAM FOR COMPETI-**  
10           **TIVE-DEMONSTRATION AREAS.**

11           (a) IDENTIFICATION OF COMPETITIVE-DEMONSTRATION  
12           AREAS FOR DEMONSTRATION PROGRAM; COMPUTATION OF  
13           CHOICE NON-DRUG BENCHMARKS.—Section 1853, as amended  
14           by section 211(b)(2), is amended by adding at the end the fol-  
15           lowing new subsection:

16           “(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRATION  
17           PROGRAM.—

18           “(1) DESIGNATION OF COMPETITIVE-DEMONSTRATION  
19           AREAS AS PART OF PROGRAM.—

20           “(A) IN GENERAL.—For purposes of this part, the  
21           Administrator shall establish a demonstration program  
22           under which the Administrator designates  
23           Medicare+Choice areas as competitive-demonstration  
24           areas consistent with the following limitations:

25           “(i) LIMITATION ON NUMBER OF AREAS THAT  
26           MAY BE DESIGNATED.—The Administrator may not  
27           designate more than 4 areas as competitive-dem-  
28           onstration areas.

29           “(ii) LIMITATION ON PERIOD OF DESIGNATION  
30           OF ANY AREA.—The Administrator may not des-  
31           ignate any area as a competitive-demonstration  
32           area for a period of more than 2 years.

33           The Administrator has the discretion to decide whether  
34           or not to designate as a competitive-demonstration area  
35           an area that qualifies for such designation.

36           “(B) QUALIFICATIONS FOR DESIGNATION.—For  
37           purposes of this title, a Medicare+Choice area (which

1 is a metropolitan statistical area or other area with a  
2 substantial number of Medicare+Choice enrollees) may  
3 not be designated as a ‘competitive-demonstration area’  
4 for a 2-year period beginning with a year unless the  
5 Administrator determines, by such date before the be-  
6 ginning of the year as the Administrator determines  
7 appropriate, that—

8 “(i) there will be offered during the open en-  
9 rollment period under this part before the begin-  
10 ning of the year at least 2 Medicare+Choice plans  
11 (in addition to the fee-for-service program under  
12 parts A and B), each offered by a different  
13 Medicare+Choice organization; and

14 “(ii) during March of the previous year at  
15 least 50 percent of the number of Medicare+Choice  
16 eligible individuals who reside in the area were en-  
17 rolled in a Medicare+Choice plan.

18 “(2) CHOICE NON-DRUG BENCHMARK AMOUNT.—For  
19 purposes of this part, the term ‘choice non-drug benchmark  
20 amount’ means, with respect to a Medicare+Choice pay-  
21 ment area for a month in a year, the sum of the 2 compo-  
22 nents described in paragraph (3) for the area and year.  
23 The Administrator shall compute such benchmark amount  
24 for each competitive-demonstration area before the begin-  
25 ning of each annual, coordinated election period under sec-  
26 tion 1851(e)(3)(B) for each year (beginning with 2005) in  
27 which it is designated as such an area.

28 “(3) 2 COMPONENTS.—For purposes of paragraph (2),  
29 the 2 components described in this paragraph for an area  
30 and a year are the following:

31 “(A) FEE-FOR-SERVICE COMPONENT WEIGHTED  
32 BY NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The  
33 product of the following:

34 “(i) NATIONAL FEE-FOR-SERVICE MARKET  
35 SHARE.—The national fee-for-service market share  
36 percentage (determined under paragraph (5)) for  
37 the year.

1                   “(ii) FEE-FOR-SERVICE AREA-SPECIFIC NON-  
2                   DRUG BID.—The fee-for-service area-specific non-  
3                   drug bid (as defined in paragraph (6)) for the area  
4                   and year.

5                   “(B) M+C COMPONENT WEIGHTED BY NATIONAL  
6                   MEDICARE+CHOICE MARKET SHARE.—The product of  
7                   the following:

8                   “(i) NATIONAL MEDICARE+CHOICE MARKET  
9                   SHARE.—1 minus the national fee-for-service mar-  
10                  ket share percentage for the year.

11                  “(ii) WEIGHTED AVERAGE OF PLAN BIDS IN  
12                  AREA.—The weighted average of the plan bids for  
13                  the area and year (as determined under paragraph  
14                  (4)(A)).

15                  “(4) DETERMINATION OF WEIGHTED AVERAGE BIDS  
16                  FOR AN AREA.—

17                  “(A) IN GENERAL.—For purposes of paragraph  
18                  (3)(B)(ii), the weighted average of plan bids for an  
19                  area and a year is the sum of the following products  
20                  for Medicare+Choice plans described in subparagraph  
21                  (C) in the area and year:

22                  “(i) PROPORTION OF EACH PLAN’S ENROLL-  
23                  EES IN THE AREA.—The number of individuals de-  
24                  scribed in subparagraph (B), divided by the total  
25                  number of such individuals for all  
26                  Medicare+Choice plans described in subparagraph  
27                  (C) for that area and year.

28                  “(ii) MONTHLY NON-DRUG BID AMOUNT.—The  
29                  unadjusted non-drug monthly bid amount.

30                  “(B) COUNTING OF INDIVIDUALS.—The Adminis-  
31                  trator shall count, for each Medicare+Choice plan de-  
32                  scribed in subparagraph (C) for an area and year, the  
33                  number of individuals who reside in the area and who  
34                  were enrolled under such plan under this part during  
35                  March of the previous year.

36                  “(C) EXCLUSION OF PLANS NOT OFFERED IN PRE-  
37                  VIOUS YEAR.—For an area and year, the

1 Medicare+Choice plans described in this subparagraph  
 2 are plans that are offered in the area and year and  
 3 were offered in the area in March of the previous year.

4 “(5) COMPUTATION OF NATIONAL FEE-FOR-SERVICE  
 5 MARKET SHARE PERCENTAGE.—The Administrator shall  
 6 determine, for a year, the proportion (in this subsection re-  
 7 ferred to as the ‘national fee-for-service market share per-  
 8 centage’) of Medicare+Choice eligible individuals who dur-  
 9 ing March of the previous year were not enrolled in a  
 10 Medicare+Choice plan.

11 “(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG  
 12 BID.—For purposes of this part, the term ‘fee-for-service  
 13 area-specific non-drug bid’ means, for an area and year,  
 14 the amount described in section 1853(j)(1) for the area and  
 15 year, except that any reference to a percent of less than  
 16 100 percent shall be deemed a reference to 100 percent.”.

17 (b) APPLICATION OF CHOICE NON-DRUG BENCHMARK IN  
 18 COMPETITIVE-DEMONSTRATION AREAS.—

19 (1) IN GENERAL.—Section 1854 is amended—

20 (A) in subsection (b)(1)(C)(i), as added by section  
 21 211(b)(1)(A), by striking “(i) REQUIREMENT.—If” and  
 22 inserting “(i) REQUIREMENT FOR NON-COMPETITIVE-  
 23 DEMONSTRATION AREAS.—In the case of a  
 24 Medicare+Choice payment area that is not a competi-  
 25 tive-demonstration area designated under section  
 26 1853(k)(1), if”;

27 (B) in subsection (b)(1)(C), as so added, by insert-  
 28 ing after clause (i) the following new clause:

29 “(ii) REQUIREMENT FOR COMPETITIVE-DEM-  
 30 ONSTRATION AREAS.—In the case of a  
 31 Medicare+Choice payment area that is designated  
 32 as a competitive-demonstration area under section  
 33 1853(k)(1), if there are average per capita monthly  
 34 savings described in paragraph (4) for a  
 35 Medicare+Choice plan and year, the  
 36 Medicare+Choice plan shall provide to the enrollee

1 a monthly rebate equal to 75 percent of such sav-  
2 ings.”;

3 (C) by adding at the end of subsection (b), as  
4 amended by section 211(b)(1), the following new para-  
5 graph:

6 “(4) COMPUTATION OF AVERAGE PER CAPITA MONTH-  
7 LY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—  
8 For purposes of paragraph (1)(C)(ii), the average per cap-  
9 ita monthly savings referred to in such paragraph for a  
10 Medicare+Choice plan and year shall be computed in the  
11 same manner as the average per capita monthly savings is  
12 computed under paragraph (3) except that the reference to  
13 the fee-for-service area-specific non-drug benchmark in  
14 paragraph (3)(B)(i) (or to the benchmark amount as ad-  
15 justed under paragraph (3)(C)(i)) is deemed to be a ref-  
16 erence to the choice non-drug benchmark amount (or such  
17 amount as adjusted in the manner described in paragraph  
18 (3)(B)(i)).”; and

19 (D) in subsection (d), as amended by section  
20 211(d)(4), by inserting “and subsection (b)(1)(D)”  
21 after “subsection (b)(1)(C),”.

22 (2) CONFORMING AMENDMENTS.—

23 (A) PAYMENT OF PLANS.—Section  
24 1853(a)(1)(A)(ii), as amended by section 211(c)(1), is  
25 amended—

26 (i) in subclause (I), by inserting “(or, in the  
27 case of a competitive-demonstration area, the  
28 choice non-drug benchmark amount)” after “bench-  
29 mark amount”; and

30 (ii) in subclauses (I) and (II), by inserting  
31 “(or, in the case of a competitive-demonstration  
32 area, described in section 1854(b)(4))” after “sec-  
33 tion 1854(b)(1)(C)”.

34 (B) DEFINITION OF MONTHLY BASIC PREMIUM.—  
35 Section 1854(b)(2)(A)(ii), as amended by section  
36 211(d)(2), is amended by inserting “(or, in the case of

1           a competitive-demonstration area, the choice non-drug  
2           benchmark amount)” after “benchmark amount”.

3           (c) PREMIUM ADJUSTMENT.—Section 1839 (42 U.S.C.  
4 1395r) is amended by adding at the end the following new sub-  
5 section:

6           “(h)(1) In the case of an individual who resides in a com-  
7 petitive-demonstration area designated under section  
8 1851(k)(1) and who is not enrolled in a Medicare+Choice plan  
9 under part C, the monthly premium otherwise applied under  
10 this part (determined without regard to subsections (b) and (f)  
11 or any adjustment under this subsection) shall be adjusted as  
12 follows: If the fee-for-service area-specific non-drug bid (as de-  
13 fined in section 1853(k)(6)) for the Medicare+Choice area in  
14 which the individual resides for a month—

15           “(A) does not exceed the choice non-drug benchmark  
16 (as determined under section 1853(k)(2)) for such area,  
17 the amount of the premium for the individual for the  
18 month shall be reduced by an amount equal to 75 percent  
19 of the amount by which such benchmark exceeds such fee-  
20 for-service bid; or

21           “(B) exceeds such choice non-drug benchmark, the  
22 amount of the premium for the individual for the month  
23 shall be adjusted to ensure that—

24           “(i) the sum of the amount of the adjusted pre-  
25 mium and the choice non-drug benchmark for the area,  
26 is equal to

27           “(ii) the sum of the unadjusted premium plus  
28 amount of the fee-for-service area-specific non-drug bid  
29 for the area.

30           “(2) Nothing in this subsection shall be construed as pre-  
31 venting a reduction under paragraph (1)(A) in the premium  
32 otherwise applicable under this part to zero or from requiring  
33 the provision of a rebate to the extent such premium would  
34 otherwise be required to be less than zero.

35           “(3) The adjustment in the premium under this subsection  
36 shall be effected in such manner as the Medicare Benefits Ad-  
37 ministrators determine appropriate.

1 “(4) In order to carry out this subsection (insofar as it is  
2 effected through the manner of collection of premiums under  
3 1840(a)), the Medicare Benefits Administrator shall transmit  
4 to the Commissioner of Social Security—

5 “(A) at the beginning of each year, the name, social  
6 security account number, and the amount of the adjust-  
7 ment (if any) under this subsection for each individual en-  
8 rolled under this part for each month during the year; and

9 “(B) periodically throughout the year, information to  
10 update the information previously transmitted under this  
11 paragraph for the year.”.

12 (d) CONFORMING AMENDMENT.—Section 1844(c) (42  
13 U.S.C. 1395w(c)) is amended by inserting “and without regard  
14 to any premium adjustment effected under section 1839(h)”  
15 before the period at the end.

16 (e) REPORT ON DEMONSTRATION PROGRAM.—Not later  
17 than 6 months after the date on which the designation of the  
18 4th competitive-demonstration area under section 1851(k)(1) of  
19 the Social Security Act ends, the Medicare Payment Advisory  
20 Commission shall submit to Congress a report on the impact  
21 of the demonstration program under the amendments made by  
22 this section, including such impact on premiums of medicare  
23 beneficiaries, savings to the medicare program, and on adverse  
24 selection.

25 (f) EFFECTIVE DATE.—The amendments made by this  
26 section shall apply to payments and premiums for periods be-  
27 ginning on or after January 1, 2005.

28 **SEC. 213. CONFORMING AMENDMENTS.**

29 (a) CONFORMING AMENDMENTS RELATING TO BIDS.—

30 (1) Section 1854 (42 U.S.C. 1395w-24) is amended—

31 (A) in the heading by inserting “AND BID  
32 AMOUNTS” after “PREMIUMS”;

33 (B) in the heading of subsection (a), by inserting  
34 “AND BID AMOUNTS” after “PREMIUMS”; and

35 (C) in subsection (a)(5)(A), by inserting “para-  
36 graphs (2), (3), and (4) of” after “filed under”.

37 (b) ADDITIONAL CONFORMING AMENDMENTS.—

1 (1) ANNUAL DETERMINATION AND ANNOUNCEMENT  
2 OF CERTAIN FACTORS.—Section 1853(b) (42 U.S.C.  
3 1395w-23(b)) is amended—

4 (A) in paragraph (1), by striking “the calendar  
5 year concerned” and all that follows and inserting the  
6 following: “the calendar year concerned with respect to  
7 each Medicare+Choice payment area, the following:

8 “(A) PRE-COMPETITION INFORMATION.—For  
9 years before 2005, the following:

10 “(i) MEDICARE+CHOICE CAPITATION  
11 RATES.—The annual Medicare+Choice capitation  
12 rate for each Medicare+Choice payment area for  
13 the year.

14 “(ii) ADJUSTMENT FACTORS.—The risk and  
15 other factors to be used in adjusting such rates  
16 under subsection (a)(1)(A) for payments for  
17 months in that year.

18 “(B) COMPETITION INFORMATION.—For years be-  
19 ginning with 2005, the following:

20 “(i) BENCHMARKS.—The fee-for-service area-  
21 specific non-drug benchmark under section 1853(j)  
22 and, if applicable, the choice non-drug benchmark  
23 under section 1853(k)(2), for the year involved  
24 and, if applicable, the national fee-for-service mar-  
25 ket share percentage.

26 “(ii) ADJUSTMENT FACTORS.—The adjust-  
27 ment factors applied under section  
28 1853(a)(1)(A)(iii) (relating to demographic adjust-  
29 ment), section 1853(a)(1)(B) (relating to adjust-  
30 ment for end-stage renal disease), and section  
31 1853(a)(3) (relating to health status adjustment).

32 “(iii) PROJECTED FEE-FOR-SERVICE BID.—In  
33 the case of a competitive area, the projected fee-  
34 for-service area-specific non-drug bid (as deter-  
35 mined under subsection (k)(6)) for the area.

36 “(iv) INDIVIDUALS.—The number of individ-  
37 uals counted under subsection (k)(4)(B) and en-

1 rolled in each Medicare+Choice plan in the area.”;

2 and

3 (B) in paragraph (3), by striking “in sufficient de-  
4 tail” and all that follows up to the period at the end.

5 (2) REPEAL OF PROVISIONS RELATING TO ADJUSTED  
6 COMMUNITY RATE (ACR).—

7 (A) IN GENERAL.—Subsections (e) and (f) of sec-  
8 tion 1854 (42 U.S.C. 1395w–24) are repealed.

9 (B) CONFORMING AMENDMENT.—Section  
10 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by  
11 striking “, and to reflect” and all that follows and in-  
12 serting a period.

13 (3) PROSPECTIVE IMPLEMENTATION OF NATIONAL  
14 COVERAGE DETERMINATIONS.—Section 1852(a)(5) (42  
15 U.S.C. 1395w–22(a)(5)) is amended to read as follows:

16 “(5) PROSPECTIVE IMPLEMENTATION OF NATIONAL  
17 COVERAGE DETERMINATIONS.—The Secretary shall only  
18 implement a national coverage determination that will re-  
19 sult in a significant change in the costs to a  
20 Medicare+Choice organization in a prospective manner  
21 that applies to announcements made under section 1853(b)  
22 after the date of the implementation of the determina-  
23 tion.”.

24 (4) PERMITTING GEOGRAPHIC ADJUSTMENT TO CON-  
25 SOLIDATE MULTIPLE MEDICARE+CHOICE PAYMENT AREAS  
26 IN A STATE INTO A SINGLE STATEWIDE  
27 MEDICARE+CHOICE PAYMENT AREA.—Section 1853(d)(3)  
28 (42 U.S.C. 1395w–23(e)(3)) is amended—

29 (A) by amending clause (i) of subparagraph (A) to  
30 read as follows:

31 “(i) to a single statewide Medicare+Choice  
32 payment area,”; and

33 (B) by amending subparagraph (B) to read as fol-  
34 lows:

35 “(B) BUDGET NEUTRALITY ADJUSTMENT.—In the  
36 case of a State requesting an adjustment under this  
37 paragraph, the Medicare Benefits Administrator shall

1 initially (and annually thereafter) adjust the payment  
 2 rates otherwise established under this section for  
 3 Medicare+Choice payment areas in the State in a man-  
 4 ner so that the aggregate of the payments under this  
 5 section in the State shall not exceed the aggregate pay-  
 6 ments that would have been made under this section  
 7 for Medicare+Choice payment areas in the State in the  
 8 absence of the adjustment under this paragraph.”.

9 (d) EFFECTIVE DATE.—The amendments made by this  
 10 section shall apply to payments and premiums for periods be-  
 11 ginning on or after January 1, 2005.

### 12 **TITLE III—RURAL HEALTH CARE** 13 **IMPROVEMENTS**

#### 14 **SEC. 301. REFERENCE TO FULL MARKET BASKET IN-** 15 **CREASE FOR SOLE COMMUNITY HOSPITALS.**

16 For provision eliminating any reduction from full market  
 17 basket in the update for inpatient hospital services for sole  
 18 community hospitals, see section 401.

#### 19 **SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOS-** 20 **PITAL (DSH) TREATMENT FOR RURAL HOS-** 21 **PITALS AND URBAN HOSPITALS WITH** 22 **FEWER THAN 100 BEDS.**

23 (a) BLENDING OF PAYMENT AMOUNTS.—

24 (1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C.  
 25 1395ww(d)(5)(F)) is amended by adding at the end the fol-  
 26 lowing new clause:

27 “(xiv)(I) In the case of discharges in a fiscal year begin-  
 28 ning on or after October 1, 2002, subject to subclause (II),  
 29 there shall be substituted for the disproportionate share adjust-  
 30 ment percentage otherwise determined under clause (iv) (other  
 31 than subclause (I)) or under clause (viii), (x), (xi), (xii), or  
 32 (xiii), the old blend proportion (specified under subclause (III))  
 33 of the disproportionate share adjustment percentage otherwise  
 34 determined under the respective clause and 100 percent minus  
 35 such old blend proportion of the disproportionate share adjust-  
 36 ment percentage determined under clause (vii) (relating to  
 37 large, urban hospitals).

1 “(II) Under subclause (I), the disproportionate share ad-  
 2 justment percentage shall not exceed 10 percent for a hospital  
 3 that is not classified as a rural referral center under subpara-  
 4 graph (C).

5 “(III) For purposes of subclause (I), the old blend propor-  
 6 tion for fiscal year 2003 is 80 percent, for each subsequent  
 7 year (through 2006) is the old blend proportion under this sub-  
 8 clause for the previous year minus 20 percentage points, and  
 9 for each year beginning with 2007 is 0 percent.”.

10 (2) CONFORMING AMENDMENTS.—Section  
 11 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

12 (A) in each of subclauses (II), (III), (IV), (V), and  
 13 (VI) of clause (iv), by inserting “subject to clause (xiv)  
 14 and” before “for discharges occurring”;

15 (B) in clause (viii), by striking “The formula” and  
 16 inserting “Subject to clause (xiv), the formula”; and

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

20 (b) EFFECTIVE DATE.—The amendments made by this  
 21 section shall apply with respect to discharges occurring on or  
 22 after October 1, 2002.

23 **SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STAND-**  
 24 **ARDIZED AMOUNT IN RURAL AND SMALL**  
 25 **URBAN AREAS TO ACHIEVE A SINGLE, UNI-**  
 26 **FORM STANDARDIZED AMOUNT.**

27 Section 1886(d)(3)(A)(iv) (42 U.S.C.  
 28 1395ww(d)(3)(A)(iv)) is amended—

29 (1) by striking “(iv) For discharges” and inserting  
 30 “(iv)(I) Subject to the succeeding provisions of this clause,  
 31 for discharges”; and

32 (2) by adding at the end the following new subclauses:

33 “(II) For discharges occurring during fiscal year  
 34 2003, the average standardized amount for hospitals lo-  
 35 cated other than in a large urban area shall be increased  
 36 by ½ of the difference between the average standardized  
 37 amount determined under subclause (I) for hospitals lo-

1 cated in large urban areas for such fiscal year and such  
 2 amount determined (without regard to this subclause) for  
 3 other hospitals for such fiscal year.

4 “(III) For discharges occurring in a fiscal year begin-  
 5 ning with fiscal year 2004, the Secretary shall compute an  
 6 average standardized amount for hospitals located in any  
 7 area within the United States and within each region equal  
 8 to the average standardized amount computed for the pre-  
 9 vious fiscal year under this subparagraph for hospitals lo-  
 10 cated in a large urban area (or, beginning with fiscal year  
 11 2005, for hospitals located in any area) increased by the  
 12 applicable percentage increase under subsection  
 13 (b)(3)(B)(i).”.

14 **SEC. 304. MORE FREQUENT UPDATE IN WEIGHTS USED**  
 15 **IN HOSPITAL MARKET BASKET.**

16 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After re-  
 17 vising the weights used in the hospital market basket under  
 18 section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C.  
 19 1395ww(b)(3)(B)(iii)) to reflect the most current data avail-  
 20 able, the Secretary shall establish a frequency for revising such  
 21 weights in such market basket to reflect the most current data  
 22 available more frequently than once every 5 years.

23 (b) REPORT.—Not later than October 1, 2003, the Sec-  
 24 retary shall submit a report to Congress on the frequency es-  
 25 tablished under subsection (a), including an explanation of the  
 26 reasons for, and options considered, in determining such fre-  
 27 quency.

28 **SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOS-**  
 29 **PITAL PROGRAM.**

30 (a) REINSTATEMENT OF PERIODIC INTERIM PAYMENT  
 31 (PIP).—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is  
 32 amended—

33 (1) by striking “and” at the end of subparagraph (C);

34 (2) by adding “and” at the end of subparagraph (D);

35 and

36 (3) by inserting after subparagraph (D) the following  
 37 new subparagraph:

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

2 (b) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN  
3 PAYMENT ADJUSTMENT.—Section 1834(g)(2) (42 U.S.C.  
4 1395m(g)(2)) is amended by adding after and below subpara-  
5 graph (B) the following:

6 “The Secretary may not require, as a condition for apply-  
7 ing subparagraph (B) with respect to a critical access hos-  
8 pital, that each physician providing professional services in  
9 the hospital must assign billing rights with respect to such  
10 services, except that such subparagraph shall not apply to  
11 those physicians who have not assigned such billing  
12 rights.”.

13 (c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS  
14 WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—Section  
15 1820 (42 U.S.C. 1395i-4) is amended—

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

18 (2) by adding at the end of subsection (c) the fol-  
19 lowing new paragraph:

20 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR  
21 HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUA-  
22 TIONS.—

23 “(A) IN GENERAL.—In the case of a hospital that  
24 demonstrates that it meets the standards established  
25 under subparagraph (B), the bed limitations otherwise  
26 applicable under paragraph (2)(B)(iii) and subsection  
27 (f) shall be increased by 5 beds.

28 “(B) STANDARDS.—The Secretary shall specify  
29 standards for determining whether a critical access hos-  
30 pital has sufficiently strong seasonal variations in pa-  
31 tient admissions to justify the increase in bed limitation  
32 provided under subparagraph (A).”; and

33 (3) in subsection (f), by adding at the end the fol-  
34 lowing new sentence: “The limitations in numbers of beds  
35 under the first sentence are subject to adjustment under  
36 subsection (c)(3).”.

1 (d) 5-YEAR EXTENSION OF THE AUTHORIZATION FOR AP-  
 2 PROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j) (42  
 3 U.S.C. 1395i–4(j)) is amended by striking “through 2002” and  
 4 inserting “through 2007”.

5 (e) EFFECTIVE DATES.—

6 (1) REINSTATEMENT OF PIP.—The amendments made  
 7 by subsection (a) shall apply to payments made on or after  
 8 January 1, 2003.

9 (2) PHYSICIAN PAYMENT ADJUSTMENT CONDITION.—  
 10 The amendment made by subsection (b) shall be effective  
 11 as if included in the enactment of section 403(d) of the  
 12 Medicare, Medicaid, and SCHIP Balanced Budget Refine-  
 13 ment Act of 1999 (113 Stat. 1501A–371).

14 (3) FLEXIBILITY IN BED LIMITATION.—The amend-  
 15 ments made by subsection (c) shall apply to designations  
 16 made on or after January 1, 2003, but shall not apply to  
 17 critical access hospitals that were designated as of such  
 18 date.

19 **SEC. 306. EXTENSION OF TEMPORARY INCREASE FOR**  
 20 **HOME HEALTH SERVICES FURNISHED IN A**  
 21 **RURAL AREA.**

22 (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.  
 23 2763A–533) is amended—

24 (1) by striking “24-MONTH INCREASE BEGINNING  
 25 APRIL 1, 2001” and inserting “IN GENERAL”; and

26 (2) by striking “April 1, 2003” and inserting “Janu-  
 27 ary 1, 2005”.

28 (b) CONFORMING AMENDMENT.—Section 547(e)(2) of  
 29 BIPA (114 Stat. 2763A–553) is amended by striking “the pe-  
 30 riod beginning on April 1, 2001, and ending on September 30,  
 31 2002,” and inserting “a period under such section”.

32 **SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN**  
 33 **PAYMENT FOR HOSPICE CARE FURNISHED**  
 34 **IN A FRONTIER AREA AND RURAL HOSPICE**  
 35 **DEMONSTRATION PROJECT.**

36 For—

1 (1) provision of 10 percent increase in payment for  
 2 hospice care furnished in a frontier area, see section 422;  
 3 and

4 (2) provision of a rural hospice demonstration project,  
 5 see section 423.

6 **SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LO-**  
 7 **CATED IN RURAL OR SMALL URBAN AREAS**  
 8 **IN REDISTRIBUTION OF UNUSED GRADUATE**  
 9 **MEDICAL EDUCATION RESIDENCIES.**

10 For provision providing priority for hospitals located in  
 11 rural or small urban areas in redistribution of unused graduate  
 12 medical education residencies, see section 612.

13 **SEC. 309. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN**  
 14 **PAYMENTS FOR PHYSICIANS' SERVICES.**

15 (a) STUDY.—The Comptroller General of the United  
 16 States shall conduct a study of differences in payment amounts  
 17 under the physician fee schedule under section 1848 of the So-  
 18 cial Security Act (42 U.S.C. 1395w-4) for physicians' services  
 19 in different geographic areas. Such study shall include—

20 (1) an assessment of the validity of the geographic ad-  
 21 justment factors used for each component of the fee sched-  
 22 ule;

23 (2) an evaluation of the measures used for such ad-  
 24 justment, including the frequency of revisions; and

25 (3) an evaluation of the methods used to determine  
 26 professional liability insurance costs used in computing the  
 27 malpractice component, including a review of increases in  
 28 professional liability insurance premiums and variation in  
 29 such increases by State and physician specialty and meth-  
 30 ods used to update the geographic cost of practice index  
 31 and relative weights for the malpractice component.

32 (b) REPORT.—Not later than 1 year after the date of the  
 33 enactment of this Act, the Comptroller General shall submit to  
 34 Congress a report on the study conducted under subsection (a).  
 35 The report shall include recommendations regarding the use of  
 36 more current data in computing geographic cost of practice in-  
 37 dices as well as the use of data directly representative of physi-  
 38 cians' costs (rather than proxy measures of such costs).

1 **SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COL-**  
 2 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**  
 3 **CALLY UNDERSERVED POPULATIONS.**

4 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
 5 1320a–7(b)(3)) is amended—

6 (1) in subparagraph (E), by striking “and” after the  
 7 semicolon at the end;

8 (2) in subparagraph (F), by striking the period at the  
 9 end and inserting “; and”; and

10 (3) by adding at the end the following new subpara-  
 11 graph:

12 “(G) any remuneration between a public or non-  
 13 profit private health center entity described under  
 14 clause (i) or (ii) of section 1905(l)(2)(B) and any indi-  
 15 vidual or entity providing goods, items, services, dona-  
 16 tions or loans, or a combination thereof, to such health  
 17 center entity pursuant to a contract, lease, grant, loan,  
 18 or other agreement, if such agreement contributes to  
 19 the ability of the health center entity to maintain or in-  
 20 crease the availability, or enhance the quality, of serv-  
 21 ices provided to a medically underserved population  
 22 served by the health center entity.”

23 (b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER  
 24 ENTITY ARRANGEMENTS.—

25 (1) ESTABLISHMENT.—

26 (A) IN GENERAL.—The Secretary of Health and  
 27 Human Services (in this subsection referred to as the  
 28 “Secretary”) shall establish, on an expedited basis,  
 29 standards relating to the exception described in section  
 30 1128B(b)(3)(G) of the Social Security Act, as added by  
 31 subsection (a), for health center entity arrangements to  
 32 the antikickback penalties.

33 (B) FACTORS TO CONSIDER.—The Secretary shall  
 34 consider the following factors, among others, in estab-  
 35 lishing standards relating to the exception for health  
 36 center entity arrangements under subparagraph (A):

1 (i) Whether the arrangement between the  
2 health center entity and the other party results in  
3 savings of Federal grant funds or increased reve-  
4 nues to the health center entity.

5 (ii) Whether the arrangement between the  
6 health center entity and the other party expands or  
7 enhances a patient's freedom of choice.

8 (iii) Whether the arrangement between the  
9 health center entity and the other party protects a  
10 health care professional's independent medical  
11 judgment regarding medically appropriate treat-  
12 ment.

13 The Secretary may also include other standards and  
14 criteria that are consistent with the intent of Congress  
15 in enacting the exception established under this section.

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

24 **TITLE IV—PROVISIONS RELATING**  
25 **TO PART A**  
26 **Subtitle A—Inpatient Hospital**  
27 **Services**

28 **SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAY-**  
29 **MENT UPDATES.**

30 Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C.  
31 1395ww(b)(3)(B)(i)) is amended to read as follows:

32 “(XVIII) for fiscal year 2003, the market basket per-  
33 centage increase for sole community hospitals and such in-  
34 crease minus 0.25 percentage points for other hospitals,  
35 and”.

1 **SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT**  
 2 **FOR INDIRECT COSTS OF MEDICAL EDU-**  
 3 **CATION (IME).**

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

- 6 (1) in subclause (VI) by striking “and” at the end;  
 7 (2) by redesignating subclause (VII) as subclause  
 8 (IX);  
 9 (3) in subclause (VIII) as so redesignated, by striking  
 10 “2002” and inserting “2004”; and  
 11 (4) by inserting after subclause (VI) the following new  
 12 subclause:  
 13 “(VII) during fiscal year 2003, ‘c’ is equal to 1.47;  
 14 “(VIII) during fiscal year 2004, ‘c’ is equal to  
 15 1.45; and”.

16 **SEC. 403. RECOGNITION OF NEW MEDICAL TECH-**  
 17 **NOLOGIES UNDER INPATIENT HOSPITAL**  
 18 **PPS.**

19 (a) IMPROVING TIMELINESS OF DATA COLLECTION.—Sec-  
 20 tion 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended  
 21 by adding at the end the following new clause:

22 “(vii) Under the mechanism under this subparagraph, the  
 23 Secretary shall provide for the addition of new diagnosis and  
 24 procedure codes in April 1 of each year, but the addition of  
 25 such codes shall not require the Secretary to adjust the pay-  
 26 ment (or diagnosis-related group classification) under this sub-  
 27 section until the fiscal year that begins after such date.”.

