107TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPT. 107–539
Part 1

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4954

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

together with

DISSENTING AND ADDITIONAL VIEWS

JUNE 26, 2002.—Ordered to be printed

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Mr. THOMAS, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING AND ADDITIONAL VIEWS

[To accompany H.R. 4954]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (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, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Modernization and Prescription Drug Act of 2002".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this 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) sponsors; 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 individuals.
"Sec. 1860H. Subsidies for all medicare beneficiaries for qualified prescription 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.
Sec. 207. Extension of municipal health service demonstration projects.z

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.
Sec. 311. Relief for certain non-teaching hospitals.

TITLE IV—PROVISIONS RELATING TO PART A

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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.

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.
Sec. 504. 1-year extension of treatment of certain physician pathology services under medicare.

Subtitle B—Other Services

Sec. 511. Competitive acquisition of certain items and services.
Sec. 512. Payment for ambulance services.
Sec. 513. 2-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.
Sec. 517. Improved payment for certain mammography services.
Sec. 518. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 519. Coverage of cholesterol and blood lipid screening.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

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Sec. 602. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.
Sec. 603. Update in home health services.
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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

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

Subtitle C—Education and Outreach

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Sec. 822. Small provider technical assistance demonstration program.
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Subtitle D—Appeals and Recovery

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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.
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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.

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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

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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 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), the individual may enroll in the plan and obtain coverage through such plan.

"(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860J(a)(5)).

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

"(b) GENERAL ELECTION PROCEDURES.—

"(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1808(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

"(2) ELECTION PERIODS.—

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

"(i) annual coordinated election periods; and

"(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

"(B) INITIAL ELECTION PERIODS.—

"(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2004, there shall be an initial election period of 6 months beginning on that date.

"(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

"(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

"(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

"(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

"(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

"(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

"(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

"(1) GUARANTEED ISSUE.—

"(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

"(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

"(2) COMMUNITY-RATED PREMIUM.—

"(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not

deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

"(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) adjust the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

"(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

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

"(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2005, and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

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

"(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

"(E) DISCLOSURE.—

"(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide

for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

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

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

"(d) EFFECTIVE DATE OF ELECTIONS.—

"(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

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

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

"(A) termination of coverage under both part A and part B; and

"(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

"SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) REQUIREMENTS.—

"(1) IN GENERAL.—For purposes of this part and part C, the term 'qualified prescription drug coverage' means either of the following:

"(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

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

"(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

"(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

"(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

"(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

"(1) DEDUCTIBLE.—The coverage has an annual deductible—

"(A) for 2005, that is equal to $250; or

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

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(2) LIMITS ON COST-SHARING.—

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

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

"(I) is equal to 20 percent; or

"(II) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

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

"(I) is equal to 50 percent; or

"(II) is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

"(B) USE OF TIERED COPAYMENTS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

"(C) INITIAL COPAYMENT THRESHOLD.—The amount specified in this subparagraph—

"(i) for 2005, is equal to $1,000; or

"(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes—

"(A) for 2005, that is equal to $2,000; or

"(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

"(4) CATASTROPHIC PROTECTION.—

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

"(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For purposes of this part, the 'annual out-of-pocket threshold' specified in this subparagraph—

"(i) for 2005, is equal to $3,800; or

"(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

"(C) APPLICATION.—In applying subparagraph (A)—

"(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

"(ii) such costs shall be treated as incurred only if they are paid by the individual, under section 1860G, or under title XIX and the individual is not reimbursed (through insurance or otherwise) by another person for such costs.

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

"(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860H with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the sum of the following products:

"(i) FIRST COPAYMENT RANGE.—The product of—

"(I) the amount by which the initial copayment threshold described in subsection (b)(2)(C) exceeds the deductible described in subsection (b)(1); and

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

"(ii) SECONDARY COPAYMENT RANGE.—The product of—

"(I) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the initial copayment threshold described in subsection (b)(2)(C); and

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

"(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

"(d) ACCESS TO NEGOTIATED PRICES.—

"(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated by a prescription drug plan under this part, by a Medicare+Choice plan with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(2) DISCLOSURE.—The PDP sponsor or Medicare+Choice organization shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

"(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

"(A) for determining the actuarial valuation of prescription drug coverage, including—

"(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

"(ii) the use of generally accepted actuarial principles and methodologies; and

"(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

"(B) for determining annual percentage increases described in subsection (b)(5).

"(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

"(f) COVERED OUTPATIENT DRUGS DEFINED.—

"(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term 'covered outpatient drug' means—

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

"(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(2) EXCLUSIONS.—

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

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

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

"(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

"(A) for which payment would not be made if section 1862(a) applied to part D; or

"(B) which are not prescribed in accordance with the plan or this part. Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

"SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

"(b) DISSEMINATION OF INFORMATION.—

"(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

"(A) Access to covered outpatient drugs, including access through pharmacy networks.

"(B) How any formulary used by the sponsor functions.

"(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

"(D) Grievance and appeals procedures.

"(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

"(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

"(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket threshold for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

"(c) ACCESS TO COVERED BENEFITS.—

"(1) ASSURING PHARMACY ACCESS.—

"(A) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access.

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

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

"(ii) the plan may charge beneficiaries through adjustments in premiums and copayments any additional costs associated with the point-of-service option.

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

"(2) USE OF STANDARDIZED TECHNOLOGY.—

"(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

"(B) STANDARDS.—

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

"(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

"(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

"(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one physician and at least one pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a pharmacist (or both).

"(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

"(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

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

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

"(F) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

"(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

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

"(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

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

"(C) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor from applying cost management tools (including differential payments) under all methods of operation.

"(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(B) ELEMENTS.—Such program may include—

"(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

"(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

"(iii) detection of patterns of overuse and underuse of prescription drugs.

"(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

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

"(3) ELECTRONIC PRESCRIPTION PROGRAM.—

"(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with national standards established under subparagraph (B):

"(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Administrator.

"(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

"(I) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

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

"(III) information on the drugs included in the applicable formulary.

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

"(B) STANDARDS.—

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

"(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

"(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

"(II) The extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals.

"(III) Efforts to develop a common software platform for computerized prescribing.

"(IV) The cost of implementing such systems in the range of hospital and physician office settings, including hardware, software, and training costs.

"(V) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

"(iii) DEADLINES.—

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

"(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2004.

"(III) The Administrator shall develop and promulgate the national standards referred to in clause (ii) by not later than January 1, 2005.

"(C) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 399O of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

"(4) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

"(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

"(B) Subsection (c)(1) (relating to access to covered benefits).

"(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

"(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

"(e) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

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

"(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(f) APPEALS.—

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

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

"(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

"SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

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

"(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

"(2) ASSUMPTION OF FINANCIAL RISK.—

"(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860H.

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

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

"(b) CONTRACT REQUIREMENTS.—

"(1) IN GENERAL.—The Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

"(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

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

"(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

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

"(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

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

"(i) such section shall be applied separately to costs relating to this part (from costs under part C);

"(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

"(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

"(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

"(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

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

"(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

"(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

"(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

"(1) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) has been met.

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

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

"(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

"(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

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

"(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

"(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

"(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2003, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

"(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

"(e) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2003.

"(f) RELATION TO STATE LAWS.—

"(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

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

"SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

"(b) ELEMENTS.—Such process shall include the following:

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

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

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

"(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

"(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

"(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

"(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

"(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

"(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

"(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

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

"(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

"(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

"(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1808(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

"(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

"SEC. 1860F. SUBMISSION OF BIDS.

"(a) SUBMISSION OF BIDS AND RELATED INFORMATION.—

"(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

"(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

"(A) Information on the qualified prescription drug coverage to be provided.

"(B) Information on the actuarial value of the coverage.

"(C) Information on the bid for the coverage, including an actuarial certification of—

"(i) the actuarial basis for such bid;

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

"(iii) the reduction in such bid resulting from the subsidy payments provided under section 1860H.

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

"(3) REVIEW.—The Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

"(b) UNIFORM BID.—

"(1) IN GENERAL.—The bid for a prescription drug plan under this section may not vary among individuals enrolled in the plan in the same service area.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860A(c)(2)(B).

"(c) COLLECTION.—

"(1) USE AT BENEFICIARY'S OPTION OF WITHHOLDING FROM SOCIAL SECURITY PAYMENT AND USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a PDP sponsor shall permit each enrollee, at the enrollee's option, to make payment of premiums through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839. In the case in which an enrollee does not elect such option, a PDP sponsor may, in accordance with regulations, encourage enrollees to make payment of the premium established by the plan under this part through an electronic funds transfer mechanism, such as automatic charges of an account at a financial institution or a credit or debit card account. All such amounts shall be credited to the Medicare Prescription Drug Trust Fund.

"(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a Medicare+Choice plan may be used to reduce the premium otherwise imposed under paragraph (1).

"(3) PAYMENT OF PLANS.—PDP plans shall receive payment based on bid amounts in the same manner as Medicare+Choice organizations receive payment based on bid amounts under section 1853(a)(1)(A)(ii) except that such payment shall be made from the Medicare Prescription Drug Trust Fund.

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

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

"(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

"SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

"(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 175 PERCENT OF FEDERAL POVERTY LEVEL.—

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

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

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

"(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 150 percent, but does not exceed 175 percent, of the Federal poverty level, the individual is entitled under this section to—

"(A) an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 150 percent of such level to 0 percent of such amount for individuals with incomes at 175 percent of such level; and

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

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

"(4) DETERMINATION OF ELIGIBILITY.—

"(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

"(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

"(ii) has income below 175 percent of the Federal poverty line; and

"(iii) meets the resources requirement described in section 1905(p)(1)(C).

"(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

"(C) INCOME DETERMINATIONS.—For purposes of applying this section—

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

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

"(E) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term 'qualified prescription drug coverage' includes a medicare supplemental policy described in section 1860H(b)(4).

"(5) INDEXING DOLLAR AMOUNTS.—

"(A) FOR 2006.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

"(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1)(B) or (2)(B) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

"(b) PREMIUM SUBSIDY AMOUNT.—

"(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark bid amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

"(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to qualified prescription drug coverage offered under—

"(A) a prescription drug plan that—

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

"(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the bid amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

"(B) a Medicare+Choice plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

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

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

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

"(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(4) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B) and (a)(2)(B).

"(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

"(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

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

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

"(e) RELATION TO MEDICAID PROGRAM.—

"(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

"(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

"(3) COORDINATION.—The Administrator shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

"SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level of 65 percent, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

"(1) DIRECT SUBSIDY.—In the case of an individual enrolled in a prescription drug plan, Medicare+Choice plan that provides qualified prescription drug coverage, or qualified retiree prescription drug plan, a direct subsidy equal to 35

percent of the total payments made by a qualifying entity for standard coverage under the respective plan.

"(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of such total payments, for excess costs incurred in providing qualified prescription drug coverage—

"(A) for individuals enrolled with a prescription drug plan under this part;

"(B) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage; and

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

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

"(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

"(1) A PDP sponsor offering a prescription drug plan under this part.

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

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

"(c) REINSURANCE PAYMENT AMOUNT.—

"(1) IN GENERAL.—Subject to subsection (d)(1)(B) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

"(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial copayment threshold specified in section 1860B(b)(2)(C), but does not exceed the initial coverage limit specified in section 1860B(b)(3), an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

"(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860B(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

"(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

"(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

"(4) INDEXING DOLLAR AMOUNTS.—

"(A) AMOUNTS FOR 2005.—The dollar amounts applied under paragraph (1) for 2005 shall be the dollar amounts specified in such paragraph.

"(B) FOR 2006.—The dollar amounts applied under paragraph (1) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

"(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

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

"(d) ADJUSTMENT OF PAYMENTS.—

"(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—

"(A) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

"(i) the total payments to be made (without regard to this subsection) during a year under subsections (a)(2) and (c); and

"(ii) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

"(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

"(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments made under such subsection.

"(e) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

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

"(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

"(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

"(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, and the accuracy of payments made.

"(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

"(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is—

"(A) enrolled under this part;

"(B) is covered under the plan; and

"(C) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

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

"(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals enrolled under this part (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

"(B) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(g) GENERAL DEFINITIONS.—For purposes of this section:

"(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

"(A) is enrolled with a prescription drug plan under this part;

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

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

"(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.

"(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Prescription Drug Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

"(b) PAYMENTS FROM TRUST FUND.—

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

"(A) payments under section 1860G (relating to low-income subsidy payments);

"(B) payments under section 1860H (relating to subsidy payments); and

"(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

"(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

"(c) DEPOSITS INTO TRUST FUND.—

"(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

"(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

"(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

"SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

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

"(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

"(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

"(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860I(a).

"(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

"(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

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

"(B) provides qualified prescription drug coverage; and

"(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

"(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

"(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

"(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription

drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

"(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

"(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

"(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D(b); and

"(4) any reference to part C included a reference to this part.".

(b) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

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

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

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

"(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.".

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

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2004, the Medicare Benefits Administrator shall submit a report to Congress that makes recommendations regarding methods for providing benefits under part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

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

"(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

"(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(i) requiring a Medicare+Choice plan to include coverage of qualified prescription drug coverage; or

"(ii) permitting a Medicare+Choice organization from providing such coverage to an individual who has not elected such coverage under section 1860A(b).

For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860A(b) shall be treated as being ineligible to enroll in a Medicare+Choice plan under this part that offers such coverage.

"(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860F(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

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

"(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

"(B) providing a Medicare+Choice organization with direct and insurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

"(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2005 shall be the 6-month period beginning with November 2004.

"(5) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860B.".

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

(1) in subsection (a)(1)—

(A) by inserting "(other than qualified prescription drug benefits)" after "benefits";

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

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

"and may elect qualified prescription drug coverage in accordance with section 1860A."; and

(2) in subsection (g)(1), by inserting "and section 1860A(c)(2)(B)" after "in this subsection".

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

SEC. 103. MEDICAID AMENDMENTS.

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

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

(A) by striking "and" at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting "; and"; and

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

"(66) provide for making eligibility determinations under section 1935(a).".

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

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

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

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

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

"(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

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

"(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

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

"(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

"(B)(i) For expenditures attributable to costs incurred during 2006 and each subsequent year through 2013, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

"(ii) For purposes of clause (i), the 'applicable percent' for—

"(I) 2006 is 20 percent; or

"(II) a subsequent year is the applicable percent under this clause for the previous year increased by 10 percentage points.

"(C) For expenditures attributable to costs incurred after 2013, the otherwise applicable Federal matching rate shall be increased to 100 percent.

"(2) COORDINATION.—The State shall provide the Administrator with such information as may be necessary to properly allocate administrative expenditures

described in paragraph (1) that may otherwise be made for similar eligibility determinations.".

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

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

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

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

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

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

"(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

"(A) 2005 is 90 percent;

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

"(C) a year after 2013 is 0 percent.".

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

"(d) ADDITIONAL PROVISIONS.—

"(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

"(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.".

(d) TREATMENT OF TERRITORIES.—

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

(A) in subsection (a) in the matter preceding paragraph (1), by inserting "subject to subsection (e)" after "section 1903(a)";

(B) in subsection (c)(1), by inserting "subject to subsection (e)" after "1903(a)(1)"; and

(C) by adding at the end the following new subsection:

"(e) TREATMENT OF TERRITORIES.—

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

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

"(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

"(2) PLAN.—The plan described in this paragraph is a plan that—

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

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

"(3) INCREASED AMOUNT.—

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

"(i) the aggregate amount specified in subparagraph (B); and

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

"(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

"(i) 2005, is equal to $20,000,000; or

"(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860B(b)(5) for the year involved.

"(4) REPORT.—The Administrator shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Administrator deems appropriate.".

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

SEC. 104. MEDIGAP TRANSITION.

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

"(v) COVERAGE OF PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

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

"(A) IN GENERAL.—The issuer of a medicare supplemental policy—

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

"(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

"(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

"(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

"(i) enrolls in a prescription drug plan under part D; and

"(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

"(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

"(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Modernization and Prescription Drug Act of 2002, with respect to policies issued to individuals who are enrolled under part D, the changes in standards shall only

provide for substituting for the benefit packages that included coverage for prescription drugs two benefit packages that may provide for coverage of cost-sharing with respect to qualified prescription drug coverage under such part, except that such coverage may not cover the prescription drug deductible under such part. The two benefit packages shall be consistent with the following:

"(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

"(i) Coverage of 50 percent of the cost-sharing otherwise applicable, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

"(ii) No coverage of the part B deductible.

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

"(iv) A limitation on annual out-of-pocket expenditures to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

"(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

"(i) Substitute '75 percent' for '50 percent' in clause (i) of such subparagraph.

"(ii) Substitute '$2,000' for '$4,000' in clause (iv) of such subparagraph.

"(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.".

SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM.

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

"MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

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

"(1) to endorse prescription drug discount card programs that meet the requirements of this section; and

"(2) to make available to medicare beneficiaries information regarding such endorsed programs.

"(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary may not endorse a prescription drug discount card program under this section unless the program meets the following requirements:

"(1) SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

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

"(3) BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

"(4) INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

"(5) DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

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

"(7) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

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

"(1) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall

provide for the dissemination of information which compares the costs and benefits of such programs in a manner coordinated with the dissemination of educational information on Medicare+Choice plans under part C.

"(2) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the discounts and services provided.

"(3) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-medicare toll free telephone number for the receipt and response to inquiries and complaints concerning the program and programs endorsed under this section.

"(4) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary shall revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

"(5) ENROLLMENT PRACTICES.—A medicare beneficiary may not be enrolled in more than one endorsed program at any time.

"(d) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the program under this section at the time prescription drug benefits first become available under part D.

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

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

Subtitle A—Medicare+Choice Revitalization

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

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

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

"(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

"(i) IN GENERAL.—For 2003 and 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

"(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.".

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking "or (C)" and inserting "(C), or (D)".

(b) REVISION OF BLEND.—

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

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

(A) in paragraph (1)(A), by inserting "(for a year before 2003)" after "multiplied"; and

(B) in paragraph (5), by inserting "(before 2003)" after "for each year".

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

"(iv) For 2002, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2001.

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

"(vi) For 2005 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.".

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

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)", and

(2) by adding at the end the following new subparagraph:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2003), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(e) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2003, revised in accordance with the provisions of this section.

(f) MEDPAC STUDY OF AAPCC.—

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

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

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

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

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

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

SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

(a) CHANGE IN REPORTING DEADLINE.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking "2002, 2003, and 2004 (or July 1 of each other year)" and inserting "2002 and each subsequent year (or July 1 of each year before 2002)".

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

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking "and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005" and inserting "not later than March 1 before the calendar year concerned and for 2004 and each subsequent year".

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting before the period the following: "to the extent such information is available at the time of preparation of materials for the mailing".

SEC. 203. AVOIDING DUPLICATIVE STATE REGULATION.

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

"(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

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

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

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

"(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

"(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

"(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

"(i) is institutionalized (as defined by the Secretary);

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

"(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.".

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

"(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.".

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

(e) EFFECTIVE DATES.—

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

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

SEC. 205. MEDICARE MSAS.

(a) EXEMPTION FROM REPORTING ENROLLEE ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C. 1395w–22(e)(1)) is amended by inserting "(other than MSA plans)" after "Medicare+Choice plans".

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

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

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

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

(1) in the heading, by striking "ON A DEMONSTRATION BASIS";

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

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

(c) APPLYING LIMITATIONS ON BALANCE BILLING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting "or with an organization offering a MSA plan" after "section 1851(a)(2)(A)".

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

(1) by adding "or" at the end of clause (i);

(2) by striking ", or" at the end of clause (ii) and inserting a semicolon; and

(3) by striking clause (iii).

SEC. 206. EXTENSION OF REASONABLE COST AND SHMO CONTRACTS.

(a) REASONABLE COST CONTRACTS.—

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

(A) by inserting "(i)" after "(C)";

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

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

"(ii) In the case in which—

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

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

"(III) all Medicare+Choice plans subsequently terminate coverage in such area;

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

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

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

(1) IN GENERAL.—Section 4018(b)(1) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking "the date that is 30 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997" and inserting "December 31, 2004".

(2) SHMOS OFFERING MEDICARE+CHOICE PLANS.—Nothing in such section 4018 shall be construed as preventing a social health maintenance organization from offering a Medicare+Choice plan under part C of title XVIII of the Social Security Act.

SEC. 207. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004, but only with respect to" and all that follows and inserting "December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.".

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) in the heading by inserting "AND BID AMOUNTS" after "PREMIUMS";

(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.

"(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

"(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

"(i) The term 'statutory non-drug benefits' means benefits under parts A and B.

"(ii) The term 'statutory prescription drug benefits' means benefits under part D.

"(iii) The term 'statutory benefits' means statutory prescription drug benefits and statutory non-drug benefits.

"(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)). The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).".

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

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

(A) by adding at the end of paragraph (1) the following new subparagraph:

"(C) BENEFICIARY REBATE RULE.—

"(i) REQUIREMENT.—The Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

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

"(I) through the crediting of the amount of the rebate towards the Medicare+Choice monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

"(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

"(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof."; and

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

"(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year is computed as follows:

"(A) DETERMINATION OF STATE-WIDE AVERAGE RISK ADJUSTMENT.—

"(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2005), for each State the average of the risk adjustment factors to be applied to enrollees under section 1853(a)(1)(A) in that State. In the case of a State in which a Medicare+Choice plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

"(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare+Choice plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

"(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare+Choice plan offered in a State, the Administrator shall—

"(i) adjust the fee-for-service area-specific non-drug benchmark amount by the applicable average risk adjustment factor computed under subparagraph (A); and

"(ii) adjust the unadjusted non-drug monthly bid amount by such applicable average risk adjustment factor.

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

"(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

"(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

"(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.".

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

"(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term 'fee-for-service area-specific non-drug benchmark amount' means, with respect to a Medicare+Choice payment area for a month in a year, an amount equal to the greater of the following (but in no case less than 1/12 of the rate computed under subsection (c)(1), without regard to subparagraph (A), for the year):

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

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

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

(1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking "in an amount" and all that follows and inserting the following: "in an amount determined as follows:

"(i) PAYMENT BEFORE 2005.—For years before 2005, the payment amount shall be equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iii).

"(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2005.—For years beginning with 2005—

"(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment under this subsection is equal

to the unadjusted non-drug monthly bid amount, adjusted under clause (iii), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

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

"(iii) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted non-drug monthly bid amount under clause (ii)(I), and the fee-for-service area-specific non-drug benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

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

(d) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is amended by adding at the end the following: "The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare+Choice eligible individuals with the organization.".

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

"(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly basic beneficiary premium' means, with respect to a Medicare+Choice plan—

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

"(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted non-drug monthly bid amount exceeds the fee-for-service area-specific non-drug benchmark amount.

"(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly supplemental beneficiary premium' means, with respect to a Medicare+Choice plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.".

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

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

(4) PERMITTING BENEFICIARY REBATES.—

(A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–21(h)(4)(A)) is amended by inserting "except as provided under section 1854(b)(1)(C)" after "or otherwise".

(B) Section 1854(d) (42 U.S.C. 1395w–24(d)) is amended by inserting ", except as provided under subsection (b)(1)(C)," after "and may not provide".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for months beginning with January 2005.

SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-DEMONSTRATION AREAS.

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

"(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRATION PROGRAM.—

"(1) DESIGNATION OF COMPETITIVE-DEMONSTRATION AREAS AS PART OF PROGRAM.—

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

"(i) LIMITATION ON NUMBER OF AREAS THAT MAY BE DESIGNATED.—The Administrator may not designate more than 4 areas as competitive-demonstration areas.

"(ii) LIMITATION ON PERIOD OF DESIGNATION OF ANY AREA.—The Administrator may not designate any area as a competitive-demonstration area for a period of more than 2 years.

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

"(B) QUALIFICATIONS FOR DESIGNATION.—For purposes of this title, a Medicare+Choice area (which is a metropolitan statistical area or other area with a substantial number of Medicare+Choice enrollees) may not be designated as a 'competitive-demonstration area' for a 2-year period beginning with a year unless the Administrator determines, by such date before the beginning of the year as the Administrator determines appropriate, that—

"(i) there will be offered during the open enrollment period under this part before the beginning of the year at least 2 Medicare+Choice plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare+Choice organization; and

"(ii) during March of the previous year at least 50 percent of the number of Medicare+Choice eligible individuals who reside in the area were enrolled in a Medicare+Choice plan.

"(2) CHOICE NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term 'choice non-drug benchmark amount' means, with respect to a Medicare+Choice payment area for a month in a year, the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive-demonstration area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2005) in which it is designated as such an area.

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

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

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

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

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

"(i) NATIONAL MEDICARE+CHOICE MARKET SHARE.—1 minus the national fee-for-service market share percentage for the year.

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

"(4) DETERMINATION OF WEIGHTED AVERAGE BIDS FOR AN AREA.—

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

"(i) PROPORTION OF EACH PLAN'S ENROLLEES IN THE AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare+Choice plans described in subparagraph (C) for that area and year.

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

"(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare+Choice plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

"(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare+Choice plans described in this subparagraph are

plans that are offered in the area and year and were offered in the area in March of the previous year.

"(5) COMPUTATION OF NATIONAL FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year, the proportion (in this subsection referred to as the 'national fee-for-service market share percentage') of Medicare+Choice eligible individuals who during March of the previous year were not enrolled in a Medicare+Choice plan.

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

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

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

(A) in subsection (b)(1)(C)(i), as added by section 211(b)(1)(A), by striking "(i) REQUIREMENT.—The" and inserting "(i) REQUIREMENT FOR NON-COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is not a competitive-demonstration area designated under section 1853(k)(1), the";

(B) in subsection (b)(1)(C), as so added, by inserting after clause (i) the following new clause:

"(ii) REQUIREMENT FOR COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is designated as a competitive-demonstration area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (4) for a Medicare+Choice plan and year, the Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings.";

(C) by adding at the end of subsection (b), as amended by section 211(b)(1), the following new paragraph:

"(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the fee-for-service area-specific non-drug benchmark amount in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the choice non-drug benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).'"; and

(D) in subsection (d), as amended by section 211(d)(4), by inserting "and subsection (b)(1)(D)" after "subsection (b)(1)(C)".

(2) CONFORMING AMENDMENTS.—

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

(i) in subclause (I), by inserting "(or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount)" after "unadjusted non-drug monthly bid amount"; and

(ii) in subclauses (I) and (II), by inserting "(or, in the case of a competitive-demonstration area, described in section 1854(b)(4))" after "section 1854(b)(3)(C)".

(B) DEFINITION OF MONTHLY BASIC PREMIUM.—Section 1854(b)(2)(A)(ii), as amended by section 211(d)(2), is amended by inserting "(or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount)" after "benchmark amount".

(c) PREMIUM ADJUSTMENT.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

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

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

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

"(i) the sum of the amount of the adjusted premium and the choice non-drug benchmark for the area, is equal to

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

"(2) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

"(3) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

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

"(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

"(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.".

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

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

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

SEC. 213. CONFORMING AMENDMENTS.

(a) CONFORMING AMENDMENTS RELATING TO BIDS.—

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

(A) in the heading of subsection (a), by inserting "AND BID AMOUNTS" after "PREMIUMS"; and

(B) in subsection (a)(5)(A), by inserting "paragraphs (2), (3), and (4) of" after "filed under".

(b) ADDITIONAL CONFORMING AMENDMENTS.—

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

(A) in paragraph (1), by striking "the respective calendar year" and all that follows and inserting the following: "the calendar year concerned with respect to each Medicare+Choice payment area, the following:

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

"(i) MEDICARE+CHOICE CAPITATION RATES.—The annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year.

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

"(B) COMPETITION INFORMATION.—For years beginning with 2005, the following:

"(i) BENCHMARKS.—The fee-for-service area-specific non-drug benchmark under section 1853(j) and, if applicable, the choice non-drug benchmark under section 1853(k)(2), for the year involved and, if applicable, the national fee-for-service market share percentage.

"(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iii) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).

"(iii) PROJECTED FEE-FOR-SERVICE BID.—In the case of a competitive area, the projected fee-for-service area-specific non-drug bid (as determined under subsection (k)(6)) for the area.

"(iv) INDIVIDUALS.—The number of individuals counted under subsection (k)(4)(B) and enrolled in each Medicare+Choice plan in the area."; and

(B) in paragraph (3), by striking "in sufficient detail" and all that follows up to the period at the end.

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

(A) IN GENERAL.—Subsections (e) and (f) of section 1854 (42 U.S.C. 1395w–24) are repealed.

(B) CONFORMING AMENDMENT.—Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ", and to reflect" and all that follows and inserting a period.

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

"(5) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall only implement a national coverage determination that will result in a significant change in the costs to a Medicare+Choice organization in a prospective manner that applies to announcements made under section 1853(b) after the date of the implementation of the determination.".

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

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

"(i) to a single statewide Medicare+Choice payment area,"; and

(B) by amending subparagraph (B) to read as follows:

"(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Medicare Benefits Administrator shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for periods beginning on or after January 1, 2005.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

SEC. 301. REFERENCE TO FULL MARKET BASKET INCREASE FOR SOLE COMMUNITY HOSPITALS.

For provision eliminating any reduction from full market basket in the update for inpatient hospital services for sole community hospitals, see section 401.

SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) BLENDING OF PAYMENT AMOUNTS.—

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

"(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

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

"(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 80 percent, for each subsequent year (through 2006) is the old blend proportion under this subclause for the previous year minus 20 percentage points, and for each year beginning with 2007 is 0 percent.".

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

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting "subject to clause (xiv) and" before "for discharges occurring";

(B) in clause (viii), by striking "The formula" and inserting "Subject to clause (xiv), the formula"; and

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

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

SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

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

(1) by striking "(iv) For discharges" and inserting "(iv)(I) Subject to the succeeding provisions of this clause, for discharges"; and

(2) by adding at the end the following new subclauses:

"(II) For discharges occurring during fiscal year 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the average standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

"(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area within the United States and within each region equal to the average standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i).".

SEC. 304. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2003, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by striking "and" at the end of subparagraph (C);

(2) by adding "and" at the end of subparagraph (D); and

(3) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

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

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.".

(c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

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

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

"(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—

"(A) IN GENERAL.—In the case of a hospital that demonstrates that it meets the standards established under subparagraph (B), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

"(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).."; and

(3) in subsection (f), by adding at the end the following new sentence: "The limitations in numbers of beds under the first sentence are subject to adjustment under subsection (c)(3).".

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

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

(f) EFFECTIVE DATES.—

(1) REINSTATEMENT OF PIP.—The amendments made by subsection (a) shall apply to payments made on or after January 1, 2003.

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

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

SEC. 306. EXTENSION OF TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

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

(1) by striking "24-MONTH INCREASE BEGINNING APRIL 1, 2001" and inserting "IN GENERAL"; and

(2) by striking "April 1, 2003" and inserting "January 1, 2005".

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

SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA AND RURAL HOSPICE DEMONSTRATION PROJECT.

For—

(1) provision of 10 percent increase in payment for hospice care furnished in a frontier area, see section 422; and

(2) provision of a rural hospice demonstration project, see section 423.

SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LOCATED IN RURAL OR SMALL URBAN AREAS IN REDISTRIBUTION OF UNUSED GRADUATE MEDICAL EDUCATION RESIDENCIES.

For provision providing priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies, see section 612.

SEC. 309. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

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

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

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

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

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

(1) in subparagraph (F), by striking "and" after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.".

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

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

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

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

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) INTERIM FINAL EFFECT.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 311. RELIEF FOR CERTAIN NON-TEACHING HOSPITALS.

(a) IN GENERAL.—In the case of a non-teaching hospital that meets the condition of subsection (b), for its cost reporting period beginning in each of fiscal years 2003, 2004, and 2005 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during such fiscal year under section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) had been increased by 5 percentage points. The previous sentence shall be applied for each such fiscal year separately without regard to its application in a previous fiscal year and shall not affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 2005.

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

(1) it is located in a rural area and the amount of the aggregate payments under subsection (d) of such section for hospitals located in rural areas in the State for their cost reporting periods beginning during fiscal year 1999 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all subsection (d) hospitals in such areas in such State with respect to such cost reporting periods; or

(2) it is located in an urban area and the amount of the aggregate payments under subsection (d) of such section for hospitals located in urban areas in the State for their cost reporting periods beginning during fiscal year 1999 is less than 103 percent of the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all subsection (d) hospitals in such areas in such State with respect to such cost reporting periods.

The amounts under paragraphs (1) and (2) shall be determined by the Secretary of Health and Human Services based on data of the Medicare Payment Advisory Commission.

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

(1) NON-TEACHING HOSPITAL.—The term "non-teaching hospital" means, for a cost reporting period, a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B))) that is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period.

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

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

"(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and".

SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).

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

(1) in subclause (VI) by striking "and" at the end;

(2) by redesignating subclause (VII) as subclause (IX);

(3) in subclause (IX) as so redesignated, by striking "2002" and inserting "2004"; and

(4) by inserting after subclause (VI) the following new subclause:

"(VII) during fiscal year 2003, 'c' is equal to 1.47;

"(VIII) during fiscal year 2004, 'c' is equal to 1.45; and".

SEC. 403. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

"(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.".

(b) ELIGIBILITY STANDARD.—

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

(A) by inserting "(I)" after "(vi)"; and

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

"(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of a significant sample of specific discharges in which the service or technology has been used.".

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting "(applying a threshold specified by the Secretary that is the lesser of 50 percent of the national average standardized amount for operating costs of inpatient hospital services for all hospitals and all diagnosis-related groups or one standard deviation for the diagnosis-related group involved)" after "is inadequate".

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

"(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biologi-

cal that is designated under section 506 or 526 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act.".

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

(A) in clause (i), by adding at the end the following: "Such mechanism shall be modified to meet the requirements of clause (viii).''; and

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

"(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

"(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

"(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

"(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.".

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

"(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, no add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).".

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after "the estimated average cost of such service or technology" the following: "(based on the marginal rate applied to costs under subparagraph (A))".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2004.

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

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2004 under the amendments made by this section; and

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

SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

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

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

(2) by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 45 percent and the applicable Federal percentage is 55 percent;

"(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 40 percent and the applicable Federal percentage is 60 percent;

"(v) during fiscal year 2006, the applicable Puerto Rico percentage is 35 percent and the applicable Federal percentage is 65 percent;

"(vi) during fiscal year 2007, the applicable Puerto Rico percentage is 30 percent and the applicable Federal percentage is 70 percent; and

"(vii) on or after October 1, 2007, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.".

SEC. 405. REFERENCE TO PROVISION RELATING TO ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

For provision enhancing disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds, see section 302.

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.

For provision phasing in over a 2-year period an increase in the standardized amount for rural and small urban areas to achieve a single, uniform, standardized amount, see section 303.

SEC. 407. REFERENCE TO PROVISION FOR MORE FREQUENT UPDATES IN THE WEIGHTS USED IN HOSPITAL MARKET BASKET.

For provision providing for more frequent updates in the weights used in hospital market basket, see section 304.

SEC. 408. REFERENCE TO PROVISION MAKING IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

For provision providing making improvements to critical access hospital program, see section 305.

Subtitle B—Skilled Nursing Facility Services

SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

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

(b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

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

"(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

"(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

"(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.".

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

Subtitle C—Hospice

SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting "; and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

"(A) an evaluation of the individual's need for pain and symptom management;

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

"(C) advising the individual regarding advanced care planning.".

(b) PAYMENT.—Section 1814(i) (42 U.S.C. l395f(i)) is amended by adding at the end the following new paragraph:

"(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.".

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

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

SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA.

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

"(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such care shall be increased by 10 percent. For purposes of this subparagraph, the term 'frontier area' means a county in which the population density is less than 7 persons per square mile.".

(b) REPORT ON COSTS.—Not later than January 1, 2007, the Comptroller General of the United States shall submit to Congress a report on the costs of furnishing hospice care in frontier areas. Such report shall include recommendations regarding the appropriateness of extending, and modifying, the payment increase provided under the amendment made by subsection (a).

SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.

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

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

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

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

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

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

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

Subtitle D—Other Provisions

SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying and recouping overpayments under the medicare program for services for which payment is made under part A of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—The project shall cover at least 2 States and at least 3 contractors and shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those entities that the Secretary determines have demonstrated proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 501. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2003 THROUGH 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraphs:

"(5) UPDATE FOR 2003.—The update to the single conversion factor established in paragraph (1)(C) for 2003 is 2 percent.

"(6) SPECIAL RULES FOR UPDATE FOR 2004 AND 2005.—The following rules apply in determining the update adjustment factors under paragraph (4)(B) for 2004 and 2005:

"(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

"(i) The reference in clause (ii)(I) of such paragraph to April 1, 1996, is deemed to be a reference to January 1, 2002.

"(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

"(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, and 2005 is deemed to be increased by 1 percentage point.".

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting "and paragraph (6)" after "subparagraph (D)".

(3) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking "projected" and inserting "annual average"; and

(B) by striking "from the previous applicable period to the applicable period involved" and inserting "during the 10-year period ending with the applicable period involved".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2002.

(c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Section 1848(d)(4)(F) (42 U.S.C. 1395w–4(d)(4)(F)) is amended by striking "subparagraph (A)" and all that follows and inserting "subparagraph (A), for each of 2001 and 2002, of −0.2 percent."

SEC. 502. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSICIANS' SERVICES.—

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

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

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

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

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

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

SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services in the case of services for which there are no physician work relative value units, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

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

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

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

SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA is amended by striking "2-year period" and inserting "3-year period".

Subtitle B—Other Services

SEC. 511. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

"COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

"SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

"(1) IMPLEMENTATION OF PROGRAMS.—

"(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

"(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

"(i) at least ⅓ of such areas in 2004; and

"(ii) at least ⅔ of such areas in 2005.

"(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

"(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

"(A) DURABLE MEDICAL EQUIPMENT AND INHALATION DRUGS USED IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

"(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

"(3) EXEMPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

"(A) areas that are not competitive due to low population density; and

"(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

"(b) PROGRAM REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

"(2) CONDITIONS FOR AWARDING CONTRACT.—

"(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

"(i) The entity meets quality and financial standards specified by the Secretary or developed by accreditation entities or organizations recognized by the Secretary.

"(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

"(iii) Beneficiary access to a choice of multiple suppliers in the area is maintained.

"(iv) Beneficiary liability is limited to the applicable percentage of contract award price.

"(B) QUALITY STANDARDS.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, and suppliers to review (and advise the Secretary concerning) such quality standards.

"(3) CONTENTS OF CONTRACT.—

"(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

"(B) TERM OF CONTRACTS.—The Secretary shall rebid contracts under this section not less often than once every 3 years.

"(4) LIMIT ON NUMBER OF CONTRACTORS.—

"(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

"(B) MULTIPLE WINNERS.—The Secretary shall award contracts to more than one entity submitting a bid in each area for an item or service.

"(5) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

"(A) the contractor has submitted a bid for such items and services under this section; and

"(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

"(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries with respect to the program.

"(c) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction.

"(d) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

"(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

"(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

"(B) which are furnished without a face-to-face encounter between the individual and the hospital or physician ordering the tests.

"(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

"(3) REPORT.—The Secretary shall submit to Congress—

"(A) an initial report on the project not later than December 31, 2004; and

"(B) such progress and final reports on the project after such date as the Secretary determines appropriate.".

(b) CONTINUATION OF CERTAIN DEMONSTRATION PROJECTS.—Notwithstanding the amendment made by subsection (a), with respect to demonstration projects implemented by the Secretary under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) (relating to the establishment of competitive acquisition areas) that was in effect on the day before the date of the enactment of this Act, each such demonstration project may continue under the same terms and conditions applicable under that section as in effect on that date.

(c) REPORT ON DIFFERENCES IN PAYMENT FOR LABORATORY SERVICES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that analyzes differences in reimbursement between public and private payors for clinical diagnostic laboratory services.

SEC. 512. PAYMENT FOR AMBULANCE SERVICES.

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

(1) in paragraph (2)(E), by inserting "consistent with paragraph (10)" after "in an efficient and fair manner";

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

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

"(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year before January 1, 2007, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

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

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

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

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

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.".

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

"(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2003, and before January 1, 2008, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.".

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

SEC. 513. 2-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 2-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2002" and inserting "2002, 2003, and 2004".

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2002, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

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

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

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

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

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

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries;

(C) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office;

(D) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(E) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral and physician certification for physical therapist services under the medicare program.

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

SEC. 514. ACCELERATED IMPLEMENTATION OF 20 PERCENT COINSURANCE FOR HOSPITAL OUTPATIENT DEPARTMENT (OPD) SERVICES; OTHER OPD PROVISIONS.

(a) ACCELERATED IMPLEMENTATION OF COINSURANCE REDUCTIONS.—Section 1833(t)(8)(C)(ii) (42 U.S.C. 1395l(t)(8)(C)(ii)) is amended by striking subclauses (III) through (V) and inserting the following:

"(III) For procedures performed in 2004, 45 percent.

"(IV) For procedures performed in 2005, 40 percent.

"(V) For procedures performed in 2006, 2007, 2008 and 2009, 35 percent.

"(VI) For procedures performed in 2010, 30 percent.

"(VII) For procedures performed in 2011, 25 percent.

"(VIII) For procedures performed in 2012 and thereafter, 20 percent.".

(b) TREATMENT OF TEMPERATURE MONITORED CRYOABLATION.—

(1) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42 U.S.C. 1395l(t)(6)(A)(ii)) is amended by striking "or temperature monitored cryoablation".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to payment for services furnished on or after January 1, 2003.

SEC. 515. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

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

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) an initial preventive physical examination (as defined in subsection (ww));".

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

"Initial Preventive Physical Examination

"(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services specified by the Secretary in regulations.".

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking "and" before "(6)", and

(B) by inserting before the period at the end the following: ", and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))".

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

(A) in clause (N), by inserting "(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))" after "80 percent"; and

(B) in clause (O), by inserting "(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))" after "80 percent".

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting "(2)(W)," after "(2)(S),".

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

(1) in paragraph (1)—

(A) by striking "and" at the end of subparagraph (H);

(B) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

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

"(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;"; and

(2) in paragraph (7), by striking "or (H)" and inserting "(H), or (J)".

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

SEC. 516. RENAL DIALYSIS SERVICES.

(a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT SETTINGS.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing—

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

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

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

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

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

(A) in subparagraph (A), by striking "and (C)" and inserting ", (C), and (D)";

(B) in subparagraph (B), by striking "In the case" and inserting "Subject to subparagraph (D), in the case"; and

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

"(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.".

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking "The Secretary" and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary".

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

SEC. 517. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

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

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

SEC. 518. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, or 2003, and who demonstrates to the Secretary before December 31, 2003, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

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

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2003.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 519. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 515(a), is amended—

(1) in subparagraph (V), by striking "and" at the end;

(2) in subparagraph (W), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 515(b), is amended by adding at the end the following new subsection:

"Cholesterol and Other Blood Lipid Screening Test

"(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

"(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 515(e), is amended

(1) by striking "and" at the end of subparagraph (I);

(2) by striking the semicolon at the end of subparagraph (J) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

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

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

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.

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

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

"(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

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

"(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

"(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.".

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

SEC. 602. ESTABLISHMENT OF REDUCED COPAYMENT FOR A HOME HEALTH SERVICE EPISODE OF CARE FOR CERTAIN BENEFICIARIES.

(a) PART A.—

(1) IN GENERAL.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

"(5)(A)(i) Subject to clause (ii), the amount payable for home health services furnished to the individual under this title for each episode of care beginning in a year (beginning with 2003) shall be reduced by a copayment equal to the copayment amount specified in subparagraph (B)(ii) such year.

"(ii) The copayment under clause (i) shall not apply—

"(I) in the case of an individual who has been determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)) or otherwise to be entitled to medical assistance under section 1902(a)(10)(A) or 1902(a)(10)(C); and

"(II) in the case of an episode of care which consists of 4 or fewer visits.

"(B)(i) The Secretary shall estimate, before the beginning of each year (beginning with 2003), the national average payment under this title per episode for home health services projected for the year involved.

"(ii) For each year the copayment amount under this clause is equal to 1.5 percent of the national average payment estimated for the year involved under clause (i). Any amount determined under the preceding sentence which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

"(iii) There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of average payment under clause (i).".

(2) TIMELY IMPLEMENTATION.—Unless the Secretary of Health and Human Services otherwise provides on a timely basis, the copayment amount specified under section 1813(a)(5)(B)(ii) of the Social Security Act (as added by paragraph (1)) for 2003 shall be deemed to be $40.

(b) CONFORMING PROVISIONS.—

(1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) is amended by inserting "less the copayment amount applicable under section 1813(a)(5)" after "1895".

(2) Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(A) by striking "or coinsurance" and inserting ", coinsurance, or copayment"; and

(B) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

SEC. 603. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

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

(A) in paragraph (3)(B)(i)—

(i) by striking "each fiscal year (beginning with fiscal year 2002)" and inserting "fiscal year 2002 and for each subsequent year (beginning with 2003)"; and

(ii) by inserting "or year" after "the fiscal year";

(B) in paragraph (3)(B)(ii)—

(i) in subclause (II), by striking "fiscal year" and inserting "year" and by redesignating such subclause as subclause (III); and

(ii) in subclause (I), by striking "each of fiscal years 2002 and 2003" and inserting the following: "fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

"(II) 2003";

(C) in paragraph (3)(B)(iii), by inserting "or year" after "fiscal year" each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting "or year" after "fiscal year" each place it appears; and

(ii) by inserting "or years" after "fiscal years"; and

(E) in paragraph (5), by inserting "or year" after "fiscal year".

(2) TRANSITION RULE.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2002, shall be such amount (or amounts) for the previous calendar quarter.

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

(1) in subclause (II), by striking "the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points" and inserting "2.0 percentage points";

(2) by striking "or" at the end of subclause (II);

(3) by redesignating subclause (III) as subclause (V); and

(4) by inserting after subclause (II) the following new subclause:

"(III) 2004, 1.1 percentage points;

"(IV) 2005, 2.7 percentage points; or".

(c) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C. 1395fff(b)(5)) is amended by striking "5 percent" and inserting "3 percent".

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

SEC. 604. OASIS TASK FORCE; SUSPENSION OF CERTAIN OASIS DATA COLLECTION REQUIREMENTS PENDING TASK FORCE SUBMITTAL OF REPORT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish and appoint a task force (to be known as the "OASIS Task Force") to examine the data collection and reporting requirements under OASIS. For purposes of this section, the term "OASIS" means the Outcome and Assessment Information Set required by reason of section 4602(e) of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

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

(1) Staff of the Centers for Medicare & Medicaid Services with expertise in post-acute care.

(2) Representatives of home health agencies.

(3) Health care professionals and research and health care quality experts outside the Federal Government with expertise in post-acute care.

(4) Advocates for individuals requiring home health services.

(c) DUTIES.—

(1) REVIEW AND RECOMMENDATIONS.—The OASIS Task Force shall review and make recommendations to the Secretary regarding changes in OASIS to improve and simplify data collection for purposes of—

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

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

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

(A) the 41 outcome measures currently in use;

(B) the timing and frequency of data collection; and

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

(3) REPORT.—The OASIS Task Force shall submit a report to the Secretary containing its findings and recommendations for changes in OASIS by not later than 18 months after the date of the enactment of this Act.

(d) SUNSET.—The OASIS Task Force shall terminate 60 days after the date on which the report is submitted under subsection (c)(2).

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

(f) SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS PENDING TASK FORCE REPORT.—

(1) IN GENERAL.—During the period described in paragraph (2), the Secretary of Health and Human Services may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act.

(2) PERIOD OF SUSPENSION.—The period described in this paragraph—

(A) begins on January 1, 2003, and

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

SEC. 605. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

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

Subtitle B—Direct Graduate Medical Education

SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH COST PROGRAMS.

Section 1886(h)(2)(D)(iv) (42 U.S.C. 1395ww(h)(2)(D)(iv)) is amended—

(1) in subclause (I)—

(A) by striking "AND 2002" and inserting "THROUGH 2012";

(B) by striking "during fiscal year 2001 or fiscal year 2002" and inserting "during the period beginning with fiscal year 2001 and ending with fiscal year 2012"; and

(C) by striking "subject to subclause (III),";

(2) by striking subclause (II); and

(3) in subclause (III)—

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

(B) by striking "or (II)".

SEC. 612. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

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

(1) in subparagraph (F)(i), by inserting "subject to subparagraph (I)," after "October 1, 1997,";

(2) in subparagraph (H)(i), by inserting "subject to subparagraph (I)," after "subparagraphs (F) and (G),"; and

(3) by adding at the end the following new subparagraph:

"(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident

limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

"(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

"(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

"(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

"(ii) REDISTRIBUTION.—

"(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

"(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

"(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

"(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

"(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

"(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

"(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

"(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

"(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.".

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: "The provisions

of clause (i) of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection, but the provisions of clause (ii) of such subparagraph shall not apply.".

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by 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. The Commission shall examine data on uncompensated care, as well as the sahre of uncompensated care accounted for by the expenses for treating illegal aliens.

(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 section (in this section referred to as the "project") to demonstrate the impact on costs and health outcomes of applying disease management to certain medicare beneficiaries with diagnosed diabetes. In no case may the number of participants in the project exceed 30,000 at any time.

(b) VOLUNTARY PARTICIPATION.—

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

(A) they are Hispanic, as determined by the Secretary;

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

(C) their physicians approve of participation in the project; and

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

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

(A) for disease management services related to their diabetes; and

(B) for payment for all costs for prescription drugs without regard to whether or not they relate to the diabetes, except that the project may provide for modest cost-sharing with respect to prescription drug coverage.

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out the project through contracts with up to three disease management organizations. The Secretary shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Secretary in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program under title XVIII of the Social Security Act) there will be no net increase, and to the extent practicable, there will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the prohibition on net increases in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

(d) APPLICATION OF MEDIGAP PROTECTIONS TO DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph (2), the provisions of section 1882(s)(3) (other than clauses (i) through (iv) of subparagraph (B)) and 1882(s)(4) of the Social Security Act shall apply to enrollment (and termination of enrollment) in the demonstration project under this section, in the same manner as they apply to enrollment (and termination of enrollment) with a Medicare+Choice organization in a Medicare+Choice plan.

(2) In applying paragraph (1)—

(A) any reference in clause (v) or (vi) of section 1882(s)(3)(B) of such Act to 12 months is deemed a reference to the period of the demonstration project; and

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

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

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

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

(h) WORKING GROUP ON MEDICARE DISEASE MANAGEMENT PROGRAMS.—The Secretary shall establish within the Department of Health and Human Services a working group consisting of employees of the Department to carry out the following:

(1) To oversee the project.

(2) To establish policy and criteria for medicare disease management programs within the Department, including the establishment of policy and criteria for such programs.

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

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

(5) To monitor health outcomes under such programs.

(6) To measure the effectiveness of such programs in meeting any budget neutrality requirements.

(7) Otherwise to serve as a central focal point within the Department for dissemination of information on medicare disease management programs.

(i) GAO STUDY ON DISEASE MANAGEMENT PROGRAMS.—The Comptroller General of the United States shall conduct a study that compares disease management programs under title XVIII of the Social Security Act with such programs conducted in the private sector, including the prevalence of such programs and programs for case management. The study shall identify the cost-effectiveness of such programs and any savings achieved by such programs. The Comptroller General shall submit a report on such study to Congress by not later than 18 months after the date of the enactment of this Act.

SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the "demonstration project") under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care

services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 u.s.c. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

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

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

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that—

(1) are currently licensed or certified to furnish medical adult day care services; and

(2) have furnished medical adult day care services to medicare beneficiaries for a continuous 2-year period before the beginning of the demonstration project.

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

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

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

(2) MEDICAL ADULT DAY CARE FACILITY.—The term "medical adult day care facility" means a facility that—

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

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term "medical adult day care services" means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

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

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

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

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

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS ADMINISTRATION.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 105, is amended by inserting after 1806 the following new section:

"MEDICARE BENEFITS ADMINISTRATION

"SEC. 1808. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

"(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF ACTUARY.—

"(1) ADMINISTRATOR.—

"(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an administrator to be known as the 'Medicare Benefits Administrator' (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

"(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

"(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

"(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

"(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except as specified in this section.

"(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

"(2) DEPUTY ADMINISTRATOR.—

"(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

"(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign

or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

"(3) CHIEF ACTUARY.—

"(A) IN GENERAL.—There is established in the Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

"(B) COMPENSATION.—The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

"(C) DUTIES.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

"(4) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

"(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

"(1) DUTIES.—

"(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

"(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

"(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

"(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

"(C) PRESCRIPTION DRUG CARD.—The Administrator shall carry out section 1807 (relating to the medicare prescription drug discount card endorsement program).

"(D) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

"(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

"(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

"(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

"(E) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

"(2) STAFF.—

"(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3110 and 3112, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

"(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

"(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of the enactment of this Act.

"(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

"(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

"(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

"(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

"(d) OFFICE OF BENEFICIARY ASSISTANCE.—

"(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of medicare beneficiaries under this title, including the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

"(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

"(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate, directly or through contract, to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through a toll-free telephone number, information with respect to the following:

"(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

"(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

"(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.

"(e) MEDICARE POLICY ADVISORY BOARD.—

"(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

"(2) REPORTS.—

"(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

"(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

"(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

"(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

"(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

"(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

"(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

"(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

"(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

"(4) MEMBERSHIP.—

"(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of seven members to be appointed as follows:

"(i) Three members shall be appointed by the President.

"(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairmen and the ranking minority members of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

"(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

"(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

"(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

"(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(6) TERMS OF OFFICE.—

"(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

"(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

"(i) one shall be appointed for a term of 1 year;

"(ii) three shall be appointed for terms of 2 years; and

"(iii) three shall be appointed for terms of 3 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

"(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

"(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than three times during each fiscal year.

"(9) DIRECTOR AND STAFF.—

"(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

"(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

"(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

"(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

"(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

"(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) TIMING OF INITIAL APPOINTMENTS.—The Administrator and Deputy Administrator of the Medicare Benefits Administration may not be appointed before March 1, 2003.

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning or after January 1, 2005.

(4) TRANSITION.—Before the date the Administrator of the Medicare Benefits Administration is appointed and assumes responsibilities under this section and section 1807 of the Social Security Act, the Secretary of Health and Human Services shall provide for the conduct of any responsibilities of such Administrator that are otherwise provided under law.

(c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

(1) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking "and the Secretary of Health and Human Services, all ex officio," and inserting "the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,".

(2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS ADMINISTRATOR.—

(A) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

"Administrator of the Centers for Medicare & Medicaid Services .

"Administrator of the Medicare Benefits Administration.".

(B) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(C) EFFECTIVE DATE.—The amendments made by this paragraph take effect on January 1, 2003.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

"Supplier

"(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.".

SEC. 802. ISSUANCE OF REGULATIONS.

(a) CONSOLIDATION OF PROMULGATION TO ONCE A MONTH.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(d)(1) Subject to paragraph (2), the Secretary shall issue proposed or final (including interim final) regulations to carry out this title only on one business day of every month.

"(2) The Secretary may issue a proposed or final regulation described in paragraph (1) on any other day than the day described in paragraph (1) if the Secretary—

"(A) finds that issuance of such regulation on another day is necessary to comply with requirements under law; or

"(B) finds that with respect to that regulation the limitation of issuance on the date described in paragraph (1) is contrary to the public interest.

If the Secretary makes a finding under this paragraph, the Secretary shall include such finding, and brief statement of the reasons for such finding, in the issuance of such regulation.

"(3) The Secretary shall coordinate issuance of new regulations described in paragraph (1) relating to a category of provider of services or suppliers based on an analysis of the collective impact of regulatory changes on that category of providers or suppliers.".

(2) GAO REPORT ON PUBLICATION OF REGULATIONS ON A QUARTERLY BASIS.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the feasibility of requiring that regulations described in section 1871(d) of the Social Security Act be promulgated on a quarterly basis rather than on a monthly basis.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to regulations promulgated on or after the date that is 30 days after the date of the enactment of this Act.

(b) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication

of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

"(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

"(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(c) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (b), is further amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes notice of proposed rulemaking relating to a regulation (including an interim final regulation), insofar as such final regulation includes a provision that is not a logical outgrowth of such notice of proposed rulemaking, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 803. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 802(a), is amended by adding at the end the following new subsection:

"(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

"(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive

change a finding described in the first sentence, and a brief statement of the reasons for such finding.

"(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

"(2)(A) If—

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

"(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

"(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 804. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than January 1, 2004.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 803(a), is amended by adding at the end the following new subsection:

"(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

Subtitle B—Contracting Reform

SEC. 811. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

"(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

"(3) PERFORMANCE REQUIREMENTS.—

"(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

"(B) CONSULTATION.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

"(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

"(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

"(ii) shall be used for evaluating contractor performance under the contract; and

"(iii) shall be consistent with the written statement of work provided under the contract.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give sur-

ety bond to the United States in such amount as the Secretary may deem appropriate.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless in connection with such payment or in the supervision of or selection of such officer the medicare administrative contractor acted with gross negligence.

"(4) INDEMNIFICATION BY SECRETARY.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

"(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

"(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

"(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider in-

clusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services," in the matter preceding clause (i); and

(II) by striking "carrier" and inserting "medicare administrative contractor" in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,"; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking "carrier" and inserting "medicare administrative contractor"; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2004, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2009.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the

Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2003, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2007, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 811(a)(1), is amended by adding at the end the following new subsection:

"(e) REQUIREMENTS FOR INFORMATION SECURITY.—

"(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under section 3534(b)(2) of title 44, United States Code (other than requirements under subparagraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

"(2) INDEPENDENT AUDITS.—

"(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

"(ii) test the effectiveness of information security control techniques for an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines.

"(B) DEADLINE FOR INITIAL EVALUATION.—

"(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal inter-

mediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

"(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

"(C) REPORTS ON EVALUATIONS.—

"(i) TO THE INSPECTOR GENERAL.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services.

"(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations.".

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by section 812(a), is amended by adding at the end the following new subsection:

"(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.".

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2003, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include

in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by section 812(a) and subsection (b), is further amended by adding at the end the following new subsection:

"(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

"(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) MONITORING OF CONTRACTOR RESPONSES.—

"(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) DEVELOPMENT OF STANDARDS.—

"(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2003.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall

apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

"(b) ENHANCED EDUCATION AND TRAINING.—

"(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2004 and 2005 and such sums as may be necessary for succeeding fiscal years.