28 (b) ELIGIBILITY STANDARD.—

29 (1) MINIMUM PERIOD FOR RECOGNITION OF NEW  
 30 TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C.  
 31 1395ww(d)(5)(K)(vi)) is amended—

- 32 (A) by inserting “(I)” after “(vi)”; and  
 33 (B) by adding at the end the following new sub-  
 34 clause:

35 “(II) Under such criteria, a service or technology shall not  
 36 be denied treatment as a new service or technology on the basis  
 37 of the period of time in which the service or technology has  
 38 been in use if such period ends before the end of the 2-to-3-

1 year period that begins on the effective date of implementation  
2 of a code under ICD-9-CM (or a successor coding method-  
3 ology) that enables the identification of a significant sample of  
4 specific discharges in which the service or technology has been  
5 used.”.

6 (2) ADJUSTMENT OF THRESHOLD.—Section  
7 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is  
8 amended by inserting “(applying a threshold specified by  
9 the Secretary that is the lesser of 50 percent of the na-  
10 tional average standardized amount for operating costs of  
11 inpatient hospital services for all hospitals and all diag-  
12 nosis-related groups or one standard deviation for the diag-  
13 nosis-related group involved)” after “is inadequate”.

14 (3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—  
15 Section 1886(d)(5)(K)(vi) (42 U.S.C.  
16 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is  
17 further amended by adding at the end the following sub-  
18 clause:

19 “(III) The Secretary shall by regulation provide for fur-  
20 ther clarification of the criteria applied to determine whether  
21 a new service or technology represents an advance in medical  
22 technology that substantially improves the diagnosis or treat-  
23 ment of beneficiaries. Under such criteria, in determining  
24 whether a new service or technology represents an advance in  
25 medical technology that substantially improves the diagnosis or  
26 treatment of beneficiaries, the Secretary shall deem a service  
27 or technology as meeting such requirement if the service or  
28 technology is a drug or biological that is designated under sec-  
29 tion 506 or 526 of the Federal Food, Drug, and Cosmetic Act,  
30 approved under section 314.510 or 601.41 of title 21, Code of  
31 Federal Regulations, or designated for priority review when the  
32 marketing application for such drug or biological was filed or  
33 is a medical device for which an exemption has been granted  
34 under section 520(m) of such Act, for which priority review has  
35 been provided under section 515(d)(5) of such Act, or is a sub-  
36 stantially equivalent device for which an expedited review is  
37 provided under section 513(f) of such Act.”.

1           (4) PROCESS FOR PUBLIC INPUT.—Section  
2           1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended  
3           by paragraph (1), is amended—

4           (A) in clause (i), by adding at the end the fol-  
5           lowing: “Such mechanism shall be modified to meet the  
6           requirements of clause (viii).”; and

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

8           “(viii) The mechanism established pursuant to clause (i)  
9           shall be adjusted to provide, before publication of a proposed  
10          rule, for public input regarding whether a new service or tech-  
11          nology not described in the second sentence of clause (vi)(III)  
12          represents an advance in medical technology that substantially  
13          improves the diagnosis or treatment of beneficiaries as follows:

14          “(I) The Secretary shall make public and periodically  
15          update a list of all the services and technologies for which  
16          an application for additional payment under this subpara-  
17          graph is pending.

18          “(II) The Secretary shall accept comments, rec-  
19          ommendations, and data from the public regarding whether  
20          the service or technology represents a substantial improve-  
21          ment.

22          “(III) The Secretary shall provide for a meeting at  
23          which organizations representing hospitals, physicians,  
24          medicare beneficiaries, manufacturers, and any other inter-  
25          ested party may present comments, recommendations, and  
26          data to the clinical staff of the Centers for Medicare &  
27          Medicaid Services before publication of a notice of proposed  
28          rulemaking regarding whether service or technology rep-  
29          resents a substantial improvement.”.

30          (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Sec-  
31          tion 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further  
32          amended by adding at the end the following new clause:

33          “(ix) Before establishing any add-on payment under this  
34          subparagraph with respect to a new technology, the Secretary  
35          shall seek to identify one or more diagnosis-related groups as-  
36          sociated with such technology, based on similar clinical or ana-  
37          tomical characteristics and the cost of the technology. Within

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

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

14 (e) EFFECTIVE DATE.—

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

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

26 (A) the Secretary shall automatically reconsider  
 27 the application as an application for fiscal year 2004  
 28 under the amendments made by this section; and

29 (B) the maximum time period otherwise permitted  
 30 for such classification of the service or technology shall  
 31 be extended by 12 months.

32 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS**  
 33 **IN PUERTO RICO.**

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

36 (1) in subparagraph (A)—

1 (A) in clause (i), by striking “for discharges begin-  
2 ning on or after October 1, 1997, 50 percent (and for  
3 discharges between October 1, 1987, and September  
4 30, 1997, 75 percent)” and inserting “the applicable  
5 Puerto Rico percentage (specified in subparagraph  
6 (E))”; and

7 (B) in clause (ii), by striking “for discharges be-  
8 ginning in a fiscal year beginning on or after October  
9 1, 1997, 50 percent (and for discharges between Octo-  
10 ber 1, 1987, and September 30, 1997, 25 percent)”  
11 and inserting “the applicable Federal percentage (spec-  
12 ified in subparagraph (E))”; and

13 (2) by adding at the end the following new subpara-  
14 graph:

15 “(E) For purposes of subparagraph (A), for discharges  
16 occurring—

17 “(i) between October 1, 1987, and September 30,  
18 1997, the applicable Puerto Rico percentage is 75 percent  
19 and the applicable Federal percentage is 25 percent;

20 “(ii) on or after October 1, 1997, and before October  
21 1, 2003, the applicable Puerto Rico percentage is 50 per-  
22 cent and the applicable Federal percentage is 50 percent;

23 “(iii) during fiscal year 2004, the applicable Puerto  
24 Rico percentage is 45 percent and the applicable Federal  
25 percentage is 55 percent;

26 “(iv) during fiscal year 2005, the applicable Puerto  
27 Rico percentage is 40 percent and the applicable Federal  
28 percentage is 60 percent;

29 “(v) during fiscal year 2006, the applicable Puerto  
30 Rico percentage is 35 percent and the applicable Federal  
31 percentage is 65 percent;

32 “(vi) during fiscal year 2007, the applicable Puerto  
33 Rico percentage is 30 percent and the applicable Federal  
34 percentage is 70 percent; and

35 “(vii) on or after October 1, 2007, the applicable  
36 Puerto Rico percentage is 25 percent and the applicable  
37 Federal percentage is 75 percent.”.

1 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**  
 2 **HANCED DISPROPORTIONATE SHARE HOS-**  
 3 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**  
 4 **PITALS AND URBAN HOSPITALS WITH**  
 5 **FEWER THAN 100 BEDS.**

6 For provision enhancing disproportionate share hospital  
 7 (DSH) treatment for rural hospitals and urban hospitals with  
 8 fewer than 100 beds, see section 302.

9 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-**  
 10 **YEAR PHASED-IN INCREASE IN THE STAND-**  
 11 **ARDIZED AMOUNT IN RURAL AND SMALL**  
 12 **URBAN AREAS TO ACHIEVE A SINGLE, UNI-**  
 13 **FORM STANDARDIZED AMOUNT.**

14 For provision phasing in over a 2-year period an increase  
 15 in the standardized amount for rural and small urban areas to  
 16 achieve a single, uniform, standardized amount, see section  
 17 303.

18 **SEC. 407. REFERENCE TO PROVISION FOR MORE FRE-**  
 19 **QUENT UPDATES IN THE WEIGHTS USED IN**  
 20 **HOSPITAL MARKET BASKET.**

21 For provision providing for more frequent updates in the  
 22 weights used in hospital market basket, see section 304.

23 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**  
 24 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**  
 25 **GRAM.**

26 For provision providing making improvements to critical  
 27 access hospital program, see section 305.

28 **Subtitle B—Skilled Nursing Facility**  
 29 **Services**

30 **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING**  
 31 **FACILITY SERVICES.**

32 (a) TEMPORARY INCREASE IN NURSING COMPONENT OF  
 33 PPS FEDERAL RATE.—Section 312(a) of BIPA is amended by  
 34 adding at the end the following new sentence: “The Secretary  
 35 of Health and Human Services shall increase by 8 percent the  
 36 nursing component of the case-mix adjusted Federal prospec-  
 37 tive payment rate specified in Tables 3 and 4 of the final rule  
 38 published in the Federal Register by the Health Care Financ-  
 39 ing Administration on July 31, 2000 (65 Fed. Reg. 46770) and

1 as subsequently updated under section 1888(e)(4)(E)(ii) of the  
 2 Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effective  
 3 for services furnished on or after October 1, 2002, and before  
 4 October 1, 2005.”.

5 (b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

6 (1) IN GENERAL.—Paragraph (12) of section 1888(e)  
 7 (42 U.S.C. 1395yy(e)) is amended to read as follows:

8 “(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

9 “(A) IN GENERAL.—Subject to subparagraph (B),  
 10 in the case of a resident of a skilled nursing facility  
 11 who is afflicted with acquired immune deficiency syn-  
 12 drome (AIDS), the per diem amount of payment other-  
 13 wise applicable shall be increased by 128 percent to re-  
 14 flect increased costs associated with such residents.

15 “(B) SUNSET.—Subparagraph (A) shall not apply  
 16 on and after such date as the Secretary certifies that  
 17 there is an appropriate adjustment in the case mix  
 18 under paragraph (4)(G)(i) to compensate for the in-  
 19 creased costs associated with residents described in  
 20 such subparagraph.”.

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

## 24 **Subtitle C—Hospice**

### 25 **SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERV-** 26 **ICES.**

27 (a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—  
 28 Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

29 (1) by striking “and” at the end of paragraph (3);

30 (2) by striking the period at the end of paragraph (4)  
 31 and inserting “; and”; and

32 (3) by inserting after paragraph (4) the following new  
 33 paragraph:

34 “(5) for individuals who are terminally ill, have not  
 35 made an election under subsection (d)(1), and have not  
 36 have previously received services under this paragraph,  
 37 services that are furnished by a physician who is the med-

1 ical director or an employee of a hospice program and that  
2 consist of—

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

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

7 “(C) advising the individual regarding advanced  
8 care planning.”.

9 (b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is  
10 amended by adding at the end the following new paragraph:

11 “(4) The amount paid to a hospice program with respect  
12 to the services under section 1812(a)(5) for which payment  
13 may be made under this part shall be equal to an amount  
14 equivalent to the amount established for an office or other out-  
15 patient visit for evaluation and management associated with  
16 presenting problems of moderate severity under the fee sched-  
17 ule established under section 1848(b), other than the portion  
18 of such amount attributable to the practice expense compo-  
19 nent.”.

20 (c) CONFORMING AMENDMENT.—Section  
21 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended  
22 by inserting before the comma at the end the following: “and  
23 services described in section 1812(a)(5)”.

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

27 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**  
28 **PICE CARE FURNISHED IN A FRONTIER**  
29 **AREA.**

30 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.  
31 1395f(i)(1)) is amended by adding at the end the following new  
32 subparagraph:

33 “(D) With respect to hospice care furnished in a frontier  
34 area on or after January 1, 2003, and before January 1, 2008,  
35 the payment rates otherwise established for such care shall be  
36 increased by 10 percent. For purposes of this subparagraph,

1 the term ‘frontier area’ means a county in which the population  
2 density is less than 7 persons per square mile.”.

3 (b) REPORT ON COSTS.—Not later than January 1, 2007,  
4 the Comptroller General of the United States shall submit to  
5 Congress a report on the costs of furnishing hospice care in  
6 frontier areas. Such report shall include recommendations re-  
7 garding the appropriateness of extending, and modifying, the  
8 payment increase provided under the amendment made by sub-  
9 section (a).

10 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

11 (a) IN GENERAL.—The Secretary shall conduct a dem-  
12 onstration project for the delivery of hospice care to medicare  
13 beneficiaries in rural areas. Under the project medicare bene-  
14 ficiaries who are unable to receive hospice care in the home for  
15 lack of an appropriate caregiver are provided such care in a fa-  
16 cility of 20 or fewer beds which offers, within its walls, the full  
17 range of services provided by hospice programs under section  
18 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

19 (b) SCOPE OF PROJECT.—The Secretary shall conduct the  
20 project under this section with respect to no more than 3 hos-  
21 pice programs over a period of not longer than 5 years each.

22 (c) COMPLIANCE WITH CONDITIONS.—Under the dem-  
23 onstration project—

24 (1) the hospice program shall comply with otherwise  
25 applicable requirements, except that it shall not be required  
26 to offer services outside of the home or to meet the require-  
27 ments of section 1861(dd)(2)(A)(iii) of the Social Security  
28 Act; and

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

32 The Secretary may require the program to comply with such  
33 additional quality assurance standards for its provision of serv-  
34 ices in its facility as the Secretary deems appropriate.

35 (d) REPORT.—Upon completion of the project, the Sec-  
36 retary shall submit a report to Congress on the project and

1 shall include in the report recommendations regarding exten-  
2 sion of such project to hospice programs serving rural areas.

### 3 **Subtitle D—Other Provisions**

#### 4 **SEC. 431. DEMONSTRATION PROJECT FOR USE OF RE-** 5 **COVERY AUDIT CONTRACTORS.**

6 (a) IN GENERAL.—The Secretary of Health and Human  
7 Services shall conduct a demonstration project under this sec-  
8 tion (in this section referred to as the “project”) to dem-  
9 onstrate the use of recovery audit contractors under the Medi-  
10 care Integrity Program in identifying and recouping overpay-  
11 ments under the medicare program for services for which pay-  
12 ment is made under part A of title XVIII of the Social Security  
13 Act. Under the project—

14 (1) payment may be made to such a contractor on a  
15 contingent basis;

16 (2) a percentage of the amount recovered may be re-  
17 tained by the Secretary and shall be available to the pro-  
18 gram management account of the Centers for Medicare &  
19 Medicaid Services; and

20 (3) the Secretary shall examine the efficacy of such  
21 use with respect to duplicative payments, accuracy of cod-  
22 ing, and other payment policies in which overpayments  
23 arise.

24 (b) SCOPE AND DURATION.—The project shall cover at  
25 least 2 States and at least 3 contractors and shall last for not  
26 longer than 3 years.

27 (c) WAIVER.—The Secretary of Health and Human Serv-  
28 ices shall waive such provisions of title XVIII of the Social Se-  
29 curity Act as may be necessary to provide for payment for serv-  
30 ices under the project in accordance with subsection (a).

31 (d) QUALIFICATIONS OF CONTRACTORS.—

32 (1) IN GENERAL.—The Secretary shall enter into a re-  
33 covery audit contract under this section with an entity only  
34 if the entity has staff that has knowledge of and experience  
35 with the payment rules and regulations under the medicare  
36 program or the entity has or will contract with another en-  
37 tity that has such knowledgeable and experienced staff.



1           “(6) SPECIAL RULES FOR UPDATE FOR 2004 AND  
2           2005.—The following rules apply in determining the update  
3           adjustment factors under paragraph (4)(B) for 2004 and  
4           2005:

5                   “(A) USE OF 2002 DATA IN DETERMINING ALLOW-  
6           ABLE COSTS.—

7                           “(i) The reference in clause (ii)(I) of such  
8           paragraph to April 1, 1996, is deemed to be a ref-  
9           erence to January 1, 2002.

10                           “(ii) The allowed expenditures for 2002 is  
11           deemed to be equal to the actual expenditures for  
12           physicians’ services furnished during 2002, as esti-  
13           mated by the Secretary.

14                   “(B) 1 PERCENTAGE POINT INCREASE IN GDP  
15           UNDER SGR.—The annual average percentage growth  
16           in real gross domestic product per capita under sub-  
17           section (f)(2)(C) for each of 2003, 2004, and 2005 is  
18           deemed to be increased by 1 percentage point.”.

19           (2) CONFORMING AMENDMENT.—Paragraph (4)(B) of  
20           such section is amended, in the matter before clause (i), by  
21           inserting “and paragraph (6)” after “subparagraph (D)”.

22           (b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING  
23           GROSS DOMESTIC PRODUCT.—

24                   (1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C.  
25           1395w-4(f)(2)(C)) is amended—

26                           (A) by striking “projected” and inserting “annual  
27           average”; and

28                           (B) by striking “from the previous applicable pe-  
29           riod to the applicable period involved” and inserting  
30           “during the 10-year period ending with the applicable  
31           period involved”.

32           (2) EFFECTIVE DATE.—The amendment made by  
33           paragraph (1) shall apply to computations of the sustain-  
34           able growth rate for years beginning with 2002.

35           (c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Sec-  
36           tion 1848(d)(4)(F) (42 U.S.C. 1395w-4(d)(4)(F)) is amended  
37           by striking “subparagraph (A)” and all that follows and insert-

1 ing “subparagraph (A), for each of 2001 and 2002, of –0.2  
2 percent.”

3 **SEC. 502. STUDIES ON ACCESS TO PHYSICIANS’ SERV-**  
4 **ICES.**

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

7 (1) STUDY.—The Comptroller General of the United  
8 States shall conduct a study on access of medicare bene-  
9 ficiaries to physicians’ services under the medicare pro-  
10 gram. The study shall include—

11 (A) an assessment of the use by beneficiaries of  
12 such services through an analysis of claims submitted  
13 by physicians for such services under part B of the  
14 medicare program;

15 (B) an examination of changes in the use by bene-  
16 ficiaries of physicians’ services over time;

17 (C) an examination of the extent to which physi-  
18 cians are not accepting new medicare beneficiaries as  
19 patients.

20 (2) REPORT.—Not later than 1 year after the date of  
21 the enactment of this Act, the Comptroller General shall  
22 submit to Congress a report on the study conducted under  
23 paragraph (1). The report shall include a determination  
24 whether—

25 (A) data from claims submitted by physicians  
26 under part B of the medicare program indicate poten-  
27 tial access problems for medicare beneficiaries in cer-  
28 tain geographic areas; and

29 (B) access by medicare beneficiaries to physicians’  
30 services may have improved, remained constant, or de-  
31 teriorated over time.

32 (b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

33 (1) STUDY.—The Secretary shall request the Institute  
34 of Medicine of the National Academy of Sciences to con-  
35 duct a study on the adequacy of the supply of physicians  
36 (including specialists) in the United States and the factors  
37 that affect such supply.

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

6 **SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSI-**  
 7 **CIANs' SERVICES.**

8 Not later than 1 year after the date of the enactment of  
 9 this Act, the Medicare Payment Advisory Commission shall  
 10 submit to Congress a report on the effect of refinements to the  
 11 practice expense component of payments for physicians' serv-  
 12 ices in the case of services for which there are no physician  
 13 work relative value units, after the transition to a full resource-  
 14 based payment system in 2002, under section 1848 of the So-  
 15 cial Security Act (42 U.S.C. 1395w-4). Such report shall ex-  
 16 amine the following matters by physician specialty:

17 (1) The effect of such refinements on payment for  
 18 physicians' services.

19 (2) The interaction of the practice expense component  
 20 with other components of and adjustments to payment for  
 21 physicians' services under such section.

22 (3) The appropriateness of the amount of compensa-  
 23 tion by reason of such refinements.

24 (4) The effect of such refinements on access to care  
 25 by medicare beneficiaries to physicians' services.

26 (5) The effect of such refinements on physician par-  
 27 ticipation under the medicare program.

28 **Subtitle B—Other Services**

29 **SEC. 511. COMPETITIVE ACQUISITION OF CERTAIN**  
 30 **ITEMS AND SERVICES.**

31 (a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w-3) is  
 32 amended to read as follows:

33 “COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

34 “SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE AC-  
 35 QUISITION PROGRAMS.—

36 “(1) IMPLEMENTATION OF PROGRAMS.—

1           “(A) IN GENERAL.—The Secretary shall establish  
2 and implement programs under which competitive ac-  
3 quisition areas are established throughout the United  
4 States for contract award purposes for the furnishing  
5 under this part of competitively priced items and serv-  
6 ices (described in paragraph (2)) for which payment is  
7 made under this part. Such areas may differ for dif-  
8 ferent items and services.

9           “(B) PHASED-IN IMPLEMENTATION.—The pro-  
10 grams shall be phased-in among competitive acquisition  
11 areas over a period of not longer than 3 years in a  
12 manner so that the competition under the programs oc-  
13 curs in—

14                   “(i) at least  $\frac{1}{3}$  of such areas in 2004; and

15                   “(ii) at least  $\frac{2}{3}$  of such areas in 2005.

16           “(C) WAIVER OF CERTAIN PROVISIONS.—In car-  
17 rying out the programs, the Secretary may waive such  
18 provisions of the Federal Acquisition Regulation as are  
19 necessary for the efficient implementation of this sec-  
20 tion, other than provisions relating to confidentiality of  
21 information and such other provisions as the Secretary  
22 determines appropriate.

23           “(2) ITEMS AND SERVICES DESCRIBED.—The items  
24 and services referred to in paragraph (1) are the following:

25                   “(A) DURABLE MEDICAL EQUIPMENT AND INHA-  
26 LATION DRUGS USED IN CONNECTION WITH DURABLE  
27 MEDICAL EQUIPMENT.—Covered items (as defined in  
28 section 1834(a)(13)) for which payment is otherwise  
29 made under section 1834(a), other than items used in  
30 infusion, and inhalation drugs used in conjunction with  
31 durable medical equipment.

32                   “(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (de-  
33 scribed in section 1861(s)(9)) for which payment is  
34 otherwise made under section 1834(h) which require  
35 minimal self-adjustment for appropriate use and does  
36 not require expertise in trimming, bending, molding,  
37 assembling, or customizing to fit to the patient.

1           “(3) EXEMPTION AUTHORITY.—In carrying out the  
2 programs under this section, the Secretary may exempt—

3           “(A) areas that are not competitive due to low  
4 population density; and

5           “(B) items and services for which the application  
6 of competitive acquisition is not likely to result in sig-  
7 nificant savings.

8           “(b) PROGRAM REQUIREMENTS.—

9           “(1) IN GENERAL.—The Secretary shall conduct a  
10 competition among entities supplying items and services de-  
11 scribed in subsection (a)(2) for each competitive acquisition  
12 area in which the program is implemented under subsection  
13 (a) with respect to such items and services.

14           “(2) CONDITIONS FOR AWARDING CONTRACT.—

15           “(A) IN GENERAL.—The Secretary may not award  
16 a contract to any entity under the competition con-  
17 ducted in an competitive acquisition area pursuant to  
18 paragraph (1) to furnish such items or services unless  
19 the Secretary finds all of the following:

20           “(i) The entity meets quality and financial  
21 standards specified by the Secretary or developed  
22 by accreditation entities or organizations recognized  
23 by the Secretary.

24           “(ii) The total amounts to be paid under the  
25 contract (including costs associated with the ad-  
26 ministration of the contract) are expected to be less  
27 than the total amounts that would otherwise be  
28 paid.

29           “(iii) Beneficiary access to a choice of multiple  
30 suppliers in the area is maintained.

31           “(iv) Beneficiary liability is limited to the ap-  
32 plicable percentage of contract award price.

33           “(B) QUALITY STANDARDS.—The quality stand-  
34 ards specified under subparagraph (A)(i) shall not be  
35 less than the quality standards that would otherwise  
36 apply if this section did not apply and shall include  
37 consumer services standards. The Secretary shall con-

1           sult with an expert outside advisory panel composed of  
2           an appropriate selection of representatives of physi-  
3           cians, practitioners, and suppliers to review (and advise  
4           the Secretary concerning) such quality standards.

5           “(3) CONTENTS OF CONTRACT.—

6           “(A) IN GENERAL.—A contract entered into with  
7           an entity under the competition conducted pursuant to  
8           paragraph (1) is subject to terms and conditions that  
9           the Secretary may specify.

10          “(B) TERM OF CONTRACTS.—The Secretary shall  
11          rebid contracts under this section not less often than  
12          once every 3 years.

13          “(4) LIMIT ON NUMBER OF CONTRACTORS.—

14          “(A) IN GENERAL.—The Secretary may limit the  
15          number of contractors in a competitive acquisition area  
16          to the number needed to meet projected demand for  
17          items and services covered under the contracts. In  
18          awarding contracts, the Secretary shall take into ac-  
19          count the ability bidding entities to furnish items or  
20          services in sufficient quantities to meet the anticipated  
21          needs of beneficiaries for such items or services in the  
22          geographic area covered under the contract on a timely  
23          basis.

24          “(B) MULTIPLE WINNERS.—The Secretary shall  
25          award contracts to more than one entity submitting a  
26          bid in each area for an item or service.

27          “(5) PARTICIPATING CONTRACTORS.—Payment shall  
28          not be made for items and services described in subsection  
29          (a)(2) furnished by a contractor and for which competition  
30          is conducted under this section unless—

31                  “(A) the contractor has submitted a bid for such  
32                  items and services under this section; and

33                  “(B) the Secretary has awarded a contract to the  
34                  contractor for such items and services under this sec-  
35                  tion.

36          “(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUT-  
37          REACH AND COMPLAINT SERVICES.—The Secretary may

1 enter into a contract with an appropriate entity to address  
 2 complaints from beneficiaries who receive items and serv-  
 3 ices from an entity with a contract under this section and  
 4 to conduct appropriate education of and outreach to such  
 5 beneficiaries with respect to the program.

6 “(c) ANNUAL REPORTS.—The Secretary shall submit to  
 7 Congress an annual management report on the programs under  
 8 this section. Each such report shall include information on sav-  
 9 ings, reductions in cost-sharing, access to items and services,  
 10 and beneficiary satisfaction.

11 “(d) DEMONSTRATION PROJECT FOR CLINICAL LABORA-  
 12 TORY SERVICES.—

13 “(1) IN GENERAL.—The Secretary shall conduct a  
 14 demonstration project on the application of competitive ac-  
 15 quisition under this section to clinical diagnostic laboratory  
 16 tests—

17 “(A) for which payment is otherwise made under  
 18 section 1833(h) or 1834(d)(1) (relating to colorectal  
 19 cancer screening tests); and

20 “(B) which are furnished without a face-to-face  
 21 encounter between the individual and the hospital or  
 22 physician ordering the tests.

23 “(2) TERMS AND CONDITIONS.—Such project shall be  
 24 under the same conditions as are applicable to items and  
 25 services described in subsection (a)(2).

26 “(3) REPORT.—The Secretary shall submit to  
 27 Congress—

28 “(A) an initial report on the project not later than  
 29 December 31, 2004; and

30 “(B) such progress and final reports on the  
 31 project after such date as the Secretary determines ap-  
 32 propriate.”.

33 (b) CONTINUATION OF CERTAIN DEMONSTRATION  
 34 PROJECTS.—Notwithstanding the amendment made by sub-  
 35 section (a), with respect to demonstration projects implemented  
 36 by the Secretary under section 1847 of the Social Security Act  
 37 (42 U.S.C. 1395w-3) (relating to the establishment of competi-

1 tive acquisition areas) that was in effect on the day before the  
 2 date of the enactment of this Act, each such demonstration  
 3 project may continue under the same terms and conditions ap-  
 4 plicable under that section as in effect on that date.

5 (c) REPORT ON DIFFERENCES IN PAYMENT FOR LABORA-  
 6 TORY SERVICES.—Not later than 18 months after the date of  
 7 the enactment of this Act, the Comptroller General of the  
 8 United States shall submit to Congress a report that analyzes  
 9 differences in reimbursement between public and private payors  
 10 for clinical diagnostic laboratory services.

11 **SEC. 512. PAYMENT FOR AMBULANCE SERVICES.**

12 (a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE  
 13 SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l)  
 14 (42 U.S.C. 1395m(l)) is amended—

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

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

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

20 “(10) PHASE-IN PROVIDING FLOOR USING BLEND OF  
 21 FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In car-  
 22 rying out the phase-in under paragraph (2)(E) for each  
 23 level of service furnished in a year before January 1, 2007,  
 24 the portion of the payment amount that is based on the fee  
 25 schedule shall not be less than the following blended rate  
 26 of the fee schedule under paragraph (1) and of a regional  
 27 fee schedule for the region involved:

28 “(A) For 2003, the blended rate shall be based 20  
 29 percent on the fee schedule under paragraph (1) and  
 30 80 percent on the regional fee schedule.

31 “(B) For 2004, the blended rate shall be based 40  
 32 percent on the fee schedule under paragraph (1) and  
 33 60 percent on the regional fee schedule.

34 “(C) For 2005, the blended rate shall be based 60  
 35 percent on the fee schedule under paragraph (1) and  
 36 40 percent on the regional fee schedule.



1 4541(d)(2) of the Balanced Budget Act of 1997 (relating to al-  
 2 ternatives to a single annual dollar cap on outpatient therapy)  
 3 and under section 221(d) of the Medicare, Medicaid, and  
 4 SCHIP Balanced Budget Refinement Act of 1999 (relating to  
 5 utilization patterns for outpatient therapy).

6 (c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING  
 7 WAIVER OF THERAPY CAP.—

8 (1) STUDY.—The Secretary shall request the Institute  
 9 of Medicine of the National Academy of Sciences to identify  
 10 conditions or diseases that should justify conducting an as-  
 11 sessment of the need to waive the therapy caps under sec-  
 12 tion 1833(g)(4) of the Social Security Act (42 U.S.C.  
 13 1395l(g)(4)).

14 (2) REPORTS TO CONGRESS.—Not later than July 1,  
 15 2003, the Secretary shall submit to Congress a preliminary  
 16 report on the conditions and diseases identified under para-  
 17 graph (1) and not later than September 1, 2003, a final  
 18 report on the conditions and diseases so identified.

19 (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL  
 20 THERAPIST SERVICES.—

21 (1) STUDY.—The Comptroller General of the United  
 22 States shall conduct a study on access to physical therapist  
 23 services in States authorizing such services without a physi-  
 24 cian referral and in States that require such a physician re-  
 25 ferral. The study shall—

26 (A) examine the use of and referral patterns for  
 27 physical therapist services for patients age 50 and older  
 28 in States that authorize such services without a physi-  
 29 cian referral and in States that require such a physi-  
 30 cian referral;

31 (B) examine the use of and referral patterns for  
 32 physical therapist services for patients who are medi-  
 33 care beneficiaries; and

34 (C) examine the delivery of physical therapists'  
 35 services within the facilities of Department of Defense;  
 36 and

1 (D) analyze the potential impact on medicare  
 2 beneficiaries and on expenditures under the medicare  
 3 program of eliminating the need for a physician refer-  
 4 ral for physical therapist services under the medicare  
 5 program.

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

10 **SEC. 514. ACCELERATED IMPLEMENTATION OF 20 PER-**  
 11 **CENT COINSURANCE FOR HOSPITAL OUT-**  
 12 **PATIENT DEPARTMENT (OPD) SERVICES;**  
 13 **OTHER OPD PROVISIONS.**

14 (a) ACCELERATED IMPLEMENTATION OF COINSURANCE  
 15 REDUCTIONS.—Section 1833(t)(8)(C)(ii) (42 U.S.C.  
 16 1395l(t)(8)(C)(ii)) is amended by striking subclauses (III)  
 17 through (V) and inserting the following:

18 “(III) For procedures performed in 2004,  
 19 45 percent.

20 “(IV) For procedures performed in 2005,  
 21 40 percent.

22 “(V) For procedures performed in 2006,  
 23 2007, 2008 and 2009, 35 percent.

24 “(VI) For procedures performed in 2010,  
 25 30 percent.

26 “(VII) For procedures performed in 2011,  
 27 25 percent.

28 “(VIII) For procedures performed in 2012  
 29 and thereafter, 20 percent.”.

30 (b) TREATMENT OF TEMPERATURE MONITORED  
 31 CRYOABLATION.—

32 (1) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42  
 33 U.S.C. 1395l(t)(6)(A)(ii)) is amended by striking “or tem-  
 34 perature monitored cryoablation”.

35 (2) EFFECTIVE DATE.—The amendment made by  
 36 paragraph (1) applies to payment for services furnished on  
 37 or after January 1, 2003.

1 **SEC. 515. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**  
 2 **ICAL EXAMINATION.**

3 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
 4 1395x(s)(2)), is amended—

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

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

9 (3) by adding at the end the following new subpara-  
 10 graph:

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

13 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
 14 1395x) is amended by adding at the end the following new sub-  
 15 section:

16 “Initial Preventive Physical Examination

17 “(ww) The term ‘initial preventive physical examination’  
 18 means physicians’ services consisting of a physical examination  
 19 with the goal of health promotion and disease detection and in-  
 20 cludes items and services specified by the Secretary in regula-  
 21 tions.”.

22 (c) PAYMENT AS PHYSICIANS’ SERVICES.—Section  
 23 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) by inserting “(2)(W),”  
 24 after “(2)(S),”.

25 (d) OTHER CONFORMING AMENDMENTS.—Section 1862(a)  
 26 (42 U.S.C. 1395y(a)) is amended—

27 (1) in paragraph (1)—

28 (A) by striking “and” at the end of subparagraph  
 29 (H);

30 (B) by striking the semicolon at the end of sub-  
 31 paragraph (I) and inserting “, and”; and

32 (C) by adding at the end the following new sub-  
 33 paragraph:

34 “(J) in the case of an initial preventive physical exam-  
 35 ination, which is performed not later than 6 months after  
 36 the date the individual’s first coverage period begins under  
 37 part B;” and

1 (2) in paragraph (7), by striking “or (H)” and insert-  
 2 ing “(H), or (J)”.

3 (e) EFFECTIVE DATE.—The amendments made by this  
 4 section shall apply to services furnished on or after January 1,  
 5 2004, but only for individuals whose coverage period begins on  
 6 or after such date.

7 **SEC. 516. RENAL DIALYSIS SERVICES.**

8 (a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT  
 9 SETTINGS.—Not later than 1 year after the date of the enact-  
 10 ment of this Act, the Comptroller General of the United States  
 11 shall submit to Congress a report containing—

12 (1) an analysis of the differences in costs of providing  
 13 renal dialysis services under the medicare program in home  
 14 settings and in facility settings;

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

17 (3) an evaluation of whether the charges for home di-  
 18 alysis supplies and equipment are reasonable and nec-  
 19 essary.

20 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDI-  
 21 ATRIC FACILITIES.—

22 (1) IN GENERAL.—Section 422(a)(2) of BIPA is  
 23 amended—

24 (A) in subparagraph (A), by striking “and (C)”  
 25 and inserting “, (C), and (D)”;

26 (B) in subparagraph (B), by striking “In the  
 27 case” and inserting “Subject to subparagraph (D), in  
 28 the case”; and

29 (C) by adding at the end the following new sub-  
 30 paragraph:

31 “(D) INAPPLICABILITY TO PEDIATRIC FACILI-  
 32 TIES.—Subparagraphs (A) and (B) shall not apply, as  
 33 of October 1, 2002, to pediatric facilities that do not  
 34 have an exception rate described in subparagraph (C)  
 35 in effect on such date. For purposes of this subpara-  
 36 graph, the term ‘pediatric facility’ means a renal facil-

1           ity at least 50 percent of whose patients are individuals  
2           under 18 years of age.”.

3           (2) CONFORMING AMENDMENT.—The fourth sentence  
4           of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended  
5           by striking “The Secretary” and inserting “Subject to sec-  
6           tion 422(a)(2) of the Medicare, Medicaid, and SCHIP Ben-  
7           efits Improvement and Protection Act of 2000, the Sec-  
8           retary”.

9           (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR  
10          SERVICES FURNISHED IN 2004.—Notwithstanding any other  
11          provision of law, with respect to payment under part B of title  
12          XVIII of the Social Security Act for renal dialysis services fur-  
13          nished in 2004, the composite payment rate otherwise estab-  
14          lished under section 1881(b)(7) of such Act (42 U.S.C.  
15          1395rr(b)(7)) shall be increased by 1.2 percent.

## 16           **TITLE VI—PROVISIONS RELATING** 17           **TO PARTS A AND B**

### 18           **Subtitle A—Home Health Services**

#### 19           **SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN** 20           **PAYMENT RATES UNDER THE PROSPECTIVE** 21           **PAYMENT SYSTEM.**

22          (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.  
23          1395fff(b)(3)(A)) is amended to read as follows:

24           “(A) INITIAL BASIS.—Under such system the Sec-  
25           retary shall provide for computation of a standard pro-  
26           spective payment amount (or amounts) as follows:

27           “(i) Such amount (or amounts) shall initially  
28           be based on the most current audited cost report  
29           data available to the Secretary and shall be com-  
30           puted in a manner so that the total amounts pay-  
31           able under the system for fiscal year 2001 shall be  
32           equal to the total amount that would have been  
33           made if the system had not been in effect and if  
34           section 1861(v)(1)(L)(ix) had not been enacted.

35           “(ii) For fiscal year 2002 and for the first  
36           quarter of fiscal year 2003, such amount (or  
37           amounts) shall be equal to the amount (or

1 amounts) determined under this paragraph for the  
 2 previous fiscal year, updated under subparagraph  
 3 (B).

4 “(iii) For 2003, such amount (or amounts)  
 5 shall be equal to the amount (or amounts) deter-  
 6 mined under this paragraph for fiscal year 2002,  
 7 updated under subparagraph (B) for 2003.

8 “(iv) For 2004 and each subsequent year,  
 9 such amount (or amounts) shall be equal to the  
 10 amount (or amounts) determined under this para-  
 11 graph for the previous year, updated under sub-  
 12 paragraph (B).

13 Each such amount shall be standardized in a manner  
 14 that eliminates the effect of variations in relative case  
 15 mix and area wage adjustments among different home  
 16 health agencies in a budget neutral manner consistent  
 17 with the case mix and wage level adjustments provided  
 18 under paragraph (4)(A). Under the system, the Sec-  
 19 retary may recognize regional differences or differences  
 20 based upon whether or not the services or agency are  
 21 in an urbanized area.”.

22 (b) EFFECTIVE DATE.—The amendment made by sub-  
 23 section (a) shall take effect as if included in the amendments  
 24 made by section 501 of the Medicare, Medicaid, and SCHIP  
 25 Benefits Improvement and Protection Act of 2000 (as enacted  
 26 into law by section 1(a)(6) of Public Law 106–554).

27 **SEC. 602. ESTABLISHMENT OF REDUCED COPAYMENT**  
 28 **FOR A HOME HEALTH SERVICE EPISODE OF**  
 29 **CARE FOR CERTAIN BENEFICIARIES.**

30 (a) PART A.—

31 (1) IN GENERAL.—Section 1813(a) (42 U.S.C.  
 32 1395e(a)) is amended by adding at the end the following  
 33 new paragraph:

34 “(5)(A)(i) Subject to clause (ii), the amount payable for  
 35 home health services furnished to the individual under this title  
 36 for each episode of care beginning in a year (beginning with

1 2003) shall be reduced by a copayment equal to the copayment  
2 amount specified in subparagraph (B)(ii) such year.

3 “(ii) The copayment under clause (i) shall not apply—

4 “(I) in the case of an individual who has been deter-  
5 mined to be a qualified medicare beneficiary (as defined in  
6 section 1905(p)(1)) or otherwise to be entitled to medical  
7 assistance under section 1902(a)(10)(A) or  
8 1902(a)(10)(C); and

9 “(II) in the case of an episode of care which consists  
10 of 4 or fewer visits.

11 “(B)(i) The Secretary shall estimate, before the beginning  
12 of each year (beginning with 2003), the national average pay-  
13 ment under this title per episode for home health services pro-  
14 jected for the year involved.

15 “(ii) For each year the copayment amount under this  
16 clause is equal to 1.5 percent of the national average payment  
17 estimated for the year involved under clause (i). Any amount  
18 determined under the preceding sentence which is not a mul-  
19 tiple of \$5 shall be rounded to the nearest multiple of \$5.

20 “(iii) There shall be no administrative or judicial review  
21 under section 1869, 1878, or otherwise of the estimation of av-  
22 erage payment under clause (i).”.

23 (2) TIMELY IMPLEMENTATION.—Unless the Secretary  
24 of Health and Human Services otherwise provides on a  
25 timely basis, the copayment amount specified under section  
26 1813(a)(5)(B)(ii) of the Social Security Act (as added by  
27 paragraph (1)) for 2003 shall be deemed to be \$40.

28 (b) CONFORMING PROVISIONS.—

29 (1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A))  
30 is amended by inserting “less the copayment amount appli-  
31 cable under section 1813(a)(5)” after “1895”.

32 (2) Section 1866(a)(2)(A)(i) (42 U.S.C.  
33 1395cc(a)(2)(A)(i)) is amended—

34 (A) by striking “or coinsurance” and inserting “,  
35 coinsurance, or copayment”; and

36 (B) by striking “or (a)(4)” and inserting “(a)(4),  
37 or (a)(5)”.

1 **SEC. 603. UPDATE IN HOME HEALTH SERVICES.**

2 (a) CHANGE TO CALENDAR YEAR UPDATE.—

3 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.  
4 1395fff(b)(3)) is amended—

5 (A) in paragraph (3)(B)(i)—

6 (i) by striking “each fiscal year (beginning  
7 with fiscal year 2002)” and inserting “fiscal year  
8 2002 and for each subsequent year (beginning with  
9 2003)”; and

10 (ii) by inserting “or year” after “the fiscal  
11 year”;

12 (B) in paragraph (3)(B)(ii)—

13 (i) in subclause (II), by striking “fiscal year”  
14 and inserting “year” and by redesignating such  
15 subclause as subclause (III); and

16 (ii) in subclause (I), by striking “each of fiscal  
17 years 2002 and 2003” and inserting the following:  
18 “fiscal year 2002, the home health market basket  
19 percentage increase (as defined in clause (iii))  
20 minus 1.1 percentage points;

21 “(II) 2003”;

22 (C) in paragraph (3)(B)(iii), by inserting “or  
23 year” after “fiscal year” each place it appears;

24 (D) in paragraph (3)(B)(iv)—

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

27 (ii) by inserting “or years” after “fiscal  
28 years”; and

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

31 (2) TRANSITION RULE.—The standard prospective  
32 payment amount (or amounts) under section 1895(b)(3) of  
33 the Social Security Act for the calendar quarter beginning  
34 on October 1, 2002, shall be such amount (or amounts) for  
35 the previous calendar quarter.

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

4 (1) in subclause (II), by striking “the home health  
 5 market basket percentage increase (as defined in clause  
 6 (iii)) minus 1.1 percentage points” and inserting “2.0 per-  
 7 centage points”;

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

9 (3) by redesignating subclause (III) as subclause (V);  
 10 and

11 (4) by inserting after subclause (II) the following new  
 12 subclause:

13 “(III) 2004, 1.0 percentage points;

14 “(IV) 2005, the home health market bas-  
 15 ket percentage increase (as defined in clause  
 16 (iii)) minus 0.8 percentage points; or”.

17 (c) PAYMENT ADJUSTMENT.—

18 (1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C.  
 19 1395fff(b)(5)) is amended “5 percent” and inserting “3  
 20 percent”.

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

23 **SEC. 604. OASIS TASK FORCE; SUSPENSION OF CERTAIN**  
 24 **OASIS DATA COLLECTION REQUIREMENTS**  
 25 **PENDING TASK FORCE SUBMITTAL OF RE-**  
 26 **PORT.**

27 (a) ESTABLISHMENT.—The Secretary of Health and  
 28 Human Services shall establish and appoint a task force (to be  
 29 known as the “OASIS Task Force”) to examine the data col-  
 30 lection and reporting requirements under OASIS. For purposes  
 31 of this section, the term “OASIS” means the Outcome and As-  
 32 sessment Information Set required by reason of section 4602(e)  
 33 of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

34 (b) COMPOSITION.—The OASIS Task Force shall be com-  
 35 posed of the following:

36 (1) Staff of the Centers for Medicare & Medicaid Serv-  
 37 ices with expertise in post-acute care.

1 (2) Representatives of home health agencies.

2 (3) Health care professionals and research and health  
3 care quality experts outside the Federal Government with  
4 expertise in post-acute care.

5 (4) Advocates for individuals requiring home health  
6 services.

7 (c) DUTIES.—

8 (1) REVIEW AND RECOMMENDATIONS.—The OASIS  
9 Task Force shall review and make recommendations to the  
10 Secretary regarding changes in OASIS to improve and sim-  
11 plify data collection for purposes of—

12 (A) assessing the quality of home health services;  
13 and

14 (B) providing consistency in classification of pa-  
15 tients into home health resource groups (HHRGs) for  
16 payment under section 1895 of the Social Security Act  
17 (42 U.S.C. 1395fff).

18 (2) SPECIFIC ITEMS.—In conducting the review under  
19 paragraph (1), the OASIS Task Force shall specifically  
20 examine—

21 (A) the 41 outcome measures currently in use;

22 (B) the timing and frequency of data collection;  
23 and

24 (C) the collection of information on comorbidities  
25 and clinical indicators.

26 (3) REPORT.—The OASIS Task Force shall submit a  
27 report to the Secretary containing its findings and rec-  
28 ommendations for changes in OASIS by not later than 18  
29 months after the date of the enactment of this Act.

30 (d) SUNSET.—The OASIS Task Force shall terminate 60  
31 days after the date on which the report is submitted under sub-  
32 section (c)(2).

33 (e) NONAPPLICATION OF FACCA.—The provisions of the  
34 Federal Advisory Committee Act shall not apply to the OASIS  
35 Task Force.

1 (f) SUSPENSION OF OASIS REQUIREMENT FOR COLLEC-  
 2 TION OF DATA ON NON-MEDICARE AND NON-MEDICAID PA-  
 3 TIENTS PENDING TASK FORCE REPORT.—

4 (1) IN GENERAL.—During the period described in  
 5 paragraph (2), the Secretary of Health and Human Serv-  
 6 ices may not require, under section 4602(e) of the Bal-  
 7 anced Budget Act of 1997 or otherwise under OASIS, a  
 8 home health agency to gather or submit information that  
 9 relates to an individual who is not eligible for benefits  
 10 under either title XVIII or title XIX of the Social Security  
 11 Act.

12 (2) PERIOD OF SUSPENSION.—The period described in  
 13 this paragraph—

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

15 (B) ends on the last day of the 2nd month begin-  
 16 ning after the date the report is submitted under sub-  
 17 section (c)(2).

18 **SEC. 605. MEDPAC STUDY ON MEDICARE MARGINS OF**  
 19 **HOME HEALTH AGENCIES.**

20 (a) STUDY.—The Medicare Payment Advisory Commission  
 21 shall conduct a study of payment margins of home health agen-  
 22 cies under the home health prospective payment system under  
 23 section 1895 of the Social Security Act (42 U.S.C. 1395fff).  
 24 Such study shall examine whether systematic differences in  
 25 payment margins are related to differences in case mix (as  
 26 measured by home health resource groups (HHRGs)) among  
 27 such agencies. The study shall use the partial or full-year cost  
 28 reports filed by home health agencies.

29 (b) REPORT.—Not later than 2 years after the date of the  
 30 enactment of this Act, the Commission shall submit to Con-  
 31 gress a report on the study under subsection (a).

32 **Subtitle B—Direct Graduate Medical**  
 33 **Education**

34 **SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH**  
 35 **COST PROGRAMS.**

36 Section 1886(h)(2)(D)(iv) (42 U.S.C.  
 37 1395ww(h)(2)(D)(iv)) is amended—

- 1 (1) in subclause (I)—  
 2 (A) by striking “AND 2002” and inserting  
 3 “THROUGH 2012”;  
 4 (B) by striking “during fiscal year 2001 or fiscal  
 5 year 2002” and inserting “during the period beginning  
 6 with fiscal year 2001 and ending with fiscal year  
 7 2012”; and  
 8 (C) by striking “subject to subclause (III),”;  
 9 (2) by striking subclause (II); and  
 10 (3) in subclause (III)—  
 11 (A) by redesignating such subclause as subclause  
 12 (II); and  
 13 (B) by striking “or (II)”.

14 **SEC. 612. REDISTRIBUTION OF UNUSED RESIDENT POSI-**  
 15 **TIONS.**

16 (a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C.  
 17 1395ww(h)(4)) is amended—

- 18 (1) in subparagraph (F), by inserting “subject to sub-  
 19 paragraph (I),” after “October 1, 1997,”;  
 20 (2) in subparagraph (H), by inserting “subject to sub-  
 21 paragraph (I),” after “subparagraphs (F) and (G),”; and  
 22 (3) by adding at the end the following new subpara-  
 23 graph:

24 “(I) REDISTRIBUTION OF UNUSED RESIDENT PO-  
 25 SITIONS.—

26 “(i) REDUCTION IN LIMIT BASED ON UNUSED  
 27 POSITIONS.—

28 “(I) IN GENERAL.—If a hospital’s resident  
 29 level (as defined in clause (iii)(I)) is less than  
 30 the otherwise applicable resident limit (as de-  
 31 fined in clause (iii)(II)) for each of the ref-  
 32 erence periods (as defined in subclause (II)),  
 33 effective for cost reporting periods beginning on  
 34 or after January 1, 2003, the otherwise appli-  
 35 cable resident limit shall be reduced by 75 per-  
 36 cent of the difference between such limit and

1 the reference resident level specified in sub-  
2 clause (III) (or subclause (IV) if applicable).

3 “(II) REFERENCE PERIODS DEFINED.—In  
4 this clause, the term ‘reference periods’ means,  
5 for a hospital, the 3 most recent consecutive  
6 cost reporting periods of the hospital for which  
7 cost reports have been settled (or, if not, sub-  
8 mitted) on or before September 30, 2001.

9 “(III) REFERENCE RESIDENT LEVEL.—  
10 Subject to subclause (IV), the reference resi-  
11 dent level specified in this subclause for a hos-  
12 pital is the highest resident level for the hos-  
13 pital during any of the reference periods.

14 “(IV) ADJUSTMENT PROCESS.—Upon the  
15 timely request of a hospital, the Secretary may  
16 adjust the reference resident level for a hospital  
17 to be the resident level for the hospital for the  
18 cost reporting period that includes July 1,  
19 2002.

20 “(ii) REDISTRIBUTION.—

21 “(I) IN GENERAL.—The Secretary is au-  
22 thorized to increase the otherwise applicable  
23 resident limits for hospitals by an aggregate  
24 number estimated by the Secretary that does  
25 not exceed the aggregate reduction in such lim-  
26 its attributable to clause (i) (without taking  
27 into account any adjustment under subclause  
28 (IV) of such clause).

29 “(II) EFFECTIVE DATE.—No increase  
30 under subclause (I) shall be permitted or taken  
31 into account for a hospital for any portion of  
32 a cost reporting period that occurs before July  
33 1, 2003, or before the date of the hospital’s ap-  
34 plication for an increase under this clause. No  
35 such increase shall be permitted for a hospital  
36 unless the hospital has applied to the Secretary  
37 for such increase by December 31, 2004.

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

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

23                  “(V) APPLICATION OF LOCALITY AD-  
24                  JUSTED NATIONAL AVERAGE PER RESIDENT  
25                  AMOUNT.—With respect to additional residency  
26                  positions in a hospital attributable to the in-  
27                  crease provided under this clause, notwith-  
28                  standing any other provision of this subsection,  
29                  the approved FTE resident amount is deemed  
30                  to be equal to the locality adjusted national av-  
31                  erage per resident amount computed under  
32                  subparagraph (E) for that hospital.

33                  “(VI) CONSTRUCTION.—Nothing in this  
34                  clause shall be construed as permitting the re-  
35                  distribution of reductions in residency positions  
36                  attributable to voluntary reduction programs  
37                  under paragraph (6) or as affecting the ability

1 of a hospital to establish new medical residency  
2 training programs under subparagraph (H).

3 “(iii) RESIDENT LEVEL AND LIMIT DE-  
4 FINED.—In this subparagraph:

5 “(I) RESIDENT LEVEL.—The term ‘resi-  
6 dent level’ means, with respect to a hospital,  
7 the total number of full-time equivalent resi-  
8 dents, before the application of weighting fac-  
9 tors (as determined under this paragraph), in  
10 the fields of allopathic and osteopathic medi-  
11 cine for the hospital.

12 “(II) OTHERWISE APPLICABLE RESIDENT  
13 LIMIT.—The term ‘otherwise applicable resi-  
14 dent limit’ means, with respect to a hospital,  
15 the limit otherwise applicable under subpara-  
16 graphs (F)(i) and (H) on the resident level for  
17 the hospital determined without regard to this  
18 subparagraph.”.

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

27 (c) REPORT ON EXTENSION OF APPLICATIONS UNDER  
28 REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the  
29 Secretary shall submit to Congress a report containing rec-  
30 ommendations regarding whether to extend the deadline for ap-  
31 plications for an increase in resident limits under section  
32 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by  
33 subsection (a)).

## Subtitle C—Other Provisions

### SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

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

“(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.”.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting “the efficient provision of” after “expenditures for”.

(c) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2003, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services.

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

(A) Investments and capital financing of hospitals participating under the medicare program and related foundations.

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

### SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR CERTAIN MEDICARE BENEFICIARIES WITH DIABETES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this sec-

1 tion (in this section referred to as the “project”) to dem-  
 2 onstrate the impact on costs and health outcomes of applying  
 3 disease management to certain medicare beneficiaries with di-  
 4 agnosed diabetes. In no case may the number of participants  
 5 in the project exceed 30,000 at any time.

6 (b) VOLUNTARY PARTICIPATION.—

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

9 (a) they are Hispanic, as determined by the Sec-  
 10 retary;

11 (A) they meet specific medical criteria dem-  
 12 onstrating the appropriate diagnosis and the advanced  
 13 nature of their disease;

14 (B) their physicians approve of participation in the  
 15 project; and

16 (C) they are not enrolled in a Medicare+Choice  
 17 plan.

18 (2) BENEFITS.—A medicare beneficiary who is en-  
 19 rolled in the project shall be eligible—

20 (A) for disease management services related to  
 21 their diabetes; and

22 (B) for payment for all costs for prescription  
 23 drugs without regard to whether or not they relate to  
 24 the diabetes, except that the project may provide for  
 25 modest cost-sharing with respect to prescription drug  
 26 coverage.

27 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZA-  
 28 TIONS.—

29 (1) IN GENERAL.—The Secretary of Health and  
 30 Human Services shall carry out the project through con-  
 31 tracts with up to three disease management organizations.  
 32 The Secretary shall not enter into such a contract with an  
 33 organization unless the organization demonstrates that it  
 34 can produce improved health outcomes and reduce aggre-  
 35 gate medicare expenditures consistent with paragraph (2).

36 (2) CONTRACT PROVISIONS.—Under such contracts—

1 (A) such an organization shall be required to pro-  
2 vide for prescription drug coverage described in sub-  
3 section (b)(2)(B);

4 (B) such an organization shall be paid a fee nego-  
5 tiated and established by the Secretary in a manner so  
6 that (taking into account savings in expenditures under  
7 parts A and B of the medicare program under title  
8 XVIII of the Social Security Act) there will be no net  
9 increase, and to the extent practicable, there will be a  
10 net reduction in expenditures under the medicare pro-  
11 gram as a result of the project; and

12 (C) such an organization shall guarantee, through  
13 an appropriate arrangement with a reinsurance com-  
14 pany or otherwise, the prohibition on net increases in  
15 expenditures described in subparagraph (B).

16 (3) PAYMENTS.—Payments to such organizations shall  
17 be made in appropriate proportion from the Trust Funds  
18 established under title XVIII of the Social Security Act.

19 (4) WORKING GROUP.—The Secretary shall establish  
20 within the Department of Health and Human Services a  
21 working group consisting of employees of the Department  
22 to carry out the following:

23 (A) To oversee the project.

24 (B) To establish policy and criteria for medicare  
25 disease management programs within the Department,  
26 including the establishment of policy and criteria for  
27 such programs.

28 (C) To identify targeted medical conditions and  
29 targeted individuals.

30 (D) To select areas in which such programs are  
31 carried out.

32 (E) To monitor health outcomes under such pro-  
33 grams.

34 (F) To measure the effectiveness of such programs  
35 in meeting any budget neutrality requirements.

1 (G) Otherwise to serve as a central focal point  
2 within the Department for dissemination of information  
3 on medicare disease management programs.

4 (d) APPLICATION OF MEDIGAP PROTECTIONS TO DEM-  
5 ONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph  
6 (2), the provisions of section 1882(s)(3) (other than clauses (i)  
7 through (iv) of subparagraph (B)) and 1882(s)(4) of the Social  
8 Security Act shall apply to enrollment (and termination of en-  
9 rollment) in the demonstration project under this section, in  
10 the same manner as they apply to enrollment (and termination  
11 of enrollment) with a Medicare+Choice organization in a  
12 Medicare+Choice plan.

13 (2) In applying paragraph (1)—

14 (A) any reference in clause (v) or (vi) of section  
15 1882(s)(3)(B) of such Act to 12 months is deemed a ref-  
16 erence to the period of the demonstration project; and

17 (B) the notification required under section  
18 1882(s)(3)(D) of such Act shall be provided in a manner  
19 specified by the Secretary of Health and Human Services.

20 (e) DURATION.—The project shall last for not longer than  
21 3 years.

22 (f) WAIVER.—The Secretary of Health and Human Serv-  
23 ices shall waive such provisions of title XVIII of the Social Se-  
24 curity Act as may be necessary to provide for payment for serv-  
25 ices under the project in accordance with subsection (c)(3).

26 (g) REPORT.—The Secretary of Health and Human Serv-  
27 ices shall submit to Congress an interim report on the project  
28 not later than 2 years after the date it is first implemented and  
29 a final report on the project not later than 6 months after the  
30 date of its completion. Such reports shall include information  
31 on the impact of the project on costs and health outcomes and  
32 recommendations on the cost-effectiveness of extending or ex-  
33 panding the project.

34 (h) GAO STUDY ON DISEASE MANAGEMENT PRO-  
35 GRAMS.—The Comptroller General of the United States shall  
36 conduct a study that compares disease management programs  
37 under title XVIII of the Social Security Act with such pro-

1 grams conducted in the private sector, including the prevalence  
2 of such programs and programs for case management. The  
3 study shall identify the cost-effectiveness of such programs and  
4 any savings achieved by such programs. The Comptroller Gen-  
5 eral shall submit a report on such study to Congress by not  
6 later than 18 months after the date of the enactment of this  
7 Act.

8 **SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL**  
9 **ADULT DAY CARE SERVICES.**

10 (a) ESTABLISHMENT.—Subject to the succeeding provi-  
11 sions of this section, the Secretary of Health and Human Serv-  
12 ices shall establish a demonstration project (in this section re-  
13 ferred to as the “demonstration project”) under which the Sec-  
14 retary shall, as part of a plan of an episode of care for home  
15 health services established for a medicare beneficiary, permit a  
16 home health agency, directly or under arrangements with a  
17 medical adult day care facility, to provide medical adult day  
18 care services as a substitute for a portion of home health serv-  
19 ices that would otherwise be provided in the beneficiary’s home.

20 (b) PAYMENT.—

21 (1) IN GENERAL.—The amount of payment for an epi-  
22 sode of care for home health services, a portion of which  
23 consists of substitute medical adult day care services, under  
24 the demonstration project shall be made at a rate equal to  
25 95 percent of the amount that would otherwise apply for  
26 such home health services under section 1895 of the Social  
27 Security Act (42 u.s.c. 1395fff). In no case may a home  
28 health agency, or a medical adult day care facility under  
29 arrangements with a home health agency, separately charge  
30 a beneficiary for medical adult day care services furnished  
31 under the plan of care.

32 (2) BUDGET NEUTRALITY FOR DEMONSTRATION  
33 PROJECT.—Notwithstanding any other provision of law, the  
34 Secretary shall provide for an appropriate reduction in the  
35 aggregate amount of additional payments made under sec-  
36 tion 1895 of the Social Security Act (42 U.S.C. 1395fff)  
37 to reflect any increase in amounts expended from the Trust

1 Funds as a result of the demonstration project conducted  
2 under this section.

3 (c) DEMONSTRATION PROJECT SITES.—The project estab-  
4 lished under this section shall be conducted in not more than  
5 5 sites in States selected by the Secretary that license or certify  
6 providers of services that furnish medical adult day care serv-  
7 ices.

8 (d) DURATION.—The Secretary shall conduct the dem-  
9 onstration project for a period of 3 years.

10 (e) VOLUNTARY PARTICIPATION.—Participation of medi-  
11 care beneficiaries in the demonstration project shall be vol-  
12 untary. The total number of such beneficiaries that may par-  
13 ticipate in the project at any given time may not exceed  
14 15,000.

15 (f) PREFERENCE IN SELECTING AGENCIES.—In selecting  
16 home health agencies to participate under the demonstration  
17 project, the Secretary shall give preference to those agencies  
18 that—

19 (1) are currently licensed or certified to furnish med-  
20 ical adult day care services; and

21 (2) have furnished medical adult day care services to  
22 medicare beneficiaries for a continuous 2-year period before  
23 the beginning of the demonstration project.

24 (g) WAIVER AUTHORITY.—The Secretary may waive such  
25 requirements of title XVIII of the Social Security Act as may  
26 be necessary for the purposes of carrying out the demonstra-  
27 tion project, other than waiving the requirement that an indi-  
28 vidual be homebound in order to be eligible for benefits for  
29 home health services.

30 (h) EVALUATION AND REPORT.—The Secretary shall con-  
31 duct an evaluation of the clinical and cost effectiveness of the  
32 demonstration project. Not later 30 months after the com-  
33 mencement of the project, the Secretary shall submit to Con-  
34 gress a report on the evaluation, and shall include in the report  
35 the following:

36 (1) An analysis of the patient outcomes and costs of  
37 furnishing care to the medicare beneficiaries participating

1 in the project as compared to such outcomes and costs to  
 2 beneficiaries receiving only home health services for the  
 3 same health conditions.

4 (2) Such recommendations regarding the extension,  
 5 expansion, or termination of the project as the Secretary  
 6 determines appropriate.

7 (i) DEFINITIONS.—In this section:

8 (1) HOME HEALTH AGENCY.—The term “home health  
 9 agency” has the meaning given such term in section  
 10 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

11 (2) MEDICAL ADULT DAY CARE FACILITY.—The term  
 12 “medical adult day care facility” means a facility that—

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

16 (B) is engaged in providing skilled nursing serv-  
 17 ices and other therapeutic services directly or under ar-  
 18 rangement with a home health agency;

19 (C) meets such standards established by the Sec-  
 20 retary to assure quality of care and such other require-  
 21 ments as the Secretary finds necessary in the interest  
 22 of the health and safety of individuals who are fur-  
 23 nished services in the facility; and

24 (D) provides medical adult day care services.

25 (3) MEDICAL ADULT DAY CARE SERVICES.—The term  
 26 “medical adult day care services” means—

27 (A) home health service items and services de-  
 28 scribed in paragraphs (1) through (7) of section  
 29 1861(m) furnished in a medical adult day care facility;

30 (B) a program of supervised activities furnished in  
 31 a group setting in the facility that—

32 (i) meet such criteria as the Secretary deter-  
 33 mines appropriate; and

34 (ii) is designed to promote physical and mental  
 35 health of the individuals; and

36 (C) such other services as the Secretary may  
 37 specify.

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

## 5 **TITLE VII—MEDICARE BENEFITS** 6 **ADMINISTRATION**

### 7 **SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS AD-** 8 **MINISTRATION.**

9 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.),  
10 as amended by section 105, is amended by inserting after 1806  
11 the following new section:

12 “MEDICARE BENEFITS ADMINISTRATION

13 “SEC. 1808. (a) ESTABLISHMENT.—There is established  
14 within the Department of Health and Human Services an agen-  
15 cy to be known as the Medicare Benefits Administration.