"(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

"(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

"(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

"(1) provides answers in an easily accessible format to frequently asked questions, and

"(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

"(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

"(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small providers of services or suppliers" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2004, $1,000,000, and

(2) for fiscal year 2005, $6,000,000.

SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; MEDICARE PROVIDER OMBUDSMAN";

(2) by inserting "PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

"(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

"(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.".

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII, as amended by sections 105 and 701, is amended by inserting after section 1808 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

"SEC. 1809. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

"(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

"(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

"(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

"(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

"(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

"(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

"(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.".

(c) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amend-

ments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1809 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2003 and each succeeding fiscal year.

(e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: "The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through outstationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

Subtitle D—Appeals and Recovery

SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2003, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2004, and not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2004 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking "of the Social Security Administration".

SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision";

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking "PROCEEDING" and all that follows through "DETERMINATION" and inserting "DETERMINATIONS AND RECONSIDERATIONS"; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

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

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review panel—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

"(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

"(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection

(c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.".

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2003.

(d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 832(a), is further amended by adding at the end the following new paragraph:

"(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraph:

"(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall include—

"(A) the specific reasons for the determination, including—

"(i) upon request, the provision of the policy, manual, or regulation used in making the determination; and

"(ii) as appropriate in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination;

"(B) the procedures for obtaining additional information concerning the determination or redetermination; and

"(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.

The written notice on a redetermination shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)" after "in writing, "; and

(B) by inserting "and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section" after "such decision, ".

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting "; NOTICE" after "SECRETARY"; and

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

"(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

"(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

"(B) the procedures for obtaining additional information concerning the decision; and

"(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking "prepare" and inserting "submit" and by striking "with respect to" and all that follows through "and relevant policies".

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking "sufficient training and expertise in medical science and legal matters" and inserting "sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing"; and

(B) by adding at the end the following new subparagraph:

"(K) INDEPENDENCE REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party.

"(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.".

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

"(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).'; and

(B) by adding at the end the following new subsection:

"(g) QUALIFICATIONS OF REVIEWERS.—

"(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

"(2) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party.

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) the individual is not involved in the provision of items or services in the case under review;

"(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

"(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

"(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

"(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(4) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 834. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by sections 812(b), 821(b)(1), and 821(c)(1), is further amended by adding at the end the following new subsection:

"(h) CONDUCT OF PREPAYMENT REVIEW.—

"(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

"(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

"(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

"(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

"(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

"(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

"(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 835. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

"(f) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) HARDSHIP.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

"(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

"(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

"(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

"(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

"(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

"(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

"(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

"(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

"(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

"(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) CONSENT SETTLEMENT REFORMS.—

"(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services or supplier—

"(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

"(II) the nature of the problems identified in such evaluation; and

"(III) the steps that the provider of services or supplier should take to address the problems; and

"(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

"(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(7) PAYMENT AUDITS.—

"(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

"(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

"(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

"(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.".

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: "; ENROLLMENT PROCESSES"; and

(2) by adding at the end the following new subsection:

"(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) ENROLLMENT PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

"(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

"(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of

such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.".

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2003.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 837. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 821(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

SEC. 838. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 833(d)(2)(B), is further amended by adding at the end the following new subsection:

"(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

"(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

"(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

"(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

"(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

"(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

"(3) REQUEST FOR PRIOR DETERMINATION.—

"(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

"(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request

submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

"(4) RESPONSE TO REQUEST.—

"(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

"(i) the item or service is so covered;

"(ii) the item or service is not so covered; or

"(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

"(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

"(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

"(5) EFFECT OF DETERMINATIONS.—

"(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

"(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

"(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

"(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

"(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

"(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

"(6) LIMITATION ON FURTHER REVIEW.—

"(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

"(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

"(i) decides not to seek a prior determination under this subsection with respect to items or services; or

"(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

"(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.".

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to

provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (4)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term "advance beneficiary notice" means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

Subtitle E—Miscellaneous Provisions

SEC. 841. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2004, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2004, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term "rural area" has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term "teaching settings" are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) IMPROVED COORDINATION BETWEEN FDA AND CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

(1) IN GENERAL.—Upon request by an applicant and to the extent feasible (as determined by the Secretary), the Secretary shall, in the case of a class III medical device that is subject to premarket approval under section 515 of the Federal Food, Drug, and Cosmetic Act, ensure the sharing of appropriate information from the review for application for premarket approval conducted by the Food and Drug Administration for coverage decisions under title XVIII of the Social Security Act.

(2) PUBLICATION OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to appropriate Committees of Congress a report that contains the plan for improving such coordination and for shortening the time lag between the premarket approval by the Food and Drug Administration and coding and coverage decisions by the Centers for Medicare & Medicaid Services.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the criteria for coverage of a medical device under title XVIII of the Social Security Act nor premarket approval by the Food and Drug Administration and nothing in this subsection shall be construed to increase premarket approval application requirements under the Federal Food, Drug, and Cosmetic Act.

(b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 823(a), is amended by adding at the end the following new subsection:

"(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups

and entities regarding the coverage, coding, and payment processes under this title.".

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2003, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) IOM STUDY ON LOCAL COVERAGE DETERMINATIONS.—

(1) STUDY.—The Secretary shall enter into an arrangement with the Institute of Medicine of the National Academy of Sciences under which the Institute shall conduct a study on local coverage determinations (including the application of local medical review policies) under the medicare program under title XVIII of the Social Security Act. Such study shall examine—

(A) the consistency of the definitions used in such determinations;

(B) the types of evidence on which such determinations are based, including medical and scientific evidence;

(C) the advantages and disadvantages of local coverage decisionmaking, including the flexibility it offers for ensuring timely patient access to new medical technology for which data are still be collected;

(D) the manner in which the local coverage determination process is used to develop data needed for a national coverage determination, including the need for collection of such data within a protocol and informed consent by individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both; and

(E) the advantages and disadvantages of maintaining local medicare contractor advisory committees that can advise on local coverage decisions based on an open, collaborative public process.

(2) REPORT.—Such arrangement shall provide that the Institute shall submit to the Secretary a report on such study by not later than 3 years after the date of the enactment of this Act. The Secretary shall promptly transmit a copy of such report to Congress.

(e) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2004 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and

other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 844. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2003.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

"(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.".

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and

(B) by adding at the end the following new sentences: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as

required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 845. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH OTHER HOSPICE PROGRAMS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following new subparagraph:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.".

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)), as amended by section 421(b), is amended by adding at the end the following new paragraph:

"(5) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking "and" at the end;

(B) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(C) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).."; and

(2) by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.".

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2003.

SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking "established under section 1114(f)"; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking "under subsection (f)"; and

(ii) by striking "section 1862(a)(1)" and inserting "subsection (a)(1)".

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking "policy" and inserting "determination"; and

(B) in subclause (IV), by striking "medical review policies" and inserting "coverage determinations".

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking "policy" and "POLICY" and inserting "determination" each place it appears and "DETERMINATION", respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking "subclause (I), (II), or (III)" and inserting "clause (i), (ii), or (iii)";

(2) in subparagraph (B), by striking "clause (i)(IV)" and "clause (i)(III)" and inserting "subparagraph (A)(iv)" and "subparagraph (A)(iii)", respectively; and

(3) in subparagraph (C), by striking "clause (i)", "subclause (IV)" and "subparagraph (A)" and inserting "subparagraph (A)", "clause (iv)" and "paragraph (1)(A)", respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 849. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.".

SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.

The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

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

Subtitle A—Medicaid Provisions

SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICAID.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicaid (in this section referred to as the "Commission").

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) identify the factors that are causing, and the consequences of, increases in costs under the medicaid program, including—

(A) the impact of these cost increases upon State budgets, funding for other State programs, and levels of State taxes necessary to fund growing expenditures under the medicaid program;

(B) the financial obligations of the Federal government arising from the Federal matching requirement for expenditures under the medicaid program; and

(C) the size and scope of the current program and how the program has evolved over time;

(3) analyze potential policies that will ensure both the financial integrity of the medicaid program and the provision of appropriate benefits under such program;

(4) make recommendations for establishing incentives and structures to promote enhanced efficiencies and ways of encouraging innovative State policies under the medicaid program;

(5) make recommendations for establishing the appropriate balance between benefits covered, payments to providers, State and Federal contributions and, where appropriate, recipient cost-sharing obligations;

(6) make recommendations on the impact of promoting increased utilization of competitive, private enterprise models to contain program cost growth,

through enhanced utilization of private plans, pharmacy benefit managers, and other methods currently being used to contain private sector health-care costs;

(7) make recommendations on the financing of prescription drug benefits currently covered under medicaid programs, including analysis of the current Federal manufacturer rebate program, its impact upon both private market prices as well as those paid by other government purchasers, recent State efforts to negotiate additional supplemental manufacturer rebates and the ability of pharmacy benefit managers to lower drug costs;

(8) review and analyze such other matters relating to the medicaid program as the Commission deems appropriate; and

(9) analyze the impact of impending demographic changes upon medicaid benefits, including long term care services, and make recommendations for how best to appropriately divide State and Federal responsibilities for funding these benefits.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairman of the Commission, appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than December 1, 2002.

(3) TERMS OF APPOINTMENT.—The term of any appointment under paragraph (1) to the Commission shall be for the life of the Commission.

(4) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(5) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy and shall not affect the power of the remaining members to execute the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairman shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF CMS.—

(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than March 1, 2004, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of only those the recommendations, findings, and conclusions of the Commission.

(g) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section.

SEC. 902. GAO STUDY ON MEDICAID DRUG PAYMENT SYSTEM.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the reimbursement under the medicaid program for covered outpatient drugs. Such study shall examine—

(1) the extent to which such reimbursements for a drug exceed the acquisition costs for that drug;

(2) the services and resources associated with dispensing a prescription and any additional payments available to compensate for expenses for these services and resources; and

(3) efforts undertaken by States to change the levels of such reimbursement and the price data they use in effecting such change.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for changes for legislative or administrative action regarding medicaid reimbursement methodologies for outpatient prescription drugs, and their application to the medicare program, as the Comptroller General deems appropriate.

Subtitle B—Internet Pharmacies

SEC. 911. FINDINGS.

The Congress finds as follows:

(1) Legitimate Internet sellers of prescription drugs can offer substantial benefits to consumers. These potential benefits include convenience, privacy, valuable information, competitive prices, and personalized services.

(2) Unlawful Internet sellers of prescription drugs may dispense inappropriate, contaminated, counterfeit, or subpotent prescription drugs that could put at risk the health and safety of consumers.

(3) Unlawful Internet sellers have exposed consumers to significant health risks by knowingly filling invalid prescriptions, such as prescriptions based solely on an online questionnaire, or by dispensing prescription drugs without any prescription.

(4) Consumers may have difficulty distinguishing legitimate from unlawful Internet sellers, as well as foreign from domestic Internet sellers, of prescription drugs.

SEC. 912. AMENDMENT TO FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503A the following:

"SEC. 503B. INTERNET PRESCRIPTION DRUG SALES.

"(a) DEFINITIONS.—For purposes of this section:

"(1) CONSUMER.—The term 'consumer' means a person (other than an entity licensed or otherwise authorized under Federal or State law as a pharmacy or to dispense or distribute prescription drugs) that purchases or seeks to purchase prescription drugs through the Internet.

"(2) HOME PAGE.—The term 'home page' means the entry point or main web page for an Internet site.

"(3) INTERNET.—The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio, including electronic mail.

"(4) INTERSTATE INTERNET SELLER.—

"(A) IN GENERAL.—The term 'interstate Internet seller' means a person whether in the United States or abroad, that engages in, offers to engage in, or causes the delivery or sale of a prescription drug through the Internet and has such drug delivered directly to the consumer via the Postal Service, or any private or commercial interstate carrier to a consumer in the United States who is residing in a State other than the State in which the seller's place of business is located. This definition excludes a person who only delivers a prescription drug to a consumer, such as an interstate carrier service.

"(B) EXEMPTION.—With respect to the consumer involved, the term 'interstate Internet seller' does not include a person described in subparagraph (A) whose place of business is located within 75 miles of the consumer.

"(5) LINK.—The term 'link' means either a textual or graphical marker on a web page that, when clicked on, takes the consumer to another part of the Internet, such as to another web page or a different area on the same web page, or from an electronic message to a web page.

"(6) PHARMACY.—The term 'pharmacy' means any place licensed or otherwise authorized as a pharmacy under State law.

"(7) PRESCRIBER.—The term 'prescriber' means an individual, licensed or otherwise authorized under applicable Federal and State law to issue prescriptions for prescription drugs.

"(8) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug under section 503(b)(1).

"(9) VALID PRESCRIPTION.—The term 'valid prescription' means a prescription that meets the requirements of section 503(b)(1) and other applicable Federal and State law.

"(10) WEB SITE; SITE.—The terms 'web site' and 'site' mean a specific location on the Internet that is determined by Internet protocol numbers or by a domain name.

"(b) REQUIREMENTS FOR INTERSTATE INTERNET SELLERS.—

"(1) IN GENERAL.—Each interstate Internet seller shall comply with the requirements of this subsection with respect to the sale of, or the offer to sell, prescription drugs through the Internet and shall at all times display on its web site information in accordance with paragraph (2).

"(2) WEB SITE DISCLOSURE INFORMATION.—An interstate Internet seller shall post in a visible and clear manner (as determined by regulation) on the home page of its web site, or on a page directly linked to such home page—

"(A) the street address of the interstate Internet seller's place of business, and the telephone number of such place of business;

"(B) each State in which the interstate Internet seller is licensed or otherwise authorized as a pharmacy, or if the interstate Internet seller is not licensed or otherwise authorized by a State as a pharmacy, each State in which the interstate Internet seller is licensed or otherwise authorized to dispense prescription drugs, and the type of State license or authorization;

"(C) in the case of an interstate Internet seller that makes referrals to or solicits on behalf of a prescriber, the name of each prescriber, the street address of each such prescriber's place of business, the telephone number of such place of business, each State in which each such prescriber is licensed or otherwise authorized to prescribe prescription drugs, and the type of such license or authorization; and

"(D) a statement that the interstate Internet seller will dispense prescription drugs only upon a valid prescription.

"(3) DATE OF POSTING.—Information required to be posted under paragraph (2) shall be posted by an interstate Internet seller—

"(A) not later than 90 days after the effective date of this section if the web site of such seller is in operation as of such date; or

"(B) on the date of the first day of operation of such seller's web site if such site goes into operation after such date.

"(4) QUALIFYING STATEMENTS.—An interstate Internet seller shall not indicate in any manner that posting disclosure information on its web site signifies that the Federal Government has made any determination on the legitimacy of the interstate Internet seller or its business.

"(5) DISCLOSURE TO STATE LICENSING BOARDS.—An interstate Internet seller licensed or otherwise authorized to dispense prescription drugs in accordance with applicable State law shall notify each State entity that granted such licensure or authorization that it is an interstate Internet seller, the name of its business, the Internet address of its business, the street address of its place of business, and the telephone number of such place of business.

"(6) REGULATIONS.—The Secretary is authorized to promulgate such regulations as are necessary to carry out the provisions of this subsection. In issuing such regulations, the Secretary—

"(A) shall take into consideration disclosure formats used by existing interstate Internet seller certification programs; and

"(B) shall in defining the term 'place of business' include provisions providing that such place is a single location at which employees of the business perform job functions, and not a post office box or similar locale.".

(b) PROHIBITED ACTS.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by adding at the end the following:

"(bb) The failure to post information required under section 503B(b)(2) or for knowingly making a materially false statement when posting such information as required under such section or violating section 503B(b)(4).".

SEC. 913. PUBLIC EDUCATION.

The Secretary of Health and Human Services shall engage in activities to educate the public about the dangers of purchasing prescription drugs from unlawful Internet sources. The Secretary should educate the public about effective public and private sector consumer protection efforts, as appropriate, with input from the public and private sectors, as appropriate.

SEC. 914. STUDY REGARDING COORDINATION OF REGULATORY ACTIVITIES.

Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services, after consultation with the Attorney General, shall submit to Congress a report providing recommendations for coordinating the activities of Federal agencies regarding interstate Internet sellers that operate from foreign countries and for coordinating the activities of the Federal Government with the activities of governments of foreign countries regarding such interstate Internet sellers.

SEC. 915. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect 1 year after the date of enactment of this Act, except that the authority of the Secretary of Health and Human Services to commence the process of rulemaking is effective on the date of enactment of this Act.

Subtitle C—Promotion of Electronic Prescription

SEC. 921. PROGRAM OF GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS.

Part P of title III of the Public Health Service Act is amended by inserting after section 399N the following new section:

"SEC. 399O. GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS.

"(a) IN GENERAL.—The Secretary is authorized to make grants for the purpose of assisting health care providers who prescribe drugs and biologicals in implementing electronic prescription programs described in section 1860C(d)(3) of the Social Security Act.

"(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal year 2004, such sums as may be appropriate to carry out this section.".

Subtitle D—Treatment of Rare Diseases

SEC. 931. NIH OFFICE OF RARE DISEASES AT NATIONAL INSTITUTES OF HEALTH.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.), as amended by Public Law 107–84, is amended by inserting after section 404E the following:

"OFFICE OF RARE DISEASES

"SEC. 404F. (a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of Rare Diseases (in this section referred to as the 'Office'), which shall be headed by a Director (in this section referred to as the 'Director'), appointed by the Director of NIH.

"(b) DUTIES.—

"(1) IN GENERAL.—The Director of the Office shall carry out the following:

"(A) The Director shall recommend an agenda for conducting and supporting research on rare diseases through the national research institutes and centers. The agenda shall provide for a broad range of research and education activities, including scientific workshops and symposia to identify research opportunities for rare diseases.

"(B) The Director shall, with respect to rare diseases, promote coordination and cooperation among the national research institutes and centers and entities whose research is supported by such institutes.

"(C) The Director, in collaboration with the directors of the other relevant institutes and centers of the National Institutes of Health, may enter into cooperative agreements with and make grants for regional centers of excellence on rare diseases in accordance with section 404G.

"(D) The Director shall promote the sufficient allocation of the resources of the National Institutes of Health for conducting and supporting research on rare diseases.

"(E) The Director shall promote and encourage the establishment of a centralized clearinghouse for rare and genetic disease information that will provide understandable information about these diseases to the public, medical professionals, patients and families.

"(F) The Director shall biennially prepare a report that describes the research and education activities on rare diseases being conducted or supported through the national research institutes and centers, and that identifies particular projects or types of projects that should in the future be conducted or supported by the national research institutes and centers or other entities in the field of research on rare diseases.

"(G) The Director shall prepare the NIH Director's annual report to Congress on rare disease research conducted by or supported through the national research institutes and centers.

"(2) PRINCIPAL ADVISOR REGARDING ORPHAN DISEASES.—With respect to rare diseases, the Director shall serve as the principal advisor to the Director of NIH and shall provide advice to other relevant agencies. The Director shall provide liaison with national and international patient, health and scientific organizations concerned with rare diseases.

"(c) DEFINITION.—For purposes of this section, the term 'rare disease' means any disease or condition that affects less than 200,000 persons in the United States.

"(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as already have been appropriated for fiscal year 2002, and $4,000,000 for each of the fiscal years 2003 through 2006.".

SEC. 932. RARE DISEASE REGIONAL CENTERS OF EXCELLENCE.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.), as amended by section 931, is further amended by inserting after section 404F the following:

"RARE DISEASE REGIONAL CENTERS OF EXCELLENCE

"SEC. 404G. (a) COOPERATIVE AGREEMENTS AND GRANTS.—

"(1) IN GENERAL.—The Director of the Office of Rare Diseases (in this section referred to as the 'Director'), in collaboration with the directors of the other relevant institutes and centers of the National Institutes of Health, may enter into cooperative agreements with and make grants to public or private nonprofit entities to pay all or part of the cost of planning, establishing, or strengthening, and providing basic operating support for regional centers of excellence for clinical research into, training in, and demonstration of diagnostic, prevention, control, and treatment methods for rare diseases.

"(2) POLICIES.—A cooperative agreement or grant under paragraph (1) shall be entered into in accordance with policies established by the Director of NIH.

"(b) COORDINATION WITH OTHER INSTITUTES.—The Director shall coordinate the activities under this section with similar activities conducted by other national research institutes, centers and agencies of the National Institutes of Health and by the Food and Drug Administration to the extent that such institutes, centers and agencies have responsibilities that are related to rare diseases.

"(c) USES FOR FEDERAL PAYMENTS UNDER COOPERATIVE AGREEMENTS OR GRANTS.—Federal payments made under a cooperative agreement or grant under subsection (a) may be used for—

"(1) staffing, administrative, and other basic operating costs, including such patient care costs as are required for research;

"(2) clinical training, including training for allied health professionals, continuing education for health professionals and allied health professions personnel, and information programs for the public with respect to rare diseases; and

"(3) clinical research and demonstration programs.

"(d) PERIOD OF SUPPORT; ADDITIONAL PERIODS.—Support of a center under subsection (a) may be for a period of not to exceed 5 years. Such period may be extended by the Director for additional periods of not more than 5 years if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period should be extended.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as already have been appropriated for fiscal year 2002, and $20,000,000 for each of the fiscal years 2003 through 2006.".

Subtitle E—Other Provisions Relating to Drugs

SEC. 941. GAO STUDY REGARDING DIRECT-TO-CONSUMER ADVERTISING OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study for the purpose of determining—

(1) whether and to what extent there have been increases in utilization rates of prescription drugs that are attributable to guidance regarding direct-to-consumer advertising of such drugs that has been issued by the Food and Drug Administration under section 502(n) of the Federal Food, Drug, and Cosmetic Act; and

(2) if so, whether and to what extent such increased utilization rates have resulted in increases in the costs of public or private health plans, health insurance, or other health programs.

(b) CERTAIN DETERMINATIONS.—The study under subsection (a) shall include determinations of the following:

(1) The extent to which advertisements referred to in such subsection have resulted in effective consumer education about the prescription drugs involved, including an understanding of the risks of the drugs relative to the benefits.

(2) The extent of consumer satisfaction with such advertisements.

(3) The extent of physician satisfaction with the advertisements, including determining whether physicians believe that the advertisements interfere with the exercise of their medical judgment by influencing consumers to prefer advertised drugs over alternative therapies.

(4) The extent to which the advertisements have resulted in increases in health care costs for taxpayers, for employers, or for consumers due to consumer decisions to seek advertised drugs rather than lower-costs alternative therapies.

(5) The extent to which the advertisements have resulted in decreases in health care costs for taxpayers, for employers, or for consumers due to decreased hospitalization rates, fewer physician visits (not related to hospitalization), lower treatment costs, or reduced instances of employee absences to care for family members with diseases or disorders.

(c) REPORT.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Congress a report providing the findings of the study under subsection (a).

SEC. 942. CERTAIN HEALTH PROFESSIONS PROGRAMS REGARDING PRACTICE OF PHARMACY.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following subpart:

"Subpart 3—Pharmacist Workforce Programs

"SEC. 771. PUBLIC SERVICE ANNOUNCEMENTS.

"(a) PUBLIC SERVICE ANNOUNCEMENTS.—

"(1) IN GENERAL.—The Secretary shall develop and issue public service announcements that advertise and promote the pharmacist profession, highlight the advantages and rewards of being a pharmacist, and encourage individuals to enter the pharmacist profession.

"(2) METHOD.—The public service announcements described in subsection (a) shall be broadcast through appropriate media outlets, including television or radio, in a manner intended to reach as wide and diverse an audience as possible.

"(b) STATE AND LOCAL PUBLIC SERVICE ANNOUNCEMENTS.—

"(1) IN GENERAL.—The Secretary shall award grants to entities to support State and local advertising campaigns through appropriate media outlets to promote the pharmacist profession, highlight the advantages and rewards of being a pharmacist, and encourage individuals to enter the pharmacist profession.

"(2) USE OF FUNDS.—An entity that receives a grant under subsection (a) shall use funds received through such grant to acquire local television and radio time, place advertisements in local newspapers, and post information on billboards or on the Internet, in order to—

"(A) advertise and promote the pharmacist profession;

"(B) promote pharmacist education programs;

"(C) inform the public of public assistance regarding such education programs;

"(D) highlight individuals in the community that are presently practicing as pharmacists to recruit new pharmacists; and

"(E) provide any other information to recruit individuals for the pharmacist profession.

"(3) METHOD.—The campaigns described in subsection (a) shall be broadcast on television or radio, placed in newspapers as advertisements, or posted on billboards or the Internet, in a manner intended to reach as wide and diverse an audience as possible.

"SEC. 772. DEMONSTRATION PROJECT.

"(a) IN GENERAL.—The Secretary shall establish a demonstration project to enhance the participation of individuals who are pharmacists in the National Health Service Corps Loan Repayment Program described in section 338B.

"(b) SERVICES.—Services that may be provided by pharmacists pursuant to the demonstration project established under this section include medication therapy management services to assure that medications are used appropriately by patients, to enhance patients' understanding of the appropriate use of medications, to increase patients' adherence to prescription medication regimens, to reduce the risk of adverse events associated with medications, and to reduce the need for other costly medical services through better management of medication therapy. Such services may include case management, disease management, drug therapy management, patient training and education, counseling, drug therapy problem resolution, medication administration, the provision of special packaging, or other services that enhance the use of prescription medications.

"(c) PROCEDURE.—The Secretary may not provide assistance to an individual under this section unless the individual agrees to comply with all requirements described in sections 338B and 338D.

"(d) LIMITATIONS.—The demonstration project described in this section shall provide for the participation of—

"(1) individuals to provide services in rural and urban areas; and

"(2) enough individuals to allow the Secretary to properly analyze the effectiveness of such project.

"(e) DESIGNATIONS.—The demonstration project described in this section, and any pharmacists who are selected to participate in such project, shall not be considered by the Secretary in the designation of a health professional shortage area under section 332 during fiscal years 2003 through 2005.

"(f) RULE OF CONSTRUCTION.—This section shall not be construed to require any State to participate in the project described in this section.

"(g) REPORT.—The Secretary shall prepare and submit a report on the project to—

"(1) the Committee on Health, Education, Labor, and Pensions of the Senate;

"(2) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the Senate;

"(3) the Committee on Energy and Commerce of the House of Representatives; and

"(4) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the House of Representatives.

"SEC. 773. INFORMATION TECHNOLOGY.

"(a) GRANTS AND CONTRACTS.—The Secretary may make awards of grants or contracts to qualifying schools of pharmacy for the purpose of assisting such schools in acquiring and installing computer-based systems to provide pharmaceutical education. Education provided through such systems may be graduate education, professional education, or continuing education. The computer-based systems may be designed to provide on-site education, or education at remote sites (commonly referred to as distance learning), or both.

"(b) QUALIFYING SCHOOL OF PHARMACY.—For purposes of this section, the term 'qualifying school of pharmacy' means a school of pharmacy (as defined in section 799B) that requires students to serve in a clinical rotation in which pharmacist services are part of the curriculum.

"SEC. 774. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying out this subpart, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2003 through 2006.".

I. INTRODUCTION

A. Purpose and Summary and,

B. Background and Need for Legislation

Thirty-seven years ago Congress enacted the Medicare program to help provide health care to our nation's seniors. Medicare has improved and lengthened the lives of millions of people. In recent years, Congress successively slowed Medicare's growth rate and added new preventive benefits to keep seniors healthier. Yet Medicare has still not met its true promise because it remains mired in a rigid administrative structure, which can only change when Congress enacts a law.

When Medicare was enacted, there were few prescription drugs, and most care was delivered in hospitals. Consequently, prescription drugs were not covered under Medicare. While about two-thirds of seniors have some prescription drug coverage through former employers, Medicare+Choice organizations, Medicaid, state pharmacy assistance programs and Medigap, that coverage has been declining and is often inadequate. Many other seniors lack prescription drug coverage and the bargaining power to reduce the price of drugs.

Prescription drugs are an integral part of healthcare today. They prevent and manage diseases and are less invasive and costly than alternative health care options (e.g. surgery, hospitalization, nursing home admissions, etc.) Most private health plans voluntarily integrated prescription drugs into their benefits. Nobody today with a blank sheet of paper would design a seniors health care program that excluded prescription drugs. Yet, the absence of a prescription drug benefit epitomizes how Medicare has not kept pace with modern medicine. While a Medicare prescription drug benefit is long overdue, it is not the only problem afflicting a program so many of us cherish and want to strengthen.

Medicare's irrational and unpredictable payments to physicians are just one example of what is wrong with reimbursement policy in the Medicare program. While health costs are escalating, under the current Sustainable Growth Rate formula, payments to physicians are being substantially reduced. Failure to change the law would result in nearly a 20 percent cut in physician reimbursement over the next several years. Patients' access to physicians will suffer and the doctors Medicare beneficiaries rely on will only become more demoralized. Similarly, rural hospitals continue to struggle and are not paid equitably in comparison to large urban hospitals. In addition, numerous Medicare+Choice plans are withdrawing from the program and are substantially cutting benefits because government payments are not related to the actual costs of health care.

At the same time Medicare is arguably overpaying for other services, such as durable medical equipment. Recently, the Office of Inspector General documented that taxpayers and Medicare beneficiaries are paying millions more for durable medical equipment than other programs, such as the Federal Employee Health Benefit Plan.