16 “(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF  
17 ACTUARY.—

18 “(1) ADMINISTRATOR.—

19 “(A) IN GENERAL.—The Medicare Benefits Ad-  
20 ministration shall be headed by an administrator to be  
21 known as the ‘Medicare Benefits Administrator’ (in  
22 this section referred to as the ‘Administrator’) who  
23 shall be appointed by the President, by and with the  
24 advice and consent of the Senate. The Administrator  
25 shall be in direct line of authority to the Secretary.

26 “(B) COMPENSATION.—The Administrator shall  
27 be paid at the rate of basic pay payable for level III  
28 of the Executive Schedule under section 5314 of title  
29 5, United States Code.

30 “(C) TERM OF OFFICE.—The Administrator shall  
31 be appointed for a term of 5 years. In any case in  
32 which a successor does not take office at the end of an  
33 Administrator’s term of office, that Administrator may  
34 continue in office until the entry upon office of such a  
35 successor. An Administrator appointed to a term of of-  
36 fice after the commencement of such term may serve

1 under such appointment only for the remainder of such  
2 term.

3 “(D) GENERAL AUTHORITY.—The Administrator  
4 shall be responsible for the exercise of all powers and  
5 the discharge of all duties of the Administration, and  
6 shall have authority and control over all personnel and  
7 activities thereof.

8 “(E) RULEMAKING AUTHORITY.—The Adminis-  
9 trator may prescribe such rules and regulations as the  
10 Administrator determines necessary or appropriate to  
11 carry out the functions of the Administration. The reg-  
12 ulations prescribed by the Administrator shall be sub-  
13 ject to the rulemaking procedures established under  
14 section 553 of title 5, United States Code.

15 “(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL  
16 UNITS.—The Administrator may establish, alter, con-  
17 solidate, or discontinue such organizational units or  
18 components within the Administration as the Adminis-  
19 trator considers necessary or appropriate, except as  
20 specified in this section.

21 “(G) AUTHORITY TO DELEGATE.—The Adminis-  
22 trator may assign duties, and delegate, or authorize  
23 successive redelegations of, authority to act and to  
24 render decisions, to such officers and employees of the  
25 Administration as the Administrator may find nec-  
26 essary. Within the limitations of such delegations, re-  
27 delegations, or assignments, all official acts and deci-  
28 sions of such officers and employees shall have the  
29 same force and effect as though performed or rendered  
30 by the Administrator.

31 “(2) DEPUTY ADMINISTRATOR.—

32 “(A) IN GENERAL.—There shall be a Deputy Ad-  
33 ministrator of the Medicare Benefits Administration  
34 who shall be appointed by the President, by and with  
35 the advice and consent of the Senate.

36 “(B) COMPENSATION.—The Deputy Administrator  
37 shall be paid at the rate of basic pay payable for level

1 IV of the Executive Schedule under section 5315 of  
2 title 5, United States Code.

3 “(C) TERM OF OFFICE.—The Deputy Adminis-  
4 trator shall be appointed for a term of 5 years. In any  
5 case in which a successor does not take office at the  
6 end of a Deputy Administrator’s term of office, such  
7 Deputy Administrator may continue in office until the  
8 entry upon office of such a successor. A Deputy Ad-  
9 ministrator appointed to a term of office after the com-  
10 mencement of such term may serve under such ap-  
11 pointment only for the remainder of such term.

12 “(D) DUTIES.—The Deputy Administrator shall  
13 perform such duties and exercise such powers as the  
14 Administrator shall from time to time assign or dele-  
15 gate. The Deputy Administrator shall be Acting Ad-  
16 ministrator of the Administration during the absence or  
17 disability of the Administrator and, unless the Presi-  
18 dent designates another officer of the Government as  
19 Acting Administrator, in the event of a vacancy in the  
20 office of the Administrator.

21 “(3) CHIEF ACTUARY.—

22 “(A) IN GENERAL.—There is established in the  
23 Administration the position of Chief Actuary. The  
24 Chief Actuary shall be appointed by, and in direct line  
25 of authority to, the Administrator of such Administra-  
26 tion. The Chief Actuary shall be appointed from among  
27 individuals who have demonstrated, by their education  
28 and experience, superior expertise in the actuarial  
29 sciences. The Chief Actuary may be removed only for  
30 cause.

31 “(B) COMPENSATION.—The Chief Actuary shall  
32 be compensated at the highest rate of basic pay for the  
33 Senior Executive Service under section 5382(b) of title  
34 5, United States Code.

35 “(C) DUTIES.—The Chief Actuary shall exercise  
36 such duties as are appropriate for the office of the

1 Chief Actuary and in accordance with professional  
2 standards of actuarial independence.

3 “(4) SECRETARIAL COORDINATION OF PROGRAM AD-  
4 MINISTRATION.—The Secretary shall ensure appropriate  
5 coordination between the Administrator and the Adminis-  
6 trator of the Centers for Medicare & Medicaid Services in  
7 carrying out the programs under this title.

8 “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

9 “(1) DUTIES.—

10 “(A) GENERAL DUTIES.—The Administrator shall  
11 carry out parts C and D, including—

12 “(i) negotiating, entering into, and enforcing,  
13 contracts with plans for the offering of  
14 Medicare+Choice plans under part C, including the  
15 offering of qualified prescription drug coverage  
16 under such plans; and

17 “(ii) negotiating, entering into, and enforcing,  
18 contracts with PDP sponsors for the offering of  
19 prescription drug plans under part D.

20 “(B) OTHER DUTIES.—The Administrator shall  
21 carry out any duty provided for under part C or part  
22 D, including demonstration projects carried out in part  
23 or in whole under such parts, the programs of all-inclu-  
24 sive care for the elderly (PACE program) under section  
25 1894, the social health maintenance organization  
26 (SHMO) demonstration projects (referred to in section  
27 4104(c) of the Balanced Budget Act of 1997), and  
28 through a Medicare+Choice project that demonstrates  
29 the application of capitation payment rates for frail el-  
30 derly medicare beneficiaries through the use of a inter-  
31 disciplinary team and through the provision of primary  
32 care services to such beneficiaries by means of such a  
33 team at the nursing facility involved).

34 “(C) PRESCRIPTION DRUG CARD.—The Adminis-  
35 trator shall carry out section 1807 (relating to the  
36 medicare prescription drug discount card endorsement  
37 program).

1           “(D) NONINTERFERENCE.—In carrying out its  
2 duties with respect to the provision of qualified pre-  
3 scription drug coverage to beneficiaries under this title,  
4 the Administrator may not—

5           “(i) require a particular formulary or institute  
6 a price structure for the reimbursement of covered  
7 outpatient drugs;

8           “(ii) interfere in any way with negotiations be-  
9 tween PDP sponsors and Medicare+Choice organi-  
10 zations and drug manufacturers, wholesalers, or  
11 other suppliers of covered outpatient drugs; and

12           “(iii) otherwise interfere with the competitive  
13 nature of providing such coverage through such  
14 sponsors and organizations.

15           “(E) ANNUAL REPORTS.—Not later March 31 of  
16 each year, the Administrator shall submit to Congress  
17 and the President a report on the administration of  
18 parts C and D during the previous fiscal year.

19           “(2) STAFF.—

20           “(A) IN GENERAL.—The Administrator, with the  
21 approval of the Secretary, may employ, without regard  
22 to chapter 31 of title 5, United States Code, other than  
23 sections 3110 and 3112, such officers and employees as  
24 are necessary to administer the activities to be carried  
25 out through the Medicare Benefits Administration. The  
26 Administrator shall employ staff with appropriate and  
27 necessary expertise in negotiating contracts in the pri-  
28 vate sector.

29           “(B) FLEXIBILITY WITH RESPECT TO COMPENSA-  
30 TION.—

31           “(i) IN GENERAL.—The staff of the Medicare  
32 Benefits Administration shall, subject to clause (ii),  
33 be paid without regard to the provisions of chapter  
34 51 (other than section 5101) and chapter 53 (other  
35 than section 5301) of such title (relating to classi-  
36 fication and schedule pay rates).

1           “(ii) MAXIMUM RATE.—In no case may the  
2           rate of compensation determined under clause (i)  
3           exceed the rate of basic pay payable for level IV of  
4           the Executive Schedule under section 5315 of title  
5           5, United States Code.

6           “(C) LIMITATION ON FULL-TIME EQUIVALENT  
7           STAFFING FOR CURRENT CMS FUNCTIONS BEING  
8           TRANSFERRED.—The Administrator may not employ  
9           under this paragraph a number of full-time equivalent  
10          employees, to carry out functions that were previously  
11          conducted by the Centers for Medicare & Medicaid  
12          Services and that are conducted by the Administrator  
13          by reason of this section, that exceeds the number of  
14          such full-time equivalent employees authorized to be  
15          employed by the Centers for Medicare & Medicaid Serv-  
16          ices to conduct such functions as of the date of the en-  
17          actment of this Act.

18          “(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE  
19          CENTERS FOR MEDICARE & MEDICAID SERVICES.—

20           “(A) IN GENERAL.—The Secretary, the Adminis-  
21           trator, and the Administrator of the Centers for Medi-  
22           care & Medicaid Services shall establish an appropriate  
23           transition of responsibility in order to redelegate the  
24           administration of part C from the Secretary and the  
25           Administrator of the Centers for Medicare & Medicaid  
26           Services to the Administrator as is appropriate to carry  
27           out the purposes of this section.

28           “(B) TRANSFER OF DATA AND INFORMATION.—  
29           The Secretary shall ensure that the Administrator of  
30           the Centers for Medicare & Medicaid Services transfers  
31           to the Administrator of the Medicare Benefits Adminis-  
32           tration such information and data in the possession of  
33           the Administrator of the Centers for Medicare & Med-  
34           icaid Services as the Administrator of the Medicare  
35           Benefits Administration requires to carry out the du-  
36           ties described in paragraph (1).

1           “(C) CONSTRUCTION.—Insofar as a responsibility  
2           of the Secretary or the Administrator of the Centers  
3           for Medicare & Medicaid Services is redelegated to the  
4           Administrator under this section, any reference to the  
5           Secretary or the Administrator of the Centers for Medi-  
6           care & Medicaid Services in this title or title XI with  
7           respect to such responsibility is deemed to be a ref-  
8           erence to the Administrator.

9           “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

10           “(1) ESTABLISHMENT.—The Secretary shall establish  
11           within the Medicare Benefits Administration an Office of  
12           Beneficiary Assistance to coordinate functions relating to  
13           outreach and education of medicare beneficiaries under this  
14           title, including the functions described in paragraph (2).  
15           The Office shall be separate operating division within the  
16           Administration.

17           “(2) DISSEMINATION OF INFORMATION ON BENEFITS  
18           AND APPEALS RIGHTS.—

19           “(A) DISSEMINATION OF BENEFITS INFORMA-  
20           TION.—The Office of Beneficiary Assistance shall dis-  
21           seminate, directly or through contract, to medicare  
22           beneficiaries, by mail, by posting on the Internet site  
23           of the Medicare Benefits Administration and through a  
24           toll-free telephone number, information with respect to  
25           the following:

26           “(i) Benefits, and limitations on payment (in-  
27           cluding cost-sharing, stop-loss provisions, and for-  
28           mulary restrictions) under parts C and D.

29           “(ii) Benefits, and limitations on payment  
30           under parts A and B, including information on  
31           medicare supplemental policies under section 1882.  
32           Such information shall be presented in a manner so  
33           that medicare beneficiaries may compare benefits under  
34           parts A, B, D, and medicare supplemental policies with  
35           benefits under Medicare+Choice plans under part C.

36           “(B) DISSEMINATION OF APPEALS RIGHTS INFOR-  
37           MATION.—The Office of Beneficiary Assistance shall

1 disseminate to medicare beneficiaries in the manner  
2 provided under subparagraph (A) a description of pro-  
3 cedural rights (including grievance and appeals proce-  
4 dures) of beneficiaries under the original medicare fee-  
5 for-service program under parts A and B, the  
6 Medicare+Choice program under part C, and the Vol-  
7 untary Prescription Drug Benefit Program under part  
8 D.

9 “(e) MEDICARE POLICY ADVISORY BOARD.—

10 “(1) ESTABLISHMENT.—There is established within  
11 the Medicare Benefits Administration the Medicare Policy  
12 Advisory Board (in this section referred to the ‘Board’).  
13 The Board shall advise, consult with, and make rec-  
14 ommendations to the Administrator of the Medicare Bene-  
15 fits Administration with respect to the administration of  
16 parts C and D, including the review of payment policies  
17 under such parts.

18 “(2) REPORTS.—

19 “(A) IN GENERAL.—With respect to matters of  
20 the administration of parts C and D, the Board shall  
21 submit to Congress and to the Administrator of the  
22 Medicare Benefits Administration such reports as the  
23 Board determines appropriate. Each such report may  
24 contain such recommendations as the Board determines  
25 appropriate for legislative or administrative changes to  
26 improve the administration of such parts, including the  
27 topics described in subparagraph (B). Each such report  
28 shall be published in the Federal Register.

29 “(B) TOPICS DESCRIBED.—Reports required  
30 under subparagraph (A) may include the following top-  
31 ics:

32 “(i) FOSTERING COMPETITION.—Rec-  
33 ommendations or proposals to increase competition  
34 under parts C and D for services furnished to  
35 medicare beneficiaries.

36 “(ii) EDUCATION AND ENROLLMENT.—Rec-  
37 ommendations for the improvement to efforts to

1 provide medicare beneficiaries information and edu-  
2 cation on the program under this title, and specifi-  
3 cally parts C and D, and the program for enroll-  
4 ment under the title.

5 “(iii) IMPLEMENTATION OF RISK-ADJUST-  
6 MENT.—Evaluation of the implementation under  
7 section 1853(a)(3)(C) of the risk adjustment meth-  
8 odology to payment rates under that section to  
9 Medicare+Choice organizations offering  
10 Medicare+Choice plans that accounts for variations  
11 in per capita costs based on health status and other  
12 demographic factors.

13 “(iv) DISEASE MANAGEMENT PROGRAMS.—  
14 Recommendations on the incorporation of disease  
15 management programs under parts C and D.

16 “(v) RURAL ACCESS.—Recommendations to  
17 improve competition and access to plans under  
18 parts C and D in rural areas.

19 “(C) MAINTAINING INDEPENDENCE OF BOARD.—  
20 The Board shall directly submit to Congress reports re-  
21 quired under subparagraph (A). No officer or agency of  
22 the United States may require the Board to submit to  
23 any officer or agency of the United States for approval,  
24 comments, or review, prior to the submission to Con-  
25 gress of such reports.

26 “(3) DUTY OF ADMINISTRATOR OF MEDICARE BENE-  
27 FITS ADMINISTRATION.—With respect to any report sub-  
28 mitted by the Board under paragraph (2)(A), not later  
29 than 90 days after the report is submitted, the Adminis-  
30 trator of the Medicare Benefits Administration shall submit  
31 to Congress and the President an analysis of recommenda-  
32 tions made by the Board in such report. Each such analysis  
33 shall be published in the Federal Register.

34 “(4) MEMBERSHIP.—

35 “(A) APPOINTMENT.—Subject to the succeeding  
36 provisions of this paragraph, the Board shall consist of  
37 seven members to be appointed as follows:

1           “(i) Three members shall be appointed by the  
2           President.

3           “(ii) Two members shall be appointed by the  
4           Speaker of the House of Representatives, with the  
5           advice of the chairmen and the ranking minority  
6           members of the Committees on Ways and Means  
7           and on Energy and Commerce of the House of  
8           Representatives.

9           “(iii) Two members shall be appointed by the  
10          President pro tempore of the Senate with the ad-  
11          vice of the chairman and the ranking minority  
12          member of the Senate Committee on Finance.

13          “(B) QUALIFICATIONS.—The members shall be  
14          chosen on the basis of their integrity, impartiality, and  
15          good judgment, and shall be individuals who are, by  
16          reason of their education and experience in health care  
17          benefits management, exceptionally qualified to perform  
18          the duties of members of the Board.

19          “(C) PROHIBITION ON INCLUSION OF FEDERAL  
20          EMPLOYEES.—No officer or employee of the United  
21          States may serve as a member of the Board.

22          “(5) COMPENSATION.—Members of the Board shall  
23          receive, for each day (including travel time) they are en-  
24          gaged in the performance of the functions of the board,  
25          compensation at rates not to exceed the daily equivalent to  
26          the annual rate in effect for level IV of the Executive  
27          Schedule under section 5315 of title 5, United States Code.

28          “(6) TERMS OF OFFICE.—

29          “(A) IN GENERAL.—The term of office of mem-  
30          bers of the Board shall be 3 years.

31          “(B) TERMS OF INITIAL APPOINTEES.—As des-  
32          ignated by the President at the time of appointment,  
33          of the members first appointed—

34                  “(i) one shall be appointed for a term of 1  
35                  year;

36                  “(ii) three shall be appointed for terms of 2  
37                  years; and

1                   “(iii) three shall be appointed for terms of 3  
2                   years.

3                   “(C) REAPPOINTMENTS.—Any person appointed  
4                   as a member of the Board may not serve for more than  
5                   8 years.

6                   “(D) VACANCY.—Any member appointed to fill a  
7                   vacancy occurring before the expiration of the term for  
8                   which the member’s predecessor was appointed shall be  
9                   appointed only for the remainder of that term. A mem-  
10                  ber may serve after the expiration of that member’s  
11                  term until a successor has taken office. A vacancy in  
12                  the Board shall be filled in the manner in which the  
13                  original appointment was made.

14                  “(7) CHAIR.—The Chair of the Board shall be elected  
15                  by the members. The term of office of the Chair shall be  
16                  3 years.

17                  “(8) MEETINGS.—The Board shall meet at the call of  
18                  the Chair, but in no event less than three times during  
19                  each fiscal year.

20                  “(9) DIRECTOR AND STAFF.—

21                  “(A) APPOINTMENT OF DIRECTOR.—The Board  
22                  shall have a Director who shall be appointed by the  
23                  Chair.

24                  “(B) IN GENERAL.—With the approval of the  
25                  Board, the Director may appoint, without regard to  
26                  chapter 31 of title 5, United States Code, such addi-  
27                  tional personnel as the Director considers appropriate.

28                  “(C) FLEXIBILITY WITH RESPECT TO COMPENSA-  
29                  TION.—

30                  “(i) IN GENERAL.—The Director and staff of  
31                  the Board shall, subject to clause (ii), be paid with-  
32                  out regard to the provisions of chapter 51 and  
33                  chapter 53 of such title (relating to classification  
34                  and schedule pay rates).

35                  “(ii) MAXIMUM RATE.—In no case may the  
36                  rate of compensation determined under clause (i)  
37                  exceed the rate of basic pay payable for level IV of

1           the Executive Schedule under section 5315 of title  
2           5, United States Code.

3           “(D) ASSISTANCE FROM THE ADMINISTRATOR OF  
4           THE MEDICARE BENEFITS ADMINISTRATION.—The Ad-  
5           ministrators of the Medicare Benefits Administration  
6           shall make available to the Board such information and  
7           other assistance as it may require to carry out its func-  
8           tions.

9           “(10) CONTRACT AUTHORITY.—The Board may con-  
10          tract with and compensate government and private agencies  
11          or persons to carry out its duties under this subsection,  
12          without regard to section 3709 of the Revised Statutes (41  
13          U.S.C. 5).

14          “(f) FUNDING.—There is authorized to be appropriated, in  
15          appropriate part from the Federal Hospital Insurance Trust  
16          Fund and from the Federal Supplementary Medical Insurance  
17          Trust Fund (including the Medicare Prescription Drug Ac-  
18          count), such sums as are necessary to carry out this section.”.

19          (b) EFFECTIVE DATE.—

20               (1) IN GENERAL.—The amendment made by sub-  
21               section (a) shall take effect on the date of the enactment  
22               of this Act.

23               (2) TIMING OF INITIAL APPOINTMENTS.—The Admin-  
24               istrator and Deputy Administrator of the Medicare Bene-  
25               fits Administration may not be appointed before March 1,  
26               2003.

27               (3) DUTIES WITH RESPECT TO ELIGIBILITY DETER-  
28               MINATIONS AND ENROLLMENT.—The Administrator of the  
29               Medicare Benefits Administration shall carry out enroll-  
30               ment under title XVIII of the Social Security Act, make  
31               eligibility determinations under such title, and carry out  
32               part C of such title for years beginning or after January  
33               1, 2005.

34               (4) TRANSITION.—Before the date the Administrator  
35               of the Medicare Benefits Administration is appointed and  
36               assumes responsibilities under this section and section  
37               1807 of the Social Security Act, the Secretary of Health

1 and Human Services shall provide for the conduct of any  
 2 responsibilities of such Administrator that are otherwise  
 3 provided under law.

4 (c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

5 (1) ADMINISTRATOR AS MEMBER OF THE BOARD OF  
 6 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section  
 7 1817(b) and section 1841(b) (42 U.S.C. 1395i(b),  
 8 1395t(b)) are each amended by striking “and the Secretary  
 9 of Health and Human Services, all ex officio,” and insert-  
 10 ing “the Secretary of Health and Human Services, and the  
 11 Administrator of the Medicare Benefits Administration, all  
 12 ex officio,”.

13 (2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR  
 14 THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE &  
 15 MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS AD-  
 16 MINISTRATOR.—

17 (A) IN GENERAL.—Section 5314 of title 5, United  
 18 States Code, by adding at the end the following:

19 “Administrator of the Centers for Medicare &  
 20 Medicaid Services .

21 “Administrator of the Medicare Benefits Adminis-  
 22 tration.”.

23 (B) CONFORMING AMENDMENT.—Section 5315 of  
 24 such title is amended by striking “Administrator of the  
 25 Health Care Financing Administration.”.

26 (C) EFFECTIVE DATE.—The amendments made by  
 27 this paragraph take effect on January 1, 2003.

28 **TITLE VIII—REGULATORY REDUC-**  
 29 **TION AND CONTRACTING RE-**  
 30 **FORM**

31 **Subtitle A—Regulatory Reform**

32 **SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.**

33 (a) CONSTRUCTION.—Nothing in this title shall be  
 34 construed—

35 (1) to compromise or affect existing legal remedies for  
 36 addressing fraud or abuse, whether it be criminal prosecu-



1 If the Secretary makes a finding under this paragraph, the  
2 Secretary shall include such finding, and brief statement of the  
3 reasons for such finding, in the issuance of such regulation.

4 “(3) The Secretary shall coordinate issuance of new regu-  
5 lations described in paragraph (1) relating to a category of pro-  
6 vider of services or suppliers based on an analysis of the collec-  
7 tive impact of regulatory changes on that category of providers  
8 or suppliers.”.

9 (2) GAO REPORT ON PUBLICATION OF REGULATIONS  
10 ON A QUARTERLY BASIS.—Not later than 3 years after the  
11 date of the enactment of this Act, the Comptroller General  
12 of the United States shall submit to Congress a report on  
13 the feasibility of requiring that regulations described in sec-  
14 tion 1871(d) of the Social Security Act be promulgated on  
15 a quarterly basis rather than on a monthly basis.

16 (3) EFFECTIVE DATE.—The amendment made by  
17 paragraph (1) shall apply to regulations promulgated on or  
18 after the date that is 30 days after the date of the enact-  
19 ment of this Act.

20 (b) REGULAR TIMELINE FOR PUBLICATION OF FINAL  
21 RULES.—

22 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
23 1395hh(a)) is amended by adding at the end the following  
24 new paragraph:

25 “(3)(A) The Secretary, in consultation with the Director  
26 of the Office of Management and Budget, shall establish and  
27 publish a regular timeline for the publication of final regula-  
28 tions based on the previous publication of a proposed regulation  
29 or an interim final regulation.

30 “(B) Such timeline may vary among different regulations  
31 based on differences in the complexity of the regulation, the  
32 number and scope of comments received, and other relevant  
33 factors, but shall not be longer than 3 years except under ex-  
34 ceptional circumstances. If the Secretary intends to vary such  
35 timeline with respect to the publication of a final regulation,  
36 the Secretary shall cause to have published in the Federal Reg-  
37 ister notice of the different timeline by not later than the

1 timeline previously established with respect to such regulation.  
2 Such notice shall include a brief explanation of the justification  
3 for such variation.

4 “(C) In the case of interim final regulations, upon the ex-  
5 piration of the regular timeline established under this para-  
6 graph for the publication of a final regulation after opportunity  
7 for public comment, the interim final regulation shall not con-  
8 tinue in effect unless the Secretary publishes (at the end of the  
9 regular timeline and, if applicable, at the end of each suc-  
10 ceeding 1-year period) a notice of continuation of the regulation  
11 that includes an explanation of why the regular timeline (and  
12 any subsequent 1-year extension) was not complied with. If  
13 such a notice is published, the regular timeline (or such  
14 timeline as previously extended under this paragraph) for publi-  
15 cation of the final regulation shall be treated as having been  
16 extended for 1 additional year.

17 “(D) The Secretary shall annually submit to Congress a  
18 report that describes the instances in which the Secretary failed  
19 to publish a final regulation within the applicable regular  
20 timeline under this paragraph and that provides an explanation  
21 for such failures.”.

22 (2) EFFECTIVE DATE.—The amendment made by  
23 paragraph (1) shall take effect on the date of the enact-  
24 ment of this Act. The Secretary shall provide for an appro-  
25 priate transition to take into account the backlog of pre-  
26 viously published interim final regulations.

27 (c) LIMITATIONS ON NEW MATTER IN FINAL REGULA-  
28 TIONS.—

29 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
30 1395hh(a)), as amended by subsection (b), is further  
31 amended by adding at the end the following new para-  
32 graph:

33 “(4) If the Secretary publishes notice of proposed rule-  
34 making relating to a regulation (including an interim final reg-  
35 ulation), insofar as such final regulation includes a provision  
36 that is not a logical outgrowth of such notice of proposed rule-  
37 making, that provision shall be treated as a proposed regulation

1 and shall not take effect until there is the further opportunity  
 2 for public comment and a publication of the provision again as  
 3 a final regulation.”.

4 (2) EFFECTIVE DATE.—The amendment made by  
 5 paragraph (1) shall apply to final regulations published on  
 6 or after the date of the enactment of this Act.

7 **SEC. 803. COMPLIANCE WITH CHANGES IN REGULA-**  
 8 **TIONS AND POLICIES.**

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

11 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh),  
 12 as amended by section 802(a), is amended by adding at the  
 13 end the following new subsection:

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

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

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

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

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

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

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

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

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

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

18           (c) RELIANCE ON GUIDANCE.—

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

22           “(2)(A) If—

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

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

35           “(iii) the guidance was in error;

36 the provider of services or supplier shall not be subject to any  
37 sanction (including any penalty or requirement for repayment

1 of any amount) if the provider of services or supplier reason-  
2 ably relied on such guidance.

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

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

13 **SEC. 804. REPORTS AND STUDIES RELATING TO REGU-**  
14 **LATORY REFORM.**

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

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

26 (2) REPORT.—The Comptroller General shall submit  
27 to Congress a report on the study conducted under para-  
28 graph (1) by not later than January 1, 2004.

29 (b) REPORT ON LEGAL AND REGULATORY INCONSIST-  
30 ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by  
31 section 803(a), is amended by adding at the end the following  
32 new subsection:

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

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

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

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

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

## 16 **Subtitle B—Contracting Reform**

### 17 **SEC. 811. INCREASED FLEXIBILITY IN MEDICARE AD- 18 MINISTRATION.**

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

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

23 “CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

24 “SEC. 1874A. (a) AUTHORITY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 “(5) RELATIONSHIP TO MIP CONTRACTS.—

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

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

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

9           “(b) CONTRACTING REQUIREMENTS.—

10          “(1) USE OF COMPETITIVE PROCEDURES.—

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

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

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

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

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

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

15 “(3) PERFORMANCE REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

24                  “(c) TERMS AND CONDITIONS.—

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

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

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

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

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

10 “(2) DISBURSING OFFICER.—No disbursing officer  
11 shall, in the absence of gross negligence or intent to de-  
12 fraud the United States, be liable with respect to any pay-  
13 ment by such officer under this section if it was based upon  
14 an authorization (which meets the applicable requirements  
15 for such internal controls established by the Comptroller  
16 General) of a certifying officer designated as provided in  
17 paragraph (1) of this subsection.

18 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE CON-  
19 TRACTOR.—No medicare administrative contractor shall be  
20 liable to the United States for a payment by a certifying  
21 or disbursing officer unless in connection with such pay-  
22 ment or in the supervision of or selection of such officer  
23 the medicare administrative contractor acted with gross  
24 negligence.

25 “(4) INDEMNIFICATION BY SECRETARY.—

26 “(A) IN GENERAL.—Subject to subparagraphs (B)  
27 and (D), in the case of a medicare administrative con-  
28 tractor (or a person who is a director, officer, or em-  
29 ployee of such a contractor or who is engaged by the  
30 contractor to participate directly in the claims adminis-  
31 tration process) who is made a party to any judicial or  
32 administrative proceeding arising from or relating di-  
33 rectly to the claims administration process under this  
34 title, the Secretary may, to the extent the Secretary de-  
35 termines to be appropriate and as specified in the con-  
36 tract with the contractor, indemnify the contractor and  
37 such persons.

1           “(B) CONDITIONS.—The Secretary may not pro-  
2           vide indemnification under subparagraph (A) insofar as  
3           the liability for such costs arises directly from conduct  
4           that is determined by the judicial proceeding or by the  
5           Secretary to be criminal in nature, fraudulent, or  
6           grossly negligent. If indemnification is provided by the  
7           Secretary with respect to a contractor before a deter-  
8           mination that such costs arose directly from such con-  
9           duct, the contractor shall reimburse the Secretary for  
10          costs of indemnification.

11          “(C) SCOPE OF INDEMNIFICATION.—Indemnifica-  
12          tion by the Secretary under subparagraph (A) may in-  
13          clude payment of judgments, settlements (subject to  
14          subparagraph (D)), awards, and costs (including rea-  
15          sonable legal expenses).

16          “(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A  
17          contractor or other person described in subparagraph  
18          (A) may not propose to negotiate a settlement or com-  
19          promise of a proceeding described in such subpara-  
20          graph without the prior written approval of the Sec-  
21          retary to negotiate such settlement or compromise. Any  
22          indemnification under subparagraph (A) with respect to  
23          amounts paid under a settlement or compromise of a  
24          proceeding described in such subparagraph are condi-  
25          tioned upon prior written approval by the Secretary of  
26          the final settlement or compromise.

27          “(E) CONSTRUCTION.—Nothing in this paragraph  
28          shall be construed—

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

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

35          (2) CONSIDERATION OF INCORPORATION OF CURRENT  
36          LAW STANDARDS.—In developing contract performance re-  
37          quirements under section 1874A(b) of the Social Security

1 Act, as inserted by paragraph (1), the Secretary shall con-  
2 sider inclusion of the performance standards described in  
3 sections 1816(f)(2) of such Act (relating to timely proc-  
4 essing of reconsiderations and applications for exemptions)  
5 and section 1842(b)(2)(B) of such Act (relating to timely  
6 review of determinations and fair hearing requests), as  
7 such sections were in effect before the date of the enact-  
8 ment of this Act.

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

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

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

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

18 (3) Subsection (b) is repealed.

19 (4) Subsection (c) is amended—

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

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

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

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

27 (A) by striking “An agreement with an agency or  
28 organization under this section” and inserting “A con-  
29 tract with a medicare administrative contractor under  
30 section 1874A with respect to the administration of  
31 this part”; and

32 (B) by striking “such agency or organization” and  
33 inserting “such medicare administrative contractor”  
34 each place it appears.

35 (7) Subsection (l) is repealed.