In addition, the health care professionals that serve Medicare beneficiaries are being crushed by more than 130,000 pages of overly burdensome regulations—four times more than those governing the Internal Revenue Code. This hampers their ability to provide quality care to seniors, and it must be changed.

This bill addresses all of these issues and more.

First and foremost, it provides a voluntary, affordable prescription drug benefit as an entitlement to all beneficiaries. The proposal is within the $350 billion allocated under the budget resolution and there are no gimmicks, such as a sunset that terminates the program after five years of operation, as has been suggested by the Senate. The bill provides a markedly more generous than the benefit the House passed just two years ago. First, the subsidy has been increased from 35 percent to 65 percent. Second, the front-end coverage has been improved from a 50–50 cost share, to 80–20 cost-share, which is similar to employer provided coverage. Third, the catastrophic protection has been lowered from $6,000 in out-of-pocket costs to $3,800. Finally, the bill does more for the low-income—those who need help most. It provides low-income individuals additional assistance with their premiums and cost sharing up to 175 percent of poverty, as opposed to 150 percent. It is important to note 175 percent of poverty in 2005, when this program is up and running is $17,575 for an individual and $22,624 for a couple.

The prescription drug benefit is delivered through competing private sector entities, which already deliver pharmaceutical benefits for millions of people, including every Member of Congress. The bill permits and encourages these plans to utilize private sector tools to aggressively negotiate lower prices and provide better service for beneficiaries. By exempting prices negotiated for Medicare beneficiaries from the Medicaid "best price" provision, the bill encourages steep discounting by pharmaceutical manufacturers, saving taxpayers and beneficiaries over $15 billion. The private sector delivery is backed up by a government guarantee that all seniors in every area of the country must be covered. Indeed, the Congressional Budget Office and the CMS Office of the Actuary predicts that more than 95 percent of seniors will voluntarily sign up for this benefit.

More than 57 different provider and patient groups have endorsed this legislation because it modernizes irrational reimbursements and burdensome regulatory structures, which undermine the quality and accessibility of care. The bill reforms physician payments, addresses inequities between rural and large urban hospitals, stabilizes the Medicare+Choice program, permanently repeals the 15 percent home health cut that has been hanging like a guillotine over home health agencies, and improves payments for skilled nursing facilities and dialysis centers.. More importantly, the legislation sets Medicare on a path of more rational pricing, de-

termined by the market place rather than by government edict, by moving durable medical equipment, the Medicare+Choice program, and its contractors, to a competitive system, making Medicare more efficient over the long-term.

In addition, the bill includes the bipartisan Johnson-Stark regulatory and contracting reform bill that reduces unnecessary regulation and modernizes how Medicare selects its contractors. The Johnson-Stark Regulatory and Contracting Reform Act of 2001, which the House of Representatives unanimously passed in December 2001, has failed to even receive a hearing in the Senate.

The bill also establishes a new Medicare Benefits Administration to manage and oversee the Medicare+Choice and prescription drug benefits, parts C and D of the Medicare program. Creation of the MBA eliminates the inherent conflict of interest of requiring the government-run fee-for-service plan to regulate competing private plans.

Finally, the bill provides clear improvements for beneficiaries by reducing excessive beneficiary cost-sharing charges for hospital outpatient settings by nearly $10 billion and for the first time covering physicals and cholesterol screening to keep seniors healthy and diagnose problems before they become serious.

C. Legislative History

In the 106th Congress, the House of Representatives passed the "Rx 2000" bill (H.R. 4680), which would create a prescription drug benefit in Medicare. However, President Clinton opposed that legislation and the Senate failed to act on Medicare prescription drugs.

LEGISLATIVE HEARINGS

During the 107th Congress, the Committee on Ways and Means or its Subcommittee on Health held 16 hearings exploring how Medicare should be strengthened and modernized. These hearings, which examined all aspects of the Medicare program, included expert testimony from academics and beneficiary and provider representatives.

February 28, 2001 Perspectives on Medicare Reform
March 14, 2001 Administration's Health and Welfare Priorities
March 15, 2001 Bringing Regulatory Relief to Beneficiaries and Providers
March 20, 2001 Medicare Solvency
March 27, 2001 Laying the Groundwork for a Rx Drug Benefit
May 1, 2001 Medicare+Choice: Lessons for Reform
May 9, 2001 Strengthening Medicare: Modernizing Beneficiary Cost Sharing
June 12, 2001 Rural Health Care in Medicare
July 19, 2001 Administration's Principles to Strengthen and Modernize Medicare
September 25, 2001 H.R. 2768, Medicare Regulatory and Contracting Reform Act
December 4, 2001 Status of the Medicare+Choice Program
February 28, 2002 Reforming Physician Payments
March 7, 2002 Health Quality and Medical Errors
March 14, 2002 Medicare Supplemental Insurance

April 16, 2002 Promoting Disease Management in Medicare
April 17, 2002 Integrating Prescription Drugs into Medicare

In October 2001, the Ways and Means Committee unanimously approved the Medicare Regulatory and Contracting Reform Act (H.R. 2768), sponsored by Representatives Nancy Johnson and Pete Stark. After resolving differences with the Energy and Commerce Committee, that bill was unanimously approved by the House of Representatives in December 2001, but not taken up by the Senate. That legislation constitutes Title VIII of the Medicare Modernization and Prescription Drug Act of 2002.

The House-passed Budget Resolution (H. Con. Res. 353) allocated $350 billion over 10 years for Medicare modernization, prescription drugs and adjustments to provider reimbursements.

H.R. 4954, "The Medicare Modernization and Prescription Drug Act of 2002," was introduced by Health Subcommittee Chairman Nancy Johnson on June 18 2002 (after being released to the public June 14) and jointly referred to the Ways and Means and Energy and Commerce Committee. It was marked up by the Full Committee June 18, 2002 and approved 22–16 after accepting several amendments, including the Thomas amendment in the nature of a substitute.

The reported bill has nine titles:

- Title I: Establishment of a Medicare Prescription Drug Benefit
- Title II: Medicare+Choice Revitalization and Medicare+Choice Competition Program.
- Title III: Rural Health Care Improvements
- Title IV: Provisions Relating to Part A
- Title V: Provisions Relating to Part B
- Title VI: Provisions Relating to Part A and B
- Title VII: Medicare Benefits Administration
- Title VIII: Regulatory Reduction and Contracting Reform
- Title IX: Medicaid, Public Health and Other Provisions

II. EXPLANATION OF PROVISIONS

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Section 101. Establishment of a Medicare Prescription Drug Benefit

CURRENT LAW

Medicare does not cover most outpatient prescription drugs. Beneficiaries who are inpatients of hospitals or skilled nursing facilities may receive drugs as part of their treatment. Medicare payments made to the facilities cover these costs. Medicare also makes payments to physicians for drugs or biologicals that are not usually self-administered. This means that coverage is generally limited to drugs or biologicals administered by injection. However, if the injection is generally self-administered (e.g., insulin), it is not covered.

Despite the general limitation on coverage for outpatient drugs, the law specifically authorizes coverage for the following: (1) drugs used in immunosuppressive therapy (such as cyclosporin) following discharge from a hospital for a Medicare covered organ transplant; (2) erythropoietin (EPO) for the treatment of anemia for persons

with chronic renal failure who are on dialysis; (3) drugs taken orally during cancer chemotherapy providing they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service; and (4) hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors. The program also pays for supplies (including drugs) that are necessary for the effective use of covered durable medical equipment, including those, which must be put directly into the equipment (e.g., tumor chemotherapy agents used with an infusion pump). Medicare also covers pneumococcal pneumonia vaccines, hepatitis B vaccines, and influenza virus vaccines.

EXPLANATION OF PROVISION

The provision would establish a new Voluntary Prescription Drug Benefit Program under a new Part D of Title XVIII of the Social Security Act.

New Section 1860A. Benefits; Eligibility; Enrollment; and Coverage Period

The new Section 1860A would specify that each individual entitled to Medicare Part A and enrolled in Medicare Part B would be entitled to obtain qualified prescription drug coverage. An individual enrolled in a Medicare+Choice (M+C) plan providing qualified prescription drug coverage could obtain coverage through the plan. An individual not enrolled in a M+C plan providing qualified prescription drug coverage could enroll under Part D in a new prescription drug plan (PDP). The provision would specify that an individual eligible to make an election to enroll in a PDP, or with a M+C with qualified drug coverage, would do so in accordance with regulations issued by the Administrator of the new Medicare Benefits Administration (MBA). Enrollments and changes in enrollment could occur only during a specified election period. The election periods would generally be the same as those established for M+C, including annual coordinated election periods and special election periods. An individual discontinuing a M+C election during the first year of eligibility would be permitted to enroll in a PDP at the same time as the election of coverage under the original fee-for-service plan.

The provision would establish initial election periods. A six-month election period, beginning on November 1, 2004, would be established for persons enrolled under Part B on that date. For persons first enrolling in Part B after that date, an initial election period, which is the same as that for initial part B enrollment, would be established. The Administrator would be required to establish special election periods for persons in special circumstances. Specifically these would apply to: persons having and involuntarily losing prescription drug coverage; in cases of enrollment delays or non-enrollment attributable to government action; in the case of an individual meeting exceptional circumstances specified by the Administrator (including circumstances identified by the Adminis-

trator for M+C enrollment); and in cases of individuals who become eligible for Medicaid drug coverage.

The provision would establish guaranteed issue and community-rating requirements. The provision would specify that individuals electing qualified prescription drug coverage under a PDP plan or M+C could not be denied enrollment based on health status or other factors. Existing M+C provisions relating to priority enrollment (where capacity limits have been reached) and limitations on terminations of elections would apply to PDP sponsors.

The provision would specify that PDP sponsors and M+C organizations providing qualified prescription drug coverage could not deny, limit, or condition the coverage or provision of benefits or increase the premium based on any health-related status factor in the case of persons who maintained continuous prescription drug coverage since the date they first qualified to elect drug coverage under Part D. Individuals who did not maintain continuous coverage could be subject to an adjusted premium or a pre-existing condition exclusion in a manner reflecting the additional actuarial risk involved. Such risk would be established through an appropriate actuarial opinion.

The provision would specify that an individual is considered to have had continuous prescription drug coverage if the individual establishes that he or she has had coverage under one of the following (and coverage in one plan occurs no more than 63 days after termination of coverage in another plan): (1) qualified prescription drug coverage under a PDP or M+C plan; (2) Medicaid prescription drug coverage; (3) prescription drug coverage under a group health plan, but only if benefits are at least equivalent to benefits under a qualified PDP; (4) prescription drug coverage under a Medigap plan, but only if the policy was in effect on January 1, 2005, and only if the benefits are at least equivalent to benefits under a qualified PDP; (5) state pharmaceutical assistance program, but only if benefits are at least equivalent to benefits under a qualified PDP; and (6) veterans coverage for prescription drugs, but only if benefits are at least equivalent to benefits under a qualified PDP. Individuals could apply to the Administrator to waive the requirement that such coverage be at least equivalent to benefits under a qualified prescription drug plan. They could make such application if they could establish that they were not adequately informed that the coverage did not provide such level of coverage.

The provision would prohibit PDP sponsors from establishing a service area in a manner that would discriminate based on the health or economic status of potential enrollees.

The provision would provide that elections would take effect at the same time that elections take effect for M+C plans. However, no election could take effect before January 1, 2005. The Secretary would provide for the termination of an election in the case of termination of Part B coverage or termination of an election by the M+C for cause (including failure to pay the required premium).

New Section 1860B. Requirements for Qualified Prescription Drug Coverage

The new Section 1860B specifies the requirements for qualified prescription drug coverage. Qualified coverage is defined as either

a standard coverage or actuarially equivalent coverage. The Administrator would have to approve plans as actuarially equivalent and meeting the requirements of this part. In either standard coverage or actuarially equivalent coverage, access would have to be provided to negotiated prices.

For 2005, standard coverage would be defined as having a $250 deductible; 20 percent cost-sharing up to the initial co-payment threshold ($1,000) 50 percent cost-sharing for costs above the initial co-payment threshold up to the $2,000 initial coverage limit and catastrophic coverage at $3,800. Once the beneficiary reached the catastrophic level (a stop loss at limit), full coverage would be provided. Beginning in 2006, the annual dollar amounts would be increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12–month period ending in July of the previous year.

Plans may offer alternate coverage if the plan meets the following five criteria: (1) the entire benefit is actuarially equivalent to the standard benefit; (2) costs up to the initial co-payment threshold, from the $250 deductible to $1000, are actuarially consistent with an average expected 20 percent cost-sharing for costs up to the initial co-payment threshold; (3) for costs above $1000 threshold up to the initial coverage limit ($2,000), are actuarially consistent with an average expected 50 percent cost-sharing for costs up to the initial coverage threshold; (4) the plan must offer the identical catastrophic benefit ($3,800); and (5) the unsubsidized value of the standard benefit equals the unsubsidized value of an alternative benefit.

The provision would specify incurred costs that would count toward meeting the deductible, initial coverage limit, and amounts for which benefits are not provided because of application of the initial coverage limits. Costs would be treated as incurred costs only if they were paid by the individual, paid on behalf of a low-income individual under the subsidy provisions, or paid under the Medicaid program.

Both standard coverage and actuarially equivalent coverage would have to offer access to negotiated prices, even when no benefits were payable because of the application of cost sharing or an initial coverage limit. Insofar as a state elected to use these negotiated prices for its Medicaid program, the Medicaid drug payment provisions would not apply. The PDP sponsor or M+C organization would be required to disclose to the Administrator the extent to which manufacturer discounts or rebates were made available to the sponsor or organization and passed through to enrollees through pharmacies and other dispensers. Manufacturers would be required to disclose pricing information to the Administrator under the same conditions currently required for Medicaid. In order to encourage significant discounting for pharmaceutical manufacturers, Medicaid best price requirements would not apply with respect to covered prescription drugs provided to Medicare beneficiaries. This provision removes the arbitrary floor price, which as numerous studies documents has led to discounting by pharmaceutical manufacturers. More competitive negotiation between Medicare PDPs,

Medicare+Choice organizations, retiree employee plans could commence with pharmaceutical manufacturers.

Qualified prescription drug coverage could include coverage exceeding that specified for standard coverage or actuarially equivalent coverage. However, any additional coverage would be limited to covered outpatient drugs. The Administrator could terminate a contract with a PDP sponsor or M+C organization if a determination was made that the sponsor or organizations engaged in activities intended to discourage enrollment of classes of eligible Medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage.

Covered outpatient drugs would be defined to include: (1) a drug which may only be dispensed subject to a prescription and which is described in subparagraph (A)(i) or (A)(ii) of Section 1927(k) of the Social Security Act (relating to drugs covered under Medicaid); (2) a biological product described in paragraph (b) of such subsection; (3) insulin described in subparagraph C of such section; and (4) prescription smoking cessation agents otherwise excluded under Medicaid. The definition includes any use of a covered outpatient drug for a medically accepted indication. Drugs that could be paid for under Medicare Part A or B would not be covered under Part D. A plan could elect to exclude a drug which would otherwise be covered, if the drug was excluded under the formulary and the exclusion was not successfully appealed under the new Section 1660C. In addition, a PDP or M+C plan could exclude from coverage, subject to reconsideration and appeals provisions, any drug that would not meet Medicare's definition of medically necessary or was not prescribed in accordance with the plan or Part D.

New Section 1860C. Beneficiary Protections for Qualified Prescription Drug Coverage

The New Section 1860C would specify required beneficiary protections. Plans would have to comply with guaranteed issue and community-rated premium requirements specified in the New Section 1860A and the non-discrimination provisions specified in the new Section 1860F.

PDP plan sponsors would be required to disclose, to each enrolling beneficiary, information about the plan's benefit structure. The plan would have to disclose information on: (1) access to covered drugs, including access through pharmacy networks; (2) how any formulary used by the sponsor functions; (3) co-payment and deductible requirements (including any applicable tiered co-payment requirements; and (4) grievance and appeals procedures. In addition, as is the case for M+C, beneficiaries would have the right to obtain more detailed plan information. Plans would be required to have a mechanism for providing specific information to enrollees on request. The sponsor would be required to make available, through an Internet web site and, on request, in writing, information on specific changes in the formulary. Plans would be required to furnish to enrollees, at least monthly, a detailed explanation of benefits when drug benefits were provided.

Plans would be required to secure the participation in its network of a sufficient number of pharmacies that distribute drugs directly to patients to make access to covered benefits convenient for

enrollees. Mail order only pharmacies would not count towards meeting this requirement. Medicare, not the plan, must certify this requirement. The PDP sponsor would be required to establish an optional point-of-service method of operation under which the plan provides access to any or all pharmacies that are not participating pharmacies in its network. Plans could charge beneficiaries, through adjustments in premiums or co-payments, additional costs associated with the point of service option.

The PDP sponsor would be required to issue (and reissue as appropriate) a card or other technology that may be used by an enrolled beneficiary to assure access to negotiated prices for drugs when coverage is not otherwise provided under the plan.

Plans are not required to establish formularies, however, the provision would specify that if a plan used a formulary, it would have to meet certain requirements. It would be required to establish a pharmaceutical and therapeutics committee to develop and review the formulary. The committee would include at least one physician and one pharmacist with expertise in the care of elderly or disabled persons and majority of members would be physicians or pharmacists. The committee would be required, when developing and reviewing the formulary, to base clinical decisions on the strength of scientific evidence and standards of practice. This would include assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information the committee determined appropriate. The formulary would have to include drugs within each therapeutic category and class of covered outpatient drugs, although not necessarily all drugs within such categories or classes. The committee would be required to establish policies and procedures to educate and inform health care providers concerning the formulary. Any removal of a drug from the formulary could not occur until appropriate notice had been provided to beneficiaries and physicians. The PDP sponsor would be required to have, as part of its appeals process, a process for appeals of coverage denials based on application of the formulary.

The PDP sponsor would be required to have an effective cost and drug utilization management program, quality assurance measures including a medication therapy management program. Beginning in 2006, prescriptions must be transmitted electronically. Utilization management programs would be required to include medically appropriate incentives to use generic drugs and therapeutic interchange where appropriate. Medication therapy management programs would be designed to assure, for beneficiaries with chronic diseases or multiple prescriptions, that drugs under the plan were appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions. The program would be developed in cooperation with licensed pharmacists and physicians. The PDP sponsor would be required, when establishing fees for pharmacists and other providers, to take into account the resources and time associated with the medication therapy management program.

Each PDP sponsor would ensure that enrolled beneficiaries were informed at the time of purchase, of any price differential between their prescribed drug and the price of the lowest cost generic drug

covered under the plan that was therapeutically equivalent and bioequivalent.

The electronic prescription drug program would have to be consistent with national standards developed by the Administrator. It would be required to provide for electronic transmittal of prescriptions (except in emergencies and exceptional cases) and for provision of information to the prescribing health professional. To the extent feasible, the program would permit the prescribing health professional to provide, and be provided, information on an interactive real-time basis. Grants would be authorized under the Public Health Service Act to assist health care professionals in implementing electronic prescription drug programs.

The electronic prescribing standards would be compatible with those established for the administrative simplification program established under title XI of the Social Security Act. The Administrator would establish an advisory task force that included representatives of physicians, hospitals, pharmacists, and technology experts, Department of Veterans Affairs, Department of Defense and other appropriate Federal agencies. The task force would provide recommendations to the Administrator on standards including recommendations relating to: (1) range of available computerized prescribing software and hardware and their costs to develop and implement; (2) extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals; (3) efforts to develop a common software platform for computerized prescribing; (4) cost of implementing such systems in hospital and physician office settings; and (5) implementation issues as they relate to administrative simplification requirements and current Federal and state prescribing laws and regulations and their impact on implementation and computerized prescribing. The Administrator would be required to establish the task force by April 1, 2003. It would be required to submit recommendations to the Administrator by January 1, 2004. The Administrator would be required to promulgate national standards by January 1, 2005.

Each PDP sponsor would be required to have meaningful procedures for the hearing and resolving of any grievances between the organization (including any entity or individual through which the organization provides covered benefits) and enrollees. Enrollees would be afforded access to expedited determinations and reconsiderations, in the same manner afforded under M+C. A beneficiary in a plan that provided for tiered cost-sharing could request coverage of a non-preferred drug on the same conditions applicable to preferred drugs, if the prescribing physician determined that the preferred drug was not as effective for the enrollee or had adverse effects for the enrollee.

In general, PDP plan sponsors would be required to meet the requirements for independent review of coverage denials and appeals in the same manner that such requirements apply to M+C plans. An individual enrolled in a PDP plan could appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug for treatment of the same condition was not as effective for the individual or had adverse effects for the individual. The PDP sponsor would be required to meet requirements related to confidentiality and accuracy of enrollee

records in the same manner that such requirements apply to M+C plans.

New Section 1860D. Requirements for Prescription Drug Plan (PDP) Sponsors; Contracts; Establishment of Standards

New Section 1860D would specify organizational plan requirements for entities seeking to become PDP plan sponsors. In general, the section would require PDP sponsors to be licensed under state law as a risk bearing entity eligible to offer health benefits or health insurance coverage in each state in which it offers a prescription drug plan. Alternatively it could meet solvency standards established by the Administrator for entities not licensed by the state. Plans would be required to assume full financial risk on a prospective basis for covered benefits except: (1) as covered by federal reinsurance payments for high cost enrollees; or (2) as covered by federal incentive payments to encourage plans to expand service areas for existing plans or establish new plans. The entity could obtain reinsurance to cover the risk of providing benefits.

PDP plan sponsors would be required to enter into a contract with the Administrator under which the sponsor agrees to comply both with the applicable requirements and standards and the terms and conditions of payment. The contract could cover more than one plan. The Administrator would have the same authority to negotiate the terms and conditions of the plans as the Director of Personnel Management has with respect to Federal Employee Health Benefits (FEHB) plans. The Administrator would be required to take into account reinsurance subsidy payments and the adjusted community rate for covered benefits in negotiating the terms and conditions regarding premiums.

The new section would incorporate, by reference, many of the contract requirements applicable to M+C plans including minimum enrollment, contract periods, allowable audits to protect against fraud and abuse, intermediate sanctions, and contract terminations. Pro rata user fees could be established to help finance enrollment activities; in no case could the amount of the fee exceed 20 percent of the maximum fee permitted for a M+C plan.

The new Section would permit the Administrator to waive the state licensure requirement under circumstances similar to those permitted under Part C for provider sponsored organizations. In such cases, plans would be required to meet financial solvency and capital adequacy standards established by the Administrator. The Administrator would be given authority to establish by regulation additional standards as deemed appropriate to implement Part D and would be required to publish such regulations by October 1, 2003.

The standards established under Part D would supersede any state law or regulation (other than state licensing laws or laws relating to plan solvency). In addition, states would be prohibited from imposing premium taxes or similar taxes with respect to premiums paid to PDP sponsors or payments made to such sponsors by the Administrator.

New Section 1860E. Process for Beneficiaries to Select Qualified Prescription Drug Coverage

The new Section 1860E would require the Administrator to establish a process for the selection of a PDP plan or a Medicare+Choice plan that provided qualified prescription drug coverage. The process would include the conduct of annual coordinated election periods under which individuals could change the qualifying plans through which they obtained coverage. The process would also include the active dissemination of information to promote an informed selection among qualifying plans (based on price, quality, and other features) in a manner consistent with and in coordination with the dissemination of information under M+C. Further, the process would provide for the coordination of elections through filing with a M+C organization or a PDP sponsor in a manner consistent with that provided under M+C.

The section would specify that a Medicare+Choice enrollee in a M+C plan offering qualified prescription drug coverage could only elect to receive such coverage through the plan.

The Administrator would assure that all eligible individuals residing in the U.S. would have a choice of enrollment in at least two qualifying plan options (at least one of which was a PDP) in their area of residence. The requirement would not be satisfied if only one PDP sponsor or M+C organization offered all the qualifying plans in the area. If necessary to ensure such access, the Administrator would be authorized to provide financial incentives, including the partial underwriting of risk, for a PDP sponsor to expand its service area under an existing prescription drug plan to adjoining or additional areas, or to establish such a plan, including offering such plan on a regional or nationwide basis. The assistance would be available only so long as, and to the extent, necessary to assure the guaranteed access. However, the Administrator could never provide for the full underwriting of financial risk for any PDP sponsor, nor could the Administrator provide for any assumption of financial risk for a public PDP sponsor offering a nationwide drug plan. Additionally, the Administrator would be directed to seek to maximize the assumption of financial risk by PDP sponsors and M+C organizations. The Administrator would be required to report to Congress annually on the exercise of this authority and recommendations to minimize the exercise of such authority.

New Section 1860F. Submission of Bids

Each PDP sponsor must submit to the Administrator specified information in the same manner as such information is submitted by M+C organizations. The information to be submitted would be information on the qualified drug coverage to be provided, the actuarial value of the coverage, and information on the bid for the coverage. The PDP sponsor would have to include an actuarial certification of: (1) the actuarial basis for the bid; (2) the portion of the bid attributable to benefits in excess of the standard coverage; (3) the reduction in the bid resulting from reinsurance subsidies; and (4) such other information required by the Administrator. The Administrator would review and approve the submitted information for purposes of conducting negotiations with the plan.

The bid for a PDP could not vary among individuals enrolled in the plan in the same service area, provided they were not subject to late enrollment penalties. A PDP Plan must permit an enrollee the option of withholding their premium from Social Security. Additionally it could encourage enrollees to make payment of the premium through an electronic funds transfer mechanism or withholding their premium from Social Security. The amount would be credited to the Medicare Prescription Drug Trust Fund. Reductions in Part B premiums attributable to enrollment in M+C plans could be used to reduce the premium otherwise applicable. PDP plans would receive payment based on the bid amount in the same manner applicable for M+C except that payment would be made from the Medicare Prescription Drug Trust Fund.

Under certain conditions, the PDP sponsor of any plan in an area would be required to accept, for an individual eligible for a premium subsidy, the benchmark amount (as defined in new Section 1860G) as payment in full for the premium for qualified prescription coverage; this requirement would apply if there was no standard coverage available in the area. M+C plans would be required to accept the benchmark amount under the same conditions.

New Section 1860G. Premium and Cost-Sharing Subsidies for Low-Income Individuals

The New Section 1860G would provide income-related subsidies for low-income individuals. Low-income persons would receive a premium subsidy based on the value of standard coverage. Individuals with incomes below 150 percent of poverty would have a subsidy equal to 100 percent of the value of standard drug coverage provided under the plan. Beginning in 2006, these amounts would be increased by the percentage increase in per capita beneficiary drug costs. For individuals between 150 percent and 175 percent of poverty, there would be a sliding scale premium subsidy ranging from 100 percent of such value at 150 percent of poverty to 0 percent of such value at 175 percent of poverty. For both groups, beneficiary cost-sharing for spending up to the initial coverage limit would be reduced to an amount not to exceed $2 for a multiple source or generic drug and $5 for a non-preferred drug. PDPs cannot charge individuals receiving cost-sharing subsidies more than $5 per prescription. PDPs could reduce to zero the cost sharing otherwise applicable for generic drugs.

A beneficiary would have the option of having State Medicaid plans or Social Security offices determine whether an individual was eligible for the subsidy and the amount of the subsidy. Funds would be authorized to fund the new responsibility for the Social Security offices. The Administrator would make the determination if the state did not operate such a plan (or a state waiver program under Section 1115 of the Social Security Act). Individuals not in the 50 states or the District of Columbia could not be subsidy eligible individuals but could be eligible for financial assistance with drug costs under new Section 1935(e) added by Section 103.

The premium subsidy amount would be defined as the benchmark bid amount for the qualified prescription drug coverage that the beneficiary selects whether offered by a PDP plan or a M+C plan in the area. The benchmark bid amount for a PDP plan means

the bid amount for enrollment under the plan (without regard to any subsidies or late enrollment penalties) for enrollment in a plan-providing standard converge (or alternative coverage if the actuarial value is equivalent). If a plan provides alternative coverage with a higher actuarial value than that for standard coverage, the benchmark amount would bear the same ratio to the total bid as the actuarial value of standard coverage was to the actuarial value of alternative coverage. The benchmark amount for M+C plans would be the portion of the bid attributable to standard drug coverage.

The Administrator would provide a process whereby the Administrator would notify the PDP sponsor or M+C organization that an individual is eligible for a subsidy and the amount of the subsidy. The sponsor or organization would reduce the premiums or cost-sharing otherwise imposed by the amount of the subsidy. The Administrator would periodically, and on a timely basis, reimburse the sponsor or organization for the amount of the reductions. Part D benefits would be primary to any coverage available under Medicaid.

The Administrator would be required to develop and implement a plan for the coordination of Part D benefits and Medicaid benefits. Particular attention would be given to coordination of payments and preventing fraud and abuse. The Administrator would be required to involve the Secretary, the States, the data processing industry, pharmacists, pharmaceutical manufacturers, and other experts in the development and administration of the plan.

Section 1860H. Subsidies for All Medicare Beneficiaries for Qualified Prescription Drug Coverage

New Section 1860H would provide for subsidy payments to qualifying entities. The Payments would reduce premiums for all beneficiaries, reduce adverse selection among plans, and promote the participation of PDP sponsors. Such payments would be made as direct subsidies or through reinsurance, and together create an average combined 65 percent subsidy. The section would constitute budget authority in advance of appropriations and represent the obligation of the Administrator to provide for subsidy payments specified under the section.

Direct subsidies would be made for individuals enrolled in a PDP, M+C plan, or qualified retiree prescription drug plan equal to a percentage, specified by the Administrator of the actuarial value of standard coverage provided under the plan and totaling 35 percent.

Reinsurance payments totaling 30 percent of the standard benefit would be made for specified costs incurred in providing prescription drug coverage for individuals enrolled in either a PDP plan, a M+C plan providing qualified prescription drug coverage, or a qualified retiree drug plan. The Administrator would provide for reinsurance payments to PDP sponsors, M+C plans providing qualified prescription drug coverage, and qualified retiree drug plans. Reinsurance payments would be provided for 30 percent of an individual's allowable drug costs over the initial coverage limit ($1,000 in 2005) but not over the initial coverage limit ($2,000 in

2005). Reinsurance, not to exceed 80 percent would also be provided for costs over the out-of-pocket limit ($3,800 in 2005).

For purposes of calculating reinsurance payments, allowable costs would be defined as the portion of gross covered prescription drug costs that are actually paid by the plan, but in no case be more than the part of such costs that would have been paid by the plan if the drug coverage under the plan were standard coverage. Gross covered drug costs would be defined as costs (including administrative costs) incurred under the plan for covered prescription drugs dispensed during the year, including costs related to the deductible, whether paid by the enrollee or the plan, regardless of whether coverage under the plan exceeded standard coverage and regardless of when the payment for the drugs was made.

The Administrator would be required to estimate the total subsidy payments that would be made during the year and total benefit payments that would be expected to be made by qualifying entities for standard coverage during the year. The Administrator would proportionately adjust payments such that: (1) total subsidy payments during the year were equal to 65 percent of total payments made by qualifying plans for standard coverage during the year; and (2) the ratio of total payments for direct subsidies to total reinsurance payments for the year is 35 to 30. The Administrator could adjust direct subsidy payments in order to avoid risk selection, but may not make any adjustment that would reduce the aggregate subsidy. The payment method would be determined by the Administrator who could use an interim payment system based on estimates. Payments would be made from the Medicare Prescription Drug Trust Fund.

"Qualified retiree prescription drug plans" would be defined as employment-based retiree health coverage meeting certain requirements. The sponsor of the plan would be required to annually attest to the Administrator (and to provide such assurances as required by the Administrator) that the coverage meets requirements for qualified coverage. The sponsor (and the plan) would be required to maintain and provide access to records needed to ensure the adequacy of coverage and the accuracy of payments made. Further, the sponsor would be required to provide certifications of coverage. Payment could not be made for an individual unless: the individual was covered under the retiree plan, entitled to enroll under a PDP or M+C plan with prescription drug coverage but elected not to. Payments could not be made for persons covered under the Medicare a secondary payer program.

New Section 1860I. Medicare Prescription Drug Trust Fund

New Section 1860I would create a Medicare Prescription Drug Trust Fund. Requirements applicable to the Part B trust fund would apply in the same manner to the Drug Trust Fund as they apply to the Part B Trust Fund. The Managing Trustee would pay from the account, from time to time, low-income subsidy payments, subsidy payments, and payments for administrative expenses. The Managing Trustee would transfer, from time to time, to the Medicaid account amounts attributable to allowable increases in administrative costs associated with identifying and qualifying beneficiaries eligible for low-income subsidies. Amounts deposited into

the Trust Fund would include the federal amount which would otherwise be payable by Medicaid except for the fact that Medicaid becomes the secondary payer of drug benefits for the dual eligibles. The provision would authorize appropriations to the Trust Fund an amount equal to the amount of payments from the Trust Fund reduced by the amount transferred to the Trust Fund.

The provision would specify that any provision of law relating to the solvency of the Trust Fund would take into account the Fund and the amounts received by, or payable from, the Fund.

New Section 1860J. Definitions; Treatment of References to Provisions in Part C

New section 1860J would include definitions of terms and specify how cross references to Part C would be applied. It would further provide that any reduction or waiver of cost-sharing would not be in violation of kickback and similar prohibitions. The section would further require the Administrator to submit a report to Congress by January 1, 2004, that makes recommendations regarding providing benefits under Part D.

EFFECTIVE DATE

Enactment.

Section 102. Offering of Qualified Prescription Drug Coverage Under the Medicare+Choice Program

CURRENT LAW

Under current law, Medicare+Choice plans may elect to offer prescription drug coverage under Part C. The extent of these benefits varies and is not subject to any explicit standardization requirements. However, as with all Medicare+Choice benefit specifics, the financing and design of such benefits must meet the approval of the Secretary under the adjusted community rate (ACR) approval process. Generally, plans offering drugs must either finance such benefits from the differences between the applicable county payment rate and their costs in providing Medicare's basic benefits, or by assessing beneficiaries who enroll in the plan supplemental premiums.

EXPLANATION OF PROVISION

The provision would specify that a M+C plan could not offer drug coverage (other than that already required under Medicare) unless the coverage was at least qualified prescription drug coverage. No M+C organization would be required to offer such coverage. An individual not electing qualified prescription drug coverage under Part D would be treated as ineligible to enroll in a M+C plan offering such coverage.

The organization would be required to meet beneficiary protections outlined in the new Section 1860C, including requirements relating to information dissemination and grievance and appeals. The organization would also be required to submit the same information required of PDP sponsors when submitting a bid. The Administrator could waive such requirements to the extent the Ad-

ministrator determined they were duplicative of requirements otherwise applicable to the organization or plan.

EFFECTIVE DATE

Applies to coverage provided on or after January 1, 2005.

Section 103. Medicaid Amendments

CURRENT LAW

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Within broad federal guidelines, each state sets its own eligibility criteria, including income eligibility standards. Persons meeting the state standards are entitled to coverage under Medicaid. Persons entitled to Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these dual eligibles, Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare, including prescription drugs. State Medicaid programs have the option to include prescription drugs in their Medicaid benefit packages. All states include drugs for at least some of their Medicaid beneficiaries and many offer it to all program recipients entitled to full Medicaid benefits.

Federal law specifies several population groups that are entitled to more limited Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low-income beneficiaries (SLIMBs), and certain qualified individuals. QMBs are aged or disabled persons with incomes at or below the federal poverty level and assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the federal-state Medicaid program. SLIMBs are persons who meet the QMB criteria, except that their income is over the QMB limit; the SLIMB limit is 120 percent of the federal poverty level. Medicaid protection for SLIMBs is limited to payment of the Medicare Part B premium. QMBs and SLIMBs are not entitled to Medicaid's prescription drug benefit unless they are also entitled to full Medicaid coverage under their state's Medicaid program.

Qualifying individuals (QIs) are never entitled to Medicaid drug coverage (because, by definition, they are not eligible for full Medicaid benefits). QI–1s are persons who meet the QMB criteria, except that their income is between 120 percent and 135 percent of poverty. Medicaid protection for QI–1s is limited to payment of the monthly Medicare Part B premium. QI–2s are persons who meet the QMB criteria, except that their income is between 135 percent and 175 percent of poverty. Medicaid protection for QI–2s is limited to payment of that portion of the Part B premium attributable to the gradual transfer of some home health visits from Medicare Part A to Medicare Part B. Expenditures under the QI–1 and QI–2 programs are paid for 100 percent by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation

level. Any expenditure beyond that level is paid by the state. Assistance under the QI–1 and QI–2 programs is available for the period January 1, 1998 to December 31, 2002.

EXPLANATION OF PROVISION

Section 103 would add a new Section 1935 to the Social Security Act entitled a Special Provisions Relating to Medicare Prescription Drug Benefit. The provision requires states, as a condition of receiving federal Medicaid assistance, to make eligibility determinations for low-income premium and cost-sharing subsidies. Individuals could qualify for low-income subsidies at Social Security offices as well. The provision would provide for the phased-in federal assumption of associated administrative costs. In 2005, the federal matching rate would be increased by 10 percent and in 2006 by 20 percent. In each subsequent year the percent would be increased by ten percentage points (but in no case could the rate exceed 100 percent). Beginning in 2013, the federal matching rate would be 100 percent. The state would be required to provide the Administrator with the appropriate information needed to properly allocate administrative expenditures that may be made for similar eligibility determinations.

The provision would provide for the federal phase-in of the costs of premiums and cost-sharing subsidies for dual eligibles (i.e. persons eligible for Medicare and full Medicaid benefits, including drugs). Over a 10-year period the federal matching rate for these costs would be increased to cover 100 percent of what would otherwise be state costs. States would be required to maintain Medicaid benefits as a wrap around to Medicare benefits for dual eligibles; states could require that these persons elect Part D drug coverage.

Territories would be able to get additional Medicaid funds, beginning at $20 million in 2005 and increasing in subsequent years by the annual percentage increase in prescription drug costs for Medicare beneficiaries. In order to obtain these funds, territories would be required to formulate a plan on how they would dedicate the funds to assist low-income Medicare beneficiaries in obtaining covered outpatient prescription drugs. The Administrator would be required to report to Congress on the application of the law in the territories.

EFFECTIVE DATE

Enactment.

Section 104. Medigap Transition

CURRENT LAW

Most beneficiaries have some health insurance coverage in addition to basic Medicare benefits. Some individuals obtain private supplementary coverage through an individually-purchased policy, commonly referred to as a Medigap policy. Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of 10 standardized plans, though not all 10 plans are offered in all states. The 10 plans are known as Plans A

through Plan J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive. Plans H, I, and J offer some drug coverage.

The law provided for the development by the National Association of Insurance Commissioners (NAIC) of standardized benefit packages. It also provides for modifications of such packages when Medicare benefit changes are enacted.

All insurers offering Medigap policies are required to offer open enrollment for 6 months from the date a person first enrolls in Medicare Part B (generally when the enrollee turns 65). The law also guarantees issuance of specified Medigap policies for certain persons whose previous supplementary coverage was terminated. Guaranteed issue also applies to certain persons who elect to try out a managed care option under the Medicare+Choice plan program.

EXPLANATION OF PROVISION

The provision would prohibit, effective January 1, 2005, the issuance of new Medigap policies with prescription drug coverage. The prohibition would not apply to policies replacing another policy with drug coverage. Further, it would not apply to policies meeting new standards, as outlined below.

The provision would guarantee issuance of a substitute Medigap policy for persons, enrolling in Part D, who at the time of such enrollment were enrolled in and terminated enrollment in a Medigap policy H, I, or J. The guaranteed enrollment would be for any of the Plans A through Plan G. The guarantee would apply for enrollments occurring in the new Medigap plan within 63 days of termination of enrollment in a Medigap drug Plan H, I, or J. The insurer could not impose an exclusion based on a pre-existing condition for such individuals. Further, the insurer would be prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, claims experience, receipt of health care or medical condition.

The provision would provide for the development by the NAIC of two new standardized Medigap plans and would outline the standards for these policies. The first new policy would have the following benefits (notwithstanding other provisions of law relating to core benefits): (1) coverage of 50 percent of the cost-sharing otherwise applicable (except coverage of 100 percent cost-sharing applicable for preventive benefits); (2) no coverage of the Part B deductible; (3) coverage of all hospital coinsurance for long stays (as in current core package); and (4) a limitation on annual out-of-pocket costs of $4,000 in 2005 (increased in future years by an appropriate inflation adjustment as specified by the Secretary). The second new policy would have the same benefit structure as the first new policy, except that: (1) coverage would be provided for 75 percent, rather than 50 percent, of cost-sharing otherwise applicable; and (2) the limitation on out-of-pocket costs would be $2,000, rather than $4,000. Both policies could provide for coverage of Part D cost sharing; however, neither policy could cover the Part D deductible. Medigap cost sharing of qualified prescription drug expenses would be limited to the two new policies.

EFFECTIVE DATE

Enactment.

Section 105. Medicare Prescription Drug Discount Card Endorsement Program

CURRENT LAW

On July 12, 2001, the President announced a new national drug discount card program for Medicare beneficiaries. Under this program, CMS would endorse drug card programs meeting certain requirements. This program was viewed as an interim step until a legislative reform package, including both a drug benefit and other Medicare reforms, was enacted. Implementation of the drug discount card program was delayed by court action. However, CMS was allowed to proceed with rule making. On March 6, 2002, CMS issued proposed rule making.

EXPLANATION OF PROVISION

The provision would provide the authority for the Secretary to initiate an endorsed prescription drug discount program to provide immediate savings for beneficiaries and to establish the infrastructure to later deliver the full funded prescription drug program. The program would have to pass on to enrollees' discounts on drugs, including discounts negotiated with manufacturers. The program could not be limited to mail order drugs. It would have to provide pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions. It would have to provide, through the Internet and otherwise, information to enrollees that the Secretary identified as being necessary to provide for informed choice by beneficiaries among endorsed programs. This would include information on enrollment fees, prices charged to beneficiaries, and services offered under the program. The entity operating the program would have to demonstrate experience and expertise in operating such a program or a similar program. Further, the program would be required to meet additional requirements identified by the Secretary to protect and promote the interest of Medicare beneficiaries, including requirements that assure that beneficiaries were not charged more than the lower of the negotiated retail price or the usual and customary price.

The Secretary would provide for the dissemination of information, which compared the costs and benefits of such programs. This activity would be coordinated with the dissemination of educational information on M+C plans. The Secretary would provide appropriate oversight to ensure compliance of endorsed programs with the requirements of Section 105, including verification of discounts and services. The Secretary would be required to provide, through the use of the Medicare toll free number, for the receipt and response to inquiries and complaints. The Secretary would be required to revoke the endorsement of any program the Secretary deemed no longer met requirements or engaged in false or misleading marketing practices. The provision would specify that a beneficiary could only be enrolled in one endorsed program at a time.

The provision would provide that the Secretary would provide for an appropriate transition and discontinuance of the endorsement program at the time benefits first become available under Part D.

EFFECTIVE DATE

Enactment.

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

Subtitle A—Medicare+Choice Revitalization

Section 201. Medicare+Choice Improvements

CURRENT LAW

Under current law, Medicare+Choice (M+C) plans are paid an administered monthly payment amount, called the M+C payment rate, for each enrollee. The per capita rate for a payment area is set at the highest of three amounts, calculated according to formulas established in statute. The three amounts are:

- A minimum payment (or floor) rate,
- A rate calculated as a blend of an area-specific (local) rate and a national rate or,
- A rate reflecting a minimum increase from the previous year's rate.

Each year, the three payment amounts are updated by formulas set in statute. Both the floor and the blend are updated each year by a measure of growth in program spending, the national growth percentage. The third payment amount, the minimum increase, is updated annually by an additional 2 percent over the previous year's amount.

After preliminary M+C payment rates are determined for each payment area (typically a county), a budget neutrality adjustment is required by law to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. The budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. The blend payment is also adjusted to remove the costs of direct and indirect graduate medical education. The blend payment amount is based on a weighted average of local and national rates for all Medicare beneficiaries.

EXPLANATION OF PROVISION

This provision would make changes to the M+C payment amounts for 2003 and 2004 to stabilize the program. The capitation rate for an M+C payment area would be based on the largest of 4 amounts, by adding a fee-for-service rate. If higher than other M+C payment rates, plans would be paid based on100 percent of fee-for-service (FFS) costs, as calculated by the adjusted average per capita cost (AAPCC) for that year, for a payment area, including costs for only the fee-for-service beneficiaries and not the costs for those enrolled in an M+C plan. The AAPCC would be adjusted to include

an estimate of the additional Medicare payments that would have been made if Medicare beneficiaries had not used facilities of the Department of Veterans Affairs (VA) and the Department of Defense (DOD) for Medicare-covered benefits.

This provision would make adjustments to the calculation of the blend payment in 2003 and 2004: (1) the national average used in the calculation of the blend would be revised, to reflect only M+C enrollees, rather than all beneficiaries; and (2) the area-specific rate component of the blend would be modified to include an estimate of the additional payments that would have been made if Medicare beneficiaries had not received Medicare covered benefits from facilities of the VA and the DOD. Both of these modifications would increase the blend rate. Budget neutrality would be permanently eliminated, so that plans would receive a blend rate, if that rate were the highest rate.

For 2003 and 2004, the minimum percentage increase would be 3 percent above the previous year's amount instead of 2 percent under current law. This provision would guarantee that all plans receive at least a 3 percent increase.

Within two weeks after enactment, the Secretary would be required to determine and announce the new M+C payments rates, as revised by this Section.

MedPAC would be required to conduct a study to assess the method for determining the AAPCC, including information on the appropriate geographic area, variation in cost between different areas, and the accuracy of risk adjustment. This study must be submitted within 9 months of enactment.

The Secretary would be required to submit a report to Congress describing the impact of additional financing provided under this Act and other Acts (including the Balanced Budget Refinement Act (BBRA) of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)) on the availability of Medicare+Choice plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

EFFECTIVE DATE

Enactment.

Section 202. Making Permanent Change in Medicare+Choice Reporting Deadlines and Annual, Coordinated Election Period

CURRENT LAW

Prior to enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107–188), the Centers for Medicare and Medicaid Services (CMS) was required to announce the annual Medicare+Choice (M+C) payment rates, which would be applicable on January 1st of the following year, by no later than March 1 of each year. Each M+C organization was required to submit to the Secretary of HHS, for each of its M+C plans, specific information about the adjusted community rate (ACR), M+C premiums, cost sharing, and additional benefits (if any) no later than July 1 of each year, also for the following year. The Secretary then reviewed this information and approved or disapproved the M+C plan premiums, cost-sharing amounts, and ben-

efits. Medicare beneficiaries could also make or change elections to an M+C plan each November, during the annual coordinated election period.

P.L. 107–188 made a number of temporary changes. First, CMS moved its annual announcement of M+C payment rates from no later than March 1 to no later than the 2nd Monday in May, effective for 2003 and 2004. P.L. 107–188 also temporarily moved the deadline for plans to submit information about ACRs, M+C premiums, cost sharing, and additional benefits (if any) from no later than July 1 to no later than the 2nd Monday in September in 2002, 2003, and 2004. It also changed the annual coordinated election period from the month of November to November 15th through December 31 in 2002, 2003, and 2004.

EXPLANATION OF PROVISION

This provision would permanently extend the deadline changes that were temporarily changed by P.L. 107–188. CMS would make its annual announcement of payment rates no later than the 2nd Monday in May of each year. The deadline for plans to submit their information would be no later than the 2nd Monday in September. The annual coordinated election period would take place from November 15th through December 31 of each year.

EFFECTIVE DATE

Enactment.

Section 203. Avoiding Duplicative State Regulation

CURRENT LAW

Medicare law currently preempts State law or regulation from applying to M+C plans to the extent they are inconsistent with federal requirements imposed on M+C plans, and specifically, relating to benefit requirements, the inclusion or treatment of providers, and coverage determinations (including related appeals and grievance processes).

EXPLANATION OF PROVISION

This provision would clarify that Federal standards would supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency), with respect to M+C plans offered by M+C organizations.

EFFECTIVE DATE

Enactment.

Section 204. Specialized Medicare+Choice Plans for Special Needs Beneficiaries

CURRENT LAW

One model for providing a specialized M+C plan, EverCare, operates as a demonstration program. EverCare is designed to study the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners (who function as primary Medicare care givers and case managers).

EverCare receives a fixed capitated payment, based on a percentage of the AAPCC, for all nursing home resident Medicare enrollees. There are 6 demonstration sites, for a total enrollment of about 10,000 individuals.

EXPLANATION OF PROVISION

This provision would allow specialized plans for special needs beneficiaries (such as the EverCare demonstration) to become any type of M+C coordinated care plan. Special needs beneficiaries would be defined as those M+C eligible individuals who are institutionalized, entitled to Medicaid, or meet requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2007. The Medicare Benefits Administrator would be required to report to Congress by December 31, 2005 providing an assessment of the impact of these plans. The Secretary would be required to issue final regulations establishing requirements for special needs beneficiaries within 6 months after enactment of this legislation.

EFFECTIVE DATE

Enactment.

Section 205. Medicare MSAs

CURRENT LAW

The Balanced Budget Act authorized a demonstration to test the feasibility of medical savings accounts for the Medicare program. The M+C option is a combination of a health insurance plan with a large deductible and an M+C MSA. Contributions to an M+C MSA may be made annually from the enrollee's capitation rate after the plan's insurance premium has been paid. These contributions, as well as account earnings, are exempt from taxes. Withdrawals used to pay unreimbursed enrollee medical expenses (that are deductible under the Internal Revenue Code) are not taxed. New enrollment is not allowed after 2003 or after the number of enrollees reaches 390,000.

EXPLANATION OF PROVISION

This provision would permanently extend Medicare MSAs and remove the enrollment cap. It would eliminate the requirement that Medicare MSA plans report on enrollee encounters since MSAs are not plans, but bank accounts. Non-contract providers furnishing services to enrollees of MSAs would be subject to the same balanced billing limitations as non-contract providers furnishing services to enrollees of coordinated care plans.

EFFECTIVE DATE

Enactment.

Section 206. Extension of Reasonable Cost and SHMO Contracts

CURRENT LAW

Reasonable Cost Contracts. Medicare reimburses cost-based plans for the actual cost of furnishing covered services, less the estimated

value of beneficiary cost sharing. Following the enactment of BBA 97, the Secretary was prohibited from entering into new cost reimbursement contracts, except with organizations that had provided only Part B services. Reasonable cost contracts may apply to expand service areas through September 1, 2003. The Secretary cannot extend or renew a reasonable cost reimbursement contract for any period beyond December 31, 2004.

SHMOs. The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid, capitated payment basis. The waivers have been extended on several occasions since then, and the Omnibus Budget Reconciliation Act of 1990 authorized a second generation of projects. BBA 97 extended waivers for SHMOs through December 31, 2000, and expanded the number of persons who can be served per site from 12,000 to 36,000. BBRA 99 extended the SHMO waivers until 18 months after the Secretary submits a report with a plan for integration and transition of SHMOs into an option under M+C. BIPA extended SHMO waivers until 30 months after the Secretary submits a report with a plan for integration and transition of SHMOs into an option under the M+C program. This 30-month extension supersedes the 18-month extension in BBRA 99.

EXPLANATION OF PROVISION

Reasonable Cost Contracts. This provision would allow a reasonable cost contract to be extended or renewed beyond December 31, 2004 if there were no coordinated care M+C plans in its service area. A cost contract could convert to an M+C plan to serve its previously served area. The cost contract could continue to operate in parts of its service area without M+C coordinated care plans. A cost contract could re-enter a previously served area if all other coordinated care M+C plans in the area terminated their contracts. The Medicare Benefits Administrator shall submit a report to Congress no later than February 1, 2004 on an appropriate transition for cost contract plans.

SHMOs. The provisions would extend the waivers permitting operation of SHMOs through December 31, 2004. Nothing would prevent a SHMO from offering an M+C plan.

EFFECTIVE DATE

Enactment.

Section 207. Extension of Municipal Health Service Demonstration Projects

CURRENT LAW

The Medicare Municipal Health Services demonstration projects to improve access to primary care services have been extended: through December 2000 by the BBA 97; through 2002 by the BBRA 99; and through 2004 by the BIPA of 2000.

EXPLANATION OF PROVISION

This provision would extend the Medicare Municipal Health Services demonstration projects through December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated. The total number of participants could not exceed the number participating as of January 1, 1996.

EFFECTIVE DATE

Enactment.

Subtitle B—Medicare+Choice Competition Program

Section 211. Medicare+Choice Competition Program

CURRENT LAW

See Section 201 explanation of current law.

EXPLANATION OF PROVISION

Beginning in 2005, a new M+C payment system would be established based on competitive bidding for the provision of all items and services. Plans would compete for enrollees based on cost and quality of care. Beneficiaries and the government would save when beneficiaries enroll in plans that provide efficient care.

The provision would establish a benchmark amount for each payment area and a procedure for plans to develop a bid amount. Additionally, enrollees would be eligible for rebates, under certain circumstances.

The bid amount would indicate the proportion of the bid attributable to the provision of: (1) statutory non-drug benefits, (2) statutory prescription drug benefits, and (3) non-statutory benefits. Plans would be required to submit this information and the actuarial bases for determining these amounts, as well as other information that the Administrator may require to verify the actuarial bases. The bid amount could not vary by enrollees within a plan.

The Administrator would have authority to negotiate monthly bid amounts (including portions of the bid), and may reject a bid amount, or a portion of it, that is not supported by the actuarial bases provided by the plan.

The fee-for-service area-specific non-drug benchmark (benchmark) amount would be set at the larger of 100 percent of the FFS costs (95 percent for 2008 and thereafter), the minimum update, or the minimum monthly amount (i.e., floor). FFS costs would be set at the AAPCC for that year, for a payment area (including costs for only the fee-for-service beneficiaries and not the costs for those enrolled in an M+C plan) adjusted to include estimated costs for VA and DOD services to Medicare-eligible beneficiaries.

Both the benchmark and the bids would be risk adjusted based on statewide assumptions, or based on a determination by the Administrator.

If the risk adjusted benchmark exceeded the risk adjusted bid (for statutory non-drug benefits), beneficiaries would qualify for rebates of 75 percent of the difference in the form of: (1) a credit towards their M+C monthly supplementary beneficiary premium, or

the premium imposed for prescription drug coverage; (2) a direct monthly payment; (3) other means approved by the Secretary; or (4) some combination. The government would retain the remaining 25 percent of the savings. If the monthly bid exceeded the benchmark, enrollees would pay an M+C monthly basic beneficiary premium, equal to the amount by which the monthly bid exceeded the benchmark.

Plans would be paid based on their bid amounts. For plans with bids below the benchmark, their payment would be the bid amount, risk adjusted for demographic and health status factors, plus the rebate amount. The risk adjustment procedure would not be changed from current law. The rebate amount would be distributed to the plan's enrollees by one of the approved methods, as discussed above. For plans with bids at or above the benchmark, their payments would equal the benchmark amount, risk adjusted for demographic and health status factors.

EFFECTIVE DATE

Effective for payments and premiums for months beginning with January 2005.

Section 212. Demonstration Program for Competitive-Demonstration Areas

CURRENT LAW

See Section 201 explanation of current law.

EXPLANATION OF PROVISION

This provision would establish a demonstration program for competitive-demonstration areas, defined as: (1) metropolitan statistical areas or areas with a substantial number of M+C enrollees; (2) with at least 2 M+C plans offered by different organizations; and (3) with at least 50 percent of M+C eligibles enrolled in an M+C plan. The demonstration program would be limited to a maximum of 4 sites and no area could be designated as a competitive-demonstration area for more than 2 years. The Administrator would have discretion to decide whether or not to designate a qualified area as a competitive-demonstration area.

For each competitive-demonstration area, the Administrator shall annually determine the choice non-drug benchmark amount, defined as the sum of the weighted FFS and M+C components. The weighted FFS component would be calculated by multiplying the national fee-for-service (FFS) market share for the year (defined as the nationwide proportion of M+C eligibles during March of the previous year who were not enrolled in an M+C plan) by the FFS area-specific non-drug bid (set at the AAPCC for that year, for a payment area (including costs for only the fee-for-service beneficiaries and not the costs for those enrolled in an M+C plan) adjusted to include estimated costs for VA and DOD services to Medicare-eligible beneficiaries). The M+C component would be calculated by multiplying 1 minus the national FFS market share for the year by the weighted average of plan bids for the area and year. The weighted average of plan bids would equal the sum of the

proportion of each plan's enrollees in the area times the unadjusted monthly non-drug bid amount, as calculated for each plan.

If the choice risk adjusted benchmark exceeded the risk adjusted bid (for statutory non-drug benefits), beneficiaries would qualify for rebates for 75 percent of the difference in the form of: (1) a credit towards their M+C monthly supplementary beneficiary premium, or the premium imposed for prescription drug coverage; (2) a direct monthly payment; (3) other means approved by the Secretary; or (4) some combination. If instead, the monthly bid exceeded the benchmark, enrollees would pay the amount by which the monthly bid exceeded the benchmark.

Plans would be paid based on their bid amounts. For plans with bids below the choice benchmark, their payment would be the bid amount, risk adjusted for demographic and health status factors, plus the rebate amount for beneficiaries. Plans would be responsible for passing rebates through to beneficiaries as outlined above. For plans with bids at or above the choice benchmark, their payments would equal the benchmark amount, risk adjusted for demographic and health status factors.

Effective for payments and premiums for months beginning with January 2005

No later than 6 months after the designation of the 4th competitive-demonstration area, the Medicare Benefits Administrator would be required to submit a report to Congress on the impact of this demonstration program on Medicare beneficiaries, savings to the Medicare program, and adverse selection issues.

EFFECTIVE DATE

Effective January 1, 2005.

Section 213. Conforming Amendments

CURRENT LAW

National Coverage Determinations. If National Coverage Determinations (NCDs) occur during a contract year, such changes shall not apply to the M+C plan until the following contract year. If the NCD provides for coverage of additional benefits or coverage under additional circumstances, the M+C payment rate shall not apply to payment for such benefits until the following contract year.

EXPLANATION OF PROVISION

National Coverage Determinations. The provision would allow the Secretary to implement a national coverage determination that will result in a significant change in the cost to an M+C organization only in a prospective manner.

Consolidation of M+C Payment Areas. The chief executive officer of a State may request that the Medicare Benefit Administrator make a geographic adjustment to an M+C payment area, changing the payment area from a county-based system to a single statewide M+C payment area, or a metropolitan-based system. Any adjustment to the geographic payment area must ensure that aggregate payments after geographic adjustment would equal payments that would have been made without the geographic adjustment.