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

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

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

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

10 (3) Subsection (b) is amended—

11 (A) by striking paragraph (1);

12 (B) in paragraph (2)—

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

14 (ii) in subparagraph (C), by striking “car-  
 15 riers” and inserting “medicare administrative con-  
 16 tractors”; and

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

18 (C) in paragraph (3)—

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

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

25 (iii) in subparagraph (B), in the matter before  
 26 clause (i), by striking “to the policyholders and  
 27 subscribers of the carrier” and inserting “to the  
 28 policyholders and subscribers of the medicare ad-  
 29 ministrative contractor”;

30 (iv) by striking subparagraphs (C), (D), and  
 31 (E);

32 (v) in subparagraph (H)—

33 (I) by striking “if it makes determinations  
 34 or payments with respect to physicians’ serv-  
 35 ices,”; and

36 (II) by striking “carrier” and inserting  
 37 “medicare administrative contractor”;

- 1 (vi) by striking subparagraph (I);
- 2 (vii) in subparagraph (L), by striking the  
3 semicolon and inserting a period;
- 4 (viii) in the first sentence, after subparagraph  
5 (L), by striking “and shall contain” and all that  
6 follows through the period; and
- 7 (ix) in the seventh sentence, by inserting  
8 “medicare administrative contractor,” after “car-  
9 rier,”; and
- 10 (D) by striking paragraph (5);
- 11 (E) in paragraph (6)(D)(iv), by striking “carrier”  
12 and inserting “medicare administrative contractor”;  
13 and
- 14 (F) in paragraph (7), by striking “the carrier”  
15 and inserting “the Secretary” each place it appears.
- 16 (4) Subsection (c) is amended—
- 17 (A) by striking paragraph (1);
- 18 (B) in paragraph (2), by striking “contract under  
19 this section which provides for the disbursement of  
20 funds, as described in subsection (a)(1)(B),” and in-  
21 serting “contract under section 1874A that provides for  
22 making payments under this part”;
- 23 (C) in paragraph (3)(A), by striking “subsection  
24 (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;
- 25 (D) in paragraph (4), by striking “carrier” and in-  
26 serting “medicare administrative contractor”; and
- 27 (E) by striking paragraphs (5) and (6).
- 28 (5) Subsections (d), (e), and (f) are repealed.
- 29 (6) Subsection (g) is amended by striking “carrier or  
30 carriers” and inserting “medicare administrative contractor  
31 or contractors”.
- 32 (7) Subsection (h) is amended—
- 33 (A) in paragraph (2)—
- 34 (i) by striking “Each carrier having an agree-  
35 ment with the Secretary under subsection (a)” and  
36 inserting “The Secretary”; and

1 (ii) by striking “Each such carrier” and in-  
 2 serting “The Secretary”;

3 (B) in paragraph (3)(A)—

4 (i) by striking “a carrier having an agreement  
 5 with the Secretary under subsection (a)” and in-  
 6 serting “medicare administrative contractor having  
 7 a contract under section 1874A that provides for  
 8 making payments under this part”; and

9 (ii) by striking “such carrier” and inserting  
 10 “such contractor”;

11 (C) in paragraph (3)(B)—

12 (i) by striking “a carrier” and inserting “a  
 13 medicare administrative contractor” each place it  
 14 appears; and

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

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

20 (8) Subsection (l) is amended—

21 (A) in paragraph (1)(A)(iii), by striking “carrier”  
 22 and inserting “medicare administrative contractor”;  
 23 and

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

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

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

30 (d) EFFECTIVE DATE; TRANSITION RULE.—

31 (1) EFFECTIVE DATE.—

32 (A) IN GENERAL.—Except as otherwise provided  
 33 in this subsection, the amendments made by this sec-  
 34 tion shall take effect on October 1, 2004, and the Sec-  
 35 retary is authorized to take such steps before such date  
 36 as may be necessary to implement such amendments on  
 37 a timely basis.

1 (B) CONSTRUCTION FOR CURRENT CONTRACTS.—

2 Such amendments shall not apply to contracts in effect  
3 before the date specified under subparagraph (A) that  
4 continue to retain the terms and conditions in effect on  
5 such date (except as otherwise provided under this Act,  
6 other than under this section) until such date as the  
7 contract is let out for competitive bidding under such  
8 amendments.

9 (C) DEADLINE FOR COMPETITIVE BIDDING.—The

10 Secretary shall provide for the letting by competitive  
11 bidding of all contracts for functions of medicare ad-  
12 ministrative contractors for annual contract periods  
13 that begin on or after October 1, 2009.

14 (D) WAIVER OF PROVIDER NOMINATION PROVI-

15 SIONS DURING TRANSITION.—During the period begin-  
16 ning on the date of the enactment of this Act and be-  
17 fore the date specified under subparagraph (A), the  
18 Secretary may enter into new agreements under section  
19 1816 of the Social Security Act (42 U.S.C. 1395h)  
20 without regard to any of the provider nomination provi-  
21 sions of such section.

22 (2) GENERAL TRANSITION RULES.—The Secretary

23 shall take such steps, consistent with paragraph (1)(B) and  
24 (1)(C), as are necessary to provide for an appropriate tran-  
25 sition from contracts under section 1816 and section 1842  
26 of the Social Security Act (42 U.S.C. 1395h, 1395u) to  
27 contracts under section 1874A, as added by subsection  
28 (a)(1).

29 (3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS

30 UNDER CURRENT CONTRACTS AND AGREEMENTS AND  
31 UNDER ROLLOVER CONTRACTS.—The provisions contained  
32 in the exception in section 1893(d)(2) of the Social Secu-  
33 rity Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply  
34 notwithstanding the amendments made by this section, and  
35 any reference in such provisions to an agreement or con-  
36 tract shall be deemed to include a contract under section

1 1874A of such Act, as inserted by subsection (a)(1), that  
2 continues the activities referred to in such provisions.

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

11 (f) REPORTS ON IMPLEMENTATION.—

12 (1) PLAN FOR IMPLEMENTATION.—By not later than  
13 October 1, 2003, the Secretary shall submit a report to  
14 Congress and the Comptroller General of the United States  
15 that describes the plan for implementation of the amend-  
16 ments made by this section. The Comptroller General shall  
17 conduct an evaluation of such plan and shall submit to  
18 Congress, not later than 6 months after the date the report  
19 is received, a report on such evaluation and shall include  
20 in such report such recommendations as the Comptroller  
21 General deems appropriate.

22 (2) STATUS OF IMPLEMENTATION.—The Secretary  
23 shall submit a report to Congress not later than October  
24 1, 2007, that describes the status of implementation of  
25 such amendments and that includes a description of the  
26 following:

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

29 (B) The distribution of functions among contracts  
30 and contractors.

31 (C) A timeline for complete transition to full com-  
32 petition.

33 (D) A detailed description of how the Secretary  
34 has modified oversight and management of medicare  
35 contractors to adapt to full competition.

1 **SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY**  
 2 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**  
 3 **TORS.**

4 (a) IN GENERAL.—Section 1874A, as added by section  
 5 811(a)(1), is amended by adding at the end the following new  
 6 subsection:

7 “(e) REQUIREMENTS FOR INFORMATION SECURITY.—

8 “(1) DEVELOPMENT OF INFORMATION SECURITY PRO-  
 9 GRAM.—A medicare administrative contractor that per-  
 10 forms the functions referred to in subparagraphs (A) and  
 11 (B) of subsection (a)(4) (relating to determining and mak-  
 12 ing payments) shall implement a contractor-wide informa-  
 13 tion security program to provide information security for  
 14 the operation and assets of the contractor with respect to  
 15 such functions under this title. An information security  
 16 program under this paragraph shall meet the requirements  
 17 for information security programs imposed on Federal  
 18 agencies under section 3534(b)(2) of title 44, United States  
 19 Code (other than requirements under subparagraphs  
 20 (B)(ii), (F)(iii), and (F)(iv) of such section).

21 “(2) INDEPENDENT AUDITS.—

22 “(A) PERFORMANCE OF ANNUAL EVALUATIONS.—

23 Each year a medicare administrative contractor that  
 24 performs the functions referred to in subparagraphs  
 25 (A) and (B) of subsection (a)(4) (relating to deter-  
 26 mining and making payments) shall undergo an evalua-  
 27 tion of the information security of the contractor with  
 28 respect to such functions under this title. The evalua-  
 29 tion shall—

30 “(i) be performed by an entity that meets such  
 31 requirements for independence as the Inspector  
 32 General of the Department of Health and Human  
 33 Services may establish; and

34 “(ii) test the effectiveness of information secu-  
 35 rity control techniques for an appropriate subset of  
 36 the contractor’s information systems (as defined in  
 37 section 3502(8) of title 44, United States Code) re-

1 relating to such functions under this title and an as-  
 2 sessment of compliance with the requirements of  
 3 this subsection and related information security  
 4 policies, procedures, standards and guidelines.

5 “(B) DEADLINE FOR INITIAL EVALUATION.—

6 “(i) NEW CONTRACTORS.—In the case of a  
 7 medicare administrative contractor covered by this  
 8 subsection that has not previously performed the  
 9 functions referred to in subparagraphs (A) and (B)  
 10 of subsection (a)(4) (relating to determining and  
 11 making payments) as a fiscal intermediary or car-  
 12 rier under section 1816 or 1842, the first inde-  
 13 pendent evaluation conducted pursuant subpara-  
 14 graph (A) shall be completed prior to commencing  
 15 such functions.

16 “(ii) OTHER CONTRACTORS.—In the case of a  
 17 medicare administrative contractor covered by this  
 18 subsection that is not described in clause (i), the  
 19 first independent evaluation conducted pursuant  
 20 subparagraph (A) shall be completed within 1 year  
 21 after the date the contractor commences functions  
 22 referred to in clause (i) under this section.

23 “(C) REPORTS ON EVALUATIONS.—

24 “(i) TO THE INSPECTOR GENERAL.—The re-  
 25 sults of independent evaluations under subpara-  
 26 graph (A) shall be submitted promptly to the In-  
 27 spector General of the Department of Health and  
 28 Human Services.

29 “(ii) TO CONGRESS.—The Inspector General  
 30 of Department of Health and Human Services shall  
 31 submit to Congress annual reports on the results of  
 32 such evaluations.”.

33 (b) APPLICATION OF REQUIREMENTS TO FISCAL INTER-  
 34 MEDIARIES AND CARRIERS.—

35 (1) IN GENERAL.—The provisions of section  
 36 1874A(e)(2) of the Social Security Act (other than sub-  
 37 paragraph (B)), as added by subsection (a), shall apply to

1 each fiscal intermediary under section 1816 of the Social  
 2 Security Act (42 U.S.C. 1395h) and each carrier under  
 3 section 1842 of such Act (42 U.S.C. 1395u) in the same  
 4 manner as they apply to medicare administrative contrac-  
 5 tors under such provisions.

6 (2) DEADLINE FOR INITIAL EVALUATION.—In the case  
 7 of such a fiscal intermediary or carrier with an agreement  
 8 or contract under such respective section in effect as of the  
 9 date of the enactment of this Act, the first evaluation  
 10 under section 1874A(e)(2)(A) of the Social Security Act  
 11 (as added by subsection (a)), pursuant to paragraph (1),  
 12 shall be completed (and a report on the evaluation sub-  
 13 mitted to the Secretary) by not later than 1 year after such  
 14 date.

## 15 **Subtitle C—Education and Outreach**

### 16 **SEC. 821. PROVIDER EDUCATION AND TECHNICAL AS-** 17 **SISTANCE.**

18 (a) COORDINATION OF EDUCATION FUNDING.—

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

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

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

31 (3) REPORT.—Not later than October 1, 2003, the  
 32 Secretary shall submit to Congress a report that includes  
 33 a description and evaluation of the steps taken to coordi-  
 34 nate the funding of provider education under section  
 35 1889(a) of the Social Security Act, as added by paragraph  
 36 (1).

1 (b) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-  
2 ANCE.—

3 (1) IN GENERAL.—Section 1874A, as added by section  
4 811(a)(1) and as amended by section 812(a), is amended  
5 by adding at the end the following new subsection:

6 “(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-  
7 ANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to  
8 give medicare administrative contractors an incentive to imple-  
9 ment effective education and outreach programs for providers  
10 of services and suppliers, the Secretary shall develop and imple-  
11 ment a methodology to measure the specific claims payment  
12 error rates of such contractors in the processing or reviewing  
13 of medicare claims.”.

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

22 (3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—  
23 Not later than October 1, 2003, the Comptroller General  
24 of the United States shall submit to Congress and to the  
25 Secretary a report on the adequacy of the methodology  
26 under section 1874A(f) of the Social Security Act, as  
27 added by paragraph (1), and shall include in the report  
28 such recommendations as the Comptroller General deter-  
29 mines appropriate with respect to the methodology.

30 (4) REPORT ON USE OF METHODOLOGY IN ASSESSING  
31 CONTRACTOR PERFORMANCE.—Not later than October 1,  
32 2003, the Secretary shall submit to Congress a report that  
33 describes how the Secretary intends to use such method-  
34 ology in assessing medicare contractor performance in im-  
35 plementing effective education and outreach programs, in-  
36 cluding whether to use such methodology as a basis for per-  
37 formance bonuses. The report shall include an analysis of

1 the sources of identified errors and potential changes in  
2 systems of contractors and rules of the Secretary that could  
3 reduce claims error rates.

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

6 (1) IN GENERAL.—Section 1874A, as added by section  
7 811(a)(1) and as amended by section 812(a) and sub-  
8 section (b), is further amended by adding at the end the  
9 following new subsection:

10 “(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS  
11 OF SERVICES AND SUPPLIERS.—

12 “(1) COMMUNICATION STRATEGY.—The Secretary  
13 shall develop a strategy for communications with individ-  
14 uals entitled to benefits under part A or enrolled under  
15 part B, or both, and with providers of services and sup-  
16 pliers under this title.

17 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each medi-  
18 care administrative contractor shall, for those providers of  
19 services and suppliers which submit claims to the con-  
20 tractor for claims processing and for those individuals enti-  
21 tled to benefits under part A or enrolled under part B, or  
22 both, with respect to whom claims are submitted for claims  
23 processing, provide general written responses (which may  
24 be through electronic transmission) in a clear, concise, and  
25 accurate manner to inquiries of providers of services, sup-  
26 pliers and individuals entitled to benefits under part A or  
27 enrolled under part B, or both, concerning the programs  
28 under this title within 45 business days of the date of re-  
29 ceipt of such inquiries.

30 “(3) RESPONSE TO TOLL-FREE LINES.—The Secretary  
31 shall ensure that each medicare administrative contractor  
32 shall provide, for those providers of services and suppliers  
33 which submit claims to the contractor for claims processing  
34 and for those individuals entitled to benefits under part A  
35 or enrolled under part B, or both, with respect to whom  
36 claims are submitted for claims processing, a toll-free tele-  
37 phone number at which such individuals, providers of serv-

1 ices and suppliers may obtain information regarding billing,  
2 coding, claims, coverage, and other appropriate information  
3 under this title.

4 “(4) MONITORING OF CONTRACTOR RESPONSES.—

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

8 “(i) maintain a system for identifying who  
9 provides the information referred to in paragraphs  
10 (2) and (3); and

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

13 “(B) DEVELOPMENT OF STANDARDS.—

14 “(i) IN GENERAL.—The Secretary shall estab-  
15 lish and make public standards to monitor the ac-  
16 curacy, consistency, and timeliness of the informa-  
17 tion provided in response to written and telephone  
18 inquiries under this subsection. Such standards  
19 shall be consistent with the performance require-  
20 ments established under subsection (b)(3).

21 “(ii) EVALUATION.—In conducting evaluations  
22 of individual medicare administrative contractors,  
23 the Secretary shall take into account the results of  
24 the monitoring conducted under subparagraph (A)  
25 taking into account as performance requirements  
26 the standards established under clause (i). The  
27 Secretary shall, in consultation with organizations  
28 representing providers of services, suppliers, and  
29 individuals entitled to benefits under part A or en-  
30 rolled under part B, or both, establish standards  
31 relating to the accuracy, consistency, and timeliness  
32 of the information so provided.”.

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

1           (2) EFFECTIVE DATE.—The amendment made by  
2 paragraph (1) shall take effect October 1, 2003.

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

11          (d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

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

15           “(b) ENHANCED EDUCATION AND TRAINING.—

16           “(1) ADDITIONAL RESOURCES.—There are authorized  
17 to be appropriated to the Secretary (in appropriate part  
18 from the Federal Hospital Insurance Trust Fund and the  
19 Federal Supplementary Medical Insurance Trust Fund)  
20 \$25,000,000 for each of fiscal years 2004 and 2005 and  
21 such sums as may be necessary for succeeding fiscal years.

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

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

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

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

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

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

5           (2) EFFECTIVE DATE.—The amendment made by  
6           paragraph (1) shall take effect on October 1, 2003.

7           (e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

8           (1) IN GENERAL.—Section 1889, as added by sub-  
9           section (a) and as amended by subsection (d), is further  
10          amended by adding at the end the following new sub-  
11          section:

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

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

18                 “(2) includes other published materials of the con-  
19                 tractor,

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

23          (2) EFFECTIVE DATE.—The amendment made by  
24          paragraph (1) shall take effect on October 1, 2003.

25          (f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

26          (1) IN GENERAL.—Section 1889, as added by sub-  
27          section (a) and as amended by subsections (d) and (e), is  
28          further amended by adding at the end the following new  
29          subsections:

30          “(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION  
31          PROGRAM ACTIVITIES.—A medicare contractor may not use a  
32          record of attendance at (or failure to attend) educational activi-  
33          ties or other information gathered during an educational pro-  
34          gram conducted under this section or otherwise by the Sec-  
35          retary to select or track providers of services or suppliers for  
36          the purpose of conducting any type of audit or prepayment re-  
37          view.

1           “(f) CONSTRUCTION.—Nothing in this section or section  
2 1893(g) shall be construed as providing for disclosure by a  
3 medicare contractor of information that would compromise  
4 pending law enforcement activities or reveal findings of law en-  
5 forcement-related audits.

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

8           “(1) A medicare administrative contractor with a con-  
9 tract under section 1874A, including a fiscal intermediary  
10 with a contract under section 1816 and a carrier with a  
11 contract under section 1842.

12           “(2) An eligible entity with a contract under section  
13 1893.

14 Such term does not include, with respect to activities of a spe-  
15 cific provider of services or supplier an entity that has no au-  
16 thority under this title or title IX with respect to such activities  
17 and such provider of services or supplier.”.

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

21 **SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE**  
22 **DEMONSTRATION PROGRAM.**

23           (a) ESTABLISHMENT.—

24           “(1) IN GENERAL.—The Secretary shall establish a  
25 demonstration program (in this section referred to as the  
26 “demonstration program”) under which technical assist-  
27 ance described in paragraph (2) is made available, upon re-  
28 quest and on a voluntary basis, to small providers of serv-  
29 ices or suppliers in order to improve compliance with the  
30 applicable requirements of the programs under medicare  
31 program under title XVIII of the Social Security Act (in-  
32 cluding provisions of title XI of such Act insofar as they  
33 relate to such title and are not administered by the Office  
34 of the Inspector General of the Department of Health and  
35 Human Services).

36           “(2) FORMS OF TECHNICAL ASSISTANCE.—The tech-  
37 nical assistance described in this paragraph is—

1 (A) evaluation and recommendations regarding  
2 billing and related systems; and

3 (B) information and assistance regarding policies  
4 and procedures under the medicare program, including  
5 coding and reimbursement.

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

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

11 (B) a supplier with fewer than 10 full-time-equiva-  
12 lent employees.

13 (b) QUALIFICATION OF CONTRACTORS.—In conducting the  
14 demonstration program, the Secretary shall enter into contracts  
15 with qualified organizations (such as peer review organizations  
16 or entities described in section 1889(g)(2) of the Social Secu-  
17 rity Act, as inserted by section 5(f)(1)) with appropriate exper-  
18 tise with billing systems of the full range of providers of serv-  
19 ices and suppliers to provide the technical assistance. In award-  
20 ing such contracts, the Secretary shall consider any prior inves-  
21 tigation of the entity’s work by the Inspector General of De-  
22 partment of Health and Human Services or the Comptroller  
23 General of the United States.

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

30 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS  
31 IDENTIFIED AS CORRECTED.—The Secretary shall provide  
32 that, absent evidence of fraud and notwithstanding any other  
33 provision of law, any errors found in a compliance review for  
34 a small provider of services or supplier that participates in the  
35 demonstration program shall not be subject to recovery action  
36 if the technical assistance personnel under the program deter-  
37 mine that—

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

5 (2) such problem remains corrected for such period as  
6 is appropriate.

7 The previous sentence applies only to claims filed as part of the  
8 demonstration program and lasts only for the duration of such  
9 program and only as long as the small provider of services or  
10 supplier is a participant in such program.

11 (e) GAO EVALUATION.—Not later than 2 years after the  
12 date of the date the demonstration program is first imple-  
13 mented, the Comptroller General, in consultation with the In-  
14 spector General of the Department of Health and Human Serv-  
15 ices, shall conduct an evaluation of the demonstration program.  
16 The evaluation shall include a determination of whether claims  
17 error rates are reduced for small providers of services or sup-  
18 pliers who participated in the program and the extent of im-  
19 proper payments made as a result of the demonstration pro-  
20 gram. The Comptroller General shall submit a report to the  
21 Secretary and the Congress on such evaluation and shall in-  
22 clude in such report recommendations regarding the continu-  
23 ation or extension of the demonstration program.

24 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The pro-  
25 vision of technical assistance to a small provider of services or  
26 supplier under the demonstration program is conditioned upon  
27 the small provider of services or supplier paying an amount es-  
28 timated (and disclosed in advance of a provider's or supplier's  
29 participation in the program) to be equal to 25 percent of the  
30 cost of the technical assistance.

31 (g) AUTHORIZATION OF APPROPRIATIONS.—There are au-  
32 thorized to be appropriated to the Secretary (in appropriate  
33 part from the Federal Hospital Insurance Trust Fund and the  
34 Federal Supplementary Medical Insurance Trust Fund) to  
35 carry out the demonstration program—

36 (1) for fiscal year 2004, \$1,000,000, and

37 (2) for fiscal year 2005, \$6,000,000.

1 **SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDI-**  
 2 **CARE BENEFICIARY OMBUDSMAN.**

3 (a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868  
 4 (42 U.S.C. 1395ee) is amended—

5 (1) by adding at the end of the heading the following:  
 6 “; MEDICARE PROVIDER OMBUDSMAN”;

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

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

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

14 (5) by adding at the end the following new subsection:  
 15 “(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary  
 16 shall appoint within the Department of Health and Human  
 17 Services a Medicare Provider Ombudsman. The Ombudsman  
 18 shall—

19 “(1) provide assistance, on a confidential basis, to pro-  
 20 viders of services and suppliers with respect to complaints,  
 21 grievances, and requests for information concerning the  
 22 programs under this title (including provisions of title XI  
 23 insofar as they relate to this title and are not administered  
 24 by the Office of the Inspector General of the Department  
 25 of Health and Human Services) and in the resolution of  
 26 unclear or conflicting guidance given by the Secretary and  
 27 medicare contractors to such providers of services and sup-  
 28 pliers regarding such programs and provisions and require-  
 29 ments under this title and such provisions; and

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

33 “(A) recommendations to respond to recurring  
 34 patterns of confusion in this title and such provisions  
 35 (including recommendations regarding suspending im-  
 36 position of sanctions where there is widespread confu-  
 37 sion in program administration), and

1           “(B) recommendations to provide for an appro-  
 2           appropriate and consistent response (including not providing  
 3           for audits) in cases of self-identified overpayments by  
 4           providers of services and suppliers.

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

8           (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII,  
 9   as amended by sections 105 and 701, is amended by inserting  
 10  after section 1808 the following new section:

11           “MEDICARE BENEFICIARY OMBUDSMAN

12           “SEC. 1809. (a) IN GENERAL.—The Secretary shall ap-  
 13   point within the Department of Health and Human Services a  
 14   Medicare Beneficiary Ombudsman who shall have expertise and  
 15   experience in the fields of health care and education of (and  
 16   assistance to) individuals entitled to benefits under this title.

17           “(b) DUTIES.—The Medicare Beneficiary Ombudsman  
 18   shall—

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

23           “(2) provide assistance with respect to complaints,  
 24   grievances, and requests referred to in paragraph (1),  
 25   including—

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

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

33           “(3) submit annual reports to Congress and the Sec-  
 34   retary that describe the activities of the Office and that in-  
 35   clude such recommendations for improvement in the admin-  
 36   istration of this title as the Ombudsman determines appro-  
 37   priate.

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

4 “(c) WORKING WITH HEALTH INSURANCE COUNSELING  
5 PROGRAMS.—To the extent possible, the Ombudsman shall  
6 work with health insurance counseling programs (receiving  
7 funding under section 4360 of Omnibus Budget Reconciliation  
8 Act of 1990) to facilitate the provision of information to indi-  
9 viduals entitled to benefits under part A or enrolled under part  
10 B, or both regarding Medicare+Choice plans and changes to  
11 those plans. Nothing in this subsection shall preclude further  
12 collaboration between the Ombudsman and such programs.”.

13 (c) DEADLINE FOR APPOINTMENT.—The Secretary shall  
14 appoint the Medicare Provider Ombudsman and the Medicare  
15 Beneficiary Ombudsman, under the amendments made by sub-  
16 sections (a) and (b), respectively, by not later than 1 year after  
17 the date of the enactment of this Act.

18 (d) FUNDING.—There are authorized to be appropriated to  
19 the Secretary (in appropriate part from the Federal Hospital  
20 Insurance Trust Fund and the Federal Supplementary Medical  
21 Insurance Trust Fund) to carry out the provisions of sub-  
22 section (b) of section 1868 of the Social Security Act (relating  
23 to the Medicare Provider Ombudsman), as added by subsection  
24 (a)(5) and section 1809 of such Act (relating to the Medicare  
25 Beneficiary Ombudsman), as added by subsection (b), such  
26 sums as are necessary for fiscal year 2003 and each succeeding  
27 fiscal year.

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

30 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE  
31 HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—  
32 Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by  
33 adding at the end the following: “The Secretary shall pro-  
34 vide, through the toll-free number 1-800-MEDICARE, for  
35 a means by which individuals seeking information about, or  
36 assistance with, such programs who phone such toll-free  
37 number are transferred (without charge) to appropriate en-

1 titles for the provision of such information or assistance.  
 2 Such toll-free number shall be the toll-free number listed  
 3 for general information and assistance in the annual notice  
 4 under subsection (a) instead of the listing of numbers of  
 5 individual contractors.”.

6 (2) MONITORING ACCURACY.—

7 (A) STUDY.—The Comptroller General of the  
 8 United States shall conduct a study to monitor the ac-  
 9 curacy and consistency of information provided to indi-  
 10 viduals entitled to benefits under part A or enrolled  
 11 under part B, or both, through the toll-free number 1-  
 12 800-MEDICARE, including an assessment of whether  
 13 the information provided is sufficient to answer ques-  
 14 tions of such individuals. In conducting the study, the  
 15 Comptroller General shall examine the education and  
 16 training of the individuals providing information  
 17 through such number.

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

22 **SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION**  
 23 **PROGRAM.**

24 (a) IN GENERAL.—The Secretary shall establish a dem-  
 25 onstration program (in this section referred to as the “dem-  
 26 onstration program”) under which medicare specialists em-  
 27 ployed by the Department of Health and Human Services pro-  
 28 vide advice and assistance to individuals entitled to benefits  
 29 under part A of title XVIII of the Social Security Act, or en-  
 30 rolled under part B of such title, or both, regarding the medi-  
 31 care program at the location of existing local offices of the So-  
 32 cial Security Administration.

33 (b) LOCATIONS.—

34 (1) IN GENERAL.—The demonstration program shall  
 35 be conducted in at least 6 offices or areas. Subject to para-  
 36 graph (2), in selecting such offices and areas, the Secretary

1 shall provide preference for offices with a high volume of  
2 visits by individuals referred to in subsection (a).

3 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—The  
4 Secretary shall provide for the selection of at least 2 rural  
5 areas to participate in the demonstration program. In con-  
6 ducting the demonstration program in such rural areas, the  
7 Secretary shall provide for medicare specialists to travel  
8 among local offices in a rural area on a scheduled basis.

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

11 (d) EVALUATION AND REPORT.—

12 (1) EVALUATION.—The Secretary shall provide for an  
13 evaluation of the demonstration program. Such evaluation  
14 shall include an analysis of—

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

18 (B) the cost-effectiveness of providing beneficiary  
19 assistance through out-stationing medicare specialists  
20 at local offices of the Social Security Administration.

21 (2) REPORT.—The Secretary shall submit to Congress  
22 a report on such evaluation and shall include in such report  
23 recommendations regarding the feasibility of permanently  
24 out-stationing medicare specialists at local offices of the So-  
25 cial Security Administration.

## 26 **Subtitle D—Appeals and Recovery**

### 27 **SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDI-** 28 **CARE APPEALS.**

29 (a) TRANSITION PLAN.—

30 (1) IN GENERAL.—Not later than October 1, 2003,  
31 the Commissioner of Social Security and the Secretary  
32 shall develop and transmit to Congress and the Comptroller  
33 General of the United States a plan under which the func-  
34 tions of administrative law judges responsible for hearing  
35 cases under title XVIII of the Social Security Act (and re-  
36 lated provisions in title XI of such Act) are transferred  
37 from the responsibility of the Commissioner and the Social

1 Security Administration to the Secretary and the Depart-  
2 ment of Health and Human Services.

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

8 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

9 (1) IN GENERAL.—Not earlier than July 1, 2004, and  
10 not later than October 1, 2004, the Commissioner of Social  
11 Security and the Secretary shall implement the transition  
12 plan under subsection (a) and transfer the administrative  
13 law judge functions described in such subsection from the  
14 Social Security Administration to the Secretary.

15 (2) ASSURING INDEPENDENCE OF JUDGES.—The Sec-  
16 retary shall assure the independence of administrative law  
17 judges performing the administrative law judge functions  
18 transferred under paragraph (1) from the Centers for  
19 Medicare & Medicaid Services and its contractors.

20 (3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall  
21 provide for an appropriate geographic distribution of ad-  
22 ministrative law judges performing the administrative law  
23 judge functions transferred under paragraph (1) through-  
24 out the United States to ensure timely access to such  
25 judges.

26 (4) HIRING AUTHORITY.—Subject to the amounts pro-  
27 vided in advance in appropriations Act, the Secretary shall  
28 have authority to hire administrative law judges to hear  
29 such cases, giving priority to those judges with prior experi-  
30 ence in handling medicare appeals and in a manner con-  
31 sistent with paragraph (3), and to hire support staff for  
32 such judges.

33 (5) FINANCING.—Amounts payable under law to the  
34 Commissioner for administrative law judges performing the  
35 administrative law judge functions transferred under para-  
36 graph (1) from the Federal Hospital Insurance Trust Fund  
37 and the Federal Supplementary Medical Insurance Trust

1 Fund shall become payable to the Secretary for the func-  
2 tions so transferred.

3 (6) SHARED RESOURCES.—The Secretary shall enter  
4 into such arrangements with the Commissioner as may be  
5 appropriate with respect to transferred functions of admin-  
6 istrative law judges to share office space, support staff, and  
7 other resources, with appropriate reimbursement from the  
8 Trust Funds described in paragraph (5).

9 (c) INCREASED FINANCIAL SUPPORT.—In addition to any  
10 amounts otherwise appropriated, to ensure timely action on ap-  
11 peals before administrative law judges and the Departmental  
12 Appeals Board consistent with section 1869 of the Social Secu-  
13 rity Act (as amended by section 521 of BIPA, 114 Stat.  
14 2763A–534), there are authorized to be appropriated (in appro-  
15 priate part from the Federal Hospital Insurance Trust Fund  
16 and the Federal Supplementary Medical Insurance Trust  
17 Fund) to the Secretary such sums as are necessary for fiscal  
18 year 2004 and each subsequent fiscal year to—

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

21 (2) improve education and training opportunities for  
22 administrative law judges (and their staffs); and

23 (3) increase the staff of the Departmental Appeals  
24 Board.

25 (d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i)  
26 (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of  
27 BIPA (114 Stat. 2763A–543), is amended by striking “of the  
28 Social Security Administration”.

29 **SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

30 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section  
31 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is  
32 amended—

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

36 (2) in paragraph (1)(F)—

37 (A) by striking clause (ii);

1 (B) by striking “PROCEEDING” and all that follows  
2 through “DETERMINATION” and inserting “DETER-  
3 MINATIONS AND RECONSIDERATIONS”; and

4 (C) by redesignating subclauses (I) and (II) as  
5 clauses (i) and (ii) and by moving the indentation of  
6 such subclauses (and the matter that follows) 2 ems to  
7 the left; and

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

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

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

24 “(B) PROMPT DETERMINATIONS.—If, after or co-  
25 incident with appropriately filing a request for an ad-  
26 ministrative hearing, the appellant requests a deter-  
27 mination by the appropriate review panel that no re-  
28 view panel has the authority to decide the question of  
29 law or regulations relevant to the matters in con-  
30 troversy and that there is no material issue of fact in  
31 dispute and if such request is accompanied by the doc-  
32 uments and materials as the appropriate review panel  
33 shall require for purposes of making such determina-  
34 tion, such review panel shall make a determination on  
35 the request in writing within 60 days after the date  
36 such review panel receives the request and such accom-  
37 panying documents and materials. Such a determina-

1           tion by such review panel shall be considered a final de-  
2           cision and not subject to review by the Secretary.

3           “(C) ACCESS TO JUDICIAL REVIEW.—

4           “(i) IN GENERAL.—If the appropriate review  
5           panel—

6           “(I) determines that there are no material  
7           issues of fact in dispute and that the only issue  
8           is one of law or regulation that no review panel  
9           has the authority to decide; or

10          “(II) fails to make such determination  
11          within the period provided under subparagraph  
12          (B);

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

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

17          “(I) clause (i)(I), within 60 days of date  
18          of the determination described in such subpara-  
19          graph; or

20          “(II) clause (i)(II), within 60 days of the  
21          end of the period provided under subparagraph  
22          (B) for the determination.

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

30          “(iv) INTEREST ON AMOUNTS IN CON-  
31          TROVERSY.—Where a provider of services or sup-  
32          plier seeks judicial review pursuant to this para-  
33          graph, the amount in controversy shall be subject  
34          to annual interest beginning on the first day of the  
35          first month beginning after the 60-day period as  
36          determined pursuant to clause (ii) and equal to the  
37          rate of interest on obligations issued for purchase

1 by the Federal Hospital Insurance Trust Fund and  
 2 by the Federal Supplementary Medical Insurance  
 3 Trust Fund for the month in which the civil action  
 4 authorized under this paragraph is commenced, to  
 5 be awarded by the reviewing court in favor of the  
 6 prevailing party. No interest awarded pursuant to  
 7 the preceding sentence shall be deemed income or  
 8 cost for the purposes of determining reimbursement  
 9 due providers of services or suppliers under this  
 10 Act.

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

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

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

24 (2) by adding at the end the following new subpara-  
 25 graph:

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

36 (c) EFFECTIVE DATE.—The amendments made by this  
 37 section shall apply to appeals filed on or after October 1, 2003.

1 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREE-  
2 MENT DETERMINATIONS.—

3 (1) TERMINATION AND CERTAIN OTHER IMMEDIATE  
4 REMEDIES.—The Secretary shall develop and implement a  
5 process to expedite proceedings under sections 1866(h) of  
6 the Social Security Act (42 U.S.C. 1395cc(h)) in which the  
7 remedy of termination of participation, or a remedy de-  
8 scribed in clause (i) or (iii) of section 1819(h)(2)(B) of  
9 such Act (42 U.S.C. 1395i-3(h)(2)(B)) which is applied on  
10 an immediate basis, has been imposed. Under such process  
11 priority shall be provided in cases of termination.

12 (2) INCREASED FINANCIAL SUPPORT.—In addition to  
13 any amounts otherwise appropriated, to reduce by 50 per-  
14 cent the average time for administrative determinations on  
15 appeals under section 1866(h) of the Social Security Act  
16 (42 U.S.C. 1395cc(h)), there are authorized to be appro-  
17 priated (in appropriate part from the Federal Hospital In-  
18 surance Trust Fund and the Federal Supplementary Med-  
19 ical Insurance Trust Fund) to the Secretary such addi-  
20 tional sums for fiscal year 2004 and each subsequent fiscal  
21 year as may be necessary. The purposes for which such  
22 amounts are available include increasing the number of ad-  
23 ministrative law judges (and their staffs) and the appellate  
24 level staff at the Departmental Appeals Board of the De-  
25 partment of Health and Human Services and educating  
26 such judges and staffs on long-term care issues.

27 **SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.**

28 (a) REQUIRING FULL AND EARLY PRESENTATION OF EVI-  
29 DENCE.—

30 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.  
31 1395ff(b)), as amended by BIPA and as amended by sec-  
32 tion 832(a), is further amended by adding at the end the  
33 following new paragraph:

34 “(3) REQUIRING FULL AND EARLY PRESENTATION OF  
35 EVIDENCE BY PROVIDERS.—A provider of services or sup-  
36 plier may not introduce evidence in any appeal under this  
37 section that was not presented at the reconsideration con-

1 ducted by the qualified independent contractor under sub-  
 2 section (c), unless there is good cause which precluded the  
 3 introduction of such evidence at or before that reconsider-  
 4 ation.”.

5 (2) EFFECTIVE DATE.—The amendment made by  
 6 paragraph (1) shall take effect on October 1, 2003.

7 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section  
 8 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended  
 9 by BIPA, is amended by inserting “(including the medical  
 10 records of the individual involved)” after “clinical experience”.

11 (c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

12 (1) INITIAL DETERMINATIONS AND REDETERMINA-  
 13 TIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amend-  
 14 ed by BIPA, is amended by adding at the end the following  
 15 new paragraph:

16 “(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS  
 17 AND REDETERMINATIONS.—A written notice of a deter-  
 18 mination on an initial determination or on a redetermina-  
 19 tion, insofar as such determination or redetermination re-  
 20 sults in a denial of a claim for benefits, shall include—

21 “(A) the specific reasons for the determination,  
 22 including—

23 “(i) upon request, the provision of the policy,  
 24 manual, or regulation used in making the deter-  
 25 mination; and

26 “(ii) as appropriate in the case of a redeter-  
 27 mination, a summary of the clinical or scientific  
 28 evidence used in making the determination;

29 “(B) the procedures for obtaining additional infor-  
 30 mation concerning the determination or redetermina-  
 31 tion; and

32 “(C) notification of the right to seek a redeter-  
 33 mination or otherwise appeal the determination and in-  
 34 structions on how to initiate such a redetermination or  
 35 appeal under this section.

36 The written notice on a redetermination shall be provided  
 37 in printed form and written in a manner calculated to be

1 understood by the individual entitled to benefits under part  
2 A or enrolled under part B, or both.”.

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

6 (A) by inserting “be written in a manner cal-  
7 culated to be understood by the individual entitled to  
8 benefits under part A or enrolled under part B, or  
9 both, and shall include (to the extent appropriate)”  
10 after “in writing, ”; and

11 (B) by inserting “and a notification of the right to  
12 appeal such determination and instructions on how to  
13 initiate such appeal under this section” after “such de-  
14 cision, ”.

15 (3) APPEALS.—Section 1869(d) (42 U.S.C.  
16 1395ff(d)), as amended by BIPA, is amended—

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

19 (B) by adding at the end the following new para-  
20 graph:

21 “(4) NOTICE.—Notice of the decision of an adminis-  
22 trative law judge shall be in writing in a manner calculated  
23 to be understood by the individual entitled to benefits  
24 under part A or enrolled under part B, or both, and shall  
25 include—

26 “(A) the specific reasons for the determination (in-  
27 cluding, to the extent appropriate, a summary of the  
28 clinical or scientific evidence used in making the deter-  
29 mination);

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

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

35 (4) SUBMISSION OF RECORD FOR APPEAL.—Section  
36 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking  
37 “prepare” and inserting “submit” and by striking “with re-

1 spect to” and all that follows through “and relevant poli-  
2 cies”.

3 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

4 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDE-  
5 PENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C.  
6 1395ff(c)(3)), as amended by BIPA, is amended—

7 (A) in subparagraph (A), by striking “sufficient  
8 training and expertise in medical science and legal mat-  
9 ters” and inserting “sufficient medical, legal, and other  
10 expertise (including knowledge of the program under  
11 this title) and sufficient staffing”; and

12 (B) by adding at the end the following new sub-  
13 paragraph:

14 “(K) INDEPENDENCE REQUIREMENTS.—

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

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

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

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

25 “(ii) EXCEPTION FOR REASONABLE COM-  
26 PENSATION.—Nothing in clause (i) shall be con-  
27 strued to prohibit receipt by a qualified inde-  
28 pendent contractor of compensation from the Sec-  
29 retary for the conduct of activities under this sec-  
30 tion if the compensation is provided consistent with  
31 clause (iii).

32 “(iii) LIMITATIONS ON ENTITY COMPENSA-  
33 TION.—Compensation provided by the Secretary to  
34 a qualified independent contractor in connection  
35 with reviews under this section shall not be contin-  
36 gent on any decision rendered by the contractor or  
37 by any reviewing professional.”.

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

4 (A) by amending subsection (c)(3)(D) to read as  
5 follows:

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

9 (B) by adding at the end the following new sub-  
10 section:

11 “(g) QUALIFICATIONS OF REVIEWERS.—

12 “(1) IN GENERAL.—In reviewing determinations under  
13 this section, a qualified independent contractor shall assure  
14 that—

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

17 “(B) compensation provided by the contractor to  
18 each such reviewer is consistent with paragraph (3);  
19 and

20 “(C) in the case of a review by a panel described  
21 in subsection (c)(3)(B) composed of physicians or other  
22 health care professionals (each in this subsection re-  
23 ferred to as a ‘reviewing professional’), each reviewing  
24 professional meets the qualifications described in para-  
25 graph (4) and, where a claim is regarding the fur-  
26 nishing of treatment by a physician (allopathic or os-  
27 teopathic) or the provision of items or services by a  
28 physician (allopathic or osteopathic), each reviewing  
29 professional shall be a physician (allopathic or osteo-  
30 pathic).

31 “(2) INDEPENDENCE.—

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

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

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

4           “(iii) not otherwise have a conflict of interest  
5 with such a party.

6           “(B) EXCEPTION.—Nothing in subparagraph (A)  
7 shall be construed to—

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

12           “(I) the individual is not involved in the  
13 provision of items or services in the case under  
14 review;

15           “(II) the fact of such an agreement is dis-  
16 closed to the Secretary and the individual enti-  
17 tled to benefits under part A or enrolled under  
18 part B, or both, (or authorized representative)  
19 and neither party objects; and

20           “(III) the individual is not an employee of  
21 the intermediary, carrier, or contractor and  
22 does not provide services exclusively or pri-  
23 marily to or on behalf of such intermediary,  
24 carrier, or contractor;

25           “(ii) prohibit an individual who has staff privi-  
26 leges at the institution where the treatment in-  
27 volved takes place from serving as a reviewer mere-  
28 ly on the basis of having such staff privileges if the  
29 existence of such privileges is disclosed to the Sec-  
30 retary and such individual (or authorized represent-  
31 ative), and neither party objects; or

32           “(iii) prohibit receipt of compensation by a re-  
33 viewing professional from a contractor if the com-  
34 pensation is provided consistent with paragraph  
35 (3).

36           For purposes of this paragraph, the term ‘participation  
37 agreement’ means an agreement relating to the provi-

1           sion of health care services by the individual and does  
2           not include the provision of services as a reviewer  
3           under this subsection.

4           “(3) LIMITATIONS ON REVIEWER COMPENSATION.—  
5           Compensation provided by a qualified independent con-  
6           tractor to a reviewer in connection with a review under this  
7           section shall not be contingent on the decision rendered by  
8           the reviewer.

9           “(4) LICENSURE AND EXPERTISE.—Each reviewing  
10          professional shall be—

11           “(A) a physician (allopathic or osteopathic) who is  
12           appropriately credentialed or licensed in one or more  
13           States to deliver health care services and has medical  
14           expertise in the field of practice that is appropriate for  
15           the items or services at issue; or

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

22          “(5) RELATED PARTY DEFINED.—For purposes of this  
23          section, the term ‘related party’ means, with respect to a  
24          case under this title involving a specific individual entitled  
25          to benefits under part A or enrolled under part B, or both,  
26          any of the following:

27           “(A) The Secretary, the medicare administrative  
28           contractor involved, or any fiduciary, officer, director,  
29           or employee of the Department of Health and Human  
30           Services, or of such contractor.

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

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

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

1           “(E) The manufacturer of any drug or other item  
2           that is included in the items or services involved in the  
3           case.

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

7           (3) EFFECTIVE DATE.—The amendments made by  
8           paragraphs (1) and (2) shall be effective as if included in  
9           the enactment of the respective provisions of subtitle C of  
10          title V of BIPA, (114 Stat. 2763A–534).

11          (4) TRANSITION.—In applying section 1869(g) of the  
12          Social Security Act (as added by paragraph (2)), any ref-  
13          erence to a medicare administrative contractor shall be  
14          deemed to include a reference to a fiscal intermediary  
15          under section 1816 of the Social Security Act (42 U.S.C.  
16          1395h) and a carrier under section 1842 of such Act (42  
17          U.S.C. 1395u).

18       **SEC. 834. PREPAYMENT REVIEW.**

19          (a) IN GENERAL.—Section 1874A, as added by section  
20          811(a)(1) and as amended by sections 812(b), 821(b)(1), and  
21          831(c)(1), is further amended by adding at the end the fol-  
22          lowing new subsection:

23               “(h) CONDUCT OF PREPAYMENT REVIEW.—

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

25                               “(A) IN GENERAL.—A medicare administrative  
26                               contractor may conduct random prepayment review  
27                               only to develop a contractor-wide or program-wide  
28                               claims payment error rates or under such additional  
29                               circumstances as may be provided under regulations,  
30                               developed in consultation with providers of services and  
31                               suppliers.

32                               “(B) USE OF STANDARD PROTOCOLS WHEN CON-  
33                               DUCTING PREPAYMENT REVIEWS.—When a medicare  
34                               administrative contractor conducts a random prepay-  
35                               ment review, the contractor may conduct such review  
36                               only in accordance with a standard protocol for random  
37                               prepayment audits developed by the Secretary.

1           “(C) CONSTRUCTION.—Nothing in this paragraph  
2 shall be construed as preventing the denial of payments  
3 for claims actually reviewed under a random prepay-  
4 ment review.

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

9           “(2) LIMITATIONS ON NON-RANDOM PREPAYMENT RE-  
10 VIEW.—

11           “(A) LIMITATIONS ON INITIATION OF NON-RAN-  
12 DOM PREPAYMENT REVIEW.—A medicare administra-  
13 tive contractor may not initiate non-random prepay-  
14 ment review of a provider of services or supplier based  
15 on the initial identification by that provider of services  
16 or supplier of an improper billing practice unless there  
17 is a likelihood of sustained or high level of payment  
18 error (as defined in subsection (i)(3)(A)).

19           “(B) TERMINATION OF NON-RANDOM PREPAY-  
20 MENT REVIEW.—The Secretary shall issue regulations  
21 relating to the termination, including termination  
22 dates, of non-random prepayment review. Such regula-  
23 tions may vary such a termination date based upon the  
24 differences in the circumstances triggering prepayment  
25 review.”.

26           (b) EFFECTIVE DATE.—

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

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

35           (3) APPLICATION OF STANDARD PROTOCOLS FOR RAN-  
36 DOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of  
37 the Social Security Act, as added by subsection (a), shall

1 apply to random prepayment reviews conducted on or after  
2 such date (not later than 1 year after the date of the enact-  
3 ment of this Act) as the Secretary shall specify.

4 (c) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-  
5 RIERS.—The provisions of section 1874A(h) of the Social Secu-  
6 rity Act, as added by subsection (a), shall apply to each fiscal  
7 intermediary under section 1816 of the Social Security Act (42  
8 U.S.C. 1395h) and each carrier under section 1842 of such Act  
9 (42 U.S.C. 1395u) in the same manner as they apply to medi-  
10 care administrative contractors under such provisions.

11 **SEC. 835. RECOVERY OF OVERPAYMENTS.**

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

14 “(f) RECOVERY OF OVERPAYMENTS.—

15 “(1) USE OF REPAYMENT PLANS.—

16 “(A) IN GENERAL.—If the repayment, within 30  
17 days by a provider of services or supplier, of an over-  
18 payment under this title would constitute a hardship  
19 (as defined in subparagraph (B)), subject to subpara-  
20 graph (C), upon request of the provider of services or  
21 supplier the Secretary shall enter into a plan with the  
22 provider of services or supplier for the repayment  
23 (through offset or otherwise) of such overpayment over  
24 a period of at least 6 months but not longer than 3  
25 years (or not longer than 5 years in the case of extreme  
26 hardship, as determined by the Secretary). Interest  
27 shall accrue on the balance through the period of re-  
28 payment. Such plan shall meet terms and conditions  
29 determined to be appropriate by the Secretary.

30 “(B) HARDSHIP.—

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

35 “(I) in the case of a provider of services  
36 that files cost reports, the aggregate amount of  
37 the overpayments exceeds 10 percent of the

1 amount paid under this title to the provider of  
2 services for the cost reporting period covered by  
3 the most recently submitted cost report; or

4 “(II) in the case of another provider of  
5 services or supplier, the aggregate amount of  
6 the overpayments exceeds 10 percent of the  
7 amount paid under this title to the provider of  
8 services or supplier for the previous calendar  
9 year.

10 “(ii) RULE OF APPLICATION.—The Secretary  
11 shall establish rules for the application of this sub-  
12 paragraph in the case of a provider of services or  
13 supplier that was not paid under this title during  
14 the previous year or was paid under this title only  
15 during a portion of that year.

16 “(iii) TREATMENT OF PREVIOUS OVERPAY-  
17 MENTS.—If a provider of services or supplier has  
18 entered into a repayment plan under subparagraph  
19 (A) with respect to a specific overpayment amount,  
20 such payment amount under the repayment plan  
21 shall not be taken into account under clause (i)  
22 with respect to subsequent overpayment amounts.

23 “(C) EXCEPTIONS.—Subparagraph (A) shall not  
24 apply if—

25 “(i) the Secretary has reason to suspect that  
26 the provider of services or supplier may file for  
27 bankruptcy or otherwise cease to do business or  
28 discontinue participation in the program under this  
29 title; or

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

32 “(D) IMMEDIATE COLLECTION IF VIOLATION OF  
33 REPAYMENT PLAN.—If a provider of services or sup-  
34 plier fails to make a payment in accordance with a re-  
35 payment plan under this paragraph, the Secretary may  
36 immediately seek to offset or otherwise recover the

1 total balance outstanding (including applicable interest)  
2 under the repayment plan.

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

7 “(2) LIMITATION ON RECOUPMENT.—

8 “(A) IN GENERAL.—In the case of a provider of  
9 services or supplier that is determined to have received  
10 an overpayment under this title and that seeks a recon-  
11 sideration by a qualified independent contractor on  
12 such determination under section 1869(b)(1), the Sec-  
13 retary may not take any action (or authorize any other  
14 person, including any medicare contractor, as defined  
15 in subparagraph (C) to recoup the overpayment until  
16 the date the decision on the reconsideration has been  
17 rendered. If the provisions of section 1869(b)(1) (pro-  
18 viding for such a reconsideration by a qualified inde-  
19 pendent contractor) are not in effect, in applying the  
20 previous sentence any reference to such a reconsider-  
21 ation shall be treated as a reference to a redetermina-  
22 tion by the fiscal intermediary or carrier involved.

23 “(B) COLLECTION WITH INTEREST.—Insofar as  
24 the determination on such appeal is against the pro-  
25 vider of services or supplier, interest on the overpay-  
26 ment shall accrue on and after the date of the original  
27 notice of overpayment. Insofar as such determination  
28 against the provider of services or supplier is later re-  
29 versed, the Secretary shall provide for repayment of the  
30 amount recouped plus interest at the same rate as  
31 would apply under the previous sentence for the period  
32 in which the amount was recouped.

33 “(C) MEDICARE CONTRACTOR DEFINED.—For  
34 purposes of this subsection, the term ‘medicare con-  
35 tractor’ has the meaning given such term in section  
36 1889(g).

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

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

7           “(B) documented educational intervention has  
8 failed to correct the payment error (as determined by  
9 the Secretary).

10          “(4) PROVISION OF SUPPORTING DOCUMENTATION.—  
11 In the case of a provider of services or supplier with respect  
12 to which amounts were previously overpaid, a medicare con-  
13 tractor may request the periodic production of records or  
14 supporting documentation for a limited sample of sub-  
15 mitted claims to ensure that the previous practice is not  
16 continuing.

17          “(5) CONSENT SETTLEMENT REFORMS.—

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

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

25           “(i) communicate to the provider of services or  
26 supplier—

27           “(I) that, based on a review of the medical  
28 records requested by the Secretary, a prelimi-  
29 nary evaluation of those records indicates that  
30 there would be an overpayment;

31           “(II) the nature of the problems identified  
32 in such evaluation; and

33           “(III) the steps that the provider of serv-  
34 ices or supplier should take to address the  
35 problems; and

36           “(ii) provide for a 45-day period during which  
37 the provider of services or supplier may furnish ad-

1           ditional information concerning the medical records  
2           for the claims that had been reviewed.

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

9                   “(i) shall provide notice of such determination  
10                  to the provider of services or supplier, including an  
11                  explanation of the reason for such determination;  
12                  and

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

15                          “(I) the opportunity for a statistically  
16                          valid random sample; or

17                          “(II) a consent settlement.

18           The opportunity provided under clause (ii)(I) does not  
19           waive any appeal rights with respect to the alleged  
20           overpayment involved.

21           “(D) CONSENT SETTLEMENT DEFINED.—For pur-  
22           poses of this paragraph, the term ‘consent settlement’  
23           means an agreement between the Secretary and a pro-  
24           vider of services or supplier whereby both parties agree  
25           to settle a projected overpayment based on less than a  
26           statistically valid sample of claims and the provider of  
27           services or supplier agrees not to appeal the claims in-  
28           volved.

29           “(6) NOTICE OF OVER-UTILIZATION OF CODES.—The  
30           Secretary shall establish, in consultation with organizations  
31           representing the classes of providers of services and sup-  
32           pliers, a process under which the Secretary provides for no-  
33           tice to classes of providers of services and suppliers served  
34           by the contractor in cases in which the contractor has iden-  
35           tified that particular billing codes may be overutilized by  
36           that class of providers of services or suppliers under the

1 programs under this title (or provisions of title XI insofar  
2 as they relate to such programs).

3 “(7) PAYMENT AUDITS.—

4 “(A) WRITTEN NOTICE FOR POST-PAYMENT AU-  
5 DITS.—Subject to subparagraph (C), if a medicare con-  
6 tractor decides to conduct a post-payment audit of a  
7 provider of services or supplier under this title, the con-  
8 tractor shall provide the provider of services or supplier  
9 with written notice (which may be in electronic form)  
10 of the intent to conduct such an audit.

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

15 “(i) give the provider of services or supplier a  
16 full review and explanation of the findings of the  
17 audit in a manner that is understandable to the  
18 provider of services or supplier and permits the de-  
19 velopment of an appropriate corrective action plan;

20 “(ii) inform the provider of services or supplier  
21 of the appeal rights under this title as well as con-  
22 sent settlement options (which are at the discretion  
23 of the Secretary);

24 “(iii) give the provider of services or supplier  
25 an opportunity to provide additional information to  
26 the contractor; and

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

30 “(C) EXCEPTION.—Subparagraphs (A) and (B)  
31 shall not apply if the provision of notice or findings  
32 would compromise pending law enforcement activities,  
33 whether civil or criminal, or reveal findings of law en-  
34 forcement-related audits.

35 “(8) STANDARD METHODOLOGY FOR PROBE SAM-  
36 PLING.—The Secretary shall establish a standard method-  
37 ology for medicare contractors to use in selecting a sample

1 of claims for review in the case of an abnormal billing pat-  
2 tern.”.

3 (b) EFFECTIVE DATES AND DEADLINES.—

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

8 (2) LIMITATION ON RECOUPMENT.—Section  
9 1893(f)(2) of the Social Security Act, as added by sub-  
10 section (a), shall apply to actions taken after the date of  
11 the enactment of this Act.

12 (3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of  
13 the Social Security Act, as added by subsection (a), shall  
14 apply to statistically valid random samples initiated after  
15 the date that is 1 year after the date of the enactment of  
16 this Act.

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

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

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

30 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of the  
31 Social Security Act, as added by subsection (a), shall apply  
32 to audits initiated after the date of the enactment of this  
33 Act.

34 (8) STANDARD FOR ABNORMAL BILLING PATTERNS.—  
35 Not later than 1 year after the date of the enactment of  
36 this Act, the Secretary shall first establish a standard  
37 methodology for selection of sample claims for abnormal

1 billing patterns under section 1893(f)(8) of the Social Se-  
 2 curity Act, as added by subsection (a).

3 **SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF**  
 4 **APPEAL.**

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

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

8 “; ENROLLMENT PROCESSES”; and

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

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

12 “(1) ENROLLMENT PROCESS.—

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

16 “(B) DEADLINES.—The Secretary shall establish  
 17 by regulation procedures under which there are dead-  
 18 lines for actions on applications for enrollment (and, if  
 19 applicable, renewal of enrollment). The Secretary shall  
 20 monitor the performance of medicare administrative  
 21 contractors in meeting the deadlines established under  
 22 this subparagraph.

23 “(C) CONSULTATION BEFORE CHANGING PRO-  
 24 VIDER ENROLLMENT FORMS.—The Secretary shall con-  
 25 sult with providers of services and suppliers before  
 26 making changes in the provider enrollment forms re-  
 27 quired of such providers and suppliers to be eligible to  
 28 submit claims for which payment may be made under  
 29 this title.

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

37 (b) EFFECTIVE DATES.—

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

6 (2) CONSULTATION.—Section 1866(j)(1)(C) of the So-  
 7 cial Security Act, as added by subsection (a)(2), shall apply  
 8 with respect to changes in provider enrollment forms made  
 9 on or after January 1, 2003.

10 (3) HEARING RIGHTS.—Section 1866(j)(2) of the So-  
 11 cial Security Act, as added by subsection (a)(2), shall apply  
 12 to denials occurring on or after such date (not later than  
 13 1 year after the date of the enactment of this Act) as the  
 14 Secretary specifies.

15 **SEC. 837. PROCESS FOR CORRECTION OF MINOR ER-**  
 16 **RORS AND OMISSIONS ON CLAIMS WITHOUT**  
 17 **PURSUING APPEALS PROCESS.**

18 The Secretary shall develop, in consultation with appro-  
 19 priate medicare contractors (as defined in section 1889(g) of  
 20 the Social Security Act, as inserted by section 821(a)(1)) and  
 21 representatives of providers of services and suppliers, a process  
 22 whereby, in the case of minor errors or omissions (as defined  
 23 by the Secretary) that are detected in the submission of claims  
 24 under the programs under title XVIII of such Act, a provider  
 25 of services or supplier is given an opportunity to correct such  
 26 an error or omission without the need to initiate an appeal.  
 27 Such process shall include the ability to resubmit corrected  
 28 claims.

29 **SEC. 838. PRIOR DETERMINATION PROCESS FOR CER-**  
 30 **TAIN ITEMS AND SERVICES; ADVANCE BENE-**  
 31 **FICIARY NOTICES.**

32 (a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as  
 33 amended by sections 521 and 522 of BIPA and section  
 34 833(d)(2)(B), is further amended by adding at the end the fol-  
 35 lowing new subsection:

36 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN  
 37 ITEMS AND SERVICES.—

38 “(1) ESTABLISHMENT OF PROCESS.—

1           “(A) IN GENERAL.—With respect to a medicare  
2 administrative contractor that has a contract under  
3 section 1874A that provides for making payments  
4 under this title with respect to eligible items and serv-  
5 ices described in subparagraph (C), the Secretary shall  
6 establish a prior determination process that meets the  
7 requirements of this subsection and that shall be ap-  
8 plied by such contractor in the case of eligible request-  
9 ers.

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

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

16           “(ii) An individual entitled to benefits under  
17 this title, but only with respect to an item or serv-  
18 ice for which the individual receives, from the phy-  
19 sician who may be paid directly for the item or  
20 service, an advance beneficiary notice under section  
21 1879(a) that payment may not be made (or may no  
22 longer be made) for the item or service under this  
23 title.

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

30           “(2) SECRETARIAL FLEXIBILITY.—The Secretary shall  
31 establish by regulation reasonable limits on the categories  
32 of eligible items and services for which a prior determina-  
33 tion of coverage may be requested under this subsection. In  
34 establishing such limits, the Secretary may consider the  
35 dollar amount involved with respect to the item or service,  
36 administrative costs and burdens, and other relevant fac-  
37 tors.

1 “(3) REQUEST FOR PRIOR DETERMINATION.—

2 “(A) IN GENERAL.—Subject to paragraph (2),  
3 under the process established under this subsection an  
4 eligible requester may submit to the contractor a re-  
5 quest for a determination, before the furnishing of an  
6 eligible item or service involved as to whether the item  
7 or service is covered under this title consistent with the  
8 applicable requirements of section 1862(a)(1)(A) (relat-  
9 ing to medical necessity).

10 “(B) ACCOMPANYING DOCUMENTATION.—The Sec-  
11 retary may require that the request be accompanied by  
12 a description of the item or service, supporting docu-  
13 mentation relating to the medical necessity for the item  
14 or service, and any other appropriate documentation.  
15 In the case of a request submitted by an eligible re-  
16 quester who is described in paragraph (1)(B)(ii), the  
17 Secretary may require that the request also be accom-  
18 panied by a copy of the advance beneficiary notice in-  
19 volved.

20 “(4) RESPONSE TO REQUEST.—

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

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

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

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

28 If the contractor makes the determination described in  
29 clause (iii), the contractor shall include in the notice a  
30 description of the additional information required to  
31 make the coverage determination.

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

1           “(C) INFORMING BENEFICIARY IN CASE OF PHYSI-  
2           CIAN REQUEST.—In the case of a request in which an  
3           eligible requester is not the individual described in  
4           paragraph (1)(B)(ii), the process shall provide that the  
5           individual to whom the item or service is proposed to  
6           be furnished shall be informed of any determination de-  
7           scribed in clause (ii) (relating to a determination of  
8           non-coverage) and the right (referred to in paragraph  
9           (6)(B)) to obtain the item or service and have a claim  
10          submitted for the item or service.

11          “(5) EFFECT OF DETERMINATIONS.—

12           “(A) BINDING NATURE OF POSITIVE DETERMINA-  
13           TION.—If the contractor makes the determination de-  
14           scribed in paragraph (4)(A)(i), such determination  
15           shall be binding on the contractor in the absence of  
16           fraud or evidence of misrepresentation of facts pre-  
17           sented to the contractor.

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

20           “(i) IN GENERAL.—If the contractor makes  
21           the determination described in paragraph  
22           (4)(A)(ii)—

23           “(I) the eligible requester has the right to  
24           a redetermination by the contractor on the de-  
25           termination that the item or service is not so  
26           covered; and

27           “(II) the contractor shall include in notice  
28           under paragraph (4)(A) a brief explanation of  
29           the basis for the determination, including on  
30           what national or local coverage or noncoverage  
31           determination (if any) the determination is  
32           based, and the right to such a redetermination.

33           “(ii) DEADLINE FOR REDETERMINATIONS.—  
34           The contractor shall complete and provide notice of  
35           such redetermination within the same time period  
36           as the time period applicable to the contractor pro-

1           viding notice of redeterminations relating to a  
2           claim for benefits under subsection (a)(3)(C)(ii).

3           “(6) LIMITATION ON FURTHER REVIEW.—

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

10          “(B) DECISION NOT TO SEEK PRIOR DETERMINA-  
11          TION OR NEGATIVE DETERMINATION DOES NOT IMPACT  
12          RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT,  
13          OR APPEAL RIGHTS.—Nothing in this subsection shall  
14          be construed as affecting the right of an individual  
15          who—

16                 “(i) decides not to seek a prior determination  
17                 under this subsection with respect to items or serv-  
18                 ices; or

19                 “(ii) seeks such a determination and has re-  
20                 ceived a determination described in paragraph  
21                 (4)(A)(ii),

22          from receiving (and submitting a claim for) such items  
23          services and from obtaining administrative or judicial  
24          review respecting such claim under the other applicable  
25          provisions of this section. Failure to seek a prior deter-  
26          mination under this subsection with respect to items  
27          and services shall not be taken into account in such ad-  
28          ministrative or judicial review.