EFFECTIVE DATE

Enactment.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

Section 301. Reference to Full Market Basket Increase for Sole Community Hospitals

CURRENT LAW

Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected increase in the hospital market basket index (MB). Sole community hospitals (SCH) receive special treatment under the inpatient hospital prospective payment system (PPS). A SCH can elect to be paid on the basis of its updated hospital-specific amount if that results in greater Medicare reimbursement than payment based on the federal amount. Currently, the update factor is set at MB–0.55 percentage points for FY2002 and FY2003 and at the MBI for subsequent years.

EXPLANATION OF PROVISION

The provision would eliminate the reduction from the MB update specified in Section 401(a) for SCHs for FY2003.

EFFECTIVE DATE

Upon enactment.

Section 302. Enhanced Disproportionate Share Hospital (DSH) Treatment for Rural and Urban Hospitals with Fewer than 100 Beds

CURRENT LAW

Medicare makes additional payments to certain acute hospitals that serve a large number of low-income Medicare and Medicaid patients. As specified by BIPA, all hospitals are eligible to receive disproportionate share hospital (DSH) payments when their DSH percentage or threshold amount exceeds 15 percent starting with discharges occurring on or after April 1, 2001. BIPA modified the payment formulas to create the same eligibility threshold for across all hospitals. Still, different formulas are used to establish a hospital's DSH payment, depending upon the hospital's location, number of beds and status as a rural referral center or sole community hospital. BIPA also increased the DSH payment but a small urban or rural hospital receives 5.25 percent while large (100 beds and more) urban hospitals and large rural hospitals (500 beds and more) receive a higher adjustment.

EXPLANATION OF PROVISION

Starting for discharges on or after October 1, 2002, hospitals (other than urban hospitals with a 100 or more beds or certain public hospitals) would receive payments based on a blend of their current DSH adjustment and the current DSH adjustment for large urban hospitals. However, the new DSH adjustment would not ex-

ceed 10 percent for any hospital that was not classified as a RRC. A hospital's new DSH adjustment would be calculated using 80 percent of the existing DSH adjustment in FY2003; 60 percent in FY2004; 40 percent in FY2005; 20 percent in FY2006; and 0 percent in FY2007 and subsequently.

EFFECTIVE DATE

The amendment would apply to discharges occurring on or after October 1, 2002.

Section 303. 2–Year Phased-in Increase of Small Urban Standardized Amount to Achieve a Single, Uniform Standardized Amount

CURRENT LAW

Medicare pays for inpatient services in acute hospitals in large urban areas using a standardized amount (or base rate) that is 1.6 percent larger than the standardized amount used to reimburse hospitals in other areas (both rural areas and smaller urban areas).

EXPLANATION OF PROVISION

For discharges occurring in FY2003, the average standardized amount for hospitals in other areas would be increased by half the difference between the current amount and the larger standardized amount paid to hospitals in large urban areas. For discharges occurring in FY2004, the Secretary would compute one standardized amount for all hospitals, increase this amount by the applicable update, and use this amount to pay all hospitals.

EFFECTIVE DATE

Upon enactment.

Section 304. More Frequent Update in Weights Used in Hospital Market Basket (MB)

CURRENT LAW

Medicare's payment amounts are increased annually using an update factor composed in part by the projected increase in the hospital MB. The market basket index is a fixed-weight hospital input price index which measures the average change in the price of goods and services hospitals purchased to furnish inpatient care. The Centers for Medicare and Medicaid Services (CMS) periodically revises the cost category weights, reevaluates the price proxies for such categories, and rebases (or changes the base period) for the MB. The MB used through FY2002 was last rebased in 1997 and reflected data from FY1992. As discussed in its May, 2002 proposed regulation, CMS has developed a revised and rebased MB using 1997 data for use in the FY2003 Medicare hospital payment rates.

EXPLANATION OF PROVISION

The provision would direct the Secretary to revise the MB cost weights to reflect the most currently available data and to establish a schedule for revising the cost weights more often than once every 5 years. The Secretary would be required to submit a report

to Congress by October 1, 2004 on the reasons for and the options considered in establishing such a schedule.

EFFECTIVE DATE

Upon enactment.

Section 305. Improvement to the Critical Access Hospital Program

(a) Reinstatement of Periodic Interim Payment (PIP)

CURRENT LAW

Eligible hospitals, skilled nursing facilities, and hospices, which meet certain requirements, receive Medicare periodic interim payments (PIP) every 2 weeks; these payments are based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made to account for any differences between the PIP payments and actual payments.

EXPLANATION OF PROVISION

Starting with payments made on or after January 1, 2003, eligible critical access hospitals (CAHs) would be able to receive payments made on a PIP basis for inpatient services.

EFFECTIVE DATE

As established in subsection (e), this provision would be effective starting with payments made on or after January 1, 2003.

(b) Condition for Application of Special Physician Payment Adjustment

CURRENT LAW

For cost reporting periods starting on or after October 1, 2000, CAHs can elect to be paid for outpatient services using cost-based reimbursement for its facility fee and at 115 percent of the fee schedule for professional.

EXPLANATION OF PROVISION

The provision would preclude the Secretary from requiring that all physicians providing services in a CAH assign their billing rights to the entity for the CAH to be able to be paid on the basis of 115 percent of the fee schedule for the professional services provided by the physicians. However, a CAH would not receive payment based on 115 percent of the fee schedule for any individual physician who did not assign billing rights to the CAH.

EFFECTIVE DATE

As established in subsection (e), this provision would be effective as if included in BBRA.

(c) Flexibility in Bed Limitation For Hospitals with Strong Seasonal Census Fluctuations

CURRENT LAW

CAHs are limited-service hospitals that provide 24-hour emergency care services with no more than 15 acute care beds or up 25 beds, including 10 swing beds, in limited cases. CAHs may not have patient stays that are, on average, more than 96-hours long.

EXPLANATION OF PROVISION

The Secretary would be required to specify standards for determining whether a CAH has strong seasonal variations created by influenza outbreaks, tourism, or seasonal industries such as logging or agriculture in patient admissions that would justify a 5-bed increase in the number of inpatient acute beds it can maintain (and still retain its classification as a CAH).

EFFECTIVE DATE

As established in subsection (e), this provision would apply to designations made on or after January 1, 2003, but would not apply to CAHs that were designated prior to enactment.

(d) 5-Year Extension of the Authorization for Appropriations for Grant Program

CURRENT LAW

The Rural Hospital Flexibility Grant Program that awards grants to (1) states for rural health care planning and implementation activities, rural network development, and CAH designations and to (2) hospitals that have applied to be CAHs to implement data systems required under BBA 97 expires in FY2002.

EXPLANATION OF PROVISION

The provision would extend the grant program that affords for annual appropriations from the Medicare's Federal Hospital Insurance Trust Fund of $25 million through FY2007.

EFFECTIVE DATE

Upon enactment.

(e) Prohibition of Retroactive Recoupment

CURRENT LAW

Critical Access Hospitals are paid based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made.

EXPLANATION OF PROVISION

Starting with payments made for cost reports opening prior to October 1, 2002, the Secretary could not recoup overpayments made for outpatient services related to payment based on 80 percent of reasonable costs (instead of 100% of reasonable costs minus 20 percent of charges.)

EFFECTIVE DATE

Upon enactment.

(f) Effective Dates

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

Subsection (a) concerning PIP payments would be effective starting with payments made on or after January 1, 2003; subsection (b) concerning physician payment would be effective as if included in BBRA.; and subsection (c) concerning the CAH bed limit would apply to designations made on or after January 1, 2003.

Sec. 306. Extension of Temporary Increase for Home Health Services Furnished in a Rural Area

CURRENT LAW

The Medicare home health PPS was implemented on October 1, 2000. It provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary, with the payment adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. BIPA 2000 increased PPS payments by 10 percent for home health services furnished in the home of beneficiaries living in rural areas. The increased payments are effective during the 2-year period beginning April 1, 2001 through March 31, 2003, without regard to budget neutrality for the overall home health PPS. The temporary additional payment is not included in the base for determination of payment updates.

EXPLANATION OF PROVISION

The provision would extend through December 31, 2004, the 10 percent additional payment for home health care furnished to beneficiaries residing in rural areas.

EFFECTIVE DATE

Enactment.

Sec. 307. Reference to 10 Percent Increase in Payment for Hospice Care Furnished in a Frontier Area

The provision would provide a cross reference to Section 422 of the bill.

Section 308. Reference to Priority for Hospitals Located in Rural or Small Urban Areas in Redistribution of Unused Graduate Medical Education Residencies

CURRENT LAW

With certain exceptions, Medicare limits the total number of paid residency positions in a hospital's approved teaching programs that are reimbursed based on the number that were reported by the

hospital for the cost reporting period ending in calendar year 1996. For example, hospitals that established new training programs before August 5, 1997 are partially exempt from the payment cap. Other exceptions apply to certain hospitals including those with new programs established after that date. Hospitals in rural areas (and urban hospitals operating training programs in rural areas) can be reimbursed for 130 percent of the number of residents allowed by their cap. The cap is calculated as a 3-year rolling average, that is, the resident count will be based on the average of the resident count in the current year and the 2 preceding years.

EXPLANATION OF PROVISION

Section 612 of this legislation would establish that hospitals located in rural or small urban areas would have priority for redistribution of unused graduate medical education residency payments. This provision will help attract physicians to rural and underserved areas.

EFFECTIVE DATE

Upon enactment.

Section 309. GAO Study of Geographic Differences in Payments for Physician Services

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

GAO would be required to study geographic differences in payment amounts in the physician fee schedule including: (1) an assessment of the validity of each component of the geographic adjustment factors; (2) an evaluation of the measures and the frequency with which they are revised; (3) an evaluation of the methods used to establish the costs of professional liability insurance including the variation between physician specialties and among different states, the update to the geographic cost of practice index, and the relative weighs for the malpractice component. The study, including recommendations concerning data and use of price proxies, would be due to Congress within 1 year of enactment.

EFFECTIVE DATE

Upon enactment.

Section 310. Providing Safe Harbor for Certain Collaborative Efforts that Benefit Medically Underserved Populations

CURRENT LAW

People who knowingly and willfully offer or pay a kickback, a bribe, or rebate to directly or indirectly to induce referrals or the provision of services under a Federal program may be subject to financial penalties and imprisonment. Certain exceptions or safe harbors that are not considered violations of the anti-kickback statute have been established.

EXPLANATION OF PROVISION

Remuneration in the form of a contract, lease, grant, loan or other agreement between a public or non-profit private health center and an individual or entity providing goods or services to the health center would not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population. The Secretary would be required to establish standards, on an expedited basis, related to this safe harbor that would consider whether the arrangement (1) resulted in savings of Federal grant funds or increased revenues to the health center; (2) restricts or limits a patient's freedom of choice; and (3) protects a health care professional's independence regarding the provision of medically appropriate treatment. The Secretary would also be able to include other standards that are consistent with Congressional intent. The Secretary would be required to publish an interim final rule in the Federal Register no later than 180 days from enactment that would establish these standards. The rule would be effective immediately, subject to change after a 30-day opportunity for public comment.

EFFECTIVE DATE

Upon enactment.

Section 311. Relief for Certain Non-Teaching Hospitals

CURRENT LAW

Section 4401(b) of the Balanced Budget Act of 1997 provided for temporary relief for certain non teaching and non disproportionate share hospitals located in states where operating costs exceeded operating payments in 1995. This provision expired in 1999.

EXPLANATION OF PROVISION

This provision provides for a temporary three-year adjustment for non-teaching hospitals in areas where the Medicare inpatient margin is markedly different and lower than the rest of the nation's hospitals. Specifically, in states where the average aggregate rural Medicare inpatient margin for these hospitals is negative, the Medicare inpatient payments are adjusted upwards by 5 percent for 3 years. In states where the average aggregate inpatient margin over all urban hospitals is less than 3 percent, the Medicare inpatient payments are adjusted upwards by 5 percent for 3 years. The calculation of the margin by the Medicare Payment Advisory Commission using data from the Healthcare Cost Reporting Information System (HCRIS) as of 2001 Q1, including Medicare inpatient payments in the numerator, and the allowable costs for all hospitals paid under the prospective payment system in the denominator for each of the two area groupings for each state in 1999. For sole community hospitals, the additional increase is on the hospital specific or Federal rate.

EFFECTIVE DATE

Upon enactment.

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Section 401. Revision of Acute Care Hospital Payment Updates

CURRENT LAW

Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected increase in the hospital market basket index (MBI). Sole community hospitals (SCH) receive special treatment under the inpatient hospital prospective payment system (PPS). A SCH can elect to be paid on the basis of its updated hospital-specific amount if that results in greater Medicare reimbursement than payment based on the federal amount. Currently, the update factor is set at MB–0.55 percentage points for FY2002 and FY2003 and at the MB for subsequent years.

EXPLANATION OF PROVISION

For FY2003, the hospital update factor would be MB–0.25 for all hospitals except SCHs that would receive an update factor of the full MB. The Secretary is directed to compile and clarify the procedures and policies for billing for blood and blood costs in the hospital inpatient setting as well as the operation of the collection of the blood deductible. The Secretary is also directed to permit hospitals to correct their wage index data for purposes of FY 2003 payment because of the change in policy included in the Benefit Improvement and Protection Act provision which permitted reclassification based on three prior years of data. This correction should be incorporated into the mid-year correction after review of the new applications by the Medicare Geographic Classification Board.

EFFECTIVE DATE

Upon enactment.

Section 402. 2-Year Increase in Level of Adjustment for Indirect Costs of Medical Education (IME)

CURRENT LAW

Medicare makes additional payments to teaching hospitals for indirect medical education (IME), which is a subsidy based in part on the extra clinical and diagnostic costs for residents providing care. The Balanced Budget Act of 1997 (BBA 97) reduced the IME adjustment from the existing 7.7 percent increase (for each 10 percent increase in a hospital's ratio of interns and residents to beds) in FY1997 to 7.0 percent in FY1998; to 6.5 percent in FY1999; to 6.0 percent in FY2000; and to 5.5 percent in FY2001 and subsequent years. These percentage IME adjustments were subsequently modified by the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA). Currently, the IME adjustment is set at 6.5 percent in FY2002 and 5.5 percent for FY20003 and subsequently.

EXPLANATION OF PROVISION

This provision would set the IME adjustment to 6 percent in FY2003, 5.9 percent in FY2004 and 5.5 percent for FY2005.

EFFECTIVE DATE

Upon enactment.

Section 403. Recognition of New Medical Technologies Under Inpatient Hospital PPS

CURRENT LAW

BIPA established that Medicare's inpatient hospital payment system should include a mechanism to recognize the costs of new medical services and technologies for discharges beginning on or after October 1, 2001. The additional hospital payments can be made by the means of a new technology groups, an add-on payment, a payment adjustment, or other mechanism, but cannot be a separate fee schedule and must be budget-neutral. A medical service or technology will be considered to be new if it meets criteria established by the Secretary after notice and the opportunity for public comment.

CMS published the final regulation implementing these provisions on September 7, 2001. This regulation changed the meeting schedule for decisions on the creation and implementation of new billing codes. (ICD–9–CM codes). The regulation also established that technology that provided a substantial improvement to existing treatments would qualify for additional payments. The add-on payment for eligible new technology would occur when the standard diagnosis related group (DRG) payment was inadequate; as measured by the threshold, which was established as one standard deviation above the mean standardized DRG. In these cases, the add-on payment for new technology would be the lesser of (a) 50 percent of the costs of the new technology or (b) 50 percent of the amount by which the costs exceeded the standard DRG payment; however if the new technology payments are estimated to exceed the budgeted target amount of 1 percent of the total operating inpatient payments, the add-on payments are reduced prospectively.

EXPLANATION OF PROVISION

The Secretary would be required to add new diagnosis and procedure codes on April 1 of each year that would not be required to affect Medicare's payment or DRG classification until the following fiscal year. The Secretary would not be able to deny a service or technology treatment as a new technology because the service (or technology) has been in use prior to the 2- to 3-year period before it was issued a billing code and a sample of specific discharges where the service has been used can be identified.

When establishing whether DRG payments are inadequate, the Secretary would be required to apply a threshold that is 50 percent of the national standardized amount for all hospitals and all DRGS or one standard deviation for the DRG involved. The Secretary would be required to provide additional clarification in regulation on the criteria used to determine whether a new service represents

a substantial improvement on existing treatment. The Secretary would be required to deem that a technology provides substantial improvement on an existing treatment if the technology in question is a drug or biological that is designated under section 506 (fast track product) or 526 (drugs for rare diseases and conditions) of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of Title 21, Code of Federal Regulations, designated for priority review when the marketing application was filed, is a medical device for which an exemption has been granted under section 520(m) of such Act, for which priority or expedited review has been provided under section 515(d)(5) (breakthrough technology). For other technologies that may be substantial improvements, the Secretary would be required to: (1) maintain and update a public list of pending applications for specific services and technologies to be evaluated for eligibility for additional payment; (2) accept comments recommendations and data from the public regarding whether a service or technology represents a substantial improvement; and (3) provide for a meeting at which organizations representing physicians, beneficiaries, manufacturers or other interested parties may present comments, recommendations, and data to the clinical staff of CMS regarding whether a service or technology represents a substantial improvement. These actions would occur prior to the publication of the proposed regulation. Before establishing an additional payment as the appropriate reimbursement mechanism, the Secretary would be directed to determine if instead one or more DRGs can be identified and assign the technology to that DRG, taking into account similar clinical or anatomical characteristics and the relative cost of the technology. The Secretary would assign an eligible technology into a DRG where the average cost of care most closely approximates the cost of the new technology. In such a case, no additional payment would be made and the other provisions of the new technology payment policy would not apply; the application of the budget neutrality requirement with respect to annual DRG reclassifications and recalculation of associated DRG weights would not be affected. Otherwise, the Secretary would be required to calculate additional payments based on the marginal rate associated with inpatient outlier cases.

EFFECTIVE DATE

These provisions would be effective for classifications beginning in FY2004. The Secretary would be directed to automatically reconsider an application as a new technology that was denied for FY2003 as a FY2004 application under these new provisions. If such an application is granted, the maximum time period otherwise permitted for such classification as a new technology would be extended by 12 months.

Section 404. Phase-in of Federal Rate for Hospitals in Puerto Rico

CURRENT LAW

Under Medicare's prospective payment system for inpatient services, a separate standardized amount is used to establish payments for discharges from short-term general hospitals in Puerto Rico.

BBA 97 provides for an adjustment of the Puerto Rico rate from a blended amount based on 25 percent of the federal national amount and 75 percent of the local amount to a blended amount based on a 50/50 split between national and local amounts.

EXPLANATION OF PROVISION

Hospitals in Puerto Rico would receive Medicare payments based on a 50/50 between federal and local amounts through October 1, 2003. From FY2004 though FY2007, an increasing amount of the payment rate would be based on federal national rates as follows: during FY2004, payment would be 55 percent national and 45 percent local; changing to 60 percent national and 40 percent local during FY2005; 65 percent national and 35 percent local during FY2006; 70 percent national and 30 percent local during FY2007 and 75 percent national and 25 percent local for FY2007 and subsequently.

EFFECTIVE DATE

Upon enactment.

Section 405. Reference to Provision Relating to Enhanced Disproportionate Share Hospital (DSH) Payments for Rural Hospitals and Urban Hospitals With Fewer than 100 Beds

CURRENT LAW

As explained in Section 302, Medicare makes additional payments to certain acute hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients.

EXPLANATION OF PROVISION

The provision that would increase the adjustment for rural hospitals and under 100 bed urban hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients is included in Section 302.

EFFECTIVE DATE

Upon enactment.

Section 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

CURRENT LAW

Medicare pays for inpatient services in acute hospitals in large urban areas using a standardized amount that is 1.6 percent larger than the standardized amount used to reimburse hospitals in other areas (both rural areas and smaller urban areas).

EXPLANATION OF PROVISION

The provision that would increase the standardized amount for other areas to the standardized amount paid to hospitals in large urban areas over a 2-year period is included in Section 303.

EFFECTIVE DATE

Upon enactment.

Section 407. Reference to Provision for More Frequent Updates in the Weights Used in the Hospital Market Basket

CURRENT LAW

As discussed in Section 304, Medicare's standardized amounts, which serve as the basis of its payment per discharge from acute hospital, are increased annually using an update factor, which is determined, in part by the projected increase in the hospital market basket index (MBI).

EXPLANATION OF PROVISION

The provision that would require more frequent updates in the hospital market basket is included in Section 304.

EFFECTIVE DATE

Upon enactment.

Subtitle B—Skilled Nursing Facility Services

Sec. 411. Payments for Covered Skilled Nursing Facility Services

CURRENT LAW

Medicare uses a system of daily rates to pay for care in a SNF. There are 44 daily rate categories, known as resource utilization groups (RUGS), and each group reflects a different mix and intensity of services, such as skilled nursing care and/or various therapy and other services. BIPA 2000 provided for a temporary bonus payment that increased the skilled nursing care component of each RUG by 16.66 percent over and above the RUG rates for SNF care. The Balanced Budget Retirement Act also included for temporary increases for certain rates, pending a refinement by CMS of these payments. In Spring 2002, CMS announced it would not refine the RUGs under the BBRA provision, thereby increasing payment to SNFs by $1 billion per year.

EXPLANATION OF PROVISION

The provision would retain the increase in the nursing component of each RUG at 12 percent, 10 percent, and 8 percent, respectively for FY 2003, 2004 and 2005. These increases are over and above the rates for SNF care as specified in Tables 3 and 4 of the final rule published in the Federal Register on July 31, 2000, and as subsequently updated under section 1888(e)(4)(E)(ii) of the Act. The increase would apply to SNF services furnished on or after October 1, 2002, and before October 1, 2005.

The provision would also increase by 128 percent the RUG payment for a SNF resident with acquired immune deficiency syndrome (AIDS). The 128 percent increase shall not apply on or after such date as the Secretary certifies that there is an appropriate change to the SNF case mix adjustment to compensate for in-

creased costs associated with caring for residents with AIDS. The provision would be effective October 1, 2002.

EFFECTIVE DATE

Applies to services furnished on or after October 1, 2003.

Subtitle C—Hospice

Section 421. Coverage of Hospice Consultation Services

CURRENT LAW

Current law authorizes coverage of hospice services, in lieu of certain other Medicare benefits, for individuals who elect such coverage.

EXPLANATION OF PROVISION

The provision would authorize coverage of certain physicians' services for certain terminally ill individuals. Persons entitled to these services would be individuals who had not elected the hospice benefit and had not previously received these physicians' services. Covered services would be those furnished by a physician who is either the medical director or employee of a hospice program. Services would include evaluating the individual's need for pain and symptom management, counseling the individual with respect to end-of-life issues and care options, and advising the individual regarding advanced care planning. Payment for such services would equal the amount established for a similar service of moderate complexity under the physician fee schedule, excluding the practice expense component.

EFFECTIVE DATE

Applies to consultation services provided by a hospice program on or after January 1, 2004.

Sec. 422. 10 Percent Increases in Payment for Hospice Care Furnished in a Frontier Area

CURRENT LAW

Medicare pays for hospice care for terminally ill beneficiaries at daily rates that differ depending on the level of care, i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care. The labor components of the rates are adjusted by the hospital wage index to reflect differences in area wage levels. BBRA 1999 temporarily increased payment rates for FY 2001 and FY 2002 by 0.5 percent and 0.75 percent respectively. BIPA 2000 increased Medicare daily payment rates for hospice care furnished on or after April 1, 2001, and during FY 2001 by 5 percent over the rates in effect in FY 2000.

EXPLANATION OF PROVISION

The provision would increase by 10 percent the Medicare daily payment rate for hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008. A frontier area would be defined as a county in which the population density is

less than 7 persons per square mile. The GAO would be required to submit a report to Congress, not later than January 1, 2007, on the costs of furnishing hospice care in frontier areas. The report would include recommendations regarding the appropriateness of extending, and modifying, the payment increase provided under this section.

EFFECTIVE DATE

Upon enactment.

Section 423. Rural Hospice Demonstration Project

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The provision would require the Secretary to conduct a demonstration project for the delivery of hospice care for beneficiaries in rural areas. Under the project, beneficiaries who were unable to receive hospice care in the home for lack of an appropriate caregiver would be provided such care in a facility of 20 or fewer beds which offered, within its walls, the full range of covered Medicare hospice benefits. The project could cover no more than three hospice programs over a period of 5 years each. In general, the program would comply with requirements otherwise applicable for hospices except that it would not be required to offer services outside the home nor be subject to the limitation on inpatient days. Payments would be made at the rates otherwise applicable. The Secretary would be required, upon completion of the project in five years, to submit a report to the Congress. The report would include recommendations regarding extension of such project to programs serving rural areas. However, the Congress believes that this does not preclude the Secretary of Health and Human Services usual authority to continue or expand demonstrations.

EFFECTIVE DATE

Upon Enactment.

Subtitle D—Other Provisions

Section 431. Demonstration Project for Use of Recovery Audit Contractors

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to conduct a demonstration project which would examine the use of recovery audit contractors under the Medicare Integrity Program where (1) the contractor could receive payment on a contingent basis; (2) the Secretary could retain a percentage of the amount recovered for the CMS program management account; and (3) the Secretary would examine the efficacy of such use with respect to duplicate payments and

coding accuracy as well as other payment policies where inaccurate payments may arise. The project would cover at least 2 states and 3 contractors for no longer than 3 years. The Secretary would be able to waive Medicare statutory provisions to pay for the contractors' services. The Secretary would not be able to enter into a recovery audit contract with an entity that is a fiscal intermediary, carrier, or Medicare Administrative Contractor. The Secretary would be required to show preference to contracting with entities that have employees with demonstrated proficiency in recovery audits with private insurers or Medicaid programs and have knowledge of Medicare's laws and regulations. Within 6 months of completion, the Secretary would be required to submit a report to Congress on the project's cost savings and include any recommendations on the cost-effectiveness of extending or expanding the project.

EFFECTIVE DATE

Upon enactment.

TITLE V—PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Provisions Relating to Physicians' Services

Section 501. Revisions of Updates for Physicians Services

CURRENT LAW

Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The fee schedule, in place since 1992, was intended to relate payments for a given service to the actual resources used in providing that service. The fee schedule assigns relative values to services. These relative values reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2001 was $38.2581. The conversion factor for 2002 dropped 5.4 percent to $36.1992.

The law provides a specific formula for calculating the annual update to the conversion factor. Several factors enter into the calculation of the formula. These include: (1) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; (2) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. If expenditures fall short of the target, the update for a future year is increased.

The annual percentage update to the conversion factor equals the MEI, subject to an adjustment (known as the update adjustment factor) to match target spending for physicians' services under the

SGR system. (During a transition period, 2001–2005, an additional adjustment is made to achieve budget neutrality.) The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. Allowed spending for the year is calculated using the SGR. However, in no case can the update adjustment factor be less than minus 7 percent or more than plus 3 percent.

The update adjustment factor is the sum of: (1) the prior year adjustment component, and (2) the cumulative adjustment component. The prior year adjustment component is determined by: (1) computing the difference between allowed expenditures for physicians' services for the prior year and the amount of actual expenditures for that year; (2) dividing this amount by the actual expenditures for that year; and (3) multiplying that amount by 0.75. The cumulative adjustment component is determined by: (1) computing the difference between allowed expenditures for physicians' services from April 1, 1996 through the end of the prior year and the amount of actual expenditures during such period; (2) dividing that difference by actual expenditures for the prior year as increased by the SGR for the year for which the update adjustment factor is to be determined; and (3) multiplying that amount by 0.33. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year.

The law also specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in input prices for physician services; (2) estimated change in the average number of Part B enrollees (excluding Medicare+Choice beneficiaries); (3) estimated projected growth in real gross domestic product (GDP) per capita; and (4) estimated change in expenditures due to changes in law or regulations. By November 1 of each year, (using the best data available as of September (1), CMS is required to publish the SGRs for three time periods in the Federal Register. These periods are the upcoming year, the current year, and the preceding year. For example, by November 1, 2002, CMS is to publish an estimate of the SGR for CY2003, a revision of the CY2002 SGR estimated in 2001 and a revision of the CY2001 SGR first estimated 2 years earlier and revised 1 year earlier.

The −5.4 percent negative update adjustment factor for 2002 reflected the application of the SGR system. Four items had particular importance for the 2002 calculation. First, allowed expenditures under the SGR system declined from earlier estimates, in part because GDP growth was lower than anticipated. Second, claims data for physicians services in the first half of 2001 showed higher than expected spending over the period and raised estimates for all of 2001. Third, certain technical errors in the calculations for previous years (which raised the updates in those years) further reduced the 2002 update. Fourth, underestimates of both the number of fee-for-service beneficiaries, by over one million, and the growth in GDP in 1998 and 1999 resulted in a reduction in cumulative SGR targets. CMS estimates that under current law, the updates for 2003 to 2006 would also be negative, at −5.7 percent in

2003, −5.7 percent in 2004, −2.8 percent in 2005, and −0.1 percent in 2006.

If CMS were to revise the SGR targets to reflect accurate data for the number of fee-for-service beneficiaries and GDP in 1998 and 1999, CMS projects that the updates would be positive from 2003 to 2012. The updates would be 1.0 percent in 2003, 1.4 percent in 2004, 2.3 percent in 2005, and positive, but less than 1.0 percent from 2006 through 2012. CMS claims that it lacks authority to make changes to the 1998 and 1999 SGR targets administratively, despite the fact that these changes would replace the erroneous data currently used in the calculations.