29          “(C) NO PRIOR DETERMINATION AFTER RECEIPT  
30          OF SERVICES.—Once an individual is provided items  
31          and services, there shall be no prior determination  
32          under this subsection with respect to such items or  
33          services.”.

34          (b) EFFECTIVE DATE; TRANSITION.—

35                 (1) EFFECTIVE DATE.—The Secretary shall establish  
36          the prior determination process under the amendment  
37          made by subsection (a) in such a manner as to provide for

1 the acceptance of requests for determinations under such  
2 process filed not later than 18 months after the date of the  
3 enactment of this Act.

4 (2) TRANSITION.—During the period in which the  
5 amendment made by subsection (a) has become effective  
6 but contracts are not provided under section 1874A of the  
7 Social Security Act with medicare administrative contrac-  
8 tors, any reference in section 1869(g) of such Act (as  
9 added by such amendment) to such a contractor is deemed  
10 a reference to a fiscal intermediary or carrier with an  
11 agreement under section 1816, or contract under section  
12 1842, respectively, of such Act.

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

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

20 (1) DATA COLLECTION.—The Secretary shall establish  
21 a process for the collection of information on the instances  
22 in which an advance beneficiary notice (as defined in para-  
23 graph (4)) has been provided and on instances in which a  
24 beneficiary indicates on such a notice that the beneficiary  
25 does not intend to seek to have the item or service that is  
26 the subject of the notice furnished.

27 (2) OUTREACH AND EDUCATION.—The Secretary shall  
28 establish a program of outreach and education for bene-  
29 ficiaries and providers of services and other persons on the  
30 appropriate use of advance beneficiary notices and coverage  
31 policies under the medicare program.

32 (3) GAO REPORT REPORT ON USE OF ADVANCE BENE-  
33 FICIARY NOTICES.—Not later than 18 months after the  
34 date on which section 1869(g) of the Social Security Act  
35 (as added by subsection (a)) takes effect, the Comptroller  
36 General of the United States shall submit to Congress a re-  
37 port on the use of advance beneficiary notices under title

1 XVIII of such Act. Such report shall include information  
 2 concerning the providers of services and other persons that  
 3 have provided such notices and the response of beneficiaries  
 4 to such notices.

5 (4) GAO REPORT ON USE OF PRIOR DETERMINATION  
 6 PROCESS.—Not later than 18 months after the date on  
 7 which section 1869(g) of the Social Security Act (as added  
 8 by subsection (a)) takes effect, the Comptroller General of  
 9 the United States shall submit to Congress a report on the  
 10 use of the prior determination process under such section.  
 11 Such report shall include—

12 (A) information concerning the types of proce-  
 13 dures for which a prior determination has been sought,  
 14 determinations made under the process, and changes in  
 15 receipt of services resulting from the application of  
 16 such process; and

17 (B) an evaluation of whether the process was use-  
 18 ful for physicians (and other suppliers) and bene-  
 19 ficiaries, whether it was timely, and whether the  
 20 amount of information required was burdensome to  
 21 physicians and beneficiaries.

22 (5) ADVANCE BENEFICIARY NOTICE DEFINED.—In  
 23 this subsection, the term “advance beneficiary notice”  
 24 means a written notice provided under section 1879(a) of  
 25 the Social Security Act (42 U.S.C. 1395pp(a)) to an indi-  
 26 vidual entitled to benefits under part A or B of title XVIII  
 27 of such Act before items or services are furnished under  
 28 such part in cases where a provider of services or other  
 29 person that would furnish the item or service believes that  
 30 payment will not be made for some or all of such items or  
 31 services under such title.

## 32 **Subtitle E—Miscellaneous Provisions**

### 33 **SEC. 841. POLICY DEVELOPMENT REGARDING EVALUA-** 34 **TION AND MANAGEMENT (E & M) DOCU-** 35 **MENTATION GUIDELINES.**

36 (a) IN GENERAL.—The Secretary may not implement any  
 37 new documentation guidelines for evaluation and management

1 physician services under the title XVIII of the Social Security  
2 Act on or after the date of the enactment of this Act unless  
3 the Secretary—

4 (1) has developed the guidelines in collaboration with  
5 practicing physicians (including both generalists and spe-  
6 cialists) and provided for an assessment of the proposed  
7 guidelines by the physician community;

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

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

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

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

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

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

24 (1) IN GENERAL.—The Secretary shall conduct under  
25 this subsection appropriate and representative pilot projects  
26 to test new evaluation and management documentation  
27 guidelines referred to in subsection (a).

28 (2) LENGTH AND CONSULTATION.—Each pilot project  
29 under this subsection shall—

30 (A) be voluntary;

31 (B) be of sufficient length as determined by the  
32 Secretary to allow for preparatory physician and medi-  
33 care contractor education, analysis, and use and assess-  
34 ment of potential evaluation and management guide-  
35 lines; and

36 (C) be conducted, in development and throughout  
37 the planning and operational stages of the project, in

1 consultation with practicing physicians (including both  
2 generalists and specialists).

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

5 (A) at least one shall focus on a peer review meth-  
6 od by physicians (not employed by a medicare con-  
7 tractor) which evaluates medical record information for  
8 claims submitted by physicians identified as statistical  
9 outliers relative to definitions published in the Current  
10 Procedures Terminology (CPT) code book of the Amer-  
11 ican Medical Association;

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

15 (C) at least one shall be conducted for services  
16 furnished in a rural area and at least one for services  
17 furnished outside such an area; and

18 (D) at least one shall be conducted in a setting  
19 where physicians bill under physicians' services in  
20 teaching settings and at least one shall be conducted in  
21 a setting other than a teaching setting.

22 (4) BANNING OF TARGETING OF PILOT PROJECT PAR-  
23 TICIPANTS.—Data collected under this subsection shall not  
24 be used as the basis for overpayment demands or post-pay-  
25 ment audits. Such limitation applies only to claims filed as  
26 part of the pilot project and lasts only for the duration of  
27 the pilot project and only as long as the provider is a par-  
28 ticipant in the pilot project.

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

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

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

1           (6) PERIODIC REPORTS.—The Secretary shall submit  
2           to Congress periodic reports on the pilot projects under this  
3           subsection.

4           (c) OBJECTIVES FOR EVALUATION AND MANAGEMENT  
5           GUIDELINES.—The objectives for modified evaluation and man-  
6           agement documentation guidelines developed by the Secretary  
7           shall be to—

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

10          (2) decrease the level of non-clinically pertinent and  
11          burdensome documentation time and content in the physi-  
12          cian’s medical record;

13          (3) increase accuracy by reviewers; and

14          (4) educate both physicians and reviewers.

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

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

19          (2) MATTERS DESCRIBED.—The matters referred to in  
20          paragraph (1) are—

21                (A) the development of a simpler, alternative sys-  
22                tem of requirements for documentation accompanying  
23                claims for evaluation and management physician serv-  
24                ices for which payment is made under title XVIII of  
25                the Social Security Act; and

26                (B) consideration of systems other than current  
27                coding and documentation requirements for payment  
28                for such physician services.

29          (3) CONSULTATION WITH PRACTICING PHYSICIANS.—  
30          In designing and carrying out the study under paragraph  
31          (1), the Secretary shall consult with practicing physicians,  
32          including physicians who are part of group practices and  
33          including both generalists and specialists.

34          (4) APPLICATION OF HIPAA UNIFORM CODING RE-  
35          QUIREMENTS.—In developing an alternative system under  
36          paragraph (2), the Secretary shall consider requirements of

1 administrative simplification under part C of title XI of the  
2 Social Security Act.

3 (5) REPORT TO CONGRESS.—(A) Not later than Octo-  
4 ber 1, 2004, the Secretary shall submit to Congress a re-  
5 port on the results of the study conducted under paragraph  
6 (1).

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

11 (e) STUDY ON APPROPRIATE CODING OF CERTAIN EX-  
12 TENDED OFFICE VISITS.—The Secretary shall conduct a study  
13 of the appropriateness of coding in cases of extended office vis-  
14 its in which there is no diagnosis made. Not later than October  
15 1, 2004, the Secretary shall submit a report to Congress on  
16 such study and shall include recommendations on how to code  
17 appropriately for such visits in a manner that takes into ac-  
18 count the amount of time the physician spent with the patient.

19 (f) DEFINITIONS.—In this section—

20 (1) the term “rural area” has the meaning given that  
21 term in section 1886(d)(2)(D) of the Social Security Act,  
22 42 U.S.C. 1395ww(d)(2)(D); and

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

26 **SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECH-**  
27 **NOLOGY AND COVERAGE.**

28 (a) IMPROVED COORDINATION BETWEEN FDA AND CMS  
29 ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

30 (1) IN GENERAL.—Upon request by an applicant and  
31 to the extent feasible (as determined by the Secretary), the  
32 Secretary shall, in the case of a class III medical device  
33 that is subject to premarket approval under section 515 of  
34 the Federal Food, Drug, and Cosmetic Act, ensure the  
35 sharing of appropriate information from the review for ap-  
36 plication for premarket approval conducted by the Food

1 and Drug Administration for coverage decisions under title  
2 XVIII of the Social Security Act.

3 (2) PUBLICATION OF PLAN.—Not later than 6 months  
4 after the date of the enactment of this Act, the Secretary  
5 shall submit to appropriate Committees of Congress a re-  
6 port that contains the plan for improving such coordination  
7 and for shortening the time lag between the premarket ap-  
8 proval by the Food and Drug Administration and coding  
9 and coverage decisions by the Centers for Medicare & Med-  
10 icaid Services.

11 (3) CONSTRUCTION.—Nothing in this subsection shall  
12 be construed as changing the criteria for coverage of a  
13 medical device under title XVIII of the Social Security Act  
14 nor premarket approval by the Food and Drug Administra-  
15 tion and nothing in this subsection shall be construed to in-  
16 crease premarket approval application requirements under  
17 the Federal Food, Drug, and Cosmetic Act.

18 (b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Sec-  
19 tion 1868 (42 U.S.C. 1395ee), as amended by section 821(a),  
20 is amended by adding at the end the following new subsection:

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

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

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

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

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

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

9       (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA  
 10      COLLECTION FOR USE IN THE MEDICARE INPATIENT PAY-  
 11      MENT SYSTEM.—

12       (1) STUDY.—The Comptroller General of the United  
 13      States shall conduct a study that analyzes which external  
 14      data can be collected in a shorter time frame by the Cen-  
 15      ters for Medicare & Medicaid Services for use in computing  
 16      payments for inpatient hospital services. The study may in-  
 17      clude an evaluation of the feasibility and appropriateness of  
 18      using of quarterly samples or special surveys or any other  
 19      methods. The study shall include an analysis of whether  
 20      other executive agencies, such as the Bureau of Labor Sta-  
 21      tistics in the Department of Commerce, are best suited to  
 22      collect this information.

23       (2) REPORT.—By not later than October 1, 2003, the  
 24      Comptroller General shall submit a report to Congress on  
 25      the study under paragraph (1).

26      (d) IOM STUDY ON LOCAL COVERAGE DETERMINA-  
 27      TIONS.—

28       (1) STUDY.—The Secretary shall enter into an ar-  
 29      rangement with the Institute of Medicine of the National  
 30      Academy of Sciences under which the Institute shall con-  
 31      duct a study on local coverage determinations (including  
 32      the application of local medical review policies) under the  
 33      medicare program under title XVIII of the Social Security  
 34      Act. Such study shall examine—

35       (A) the consistency of the definitions used in such  
 36      determinations;

1 (B) the types of evidence on which such deter-  
2 minations are based, including medical and scientific  
3 evidence;

4 (C) the advantages and disadvantages of local cov-  
5 erage decisionmaking, including the flexibility it offers  
6 for ensuring timely patient access to new medical tech-  
7 nology for which data are still be collected;

8 (D) the manner in which the local coverage deter-  
9 mination process is used to develop data needed for a  
10 national coverage determination, including the need for  
11 collection of such data within a protocol and informed  
12 consent by individuals entitled to benefits under part A  
13 of title XVIII of the Social Security Act, or enrolled  
14 under part B of such title, or both; and

15 (E) the advantages and disadvantages of main-  
16 taining local medicare contractor advisory committees  
17 that can advise on local coverage decisions based on an  
18 open, collaborative public process.

19 (2) REPORT.—Such arrangement shall provide that  
20 the Institute shall submit to the Secretary a report on such  
21 study by not later than 3 years after the date of the enact-  
22 ment of this Act. The Secretary shall promptly transmit a  
23 copy of such report to Congress.

24 (e) METHODS FOR DETERMINING PAYMENT BASIS FOR  
25 NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is  
26 amended by adding at the end the following:

27 “(8)(A) The Secretary shall establish by regulation proce-  
28 dures for determining the basis for, and amount of, payment  
29 under this subsection for any clinical diagnostic laboratory test  
30 with respect to which a new or substantially revised HCPCS  
31 code is assigned on or after January 1, 2004 (in this para-  
32 graph referred to as ‘new tests’).

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

35 “(i) makes available to the public (through an Internet  
36 site and other appropriate mechanisms) a list that includes

1 any such test for which establishment of a payment amount  
2 under this subsection is being considered for a year;

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

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

15 “(iv) taking into account the comments and rec-  
16 ommendations (and accompanying data) received at such  
17 meeting, develops and makes available to the public  
18 (through an Internet site and other appropriate mecha-  
19 nisms) a list of proposed determinations with respect to the  
20 appropriate basis for establishing a payment amount under  
21 this subsection for each such code, together with an expla-  
22 nation of the reasons for each such determination, the data  
23 on which the determinations are based, and a request for  
24 public written comments on the proposed determination;  
25 and

26 “(v) taking into account the comments received during  
27 the public comment period, develops and makes available to  
28 the public (through an Internet site and other appropriate  
29 mechanisms) a list of final determinations of the payment  
30 amounts for such tests under this subsection, together with  
31 the rationale for each such determination, the data on  
32 which the determinations are based, and responses to com-  
33 ments and suggestions received from the public.

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

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

1           “(ii) make available to the public the data (other than  
2           proprietary data) considered in making such determina-  
3           tions.

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

7           “(E) For purposes of this paragraph:

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

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

15       **SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN**  
16       **SERVICES UNDER MEDICARE SECONDARY**  
17       **PAYOR (MSP) PROVISIONS.**

18          (a) IN GENERAL.—The Secretary shall not require a hos-  
19          pital (including a critical access hospital) to ask questions (or  
20          obtain information) relating to the application of section  
21          1862(b) of the Social Security Act (relating to medicare sec-  
22          ondary payor provisions) in the case of reference laboratory  
23          services described in subsection (b), if the Secretary does not  
24          impose such requirement in the case of such services furnished  
25          by an independent laboratory.

26          (b) REFERENCE LABORATORY SERVICES DESCRIBED.—  
27          Reference laboratory services described in this subsection are  
28          clinical laboratory diagnostic tests (or the interpretation of  
29          such tests, or both) furnished without a face-to-face encounter  
30          between the individual entitled to benefits under part A or en-  
31          rolled under part B, or both, and the hospital involved and in  
32          which the hospital submits a claim only for such test or inter-  
33          pretation.

34       **SEC. 844. EMTALA IMPROVEMENTS.**

35          (a) PAYMENT FOR EMTALA-MANDATED SCREENING AND  
36          STABILIZATION SERVICES.—

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

4 “(d) For purposes of subsection (a)(1)(A), in the case of  
5 any item or service that is required to be provided pursuant to  
6 section 1867 to an individual who is entitled to benefits under  
7 this title, determinations as to whether the item or service is  
8 reasonable and necessary shall be made on the basis of the in-  
9 formation available to the treating physician or practitioner (in-  
10 cluding the patient’s presenting symptoms or complaint) at the  
11 time the item or service was ordered or furnished by the physi-  
12 cian or practitioner (and not on the patient’s principal diag-  
13 nosis). When making such determinations with respect to such  
14 an item or service, the Secretary shall not consider the fre-  
15 quency with which the item or service was provided to the pa-  
16 tient before or after the time of the admission or visit.”.

17 (2) EFFECTIVE DATE.—The amendment made by  
18 paragraph (1) shall apply to items and services furnished  
19 on or after January 1, 2003.

20 (b) NOTIFICATION OF PROVIDERS WHEN EMTALA IN-  
21 VESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C.  
22 1395dd(d)) is amended by adding at the end the following new  
23 paragraph:

24 “(4) NOTICE UPON CLOSING AN INVESTIGATION.—The  
25 Secretary shall establish a procedure to notify hospitals and  
26 physicians when an investigation under this section is  
27 closed.”.

28 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN  
29 EMTALA CASES INVOLVING TERMINATION OF PARTICIPA-  
30 TION.—

31 (1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C.  
32 1395dd(d)(3)) is amended—

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

36 (B) by adding at the end the following new sen-  
37 tences: “Except in the case in which a delay would

1           jeopardize the health or safety of individuals, the Sec-  
 2           retary shall also request such a review before making  
 3           a compliance determination as part of the process of  
 4           terminating a hospital's participation under this title  
 5           for violations related to the appropriateness of a med-  
 6           ical screening examination, stabilizing treatment, or an  
 7           appropriate transfer as required by this section, and  
 8           shall provide a period of 5 days for such review. The  
 9           Secretary shall provide a copy of the report on the or-  
 10          ganization's report to the hospital or physician con-  
 11          sistent with confidentiality requirements imposed on  
 12          the organization under such part B.".

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

16       **SEC. 845. EMERGENCY MEDICAL TREATMENT AND AC-**  
 17                                   **TIVE LABOR ACT (EMTALA) TECHNICAL AD-**  
 18                                   **VISORY GROUP.**

19           (a) ESTABLISHMENT.—The Secretary shall establish a  
 20          Technical Advisory Group (in this section referred to as the  
 21          “Advisory Group”) to review issues related to the Emergency  
 22          Medical Treatment and Active Labor Act (EMTALA) and its  
 23          implementation. In this section, the term “EMTALA” refers to  
 24          the provisions of section 1867 of the Social Security Act (42  
 25          U.S.C. 1395dd).

26           (b) MEMBERSHIP.—The Advisory Group shall be com-  
 27          posed of 19 members, including the Administrator of the Cen-  
 28          ters for Medicare & Medicaid Services and the Inspector Gen-  
 29          eral of the Department of Health and Human Services and of  
 30          which—

31           (1) 4 shall be representatives of hospitals, including at  
 32          least one public hospital, that have experience with the ap-  
 33          plication of EMTALA and at least 2 of which have not  
 34          been cited for EMTALA violations;

35           (2) 7 shall be practicing physicians drawn from the  
 36          fields of emergency medicine, cardiology or cardiothoracic  
 37          surgery, orthopedic surgery, neurosurgery, obstetrics-gyne-

1           cology, and psychiatry, with not more than one physician  
2           from any particular field;

3           (3) 2 shall represent patients;

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

7           (5) 1 shall be from a State survey office involved in  
8           EMTALA investigations and 1 shall be from a peer review  
9           organization, both of whom shall be from areas other than  
10          the regions represented under paragraph (4).

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

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

15           (1) shall review EMTALA regulations;

16           (2) may provide advice and recommendations to the  
17         Secretary with respect to those regulations and their appli-  
18         cation to hospitals and physicians;

19           (3) shall solicit comments and recommendations from  
20         hospitals, physicians, and the public regarding the imple-  
21         mentation of such regulations; and

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

24         (d) ADMINISTRATIVE MATTERS.—

25           (1) CHAIRPERSON.—The members of the Advisory  
26         Group shall elect a member to serve as chairperson of the  
27         Advisory Group for the life of the Advisory Group.

28           (2) MEETINGS.—The Advisory Group shall first meet  
29         at the direction of the Secretary. The Advisory Group shall  
30         then meet twice per year and at such other times as the  
31         Advisory Group may provide.

32         (e) TERMINATION.—The Advisory Group shall terminate  
33         30 months after the date of its first meeting.

34         (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Sec-  
35         retary shall establish the Advisory Group notwithstanding any  
36         limitation that may apply to the number of advisory committees

1 that may be established (within the Department of Health and  
2 Human Services or otherwise).

3 **SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH**  
4 **OTHER HOSPICE PROGRAMS TO PROVIDE**  
5 **CORE HOSPICE SERVICES IN CERTAIN CIR-**  
6 **CUMSTANCES.**

7 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.  
8 1395x(dd)(5)) is amended by adding at the end the following  
9 new subparagraph:

10 “(D) In extraordinary, exigent, or other non-routine cir-  
11 cumstances, such as unanticipated periods of high patient  
12 loads, staffing shortages due to illness or other events, or tem-  
13 porary travel of a patient outside a hospice program’s service  
14 area, a hospice program may enter into arrangements with an-  
15 other hospice program for the provision by that other program  
16 of services described in paragraph (2)(A)(ii)(I). The provisions  
17 of paragraph (2)(A)(ii)(II) shall apply with respect to the serv-  
18 ices provided under such arrangements.”.

19 (b) CONFORMING PAYMENT PROVISION.—Section 1814(i)  
20 (42 U.S.C. 1395f(i)) is amended by adding at the end the fol-  
21 lowing new paragraph:

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

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

29 **SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHO-**  
30 **GENS STANDARD TO CERTAIN HOSPITALS.**

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

33 (1) in subsection (a)(1)—

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

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

1 (C) by inserting after subparagraph (S) the fol-  
2 lowing new subparagraph:

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

8 (B) by adding at the end of subsection (b) the fol-  
9 lowing new paragraph:

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

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

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

25 (b) EFFECTIVE DATE.—The amendments made by this  
26 subsection (a) shall apply to hospitals as of July 1, 2003.

27 **SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND**  
28 **CORRECTIONS.**

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

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

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

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

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

1 (B) in subsection (j), as so transferred and  
2 redesignated—

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

4 (ii) by striking “section 1862(a)(1)” and inserting  
5 “subsection (a)(1)”.

6 (b) TERMINOLOGY CORRECTIONS.—(1) Section  
7 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by  
8 section 521 of BIPA, is amended—

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

11 (B) in subclause (IV), by striking “medical review —  
12 policies” and inserting “coverage determinations”.

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

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

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

22 (2) in subparagraph (B), by striking “clause (i)(IV)”  
23 and “clause (i)(III)” and inserting “subparagraph (A)(iv)”  
24 and “subparagraph (A)(iii)”, respectively; and

25 (3) in subparagraph (C), by striking “clause (i)”,  
26 “subclause (IV)” and “subparagraph (A)” and inserting  
27 “subparagraph (A)”, “clause (iv)” and “paragraph  
28 (1)(A)”, respectively each place it appears.

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

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

1     **SEC. 849. CONFORMING AUTHORITY TO WAIVE A PRO-**  
 2                   **GRAM EXCLUSION.**

3             The first sentence of section 1128(c)(3)(B) (42 U.S.C.  
 4     1320a-7(c)(3)(B)) is amended to read as follows: “Subject to  
 5     subparagraph (G), in the case of an exclusion under subsection  
 6     (a), the minimum period of exclusion shall be not less than five  
 7     years, except that, upon the request of the administrator of a  
 8     Federal health care program (as defined in section 1128B(f))  
 9     who determines that the exclusion would impose a hardship on  
 10    individuals entitled to benefits under part A of title XVIII or  
 11    enrolled under part B of such title, or both, the Secretary may  
 12    waive the exclusion under subsection (a)(1), (a)(3), or (a)(4)  
 13    with respect to that program in the case of an individual or en-  
 14    tity that is the sole community physician or sole source of es-  
 15    sential specialized services in a community.”.

16     **SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.**

17             (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is  
 18     amended by inserting after subsection (c) the following new  
 19     subsection:

20             “(d)(1) Subject to paragraph (2), a group health plan (as  
 21     defined in subsection (a)(1)(A)(v)) providing supplemental or  
 22     secondary coverage to individuals also entitled to services under  
 23     this title shall not require a medicare claims determination  
 24     under this title for dental benefits specifically excluded under  
 25     subsection (a)(12) as a condition of making a claims deter-  
 26     mination for such benefits under the group health plan.

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

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

1 **SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL**  
 2 **COVERAGE DETERMINATIONS.**

3 The Secretary shall provide, in an appropriate annual pub-  
 4 lication available to the public, a list of national coverage deter-  
 5 minations made under title XVIII of the Social Security Act in  
 6 the previous year and information on how to get more informa-  
 7 tion with respect to such determinations.

8 **TITLE IX—MEDICAID, PUBLIC**  
 9 **HEALTH, AND OTHER HEALTH**  
 10 **PROVISIONS**

11 **Subtitle A—Medicaid Provisions**

12 **SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE**  
 13 **FUTURE OF MEDICAID.**

14 (a) **ESTABLISHMENT.**—There is established a commission  
 15 to be known as the National Bipartisan Commission on the Fu-  
 16 ture of Medicaid (in this section referred to as the “Commis-  
 17 sion”).

18 (b) **DUTIES OF THE COMMISSION.**—The Commission  
 19 shall—

20 (1) review and analyze the long-term financial condi-  
 21 tion of the medicaid program under title XIX of the Social  
 22 Security Act (42 U.S.C. 1396 et seq.);

23 (2) identify the factors that are causing, and the con-  
 24 sequences of, increases in costs under the medicaid pro-  
 25 gram, including—

26 (A) the impact of these cost increases upon State  
 27 budgets, funding for other State programs, and levels  
 28 of State taxes necessary to fund growing expenditures  
 29 under the medicaid program;

30 (B) the financial obligations of the Federal gov-  
 31 ernment arising from the Federal matching require-  
 32 ment for expenditures under the medicaid program;  
 33 and

34 (C) the size and scope of the current program and  
 35 how the program has evolved over time;

1           (3) analyze potential policies that will ensure both the  
2 financial integrity of the medicaid program and the provi-  
3 sion of appropriate benefits under such program;

4           (4) make recommendations for establishing incentives  
5 and structures to promote enhanced efficiencies and ways  
6 of encouraging innovative State policies under the medicaid  
7 program;

8           (5) make recommendations for establishing the appro-  
9 priate balance between benefits covered, payments to pro-  
10 viders, State and Federal contributions and, where appro-  
11 priate, recipient cost-sharing obligations;

12           (6) make recommendations on the impact of pro-  
13 moting increased utilization of competitive, private enter-  
14 prise models to contain program cost growth, through en-  
15 hanced utilization of private plans, pharmacy benefit man-  
16 agers, and other methods currently being used to contain  
17 private sector health-care costs;

18           (7) make recommendations on the financing of pre-  
19 scription drug benefits currently covered under medicaid  
20 programs, including analysis of the current Federal manu-  
21 facturer rebate program, its impact upon both private mar-  
22 ket prices as well as those paid by other government pur-  
23 chasers, recent State efforts to negotiate additional supple-  
24 mental manufacturer rebates and the ability of pharmacy  
25 benefit managers to lower drug costs;

26           (8) review and analyze such other matters relating to  
27 the medicaid program as the Commission deems appro-  
28 priate; and

29           (9) analyze the impact of impending demographic  
30 changes upon medicaid benefits, including long term care  
31 services, and make recommendations for how best to appro-  
32 priately divide State and Federal responsibilities for fund-  
33 ing these benefits.

34           (c) MEMBERSHIP.—

35           (1) NUMBER AND APPOINTMENT.—The Commission  
36 shall be composed of 17 members, of whom—

37           (A) four shall be appointed by the President;

1 (B) six shall be appointed by the Majority Leader  
2 of the Senate, in consultation with the Minority Leader  
3 of the Senate, of whom not more than 4 shall be of the  
4 same political party;

5 (C) six shall be appointed by the Speaker of the  
6 House of Representatives, in consultation with the Mi-  
7 nority Leader of the House of Representatives, of  
8 whom not more than 4 shall be of the same political  
9 party; and

10 (D) one, who shall serve as Chairman of the Com-  
11 mission, appointed jointly by the President, Majority  
12 Leader of the Senate, and the Speaker of the House  
13 of Representatives.

14 (2) DEADLINE FOR APPOINTMENT.—Members of the  
15 Commission shall be appointed by not later than December  
16 1, 2002.

17 (3) TERMS OF APPOINTMENT.—The term of any ap-  
18 pointment under paragraph (1) to the Commission shall be  
19 for the life of the Commission.

20 (4) MEETINGS.—The Commission shall meet at the  
21 call of its Chairman or a majority of its members.

22 (5) QUORUM.—A quorum shall consist of 8 members  
23 of the Commission, except that 4 members may conduct a  
24 hearing under subsection (e).

25 (6) VACANCIES.—A vacancy on the Commission shall  
26 be filled in the same manner in which the original appoint-  
27 ment was made not later than 30 days after the Commis-  
28 sion is given notice of the vacancy and shall not affect the  
29 power of the remaining members to execute the duties of  
30 the Commission.

31 (7) COMPENSATION.—Members of the Commission  
32 shall receive no additional pay, allowances, or benefits by  
33 reason of their service on the Commission.

34 (8) EXPENSES.—Each member of the Commission  
35 shall receive travel expenses and per diem in lieu of subsist-  
36 ence in accordance with sections 5702 and 5703 of title 5,  
37 United States Code.

1 (d) STAFF AND SUPPORT SERVICES.—

2 (1) EXECUTIVE DIRECTOR.—

3 (A) APPOINTMENT.—The Chairman shall appoint  
4 an executive director of the Commission.

5 (B) COMPENSATION.—The executive director shall  
6 be paid the rate of basic pay for level V of the Execu-  
7 tive Schedule.

8 (2) STAFF.—With the approval of the Commission,  
9 the executive director may appoint such personnel as the  
10 executive director considers appropriate.

11 (3) APPLICABILITY OF CIVIL SERVICE LAWS.—The  
12 staff of the Commission shall be appointed without regard  
13 to the provisions of title 5, United States Code, governing  
14 appointments in the competitive service, and shall be paid  
15 without regard to the provisions of chapter 51 and sub-  
16 chapter III of chapter 53 of such title (relating to classi-  
17 fication and General Schedule pay rates).

18 (4) EXPERTS AND CONSULTANTS.—With the approval  
19 of the Commission, the executive director may procure tem-  
20 porary and intermittent services under section 3109(b) of  
21 title 5, United States Code.

22 (5) PHYSICAL FACILITIES.—The Administrator of the  
23 General Services Administration shall locate suitable office  
24 space for the operation of the Commission. The facilities  
25 shall serve as the headquarters of the Commission and  
26 shall include all necessary equipment and incidentals re-  
27 quired for the proper functioning of the Commission.

28 (e) POWERS OF COMMISSION.—

29 (1) HEARINGS AND OTHER ACTIVITIES.—For the pur-  
30 pose of carrying out its duties, the Commission may hold  
31 such hearings and undertake such other activities as the  
32 Commission determines to be necessary to carry out its du-  
33 ties.

34 (2) STUDIES BY GAO.—Upon the request of the Com-  
35 mission, the Comptroller General shall conduct such studies  
36 or investigations as the Commission determines to be nec-  
37 essary to carry out its duties.

1 (3) COST ESTIMATES BY CONGRESSIONAL BUDGET OF-  
2 FICE AND OFFICE OF THE CHIEF ACTUARY OF HCFA.—

3 (A) The Director of the Congressional Budget Of-  
4 fice or the Chief Actuary of the Centers for Medicare  
5 & Medicaid Services, or both, shall provide to the Com-  
6 mission, upon the request of the Commission, such cost  
7 estimates as the Commission determines to be nec-  
8 essary to carry out its duties.

9 (B) The Commission shall reimburse the Director  
10 of the Congressional Budget Office for expenses relat-  
11 ing to the employment in the office of the Director of  
12 such additional staff as may be necessary for the Direc-  
13 tor to comply with requests by the Commission under  
14 subparagraph (A).

15 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon the re-  
16 quest of the Commission, the head of any Federal agency  
17 is authorized to detail, without reimbursement, any of the  
18 personnel of such agency to the Commission to assist the  
19 Commission in carrying out its duties. Any such detail shall  
20 not interrupt or otherwise affect the civil service status or  
21 privileges of the Federal employee.

22 (5) TECHNICAL ASSISTANCE.—Upon the request of the  
23 Commission, the head of a Federal agency shall provide  
24 such technical assistance to the Commission as the Com-  
25 mission determines to be necessary to carry out its duties.