EXPLANATION OF PROVISION

The provision would provide for use of a 10-year rolling average GDP in setting updates, to reduce variations in SGR targets due to variations in economic growth. This change would be permanent.

The provision would set the update at 2 percent in 2003, instead of the projected −5.7 percent.

The SGR formula for 2004 and 2005 would be modified to produce updates estimated at approximately 2 percent each year. First, the provision would replace GDP with GDP + 1 percent when computing updates for 2003 and 2004. The 10–year rolling average GDP would be calculated, and then this average would be increased by 1 percentage point. This provision would recognize that growth in health care expenditures typically exceeds growth in the economy, and would adopt CMS' long-range projected rate of growth in Medicare.

Second, the provision would re-set the base for the SGR system such that the 2002 SGR target would equal 2002 actual expenditures. Re-setting the target would correct the formula for all past projection errors, including errors produced by underestimating the number of fee-for-service beneficiaries in 1998 and 1999 by one million, and not accounting for all expenditures generated by national coverage decisions.

Third, the provision would remove transitional adjustments for budget neutrality, equal to −0.2 percent in 2003, −0.2 percent in 2004, and +0.8 percent in 2005.

Under this provision, the SGR system would revert to current law in 2006, with the exception of continued use of the 10–year rolling average GDP. This provision would not be considered a change in law and regulation when calculating the SGR.

EFFECTIVE DATE

Enactment.

Section 502. Studies on Access to Physicians' Services

CURRENT LAW

Periodic analyses by the Physician Payment Review Commission, and subsequently MedPAC, as well as CMS showed that access to physicians' services generally remained good for most beneficiaries through 1999. Detailed data are not available for a subsequent period; however, several surveys have shown a decline in the percentage of physicians accepting new Medicare patients.

EXPLANATION OF PROVISION

The provision would require the GAO to conduct a study on access of Medicare beneficiaries to physicians' services under Medicare. The study would include an assessment of beneficiaries' use of services through an analysis of claims data. It would also examine changes in use of physicians' services over time. Further, it would examine the extent to which physicians are not accepting new Medicare patients. Within 18 months of enactment, GAO would be required to submit a report to Congress on this study. The report would include a determination whether data from claims submitted by physicians indicate potential access problems for beneficiaries in certain geographic areas. The report would also include a determination whether access by beneficiaries to physicians' services has improved, remained constant, or deteriorated over time.

The provision would require the Secretary to request the Institute of Medicine to conduct a study on the adequacy of the supply of physicians (including specialists) in the country and the factors that affect supply. The Secretary would be required to submit a report to Congress, within two years of enactment, on the results of the study.

EFFECTIVE DATE

Enactment.

Section 503. MedPAC Report on Payment for Physicians' Services

CURRENT LAW

Medicare pays for physicians' services on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect physician work, practice expenses and malpractice expenses. Resource-based practice expense relative values were phased-in beginning in 1999. Beginning in 2002, the values were totally resource-based.

Certain services have a professional component and a technical component. The technical component does not include a relative value for physician work. A global value includes both the professional and technical components. The physician must bill for the global value if the physician furnishes both the professional component and the technical component.

EXPLANATION OF PROVISION

The provision would require MedPAC to report to Congress on the effects of refinements to the practice expense component in the case of services for which there are no physician work relative value units. The report is to examine the following by specialty: (1) the effects of refinements on payments for physicians' services; (2) interaction of the practice expense component with other components of and adjustments to payment for physicians' services; (3) appropriateness of the amount of compensation by reason of such refinements; (4) effect of such refinements on access to physicians' services by Medicare beneficiaries; and (5) effect of such refine-

ments on physician participation under the Medicare program. The report would be due within one year of enactment.

EFFECTIVE DATE

Upon enactment.

Section 504. 1-Year Extension of Treatment of Certain Physician Pathology Services Under Medicare.

CURRENT LAW

The Beneficiary Improvement and Protection Act of 2000 allowed the continuation of separate billing and payment for the technical component of pathology services furnished by an independent laboratory for 2001 and 2002. The relationship was only for those hospitals that had an arrangement with an independent laboratory in effect of July 1999.

EXPLANATION OF PROVISION

This provision extends the BIPA provision for an additional year.

EFFECTIVE DATE

Upon enactment.

Section 511. Competitive Acquisition of Certain Items and Services.

CURRENT LAW

BBA 97 authorized the Secretary to conduct up to 5 demonstration projects to test competitive bidding as a way for Medicare to price and pay for Part B services other than physician services. The Secretary was required to establish up to 3 competitive acquisition areas for this purpose. Medicare implemented the first competitive bidding demonstration for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in Polk County, Florida. Multiple suppliers were selected through a competitive bidding process in the Spring of 1999 in five product categories: oxygen equipment and supplies, hospital beds and accessories, enteral nutrition products and supplies, urological supplies, and surgical dressings. Payments under this demonstration began on October 1, 1999, and demonstration prices remained in effect through September 30, 2001.

Medicare implemented a second DMEPOS competitive bidding demonstration in the San Antonio, Texas area (Bexar, Comal, and Guadalupe counties) on February 1, 2001. Multiple suppliers were selected through a competitive bidding process to provide the following product categories: oxygen equipment and supplies, hospital beds and accessories, manual wheelchairs and accessories, general orthotic devices, and nebulizer inhalation drugs. The demonstration prices in the San Antonio, Texas area will remain in effect until December 31, 2002.

Another round of competitive bidding was implemented in Polk County in October 2001. Multiple suppliers were selected through a competitive bidding process to provide the following product categories: oxygen equipment and supplies, hospital beds and acces-

sories, urological supplies, and surgical dressings. Demonstration prices are to remain in effect through September 30, 2002.

EXPLANATION OF PROVISION

This provision requires the Secretary to establish and implement programs under which competitive acquisition areas were established throughout the United States. The areas could differ for different items and services. The programs would be phased-in over a period of not longer than 3 years with competition under the programs occurring in at least ⅓ of the areas in 2004 and at least ⅔ of the areas in 2005. In carrying out the programs, the Secretary would be permitted to waive provisions of the Federal Acquisition Regulation as necessary for efficient implementation, other than provisions relating to confidentiality of information furnished by bidders or other provisions the Secretary determines are appropriate.

The provision would specify the items and services covered under the competitive acquisition programs as: (1) durable medical equipment as well as inhalation drugs paid for by Medicare, except for products used in infusion; and (2) orthotics paid for by Medicare which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit the patient.

The Secretary would be permitted to exempt areas that were not competitive due to low population density. The Secretary would also be able to exempt items and services for which the application of competitive acquisition was not likely to result in significant savings.

The provision would establish program requirements. The Secretary would be required to conduct a competition among entities supplying covered items and services for each competitive acquisition area in which the program was implemented for such items and services. The Secretary could not award a contract to an entity unless the Secretary made the following findings: (1) the entity met quality and financial standards specified by the Secretary or was automatically deemed to meet standards by accreditation entities or organizations recognized by the Secretary; (2) total amounts to be paid under the contract (including administrative costs) were expected to be less than what would otherwise be paid; (3) beneficiary access to a choice of multiple providers was maintained; and (4) beneficiary liability was limited to the applicable percentage of the contract award price. The specified quality standards could not be less than those that would otherwise apply and would include consumer services standards. The Secretary would be required to consult with an expert outside advisory panel composed of an appropriate selection of physicians, practitioners, and suppliers. The panel would review and advise the Secretary concerning quality standards.

The provision would provide that the Secretary would specify the terms and conditions of the contract. The Secretary would be required to rebid contracts at least once every 3 years (2 years are preferred as feasible.) The Secretary could limit the number of contractors in an area to the number needed to meet projected demand for the items and services covered under the contract. The Sec-

retary would be required to take into account the ability of bidding entities to furnish the items and services in sufficient quantities to meet anticipated beneficiary needs in the geographic area covered by the contract on a timely basis. The Secretary would award contracts to more than one entity submitting a bid in each area for an item or service. Payments could not be made for services provided by a contractor in a competition area unless the contractor had submitted a bid and the Secretary had awarded a contract to the entity. The Secretary would be authorized to award a contract to an appropriate entity for education, outreach, and complaint services.

The Secretary would be required to submit an annual management report to the Congress, which would include information on savings, reductions in beneficiary co-payments, access to items and services, and beneficiary satisfaction.

The provision would require the Secretary to conduct a demonstration project on the application of competitive acquisition to clinical diagnostic laboratory tests (including colorectal cancer screening tests) that are furnished without a face-to-face encounter between the individual and entity furnishing the test. The project would be under the same terms and conditions applicable to durable medical equipment and off the shelf orthotics. The Secretary would be required to submit to the Congress an initial report on the project not later than December 31, 2004. The Secretary would also submit progress and final reports as deemed appropriate.

The provision would specify that any competitive acquisition demonstration project in effect on the day before enactment could continue under the same terms and conditions that were applicable to that project on that date.

The provision would require the GAO to submit a report to Congress that analyses differences in reimbursement between public and private payors for clinical diagnostic laboratory services. The report would be due within 18 months of enactment.

EFFECTIVE DATE

Enactment.

Section 512. Payment for Ambulance Services

CURRENT LAW

Payments for ambulance services under Medicare have traditionally been based on reasonable charges for independent suppliers and reasonable costs for provider-based services. The BBA 97 provided for the replacement of these payment methodologies with a national fee schedule. The Secretary was required to phase-in the fee schedule in an efficient and fair manner. The fee schedule became effective April 1, 2002. By regulation, it is to be phased-in over the April 2002–January 2006 period. Under the phase-in schedule, a gradually decreasing portion of the payment is to be based on the previously existing payment (reasonable charges or reasonable costs) received by each ambulance and a gradually increasing percentage is to be based on the national fee schedule. In 2002, the blend is 80 percent of ambulance specific payments and 20 percent of the fee schedule. In 2003, the blend is 60 percent of

ambulance specific payments and 40 percent of the fee schedule. In 2004, the blend is 40 percent of ambulance specific payments and 20 percent of the fee schedule. In 2005, the blend is 20 percent of ambulance specific payments and 80 percent of the fee schedule. Beginning in 2006, the payment is to be based entirely on the fee schedule.

The fee schedule payment amount equals a base rate for the level of service plus payment for mileage and applicable adjustment factors. Additional mileage payments are made in rural areas. BIPA increased payment for rural ambulance mileage greater than 17 miles and up to 50 miles by at least one-half of the additional payment per mile established under the fee schedule for the first 17 miles of transport for services provided before January 1, 2004.

EXPLANATION OF PROVISION

The provision would substitute a new phase-in methodology for the ambulance fee schedule amount portion of the phase-in and lengthens the phase-in schedule. Under the provision, the national part phase-in calculation would be based on a blend of the national fee schedule (geographically adjusted) and a regional fee schedule (geographically adjusted) or, if higher, the current phase-in is retained. The regional fee schedule would be established by the Secretary for each of the 9 Census regions using the methodology used for calculating the regional conversion factor and regional mileage rate used for the national fee schedule. It would also use the same payment adjustments and the same relative value units as used for the national fee schedule.

In effect, the regional fee schedules would be based on the same methodology and data used to construct the national fee schedule. Essentially these fee schedules represent the national fee schedule broken out into 9 separate fee schedules. For example, to construct the national fee schedule, CMS used 1998 data and created a national conversion factor. To construct the regional fee schedules, CMS will use the 1998 data used to create the national fee schedule but will break it out region by region. Using the 1998 data for each region, CMS will create a conversion factor for each region. Some of the conversion factors will be lower than the national conversion factor and some will be higher. CMS will also use the 1998 data for each region to create a loaded mileage base rate for each region.

Under the provision, the regional conversion factor for each region would be adjusted in the same way the national conversion factor is adjusted—the relative value units will be used with each regional conversion factor to create a regional base payment rate for each level of service. The payment for a given service under the national fee schedule would be compared with the payment under the appropriate regional fee schedule.

In 2003, the blended rate would be based on 20 percent of the national fee schedule and 80 percent of the regional fee schedule. In 2004, the blended rate would be based on 40 percent of the national fee schedule and 60 percent of the regional fee schedule. In 2005, the blended rate would be based on 60 percent of the national fee schedule and 40 percent of the regional fee schedule. In 2006, the blended rate would be based on 80 percent of the na-

tional fee schedule and 20 percent of the regional fee schedule. Beginning in 2007, the payment would be based entirely on the national fee schedule. The ambulance specific reasonable charges part of the phase-in is unaffected by this calculation.

The provision would increase mileage payments for certain ground ambulance trips furnished on or after January 1, 2003, and before January 1, 2008. Payments for trips above 50 miles would be increased by at least one-quarter of the amount otherwise established under the fee schedule. This increase would apply regardless of where the transportation originated.

EFFECTIVE DATE

Applies to ambulance services furnished on or after January 1, 2003.

Section 513. 2-Year Extension of Moratorium on Therapy Caps; Provisions Relating to Reports

CURRENT LAW

BBA 97 established annual payment limits per beneficiary for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient therapy services provided by hospitals.

There were two per beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare Economic Index (MEI), rounded to the nearest multiple of $10.

BBRA 99 suspended application of the therapy limits in 2000 and 2001. BIPA extended the suspension through 2002. The limits are scheduled to go into effect in 2003.

BBA 97 required the Secretary to report to Congress by January 1, 2001, on recommendations on a revised coverage policy of outpatient physical therapy and occupational therapy services based on a classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of uniform dollar limitations. The BBRA 99 revised requirements for the BBA 97 report to include recommendations, and required a new study on utilization of therapy services. BBRA 99 required the Secretary to report to Congress on utilization of therapy services by June 30, 2001.

Medicare provides that therapy patients must be under the care of a physician. The physician or therapist must develop a plan of treatment, and the physician must periodically review the plan.

EXPLANATION OF PROVISION

The provision extends the moratorium on application of the therapy caps for an additional two years, through 2004. It would also require the Secretary to submit the reports required by BBA 97 and BBRA 99 by December 31, 2002.

The provision would require the Secretary to request the Institute of Medicine to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps. The Secretary would be required to submit to Congress a preliminary report on the conditions and diseases identified by July 1, 2003, and a final report by September 1, 2003.

The provision would require the GAO to conduct a study on access to physical therapist services in states authorizing access to such services without a physician referral compared to states that require such a physician referral. The study would: (1) examine the use of and referral patterns for physical therapist services for patients age 50 and older in states that authorize such services without a physician referral and in states that require such a referral; (2) examine the use of and referral patterns for physical therapist services for patients who are Medicare beneficiaries; (3) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office; (4) examine the physical therapist services within the facilities of the Department of Defense; and (5) analyze the potential impact on beneficiaries and on Medicare expenditures of eliminating the need for a physician referral and physician certification for physical therapist services under the Medicare program. The GAO would be required to submit a report to Congress on the study within one year of enactment.

EFFECTIVE DATE

Enactment.

Section 514. Accelerated Implementation of 20 Percent Coinsurance for Hospital Outpatient Department (OPD) Services; Other OPD Provisions

CURRENT LAW

BBA 97 provided for the implementation of a prospective payment system (PPS) for hospital outpatient department (OPD) services. This system was implemented August 2000. Under the system, services that are similar clinically and in terms of resource utilization are arranged into groups according to ambulatory payment classifications (APCs). A payment amount is established for each group and is the same for each service in the group. The payments cover hospital facility and nonphysician personnel costs with adjustments for geographic location of the facility and area wages.

Before implementation of the PPS, beneficiary coinsurance was generally based on 20 percent of the hospital's charges, while the Medicare program based its payments on the hospital's costs. Over time, hospitals' charges grew more quickly than costs in part due to an error in the formula correct by the Balanced Budget Act; as a result the share paid by beneficiaries grew to about 50 percent. BBA 97 provided for a gradual decrease in the portion paid by beneficiaries. Under the new payment system, coinsurance is set at 20 percent of historical national median charges for all services in the group. For all APC groups with coinsurance rates above 20 percent of the payment amount, the dollar amounts are frozen until

the coinsurance represents 20 percent of payment. MedPAC estimated this process could take multiple decades for certain services.

BBRA 99 limited the coinsurance by placing a dollar cap on the coinsurance for a given service equal to the inpatient hospital deductible. BIPA established an additional coinsurance reduction policy. A cap was placed on coinsurance liability for a single service. Starting April 1, 2001, the cap was 57 percent of the total payment amount for the service. This cap is 55 percent in 2002 and 2003. It is reduced by 5 percentage points each year over the 2004–2006 period until the limit is 40 percent for each service. During this period, the BBA 97 provision decreasing coinsurance continues to apply as the underlying process.

The law provides for transitional pass-through payments for additional costs of innovative medical devices, drugs, and biologicals.

EXPLANATION OF PROVISION

The provision would modify the BIPA provision to accelerate the reductions in coinsurance, saving Medicare beneficiaries $9.7 billion in reduced co-payments over ten years. The per service coinsurance cap would be 45 percent in 2004, 40 percent in 2005, 35 percent in 2006–2009, 30 percent in 2010, 25 percent in 2011, and 20 percent in 2012 and thereafter. Thus, by 2012, the coinsurance would be 20 percent for all services.

The provision would remove temperature-monitored cryoablation from the list of cancer therapy drugs and biologicals entitled to pass-through payments.

EFFECTIVE DATE

Enactment, except provision dealing with temperature-monitored cryoablation applies to payments for services furnished on or after January 1, 2003.

Section 515. Coverage of an Initial Preventive Physical Examination

CURRENT LAW

Medicare covers a number of preventive services. However, it does not cover routine physical examinations.

EXPLANATION OF PROVISION

The provision would authorize coverage of a free initial preventive physical examination. The physical examination would be defined as physicians' services consisting of a physical examination with the goal of health promotion and disease detection. It would include items and services specified by the Secretary in regulations. A covered initial preventive physical examination would be one performed not later than six months after the individual's initial coverage date under Part B.

The initial preventive physical examination would not be subject to the Part B deductible and would require no beneficiary coinsurance. Therefore, the beneficiary would pay nothing for the initial preventive physical examination.

Initial preventive physical exams would be included in the definition of physicians' services for purposes of the physicians' fee schedule.

EFFECTIVE DATE

Applies to services furnished on or after January 1, 2004 for individuals whose coverage begins on or after such date.

Section 516. Renal Dialysis Services

CURRENT LAW

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. BBRA 99 updated the composite rate by 1.2 percent for dialysis services furnished in 2000 and 1.2 percent for services furnished in 2001. BIPA provided for a 2.4 percent increase in 2001, in lieu of the 1.2 percent provided under BBRA. BIPA specified that the increase would be implemented through the application of two composite rates in 2001, in order to avoid retroactive processing of claims caused by the January 1, 2001 effective date. For services furnished from January–March 2001, the 1.2 percent increase specified under BBRA applied; for the remainder of the year a 2.79 percent transition increase applied. Effective January 1, 2002, the composite rates reverted to the December 31, 2000 rate, increased by 2.4 percent.

BIPA prohibited exceptions to the composite rates, except in the case of facilities that had exceptions for their 2000 rates or who applied for exceptions during the first 6 months of 2001.

A small proportion of ESRD patients use home dialysis. Currently, the payment system does not vary rates by different methods of treatment.

EXPLANATION OF PROVISION

The provision would increase the composite rate 1.2 percent for services furnished in 2004. The provision would specify that the prohibition on exceptions to the composite rate would not apply to pediatric facilities that, as of October 1, 2002, did not have an exception rate as of that date. Pediatric facilities would be defined as a renal facility at least 50 percent of whose patients were under age 18.

The provision would require the General Accounting Office of the Department of Health and Human Services to submit a report to Congress within one year of enactment. The report would be required to contain: (1) an analysis of the differences in costs of providing renal dialysis services in home settings and facility settings; (2) an assessment of the percentage of overhead costs in home settings and facility settings; and (3) an evaluation of whether the charges for home dialysis equipment and supplies were reasonable and necessary as well as the analysis of patient characteristics, outcomes (time spent waiting for transplantation), quality of life measures by modality.

EFFECTIVE DATE

Enactment.

Section 517. Improved Payment for Certain Mammography Services

CURRENT LAW

The Medicare physician fee schedule includes codes and amounts which apply to mammography procedures performed in physicians' offices and freestanding diagnostic imaging centers, and to payment for a physician's professional interpretation of a mammography performed in any setting. The Medicare hospital outpatient prospective payment system applies to the non-physician (i.e., facility) component of procedures furnished in hospital outpatient departments. The rates for the non-physician component of mammography differ, depending on the site of care and applicable payment system. Screening mammography services receive the same reimbursement from Medicare whether provided in a freestanding diagnostic imaging center, physician's office, or hospital outpatient department.

EXPLANATION OF PROVISION

The payment amount for the facility component for hospital outpatient services for screening mammography and unilateral and bilateral diagnostic mammography would be made under the physician fee schedule. The Secretary would appropriately adjust the payment amount for the technical component for diagnostic mammography performed on or after January 1, 2004, paid under the physician fee schedule, based on the most recent cost data available.

EFFECTIVE DATE

Applies to mammography performed on or after January 1, 2004.

Section 518. Waiver of Part B Late Enrollment Penalty for Certain Military Retirees

CURRENT LAW

Medicare charges a 10 percent penalty on the Part B premium for every year that enrollment is delayed after a beneficiary first becomes eligible for Part B. Beneficiaries may enroll in Part B upon initial eligibility for Part B (beginning 3 months before they turn 65, for a period of 7 months), or during an annual general open enrollment period, which occurs from January 1 through March 31 each year. A beneficiary can delay enrollment in Part B without penalty if the beneficiary or spouse is working and has group health insurance coverage through his or her employer or union. Such a beneficiary may enroll in Part B during a special enrollment period, which includes any time the beneficiary is still covered by the group health plan through the current or active employment, or within 8 months following the month that the health plan coverage ends or employment ends, whichever occurs first.

The Floyd A. Spence National Defense Authorization Act for FY 2001 opened TRICARE to Medicare-eligible military retirees for the first time, allowing them to keep their military health benefits past the age of 65. This TRICARE For Life benefit became available on January 1, 2001, and provides wrap-around coverage like Medigap. For services payable by both Medicare and TRICARE, Medicare is

the primary payer; TRICARE pays all remaining out-of-pocket expenses. Military retirees, Medicare-eligible family members, and certain former spouses are eligible. They must be enrolled in Medicare Part B to join the TRICARE program.

EXPLANATION OF PROVISION

This provision would waive the Part B late enrollment penalty, beginning in January 2003, for all individuals age 65 and over who are covered beneficiaries under the TRICARE For Life program, and who enroll in Part B between January 1, 2001 and December 31, 2003. The Secretary would consult with the Secretary of Defense in identifying individuals eligible for the waiver. The Secretary would establish a method for providing rebates of premium penalties paid for months on or after January 2003 for which a penalty would not apply, but for which a penalty was previously collected.

The provision would create a continuous open enrollment period through the end of 2003 to allow military retirees to enroll in Part B immediately. Part B coverage would begin on the first day of the month following the month of enrollment.

EFFECTIVE DATE

Enactment.

Section 519. Coverage of Cholesterol and Blood Lipid Screening

CURRENT LAW

Medicare currently covers cholesterol and other blood lipid testing for patients who already suffer from known disease such as heart disease, stroke, or other disorders associated with elevated cholesterol levels. Medicare does not cover cholesterol and blood lipid screening for beneficiaries without these diseases.

EXPLANATION OF PROVISION

Medicare would cover diagnostic testing of cholesterol and other blood lipid levels for early detection of abnormal cholesterol and other lipid levels. The Secretary would establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except such frequency may not be more often than once every two years.

EFFECTIVE DATE

Applies to tests furnished on or after January 1, 2004.

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

CURRENT LAW

In the first year of the home health PPS (FY 2001), payments to home health agencies were to be calculated so that, in that year,

Medicare total spending for home health care would be the same as it would have been had the previous payment system remained in effect, but with the cost of the previous system calculated to include a 15 percent cut to limits on payments per visit and per beneficiary. However, Congress postponed the adjustment to PPS rates based on the 15 percent cut to October 1, 2002, 2 years after the previous payment system had ended.

EXPLANATION OF PROVISION

The provision would eliminate the adjustment to PPS rates based on the 15 percent reduction in the per visit and per beneficiary limits, effective for episodes of home health care concluding on or after October 1, 2001. In addition, the provision would continue to specify that the Secretary could include in the PPS recognition of regional differences or differences based on whether or not home health care services were furnished in an urbanized area or the home health agency was located in an urbanized area.

EFFECTIVE DATE

Takes effect as if included in amendments made by BIPA.

Sec. 602. Establishment of Reduced Copayment for a Home Health Service Episode of Care for Certain Beneficiaries

CURRENT LAW

Current law does not require beneficiaries to pay any cost sharing, such as a deductible or coinsurance, when they use home health services. CMS and GAO have recently documented increased consumption of home health services, exceeding 30 percent a year and very profitable margins of 35 percent or more.

EXPLANATION OF PROVISION

The provision would establish, beginning with 2003, a beneficiary co-payment for each 60-day episode of care. The co-payment would be 1.5 percent of the national average payment per episode in a calendar year as projected by the Secretary before the beginning of the year. (Administrative and judicial review of the average amounts would be prohibited.) The co-payment would be rounded to the nearest multiple of $5. Unless the Secretary determines otherwise on a timely basis, the co-payment in 2003 would be $40. Qualified Medicare beneficiaries (low income beneficiaries for whom Medicaid pays the Medicare premiums, deductibles, and coinsurance), persons dually eligible for both Medicare and Medicaid, and beneficiaries receiving 4 or fewer home health visits in an episode of care would be excluded from the co-payment requirement.

EFFECTIVE DATE

Enactment.

Sec. 603. Update in Home Health Services

CURRENT LAW

Under current law, home health PPS amounts are updated annually by the increase in the home health market basket index minus

1.1 percentage points in FY 2002 and FY 2003 and by the full increase in the market basket index in subsequent years.

Current law also provides payments to home health agencies for a outlier of home health patients (those for whom care is unusually costly) over and above the PPS amount, but the total amount of the additional payment or payment adjustments in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made in such year.

EXPLANATION OF PROVISION

The provision would change the implementation updates to the home health PPS amounts from the start of a fiscal year to the start of a calendar year. It would increase payments by 2.0 percentage points at the start of 2003; by 1.1 percentage point for 2004; and by the increase in the home health market basket index minus 0.8 percentage point for 2005.

The provision would limit the total amount of outlier payments or payment adjustments for home health care in a fiscal year to no more than 3 percent of total projected payments, beginning in 2003.

EFFECTIVE DATE

Applies to years beginning with 2003.

Section 604. OASIS Task Force; Suspension of Certain Oasis Data Collection Requirements Pending Task Force Submittal of Report

CURRENT LAW

BBA 97 authorized the Secretary to require all home health agencies to submit additional information that the Secretary considered necessary for development of a reliable case mix system. The Secretary has implemented an Outcome and Assessment Information Set (OASIS). Home health agencies are required to collect OASIS data and report information to their State survey agency.

EXPLANATION OF PROVISION

The provision would require the secretary to establish and appoint a task force, known as the OASIS Task Force. The task force would be required to examine the data collection and reporting requirements under OASIS. It would be composed of staff from the Centers for Medicare and Medicaid Services with expertise in post-acute care; representatives of home health agencies, health care professionals and research and health quality experts outside the Federal government with experience in post-acute care, and advocates for individuals requiring home health services.

The task force would review and make recommendations to the Secretary regarding changes in OASIS to improve and simplify data collection for the purposes of assessing the quality of home health services and providing consistency in payment for such services under the prospective payment system. The task force would report its findings and recommendations to the Secretary within 18 months of enactment and would terminate 60 days after submis-

sion of the report. The task force would not be subject to the provisions of the Federal Advisory Committee Act.

The provision would prohibit the Secretary from requiring home health agencies to gather or submit information on persons not eligible for Medicare or Medicaid benefits for the period beginning January 1, 2003 and ending on the last day of the second month following submission of the task force report.

EFFECTIVE DATE

Enactment.

Section 605. MedPAC Study on Medicare Margins of Home Health Agencies

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The provision would require MedPAC to conduct a study of payment margins of home health agencies under the prospective payment system. The study would examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs). MedPAC would be required to submit a report on the study to Congress, within two years of enactment.

EFFECTIVE DATE

Enactment.

Subtitle B—Direct Graduate Medical Education

Section 611. Extension of Update Limitation on High Cost Programs

CURRENT LAW

Medicare pays hospitals for its share of direct graduate medical education (DGME) costs in approved programs using a count of the hospital's number of full-time equivalent residents and a hospital-specific historic cost per resident, updated for inflation. This historical cost based methodology resulted in inequities across hospitals with some hospitals receiving close to $200,000 per resident while others received less than $20,000 per resident. BBRA changed Medicare's methodology for calculating DGME payments to teaching hospitals to incorporate the concept of a national average amount adjusted by the physician geographic adjustment factor. Starting in FY2001, hospitals received no less than 70 percent of a geographically adjusted national average amount. Hospitals with per resident amounts above 140 percent of the geographically adjusted national average amount had payments frozen at current levels for FY2001 and FY2002, and in FY2003–FY2005 would receive an update equal to the Consumer Price Index (CPI) increase minus 2 percentage points. Hospitals with per resident amounts between 70 percent and 140 percent of the geographically adjusted

national average would continue to receive payments based on their hospital-specific per resident amounts updated for inflation.