26 (6) USE OF MAILS.—The Commission may use the  
27 United States mails in the same manner and under the  
28 same conditions as Federal agencies and shall, for purposes  
29 of the frank, be considered a commission of Congress as  
30 described in section 3215 of title 39, United States Code.

31 (7) OBTAINING INFORMATION.—The Commission may  
32 secure directly from any Federal agency information nec-  
33 essary to enable it to carry out its duties, if the information  
34 may be disclosed under section 552 of title 5, United States  
35 Code. Upon request of the Chairman of the Commission,  
36 the head of such agency shall furnish such information to  
37 the Commission.

1 (8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the  
2 request of the Commission, the Administrator of General  
3 Services shall provide to the Commission on a reimbursable  
4 basis such administrative support services as the Commis-  
5 sion may request.

6 (9) PRINTING.—For purposes of costs relating to  
7 printing and binding, including the cost of personnel de-  
8 tailed from the Government Printing Office, the Commis-  
9 sion shall be deemed to be a committee of the Congress.

10 (f) REPORT.—Not later than March 1, 2004, the Commis-  
11 sion shall submit a report to the President and Congress which  
12 shall contain a detailed statement of only those recommenda-  
13 tions, findings, and conclusions of the Commission.

14 (g) TERMINATION.—The Commission shall terminate 30  
15 days after the date of submission of the report required in sub-  
16 section (f).

17 (h) AUTHORIZATION OF APPROPRIATIONS.—There are au-  
18 thorized to be appropriated \$1,500,000 to carry out this sec-  
19 tion.

20 **SEC. 902. GAO STUDY ON MEDICAID DRUG PAYMENT**  
21 **SYSTEM.**

22 (a) STUDY.—The Comptroller General of the United  
23 States shall conduct a study on the reimbursement under the  
24 medicaid program for covered outpatient drugs. Such study  
25 shall examine—

26 (1) the extent to which such reimbursements for a  
27 drug exceed the acquisition costs for that drug;

28 (2) the services and resources associated with dis-  
29 pensing a prescription and any additional payments avail-  
30 able to compensate for expenses for these services and re-  
31 sources; and

32 (3) efforts undertaken by States to change the levels  
33 of such reimbursement and the price data they use in ef-  
34 fecting such change.

35 (b) REPORT.—Not later than 1 year after the date of the  
36 enactment of this Act, the Comptroller General shall submit to  
37 Congress a report on the study conducted under subsection (a)

1 and shall include in such report such recommendations for  
 2 changes for legislative or administrative action regarding med-  
 3 icaid reimbursement methodologies for outpatient prescription  
 4 drugs, and their application to the medicare program, as the  
 5 Comptroller General deems appropriate.

## 6 **Subtitle B—Internet Pharmacies**

### 7 **SEC. 911. FINDINGS.**

8 The Congress finds as follows:

9 (1) Legitimate Internet sellers of prescription drugs  
 10 can offer substantial benefits to consumers. These potential  
 11 benefits include convenience, privacy, valuable information,  
 12 competitive prices, and personalized services.

13 (2) Unlawful Internet sellers of prescription drugs  
 14 may dispense inappropriate, contaminated, counterfeit, or  
 15 subpotent prescription drugs that could put at risk the  
 16 health and safety of consumers.

17 (3) Unlawful Internet sellers have exposed consumers  
 18 to significant health risks by knowingly filling invalid pre-  
 19 scriptions, such as prescriptions based solely on an online  
 20 questionnaire, or by dispensing prescription drugs without  
 21 any prescription.

22 (4) Consumers may have difficulty distinguishing le-  
 23 gitimate from unlawful Internet sellers, as well as foreign  
 24 from domestic Internet sellers, of prescription drugs.

### 25 **SEC. 912. AMENDMENT TO FEDERAL FOOD, DRUG, AND** 26 **COSMETIC ACT.**

27 (a) IN GENERAL.—Chapter V of the Federal Food, Drug,  
 28 and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by in-  
 29 sserting after section 503A the following:

#### 30 **“SEC. 503B. INTERNET PRESCRIPTION DRUG SALES.**

31 “(a) DEFINITIONS.—For purposes of this section:

32 “(1) CONSUMER.—The term ‘consumer’ means a per-  
 33 son (other than an entity licensed or otherwise authorized  
 34 under Federal or State law as a pharmacy or to dispense  
 35 or distribute prescription drugs) that purchases or seeks to  
 36 purchase prescription drugs through the Internet.

1           “(2) HOME PAGE.—The term ‘home page’ means the  
2 entry point or main web page for an Internet site.

3           “(3) INTERNET.—The term ‘Internet’ means collec-  
4 tively the myriad of computer and telecommunications fa-  
5 cilities, including equipment and operating software, which  
6 comprise the interconnected worldwide network of networks  
7 that employ the Transmission Control Protocol/Internet  
8 Protocol, or any predecessor or successor protocols to such  
9 protocol, to communicate information of all kinds by wire  
10 or radio, including electronic mail.

11           “(4) INTERSTATE INTERNET SELLER.—

12           “(A) IN GENERAL.—The term ‘interstate Internet  
13 seller’ means a person whether in the United States or  
14 abroad, that engages in, offers to engage in, or causes  
15 the delivery or sale of a prescription drug through the  
16 Internet and has such drug delivered directly to the  
17 consumer via the Postal Service, or any private or com-  
18 mercial interstate carrier to a consumer in the United  
19 States who is residing in a State other than the State  
20 in which the seller’s place of business is located. This  
21 definition excludes a person who only delivers a pre-  
22 scription drug to a consumer, such as an interstate car-  
23 rier service.

24           “(B) EXEMPTION.—With respect to the consumer  
25 involved, the term ‘interstate Internet seller’ does not  
26 include a person described in subparagraph (A) whose  
27 place of business is located within 75 miles of the con-  
28 sumer.

29           “(5) LINK.—The term ‘link’ means either a textual or  
30 graphical marker on a web page that, when clicked on,  
31 takes the consumer to another part of the Internet, such  
32 as to another web page or a different area on the same web  
33 page, or from an electronic message to a web page.

34           “(6) PHARMACY.—The term ‘pharmacy’ means any  
35 place licensed or otherwise authorized as a pharmacy under  
36 State law.

1           “(7) PRESCRIBER.—The term ‘prescriber’ means an  
2 individual, licensed or otherwise authorized under applica-  
3 ble Federal and State law to issue prescriptions for pre-  
4 scription drugs.

5           “(8) PRESCRIPTION DRUG.—The term ‘prescription  
6 drug’ means a drug under section 503(b)(1).

7           “(9) VALID PRESCRIPTION.—The term ‘valid prescrip-  
8 tion’ means a prescription that meets the requirements of  
9 section 503(b)(1) and other applicable Federal and State  
10 law.

11           “(10) WEB SITE; SITE.—The terms ‘web site’ and  
12 ‘site’ mean a specific location on the Internet that is deter-  
13 mined by Internet protocol numbers or by a domain name.

14           “(b) REQUIREMENTS FOR INTERSTATE INTERNET SELL-  
15 ERS.—

16           “(1) IN GENERAL.—Each interstate Internet seller  
17 shall comply with the requirements of this subsection with  
18 respect to the sale of, or the offer to sell, prescription drugs  
19 through the Internet and shall at all times display on its  
20 web site information in accordance with paragraph (2).

21           “(2) WEB SITE DISCLOSURE INFORMATION.—An inter-  
22 state Internet seller shall post in a visible and clear manner  
23 (as determined by regulation) on the home page of its web  
24 site, or on a page directly linked to such home page—

25           “(A) the street address of the interstate Internet  
26 seller’s place of business, and the telephone number of  
27 such place of business;

28           “(B) each State in which the interstate Internet  
29 seller is licensed or otherwise authorized as a phar-  
30 macy, or if the interstate Internet seller is not licensed  
31 or otherwise authorized by a State as a pharmacy, each  
32 State in which the interstate Internet seller is licensed  
33 or otherwise authorized to dispense prescription drugs,  
34 and the type of State license or authorization;

35           “(C) in the case of an interstate Internet seller  
36 that makes referrals to or solicits on behalf of a pre-  
37 scriber, the name of each prescriber, the street address

1 of each such prescriber's place of business, the tele-  
2 phone number of such place of business, each State in  
3 which each such prescriber is licensed or otherwise au-  
4 thorized to prescribe prescription drugs, and the type  
5 of such license or authorization; and

6 “(D) a statement that the interstate Internet sell-  
7 er will dispense prescription drugs only upon a valid  
8 prescription.

9 “(3) DATE OF POSTING.—Information required to be  
10 posted under paragraph (2) shall be posted by an interstate  
11 Internet seller—

12 “(A) not later than 90 days after the effective date  
13 of this section if the web site of such seller is in oper-  
14 ation as of such date; or

15 “(B) on the date of the first day of operation of  
16 such seller's web site if such site goes into operation  
17 after such date.

18 “(4) QUALIFYING STATEMENTS.—An interstate Inter-  
19 net seller shall not indicate in any manner that posting dis-  
20 closure information on its web site signifies that the Fed-  
21 eral Government has made any determination on the legit-  
22 imacy of the interstate Internet seller or its business.

23 “(5) DISCLOSURE TO STATE LICENSING BOARDS.—An  
24 interstate Internet seller licensed or otherwise authorized to  
25 dispense prescription drugs in accordance with applicable  
26 State law shall notify each State entity that granted such  
27 licensure or authorization that it is an interstate Internet  
28 seller, the name of its business, the Internet address of its  
29 business, the street address of its place of business, and the  
30 telephone number of such place of business.

31 “(6) REGULATIONS.—The Secretary is authorized to  
32 promulgate such regulations as are necessary to carry out  
33 the provisions of this subsection. In issuing such regula-  
34 tions, the Secretary—

35 “(A) shall take into consideration disclosure for-  
36 mats used by existing interstate Internet seller certifi-  
37 cation programs; and

1           “(B) shall in defining the term ‘place of business’  
2           include provisions providing that such place is a single  
3           location at which employees of the business perform job  
4           functions, and not a post office box or similar locale.”.

5           (b) PROHIBITED ACTS.—Section 301 of the Federal Food,  
6           Drug, and Cosmetic Act (21 U.S.C. 331) is amended by adding  
7           at the end the following:

8           “(bb) The failure to post information required under sec-  
9           tion 503B(b)(2) or for knowingly making a materially false  
10          statement when posting such information as required under  
11          such section or violating section 503B(b)(4).”.

12          **SEC. 913. PUBLIC EDUCATION.**

13          The Secretary of Health and Human Services shall engage  
14          in activities to educate the public about the dangers of pur-  
15          chasing prescription drugs from unlawful Internet sources. The  
16          Secretary should educate the public about effective public and  
17          private sector consumer protection efforts, as appropriate, with  
18          input from the public and private sectors, as appropriate.

19          **SEC. 914. STUDY REGARDING COORDINATION OF REGU-  
20          LATORY ACTIVITIES.**

21          Not later than 180 days after the date of enactment of  
22          this Act, the Secretary of Health and Human Services, after  
23          consultation with the Attorney General, shall submit to Con-  
24          gress a report providing recommendations for coordinating the  
25          activities of Federal agencies regarding interstate Internet sell-  
26          ers that operate from foreign countries and for coordinating the  
27          activities of the Federal Government with the activities of gov-  
28          ernments of foreign countries regarding such interstate Inter-  
29          net sellers.

30          **SEC. 915. EFFECTIVE DATE.**

31          The amendments made by this subtitle shall take effect 1  
32          year after the date of enactment of this Act, except that the  
33          authority of the Secretary of Health and Human Services to  
34          commence the process of rulemaking is effective on the date of  
35          enactment of this Act.

1           **Subtitle C—Promotion of Electronic**  
 2           **Prescription**

3           **SEC. 921. PROGRAM OF GRANTS TO HEALTH CARE PRO-**  
 4           **VIDERS TO IMPLEMENT ELECTRONIC PRE-**  
 5           **SCRIPTION DRUG PROGRAMS.**

6           Part P of title III of the Public Health Service Act is  
 7           amended by inserting after section 399N the following new sec-  
 8           tion:

9           **“SEC. 399O. GRANTS TO HEALTH CARE PROVIDERS TO**  
 10           **IMPLEMENT ELECTRONIC PRESCRIPTION**  
 11           **DRUG PROGRAMS**

12           “(a) IN GENERAL.—The Secretary is authorized to make  
 13           grants for the purpose of assisting health care providers who  
 14           prescribe drugs and biologicals in implementing electronic pre-  
 15           scription programs described in section 1860C(d)(3) of the So-  
 16           cial Security Act.

17           “(b) APPLICATION.—No grant may be made under this  
 18           section except pursuant to a grant application that is submitted  
 19           in a time, manner, and form approved by the Secretary.

20           “(c) AUTHORIZATION OF APPROPRIATIONS.—There are  
 21           authorized to be appropriated for fiscal year 2004, such sums  
 22           as may be appropriate to carry out this section.”.

23           **Subtitle D—Treatment of Rare**  
 24           **Diseases**

25           **SEC. 931. NIH OFFICE OF RARE DISEASES AT NATIONAL**  
 26           **INSTITUTES OF HEALTH.**

27           Title IV of the Public Health Service Act (42 U.S.C. 281  
 28           et seq.), as amended by Public Law 107–84, is amended by in-  
 29           serting after section 404E the following:

30           “OFFICE OF RARE DISEASES

31           “SEC. 404F. (a) ESTABLISHMENT.—There is established  
 32           within the Office of the Director of NIH an office to be known  
 33           as the Office of Rare Diseases (in this section referred to as  
 34           the ‘Office’), which shall be headed by a Director (in this sec-  
 35           tion referred to as the ‘Director’), appointed by the Director of  
 36           NIH.

37           “(b) DUTIES.—

1           “(1) IN GENERAL.—The Director of the Office shall  
2 carry out the following:

3           “(A) The Director shall recommend an agenda for  
4 conducting and supporting research on rare diseases  
5 through the national research institutes and centers.  
6 The agenda shall provide for a broad range of research  
7 and education activities, including scientific workshops  
8 and symposia to identify research opportunities for rare  
9 diseases.

10          “(B) The Director shall, with respect to rare dis-  
11 eases, promote coordination and cooperation among the  
12 national research institutes and centers and entities  
13 whose research is supported by such institutes.

14          “(C) The Director, in collaboration with the direc-  
15 tors of the other relevant institutes and centers of the  
16 National Institutes of Health, may enter into coopera-  
17 tive agreements with and make grants for regional cen-  
18 ters of excellence on rare diseases in accordance with  
19 section 404G.

20          “(D) The Director shall promote the sufficient al-  
21 location of the resources of the National Institutes of  
22 Health for conducting and supporting research on rare  
23 diseases.

24          “(E) The Director shall promote and encourage  
25 the establishment of a centralized clearinghouse for  
26 rare and genetic disease information that will provide  
27 understandable information about these diseases to the  
28 public, medical professionals, patients and families.

29          “(F) The Director shall biennially prepare a re-  
30 port that describes the research and education activities  
31 on rare diseases being conducted or supported through  
32 the national research institutes and centers, and that  
33 identifies particular projects or types of projects that  
34 should in the future be conducted or supported by the  
35 national research institutes and centers or other enti-  
36 ties in the field of research on rare diseases.

1           “(G) The Director shall prepare the NIH Direc-  
2           tor’s annual report to Congress on rare disease re-  
3           search conducted by or supported through the national  
4           research institutes and centers.

5           “(2) PRINCIPAL ADVISOR REGARDING ORPHAN DIS-  
6           EASES.—With respect to rare diseases, the Director shall  
7           serve as the principal advisor to the Director of NIH and  
8           shall provide advice to other relevant agencies. The Direc-  
9           tor shall provide liaison with national and international pa-  
10          tient, health and scientific organizations concerned with  
11          rare diseases.

12          “(c) DEFINITION.—For purposes of this section, the term  
13          ‘rare disease’ means any disease or condition that affects less  
14          than 200,000 persons in the United States.

15          “(d) AUTHORIZATION OF APPROPRIATIONS.—For the pur-  
16          pose of carrying out this section, there are authorized to be ap-  
17          propriated such sums as already have been appropriated for fis-  
18          cal year 2002, and \$4,000,000 for each of the fiscal years 2003  
19          through 2006.”.

20          **SEC. 932. RARE DISEASE REGIONAL CENTERS OF EXCEL-**  
21          **LENCE.**

22          Title IV of the Public Health Service Act (42 U.S.C. 281  
23          et seq.), as amended by section 1021, is further amended by  
24          inserting after section 404F the following:

25                 “RARE DISEASE REGIONAL CENTERS OF EXCELLENCE

26                 “SEC. 404G. (a) COOPERATIVE AGREEMENTS AND  
27          GRANTS.—

28                 “(1) IN GENERAL.—The Director of the Office of Rare  
29          Diseases (in this section referred to as the ‘Director’), in  
30          collaboration with the directors of the other relevant insti-  
31          tutes and centers of the National Institutes of Health, may  
32          enter into cooperative agreements with and make grants to  
33          public or private nonprofit entities to pay all or part of the  
34          cost of planning, establishing, or strengthening, and pro-  
35          viding basic operating support for regional centers of excel-  
36          lence for clinical research into, training in, and demonstra-

1           tion of diagnostic, prevention, control, and treatment meth-  
2           ods for rare diseases.

3           “(2) POLICIES.—A cooperative agreement or grant  
4           under paragraph (1) shall be entered into in accordance  
5           with policies established by the Director of NIH.

6           “(b) COORDINATION WITH OTHER INSTITUTES.—The Di-  
7           rector shall coordinate the activities under this section with  
8           similar activities conducted by other national research insti-  
9           tutes, centers and agencies of the National Institutes of Health  
10          and by the Food and Drug Administration to the extent that  
11          such institutes, centers and agencies have responsibilities that  
12          are related to rare diseases.

13          “(c) USES FOR FEDERAL PAYMENTS UNDER COOPERA-  
14          TIVE AGREEMENTS OR GRANTS.—Federal payments made  
15          under a cooperative agreement or grant under subsection (a)  
16          may be used for—

17               “(1) staffing, administrative, and other basic operating  
18               costs, including such patient care costs as are required for  
19               research;

20               “(2) clinical training, including training for allied  
21               health professionals, continuing education for health profes-  
22               sionals and allied health professions personnel, and infor-  
23               mation programs for the public with respect to rare dis-  
24               eases; and

25               “(3) clinical research and demonstration programs.

26          “(d) PERIOD OF SUPPORT; ADDITIONAL PERIODS.—Sup-  
27          port of a center under subsection (a) may be for a period of  
28          not to exceed 5 years. Such period may be extended by the Di-  
29          rector for additional periods of not more than 5 years if the  
30          operations of such center have been reviewed by an appropriate  
31          technical and scientific peer review group established by the Di-  
32          rector and if such group has recommended to the Director that  
33          such period should be extended.

34          “(e) AUTHORIZATION OF APPROPRIATIONS.—For the pur-  
35          pose of carrying out this section, there are authorized to be ap-  
36          propriated such sums as already have been appropriated for fis-

1 cal year 2002, and \$20,000,000 for each of the fiscal years  
2 2003 through 2006.”.

3 **Subtitle E—Other Provisions**  
4 **Relating to Drugs**

5 **SEC. 941. GAO STUDY REGARDING DIRECT-TO-CON-**  
6 **SUMER ADVERTISING OF PRESCRIPTION**  
7 **DRUGS.**

8 (a) IN GENERAL.—The Comptroller General of the United  
9 States shall conduct a study for the purpose of determining—

10 (1) whether and to what extent there have been in-  
11 creases in utilization rates of prescription drugs that are  
12 attributable to guidance regarding direct-to-consumer ad-  
13 vertising of such drugs that has been issued by the Food  
14 and Drug Administration under section 502(n) of the Fed-  
15 eral Food, Drug, and Cosmetic Act; and

16 (2) if so, whether and to what extent such increased  
17 utilization rates have resulted in increases in the costs of  
18 public or private health plans, health insurance, or other  
19 health programs.

20 (b) CERTAIN DETERMINATIONS.—The study under sub-  
21 section (a) shall include determinations of the following:

22 (1) The extent to which advertisements referred to in  
23 such subsection have resulted in effective consumer edu-  
24 cation about the prescription drugs involved, including an  
25 understanding of the risks of the drugs relative to the bene-  
26 fits.

27 (2) The extent of consumer satisfaction with such ad-  
28 vertisements.

29 (3) The extent of physician satisfaction with the ad-  
30 vertisements, including determining whether physicians be-  
31 lieve that the advertisements interfere with the exercise of  
32 their medical judgment by influencing consumers to prefer  
33 advertised drugs over alternative therapies.

34 (4) The extent to which the advertisements have re-  
35 sulted in increases in health care costs for taxpayers, for  
36 employers, or for consumers due to consumer decisions to

1 seek advertised drugs rather than lower-costs alternative  
2 therapies.

3 (5) The extent to which the advertisements have re-  
4 sulted in decreases in health care costs for taxpayers, for  
5 employers, or for consumers due to decreased hospitaliza-  
6 tion rates, fewer physician visits (not related to hospitaliza-  
7 tion), lower treatment costs, or reduced instances of em-  
8 ployee absences to care for family members with diseases  
9 or disorders.

10 (c) REPORT.—Not later than two years after the date of  
11 the enactment of this Act, the Comptroller General of the  
12 United States shall submit to the Congress a report providing  
13 the findings of the study under subsection (a).

14 **SEC. 942. CERTAIN HEALTH PROFESSIONS PROGRAMS**  
15 **REGARDING PRACTICE OF PHARMACY.**

16 Part E of title VII of the Public Health Service Act (42  
17 U.S.C. 294n et seq.) is amended by adding at the end the fol-  
18 lowing subpart:

19 **“Subpart 3—Pharmacist Workforce Programs**

20 **“SEC. 771. PUBLIC SERVICE ANNOUNCEMENTS.**

21 **“(a) PUBLIC SERVICE ANNOUNCEMENTS.—**

22 **“(1) IN GENERAL.—**The Secretary shall develop and  
23 issue public service announcements that advertise and pro-  
24 mote the pharmacist profession, highlight the advantages  
25 and rewards of being a pharmacist, and encourage individ-  
26 uals to enter the pharmacist profession.

27 **“(2) METHOD.—**The public service announcements de-  
28 scribed in subsection (a) shall be broadcast through appro-  
29 priate media outlets, including television or radio, in a  
30 manner intended to reach as wide and diverse an audience  
31 as possible.

32 **“(b) STATE AND LOCAL PUBLIC SERVICE ANNOUNCE-**  
33 **MENTS.—**

34 **“(1) IN GENERAL.—**The Secretary shall award grants  
35 to entities to support State and local advertising campaigns  
36 through appropriate media outlets to promote the phar-  
37 macist profession, highlight the advantages and rewards of

1 being a pharmacist, and encourage individuals to enter the  
2 pharmacist profession.

3 “(2) USE OF FUNDS.—An entity that receives a grant  
4 under subsection (a) shall use funds received through such  
5 grant to acquire local television and radio time, place ad-  
6 vertisements in local newspapers, and post information on  
7 billboards or on the Internet, in order to—

8 “(A) advertise and promote the pharmacist profes-  
9 sion;

10 “(B) promote pharmacist education programs;

11 “(C) inform the public of public assistance regard-  
12 ing such education programs;

13 “(D) highlight individuals in the community that  
14 are presently practicing as pharmacists to recruit new  
15 pharmacists; and

16 “(E) provide any other information to recruit indi-  
17 viduals for the pharmacist profession.

18 “(3) METHOD.—The campaigns described in sub-  
19 section (a) shall be broadcast on television or radio, placed  
20 in newspapers as advertisements, or posted on billboards or  
21 the Internet, in a manner intended to reach as wide and  
22 diverse an audience as possible.

23 **“SEC. 772. DEMONSTRATION PROJECT.**

24 “(a) IN GENERAL.—The Secretary shall establish a dem-  
25 onstration project to enhance the participation of individuals  
26 who are pharmacists in the National Health Service Corps  
27 Loan Repayment Program described in section 338B.

28 “(b) SERVICES.—Services that may be provided by phar-  
29 macists pursuant to the demonstration project established  
30 under this section include medication therapy management  
31 services to assure that medications are used appropriately by  
32 patients, to enhance patients’ understanding of the appropriate  
33 use of medications, to increase patients’ adherence to prescrip-  
34 tion medication regimens, to reduce the risk of adverse events  
35 associated with medications, and to reduce the need for other  
36 costly medical services through better management of medica-  
37 tion therapy. Such services may include case management, dis-

1 ease management, drug therapy management, patient training  
2 and education, counseling, drug therapy problem resolution,  
3 medication administration, the provision of special packaging,  
4 or other services that enhance the use of prescription medica-  
5 tions.

6 “(c) PROCEDURE.—The Secretary may not provide assist-  
7 ance to an individual under this section unless the individual  
8 agrees to comply with all requirements described in sections  
9 338B and 338D.

10 “(d) LIMITATIONS.—The demonstration project described  
11 in this section shall provide for the participation of—

12 “(1) individuals to provide services in rural and urban  
13 areas; and

14 “(2) enough individuals to allow the Secretary to prop-  
15 erly analyze the effectiveness of such project.

16 “(e) DESIGNATIONS.—The demonstration project de-  
17 scribed in this section, and any pharmacists who are selected  
18 to participate in such project, shall not be considered by the  
19 Secretary in the designation of a health professional shortage  
20 area under section 332 during fiscal years 2003 through 2005.

21 “(f) RULE OF CONSTRUCTION.—This section shall not be  
22 construed to require any State to participate in the project de-  
23 scribed in this section.

24 “(g) REPORT.—The Secretary shall prepare and submit a  
25 report on the project to—

26 “(A) the Committee on Health, Education, Labor,  
27 and Pensions of the Senate;

28 “(B) the Subcommittee on Labor, Health and  
29 Human Services, and Education of the Committee on  
30 Appropriations of the Senate;

31 “(C) the Committee on Energy and Commerce of  
32 the House of Representatives; and

33 “(D) the Subcommittee on Labor, Health and  
34 Human Services, and Education of the Committee on  
35 Appropriations of the House of Representatives.

1 **“SEC. 773. INFORMATION TECHNOLOGY.**

2 “(a) GRANTS AND CONTRACTS.—The Secretary may make  
3 awards of grants or contracts to qualifying schools of pharmacy  
4 for the purpose of assisting such schools in acquiring and in-  
5 stalling computer-based systems to provide pharmaceutical edu-  
6 cation. Education provided through such systems may be grad-  
7 uate education, professional education, or continuing education.  
8 The computer-based systems may be designed to provide on-site  
9 education, or education at remote sites (commonly referred to  
10 as distance learning), or both.

11 “(b) QUALIFYING SCHOOL OF PHARMACY.—For purposes  
12 of this section, the term ‘qualifying school of pharmacy’ means  
13 a school of pharmacy (as defined in section 799B) that requires  
14 students to serve in a clinical rotation in which pharmacist  
15 services are part of the curriculum.

16 **“SEC. 774. AUTHORIZATION OF APPROPRIATIONS.**

17 “For the purpose of carrying out this subpart, there are  
18 authorized to be appropriated such sums as may be necessary  
19 for each of the fiscal years 2003 through 2006.”.

20 **TITLE X—HEALTH-CARE RELATED**  
21 **TAX PROVISIONS**

22 **SEC. 1001. ELIGIBILITY FOR ARCHER MSA’S EXTENDED**  
23 **TO ACCOUNT HOLDERS OF**  
24 **MEDICARE+CHOICE MSA’S.**

25 (a) IN GENERAL.—Subparagraph (B) of section 220(c)(2)  
26 of the Internal Revenue Code of 1986 is amended by adding  
27 at the end the following new clause:

28 “(iii) MEDICARE+CHOICE MSA’S.—In the case  
29 of an individual who is covered under an MSA plan  
30 (as defined in section 1859(b)(3) of the Social Se-  
31 curity Act) which such individual elected under sec-  
32 tion 1851(a)(2)(B) of such Act—

33 “(I) such plan shall be treated as a high  
34 deductible health plan for purposes of this sec-  
35 tion,

1                   “(II) subsection (b)(2)(A) shall be applied  
2                   by substituting ‘100 percent’ for ‘65 percent’  
3                   with respect to such individual,

4                   “(III) with respect to such individual, the  
5                   limitation under subsection (d)(1)(A)(ii) shall  
6                   be 100 percent of the highest annual deductible  
7                   limitation under section 1859(b)(3)(B) of the  
8                   Social Security Act,

9                   “(IV) paragraphs (4), (5), and (7) of sub-  
10                  section (b) and paragraph (1)(A)(iii) of this  
11                  subsection shall not apply with respect to such  
12                  individual, and

13                  “(V) the limitation which would (but for  
14                  this subclause) apply under subsection (b)(1)  
15                  with respect to such individual for any taxable  
16                  year shall be reduced (but not below zero) by  
17                  the amount which would (but for subsection  
18                  106(b)) be includible in such individual’s gross  
19                  income for the taxable year.”.

20                  (b) ACCOUNTS NOT COUNTED AGAINST NUMERICAL LIM-  
21                  ITS.—

22                  (1) IN GENERAL.—Paragraph (3) of section 220(j) of  
23                  such Code is amended—

24                         (A) in the heading, by striking “PREVIOUSLY UN-  
25                         INSURED” and inserting “CERTAIN”,

26                         (B) in subparagraph (A), by striking “by not  
27                         counting the Archer MSA of any previously uninsured  
28                         individual.” and inserting “by not counting—

29                                 “(i) the Archer MSA of any previously unin-  
30                                 sured individual, and

31                                 “(ii) the Archer MSA of any eligible individual  
32                                 who qualifies as such an individual by reason of  
33                                 subsection (c)(2)(B)(iii).”.

34                  (2) REPORTING REQUIREMENT.—Subparagraph (A) of  
35                  section 220(j)(4) of such Code is amended in clause (ii) by  
36                  striking “and” at the end, in clause (iii) by striking the pe-

1           riod and inserting “, and”, and by adding at the end the  
2           following new clause:

3                           “(iv) the number of such accounts which are  
4                           accounts of eligible individuals who qualify as such  
5                           individuals by reason of subsection (c)(2)(B)(iii).”.

6           (c) EFFECTIVE DATE.—The amendments made by this  
7           section shall apply to taxable years beginning after December  
8           31, 2002.

9           **SEC. 1002. ADJUSTMENT OF EMPLOYER CONTRIBU-**  
10                           **TIONS TO COMBINED BENEFIT FUND TO RE-**  
11                           **FLECT MEDICARE PRESCRIPTION DRUG**  
12                           **SUBSIDY PAYMENTS.**

13           Section 9704(b) of the Internal Revenue Code of 1986 (re-  
14           lating to health benefit premium) is amended by adding at the  
15           end the following new paragraph:

16                           “(4) ADJUSTMENTS FOR MEDICARE PRESCRIPTION  
17                           DRUG SUBSIDIES.—The trustees of the Combined Fund  
18                           shall decrease the per beneficiary premium for each plan  
19                           year in which a subsidy payment is provided to it under  
20                           section 1860H of the Social Security Act by the amount  
21                           which would place the Combined Fund in the same finan-  
22                           cial position as if such subsidy payment had not been re-  
23                           ceived.”.

24           **SEC. 1003. EXPANSION OF HUMAN CLINICAL TRIALS**  
25                           **QUALIFYING FOR ORPHAN DRUG CREDIT.**

26           (a) IN GENERAL.—Paragraph (2) of section 45C(b) of the  
27           Internal Revenue Code of 1986 is amended by adding at the  
28           end the following new subparagraph:

29                           “(C) TREATMENT OF CERTAIN EXPENSES IN-  
30                           CURRED BEFORE DESIGNATION.—For purposes of sub-  
31                           paragraph (A)(ii)(I), if a drug is designated under sec-  
32                           tion 526 of the Federal Food, Drug, and Cosmetic Act  
33                           not later than the due date (including extensions) for  
34                           filing the return of tax under this subtitle for the tax-  
35                           able year in which the application for such designation  
36                           of such drug was filed, such drug shall be treated as  
37                           having been designated on the date that such applica-  
38                           tion was filed.”.

1           (b) EFFECTIVE DATE.—The amendment made by sub-  
2 section (a) shall apply to expenses incurred after the date of  
3 the enactment of this Act.

○