EXPLANATION OF PROVISION

Hospitals with per resident amounts above 140 percent of the geographically adjusted national average amount in FY2001 or FY2002 would receive that payment amount through FY 2012.

EFFECTIVE DATE

Upon enactment.

Section 612. Redistribution of Unused Resident Positions

CURRENT LAW

Medicare's graduate medical education payment to teaching hospital is based on its updated cost per resident, the number of approved full-time-equivalent (FTE) residents, and Medicare's share of inpatient days in the hospital. Medicare counts residents in their initial residency period (the lesser of the minimum number of years required for board eligibility in the physician's specialty or 5 years) as 1.0 FTE. Residents whose training has extended beyond their initial residency period count as 0.5 FTE. Residents in certain specialties are allowed additional years in their initial residency period. Residents who are graduates from foreign medical schools do not count unless they pass certain exams. Medicare limits the total number of residents in a hospital's approved teaching programs that are reimbursed based on the number that were reported by the hospital for the cost reporting period ending in calendar year 1996. Hospitals that established new training programs before August 5, 1997 are partially exempt from the cap. Other exceptions apply to certain hospitals including those with new programs established after that date. Hospitals in rural areas (and non-rural hospitals operating training programs in rural areas) can be reimbursed for 130 percent of the number of residents allowed by their cap. The cap is calculated as a 3-year rolling average, that is, the resident count will be based on the average of the resident count in the current year and the 2 preceding years.

EXPLANATION OF PROVISION

The Secretary will determine if a teaching hospital's current number of residents (reference level) is less than applicable resident limit. If so, 25 percent of the unused residency payments would be retained by the hospital and 75 percent redistributed. The resident reference level would be the highest number of allopathic and osteopathic resident positions (before the application of any weighting factors) for the hospital during the reference period. A hospital's reference period would be the 3 most recent consecutive cost reporting periods for which a hospital's cost reports have been settled (or in the absence of such settled cost reports, submitted reports) on or before September 30, 2001. The Secretary would be able to adjust a hospital's resident reference level, upon the timely request for such an adjustment, for the cost reporting period that includes July 1, 2002. The Secretary should also consult with the appropriate experts in graduate medical education and training

such as the American Medical Association, the American Osteopathic Association, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine and other groups as the Secretary deems appropriate.

The Secretary would be authorized to increase the applicable resident limits for other hospitals. No increase would be permitted for any portion of cost reporting period that occurs before July 1, 2003 or before the date of a hospital's application for such an increase. No increase would be permitted unless the hospital has applied for such an increase by December 1, 2004. The Secretary would first distribute the increased resident count to programs in hospitals located in rural areas and hospitals that are not in large urban areas on a first-come-first-served basis. The hospital would have to demonstrate that the resident positions would be filled; not more than 25 positions would be given to any hospitals. These hospitals would be reimbursed for DGME for the increase in resident positions at the locality adjusted national average per resident amount rather than continuing the historically inequitable cost based methodology. A hospital's indirect medical education (IME) limit would be treated in the same way as changes to the aggregate limit except any resulting increase in resident counts would not affect a hospital's IME payments.

These provisions would not apply to reductions in residency programs that occurred as part of the voluntary reduction program or would affect the ability of certain hospitals to establish new medical residency training programs. The Secretary would be required to submit a report to Congress no later than July 1, 2004 that recommends whether to extend the application deadline for increases in resident limits.

EFFECTIVE DATE

Upon enactment.

Subtitle C—Other Provisions

Section 621. Modifications to Medicare Payment Advisory Commission (MedPAC)

CURRENT LAW

The Medicare Payment Advisory Commission (MedPAC) is required to review Medicare payment policies, make recommendations, and issue annual reports with respect to the Medicare +Choice program, Medicare's fee-for-service, and the interaction of these policies with the overall health care delivery system. MedPAC is composed of 17 members appointed by the Comptroller General to include individuals who are nationally recognized for their expertise in health finance and economics, actuarial science, health facility management, health plans and other related fields and who will provide a mix of broad geographic representation and a balance between rural and urban interests. Commission members include but are not limited to physicians, health professionals, employers, and other individuals skilled in health services and health economics research. Representatives of the elderly and consumers are also included in MedPAC. Individuals who are directly involved

in the provision or management of the delivery of Medicare covered items or services are not to constitute a majority of the Commission.

EXPLANATION OF PROVISION

MedPAC would be required to examine the budget consequences of its recommendations prior to issuing such recommendations, either directly or by consulting appropriate expert entities. MedPAC would be required to submit 2 reports to Congress no later than June 1, 2003 on: (1) the need and availability of data to determine the financial circumstances, including solvency, of hospitals and other Medicare providers; the report should also include an analysis of the advantages or disadvantages of the current TEFRA acute care payment system in the Virgin Islands compared to the Medicare prospective payment system; and (2) the investments and capital financing of participating hospitals and related foundations which would be based on data from Form 990 of the Internal Revenue Service.

EFFECTIVE DATE

Upon enactment.

Section 622. Demonstration Project for Disease Management for Certain Medicare Beneficiaries with Diabetes

CURRENT LAW

BIPA required the Secretary to conduct a demonstration project targeting certain Medicare fee-for-service beneficiaries with diagnosed, advanced stage congestive heart failure, diabetes, or coronary heart disease to examine the impact on costs and health outcomes of applying disease management services, supplemented with prescription drug coverage. No more than 30,000 beneficiaries may participate at any time and the project must result in a net reduction in aggregate Medicare expenditures. CMS published a notice requesting proposals for this project on February 22, 2002.

EXPLANATION OF PROVISION

The Secretary would be required to conduct a demonstration project, for up to 3 years, to examine the impact on costs and health outcomes of applying disease management to Hispanic Medicare beneficiaries who are diagnosed with diabetes. No more than 30,000 beneficiaries would be able to participate at any time. The beneficiaries would meet specified medical criteria, would have their physicians approve their participation in the project and would not be enrolled in a Medicare+Choice plan. These participants would be eligible for disease management services related to their diabetes and, except for modest cost sharing provided for by the project, would have all their prescription drug costs covered without regard to whether the drugs relate to the diabetes. The Secretary would carry out the project through contracts with up to 3 disease management organizations that have demonstrated improved health outcomes and reduced aggregate expenditures with such programs. Under the contracts, the organizations would be required to provide prescription drug coverage, would be paid a fee

negotiated by the Secretary so that Medicare expenditures would not increase but rather, to the extent practicable, would decrease. The organization would be required to guarantee that Medicare expenditures would not increase through an appropriate arrangement with a reinsurance company. Payments to these organizations would be made in appropriate proportion from the Medicare trust funds.

The Secretary would be required to establish a working group of employees of the Department of Health and Human Services to become the focal point of all disease management programs in the agency. Specifically, the working group would: (1) oversee the new diabetes disease management project; (2) establish policy and criteria for Medicare disease management programs; (3) identify targeted medical conditions and individuals; (4) select areas for disease management programs; (5) monitor health outcomes under the programs; (6) measure the effectiveness of such programs with respect to budget neutrality requirements; and (7) serve as a focal point for dissemination of information on all CMS run disease management programs. Participants would be offered certain protections for the period of the demonstration project that are afforded to Medicare beneficiaries enrolled in Medicare+Choice plans with respect to their existing Medicare supplemental insurance policies. The Secretary would be required to waive Medicare provisions as necessary to provide for payment for the disease management program.

The Secretary would be required to submit an interim report to Congress on the project no later than 2 years after the date it is first implemented; a final report would be due 6 months after its completion. These reports would include information on the impact of the project on costs and health outcomes as well as recommendations on the cost-effectiveness of extending or expanding the project.

GAO would be required to submit a report to Congress that compares Medicare's disease management programs with those conducted in the private sectors and identifies the cost effectiveness of such programs. The report would be due no later than 18 months from the date of enactment.

EFFECTIVE DATE

Upon enactment.

Section 623. Demonstration Project for Medical Adult Day Care

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

Subject to earlier provisions, the Secretary would be required to establish a demonstration project under which a home health agency, directly or under arrangement with a medical adult day care facility, provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Such services would have to be provided as part of a plan for an episode of care for home health services established

for a beneficiary. Payment for the episode would equal 95 percent of the amount that would otherwise apply. In no case would the agency or facility be able to charge the beneficiary separately for the medical adult day care services. The Secretary would reduce payments made under the home health prospective payment system to offset any amounts spent on the demonstration project. The 3-year demonstration project would be conducted in states that license or certify providers of medical adult day care services, as selected by the Secretary. Participation of up to 15,000 Medicare beneficiaries would be on a voluntary basis.

When selecting participants, the Secretary would give preference to home health agencies that are currently licensed or certified to furnish medical adult day care services; The Secretary would define licensure to apply both directly or under common ownership and control. A medical adult day care facility would (1) have been licensed or certified by a State to furnish medical adult day care services for a continuous 2-year period; (2) have been engaged in providing skilled nursing services or other therapeutic services directly or under arrangement with a home health agency; and (3) would meet quality standards and other requirements as established by the Secretary. The Secretary would be able to waive necessary Medicare requirements except that beneficiaries must be homebound in order to be eligible for home health services.

The Secretary would be required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than 30 months after its commencement. The report would include: (1) an analysis of patient outcomes and comparative costs relative to beneficiaries who receive only home health services for the same health conditions and (2) recommendations concerning the extension, expansion, or termination of the project.

EFFECTIVE DATE

Upon enactment.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

Section 701. Establishment of Medicare Benefits Administration

CURRENT LAW

The Medicare statute requires that the Administrator of the Health Care Financing Administration (HCFA, now known as CMS) be appointed by the President with the advice and consent of the Senate. The HCFA Administrator is paid at level III of the Executive Schedule.

The Medicare statute requires that the HCFA administrator appoint a Chief Actuary who reports directly to such administrator and is paid at the highest rate of basic pay for the Senior Executive Service. To be appointed as actuary, an individual must possess demonstrated experience and superior expertise in actuarial sciences, exercise duties that are appropriate to the office, and act in accordance with professional standards of actuarial independence. The Medicare statute specifies certain responsibilities for this position with respect to the Medicare+Choice program. Specifically, annual Medicare+Choice capitation rates are computed and pub-

lished by the Secretary, through the Chief Actuary of HCFA; adjustments to the Medicare+Choice payment rates that reflect changes in coverage are based on an cost analysis by the CMS' Chief Actuary; and the assumptions and data in the adjusted community rating submitted by Medicare+Choice plans are reviewed and assessed by CMS' Chief Actuary. The Chief Actuary may be removed only for cause.

EXPLANATION OF PROVISION

The Medicare Benefits Administration (MBA) would be an agency established within HHS that would be headed by an Administrator appointed by the President with the advice and consent of the Senate for a 5-year term. If a successor is not appointed immediately, the existing Administrator would continue in office. When the subsequent administrator was appointed, that person would serve as Administrator only for the remainder of the term. The Administrator who would be paid at level III of the Executive Schedule would report directly to the Secretary. The Secretary would ensure appropriate coordination between the Administrators of MBA and CMS.

The Administrator would be (1) responsible for all the duties of the MBA; (2) would have control over all related personnel and activities; (3) able to establish alter consolidate or discontinue organizational units except as further specified; (4) able to assign duties and delegate the authority to act to such officers and employees of MBA (these actions, within the limitation of such delegations, shall have the same force as if performed by the Administrator); and (5) able to prescribe necessary rules and regulations to carry out the functions of the MBA (subject to the rulemaking procedures of the section 553 of Title 5 of the United States Code, the Administrative Procedure Act).

The Deputy Administrator of MBA who would be paid at level IV of the Executive Schedule would be appointed by the President with the advice and consent of the Senate for a 5-year term. If a successor is not appointed immediately, the existing Deputy Administrator would continue in office. The subsequent deputy administrator would serve in that capacity only for the remainder of the term. The Deputy would perform duties as assigned by the Administrator and would act as Acting Administrator during any absence or disability, unless the President designates another officer of the Government as Acting Administrator in the event of a vacancy in that office.

The MBA Administrator would appoint a Chief Actuary who reports directly to such administrator and is paid at the highest rate of basic pay for the Senior Executive Service. To be appointed as Chief Actuary, an individual must possess demonstrated experience and superior expertise in actuarial sciences, exercise duties that are appropriate to the office, and act in accordance with professional standards of actuarial independence. The Chief Actuary would be able to be removed only for cause.

The MBA Administrator would be responsible for carrying out the duties associated with Parts C and D of Medicare including (1) negotiating, entering into, and enforcing Medicare+Choice contracts, including prescription drug coverage; (2) negotiating, enter-

ing into, and enforcing contracts with PDP sponsors for prescription drug coverage; (3) other duties provided for under Parts C or D, including certain demonstration projects; and (4) other duties relating to the Medicare prescription drug discount cared endorsement program. In carrying out the duties with respect to prescription drug coverage, the Administrator may not (1) require a particular formulary or institute a price structure for reimbursement of covered outpatient drugs; (2) interfere with negotiations between PDP sponsors and Medicare+Choice organizations, drug manufacturers, wholesalers, or other suppliers of outpatient drugs; and (3) interfere with the competitive nature of providing coverage through such sponsors and organizations. The Administrator would be required to submit to Congress a report on the administration of Parts C and D by March 31st of each year.

The MBA Administrator would be able to hire employees and officers with the necessary expertise to negotiate private sector contracts without regard to chapter 31 of Title 5 (other than 3110 and 3112) of the United States Code (relating to hiring of federal personnel and other employment matters) with the approval of the Secretary. The MBA staff would be paid without regard to the provisions of chapters 51 (other than 5101) and 53 (other than 5301) of Title 5 of the United States Code (relating to classification and pay schedules), but in no case would these employees receive more than the basic pay for level IV of the Executive Schedule. The MBA Administrator would not be able to employ more FTE's to perform a specific function than were previously used by CMS on the date of enactment to perform that function.

The Secretary and the Administrators of CMS and MBA would establish an appropriate transition of responsibility to redelegate the administration of Medicare Part C from CMS to MBA. The Secretary would ensure that the CMS Administrator transfer necessary data and information to the MBA Administrator. To the extent that a responsibility is transferred from the Secretary or from CMS to the MBA Administrator, any statutory reference with respect to such a responsibility is deemed to be a reference to the MBA Administrator.

The Secretary would be required to establish an Office of Beneficiary Assistance as a separate operating division within the MBA to (1) make Medicare eligibility determinations, and (2) enroll Medicare beneficiaries. The Office of Beneficiary Assistance would disseminate information on benefits and payment limitations (including cost-sharing requirements, stop-loss provisions, and formulary restrictions) under Parts C and D as well as benefits and payment limitations (including information on Medicare supplemental plans) under Parts A and B. The information would be disseminated by mail, through an internet site, and through a toll free telephone number in a way so that beneficiaries would be able to compare benefits under Parts A, B, D and supplemental insurance with benefits offered by Medicare +Choice plans. Information on the grievance and appeals procedures for all parts of Medicare would be disseminated as well.

A Medicare Policy Advisory Board would be established within the MBA to advice, consult with, and make recommendations to the MBA Administrator with respect to Parts C and D. The Board

would consist of 7 members who serve a 3-year term and who are appointed as follows: 3 members would be appointed by the President; 2 members would be appointed by the Speaker of the House with the advice of the chairmen and ranking minority members of the committees of jurisdiction and 2 members would be appointed by the President pro tempore of the Senate with the advice of chairman and ranking minority member of the committee of jurisdiction. The members would be chosen on the basis of their integrity, objectivity, and judgment as well as their experience with healthcare benefits management. No officer or employee of the United States would be able to serve on the Board. Board members would be compensated for each day of work (including time spent traveling) at a rates equal to level IV of the Executive Schedule.

The terms of the initial appointees would be established on a staggered basis. As designated by the President at time of appointment, 1 member would have a 1-year term; 3 members would have a 2-year term; and 3 members would have a 3-year term. No individual would be able to serve on the Board for more than 8 years. Any individual appointed to fill a vacancy on the Board would serve for the remainder of the term. A Board member would be able to serve after the expiration of that member's term until a successor is appointed. A vacancy in the Board would be filled in the manner in which the original appointment was made.

The Chair of the Board would be elected by the members to serve 3 years. The Board would meet at least 3 times during each fiscal year at the call of the chair. The Board would have a Director who would be appointed by the Chair. The Director would be able to appoint personnel, without regard to chapter 31 of Title 5 U.S.C., but with the Board's approval. The staff would be paid without regard to the provisions of chapters 51 and 53 of Title 5 U.S.C. (relating to classification and pay schedules), but in no case would these employees receive more than the basic pay for level IV of the Executive Schedule.

The Board would submit reports to Congress and the MBA Administrator that would contain recommendations for legislative or administrative changes to improve administration in such areas as fostering competition, beneficiary education, risk-adjustment methods, disease management programs, and access in rural areas. The Board would submit these reports directly to Congress without prior review and approval to any federal officer or agency. No later than 90 days after a report is submitted, the MBA Administrator would be required to submit an analysis of the Board's recommendations to Congress and the President. This analysis would also be published in the Federal Register.

The MBA Administrator would be required to make necessary information available to the Board. The Board would be able to contract with and compensate government and private agencies without regard to sections 3709 of the Revised Statutes (41 U.S.C. 5). Necessary sums would be authorized to be appropriated from the Medicare trust funds, including the Medicare Prescription Drug Account.

The MBA Administrator would become an ex-officio member of the Board of Trustees of the Medicare Trust Funds. The Administrator of CMS would be paid at level III of the Executive Schedule.

EFFECTIVE DATES

The Administrator and Deputy Administrator would be appointed on or after March 1, 2003. The MBA Administrator would be responsible for Medicare enrollment and eligibility determinations beginning on or after January 1, 2005. Before the MBA Administrator would be appointed, the Secretary would provide for the conduct of any of the Administrator's responsibilities that are otherwise provided for under law. On January 1, 2003, the MBA Administrator would become an ex-officio member of the Board of Trustees of the Medicare Trust Funds. The Administrator of CMS would be paid at level III of the Executive Schedule, effective on January 1, 2003.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Section 801. Construction; Definition of Supplier

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

None of the provisions shall be construed to (1) compromise the existing legal remedies for addressing Medicare fraud or abuse with respect to criminal prosecution, civil enforcement, or administrative remedies, including those established by the False Claims Act or (2) prevent the Department of Health and Human Services (HHS) from its ongoing efforts to eliminate waste, fraud, and abuse in Medicare. Also, consolidation of Medicare's administrative contracting functions (as provided for in this bill) would not consolidate the Federal Hospital Insurance Trust Fund, which pays for Part A, services and the Federal Supplementary Medical Insurance Trust fund, which pays for Part B services. The bill notes that this administrative consolidation does not reflect any position on that issue.

The term "supplier" refers to a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under title XVIII of the Social Security Act.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The Committees are committed to extending needed regulatory relief to providers and suppliers while at the same time protecting taxpayers from waste, fraud and abuse.

Subtitle A—Regulatory Reform

Section 802. Issuance of Regulations

(a) Consolidation of Promulgation to Once a Month

CURRENT LAW

The Secretary is required to prescribe regulations that are necessary to administer Parts A and B of the Medicare program. No rule, requirement or policy statement (other than a national coverage determination) that establishes or changes a substantive legal standard that determines Medicare's scope of benefits, level of payment, or eligibility of individuals, entities or organizations to receive benefits or furnish services can take effect unless it is promulgated by regulation. The Secretary must publish a proposed regulation in the Federal Register, with at least 60 days to solicit public comment, before issuing the final regulation with the following exceptions: (1) the statute permits the regulation to be issued in interim final form or provides for a shorter public comment period; (2) the statutory deadline for implementation of a provision is less than 150 days after the date of enactment of the statute containing the provision; (3) under the good cause exception contained in the rule-making provision of Title 5 of the United States Code, notice and public comment procedures are deemed impracticable, unnecessary or contrary to the public interest. The Secretary must publish in the Federal Register no less frequently than every three months a list of all manual instructions, interpretative rules, statements of policy, and guidelines which are promulgated to carry out Medicare's law.

EXPLANATION OF PROVISIONS

The Secretary would be required to issue proposed or final regulations (including interim final regulations) on one business day of every month, unless the Secretary finds that publication on other dates is required to comply with Medicare law or that this restriction is contrary to the public interest. In such instances, the Secretary would be required to include an explanation of such a finding when the regulations are issued. The Secretary would be required to coordinate the issuance of new regulations relating to a category of provider or supplier based on an analysis of the collective impact of the regulatory changes on such category. No later than three years after enactment, the Comptroller General of the US General Accounting Office would be required to report to Congress on the feasibility of issuing regulations only on one day in each calendar quarter.

EFFECTIVE DATE

The provisions would apply to regulations issued 30 days after enactment.

REASON FOR CHANGE

The volume of Medicare regulations issued by CMS can be difficult for health care providers and suppliers, particularly small providers and suppliers, to monitor. By requiring regulations to be

released on a certain date, providers and suppliers will be better able to keep informed of program changes. The Secretary may stagger the notice and comment periods of regulations issued on the same day, so that the comment deadlines for these regulations do not occur simultaneously, in order to ensure that interested parties have the opportunity to comment on multiple regulations.

The collective impact provision ensures that the Department will consider the overall impact of any changes it is making on categories of providers and suppliers. If the Department determines that many changes affecting a particular category of providers or suppliers are underway, the Department should consult with representatives of that category to determine whether providers and suppliers would be better able to make the systems changes needed to accommodate those changes if all the new regulations were released simultaneously or staggered. Because of the burden implementing multiple regulations simultaneously can cause, the Secretary needs to coordinate new regulations based on an analysis of the collective impact the regulatory changes will have on any given category of provider or supplier.

(b) Regular Timeline for Publication of Final Rules

CURRENT LAW

See above. The Secretary must publish in the Federal Register no less frequently than every three months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines which are promulgated to carry out Medicare's law.

EXPLANATION OF PROVISIONS

The Secretary, in consultation with the Director of the Office of Management and Budget, would establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation. The timeline may vary by regulation due to complexity, number and scope of comments received and other factors, but would not be longer than three years unless there are exceptional circumstances. If the Secretary intends to vary a regulation's timeline, a notice of the different timeline would be required to be published in the Federal Register. This notice would include a brief explanation of the justification for such variation. If the timeline established for an interim final regulation expires without promulgation of a final regulation (including the public comment period), the interim final regulation would not remain in effect unless the Secretary publishes a notice of continuation that includes an explanation for not complying with the deadlines. This provision applies to the regular timelines and any subsequent 1-year extension to the timeline. If a notice of continuation is published, the regular timeline or the timeline as previously extended would be extended for 1 additional year. The Secretary would be required to submit a report to Congress that describes and explains the instances where the final regulation was not published within the applicable timeline.

EFFECTIVE DATE

Upon enactment. The Secretary would be required to provide for a transition period for previously published interim final regulations.

REASON FOR CHANGE

Numerous regulations have been issued by CMS as interim final regulations and never finalized. This injects an element of uncertainty into the regulation in question, and it precludes the ability of CMS to incorporate changes based on comments received by interested parties into a final regulation. The provision ensures that proposed regulations will move through the process of finalization in a predictable and timely manner with input from affected parties.

(c) Limitation on New Matter in Final Regulations

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

A provision in a final regulation that is not a logical outgrowth of the proposed regulation (including an interim final regulation) would be treated as a proposed regulation and would not take effect without a separate public comment period followed by its publication as a final regulation.

EFFECTIVE DATE

Final regulations published on or after enactment.

REASON FOR CHANGE

The provision ensures that interested parties will be given an opportunity to comment on issues addressed in regulations before they take effect. The Committees recognize that proposed regulations for annual payment updates for providers and suppliers include proposed overall payment updates, and that specific payment amounts for specific codes or specific payment areas are not typically included until final rules. The Committees do not intend to change past custom to recognize such details in final rules as a "logical outgrowth" of proposed rules. It is the Committees' intent that if the Secretary publishes a final rulemaking document which includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking, such provision will not take effect until there is further opportunity for public comment and a publication of the provision again as a final regulation.

Section 803. Compliance with Changes in Regulations and Policies

(a) No Retroactive Application of Substantive Changes

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

A substantive change in a regulatory or a subregulatory issuance would not be applied retroactively to items or services, unless the Secretary determines that retroactive application (1) would be necessary to comply with statutory requirements; or (2) would be beneficial to the public interest.

EFFECTIVE DATE

For substantive changes issued on or after enactment.

REASON FOR CHANGE

This provision will ensure that Medicare's rules are not generally applied retroactively.

(b) Timeline for Compliance with Substantive Changes after Notice

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

A substantive change would not become effective before 30 days after the date the change is issued or published. The Secretary would be able to waive the 30-day period to comply with statutory requirements or if such waiver is in the public interest. If an earlier date is established, the Secretary would be required to include a brief explanation of such finding in the issuance or publication of the substantive change. No compliance action would be permitted against a provider or supplier for goods and services furnished before the effective date of the substantive change.

EFFECTIVE DATE

For compliance actions undertaken on or after enactment.

REASON FOR CHANGE

This provision will ensure providers and suppliers have sufficient time to make any changes to systems needed to comply with changes in regulations.

(c) Reliance on Guidance

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

(1) The provider or supplier follows written guidance (which may be transmitted electronically) provided by the Secretary or a Medicare contractor when furnishing an item or service and submitting a claim; (2) the Secretary finds that the circumstances relating to the furnished items and services have been accurately presented in writing to the contractor; (3) the guidance is inaccurate. A provider or supplier who reasonably relied on erroneous guidance would not be subject to any sanction or penalties, including repayment. This

provision would not prevent recoupment or repayment (without additional penalty) if the overpayment was solely the result of a clerical or technical operational error.

EFFECTIVE DATE

Upon enactment, but would not apply to sanctions where notice was provided on or before enactment.

REASON FOR CHANGE

This provision will ensure that providers and suppliers who, in good faith based, on the information received from contractors, will not be vulnerable to recovery if it turns out that the contractor was in error. Providers should be able to rely on the directions or guidance provided by their Medicare contractors.

Section 804. Reports and Studies Relating to Regulatory Reform

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

The legislation has two studies in this area. First, the Comptroller General of the United States (GAO) would be required to conduct a study to determine the appropriateness and feasibility of providing the authority to the Secretary to issue legally binding advisory opinions on the interpretation and application of Medicare regulations. The study would examine the appropriate time frame for issuing the decisions as well as the need for additional staff and funding. GAO would submit the study to Congress by January 1, 2004.

Second, the Secretary would be required to report to Congress on the administration of the Medicare program and inconsistencies among existing Medicare statutory or regulatory provisions. The report would include (1) information from beneficiaries, providers, suppliers, Medicare Beneficiary and Provider Ombudsmen (established in this legislation), and Medicare contractors; (2) descriptions of efforts to reduce inconsistencies; and (3) recommendations from the Secretary for appropriate legislation or administrative actions. The report would be due no later than two years after enactment and every two thereafter.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The Committees are interested in receiving additional information regarding both advisory opinions and inconsistencies in Medicare regulations.

Subtitle B—Contracting Reform

Section 811. Increased Flexibility in Medicare Administration.

(a) Consolidation and Flexibility in Medicare Administration

CURRENT LAW

Section 1816 of the Social Security Act authorizes the Secretary to establish agreements with fiscal intermediaries nominated by different provider associations to make Medicare payments for health care services furnished by institutional providers. Section 1842 of the Act authorizes the Secretary to enter into contracts with health insurers (or carriers) to make Medicare payments to physicians, practitioners and other health care suppliers. Section 1834(a)(12) of the Act authorizes separate regional carriers for the payment of durable medical equipment (DME) claims. Section 1893 authorizes the Secretary to contract for certain program safeguard activities under the Medicare Integrity Program (MIP).

Certain terms and conditions of the contracting agreements for fiscal intermediaries and carriers are specified in the Medicare statute. Medicare regulations coupled with long-standing agency practices have further limited the way that contracts for claims administration services can be established. Specifically, the contracts are awarded without full and open competition; generally must cover the range of claims processing and related activities; cannot be terminated without cause and without the opportunity for a public hearing; and incorporate cost-based, not performance-based, reimbursement methods with no incentive bonuses.

Certain functions and responsibilities of the fiscal intermediaries and carriers are specified in the statute as well. The Secretary may not require that carriers or intermediaries match data obtained in its other activities with Medicare data in order to identify beneficiaries who have other insurance coverage as part of the Medicare Secondary Payer (MSP) program. With the exception of prior authorization of DME claims, an entity may not perform activities (or receive related payments) under a claims processing contract to the extent that the activities are carried out pursuant to a MIP contract. Performance standards with respect to the timeliness of reviews, fair hearings, reconsiderations and exemption decisions are established as well.

A Medicare contract with an intermediary or carrier may require any of its employees certifying or making payments provide a surety bond to the United States in an amount established by the Secretary. Neither the contractor nor the contractor's employee who certifies the amount of Medicare payments is liable for erroneous payments in the absence of gross negligence or intent to defraud the United States. Neither the contractor nor the contractor's employee who disburses payments is liable for erroneous payments in the absence of gross negligence or intent to defraud the United States, if such payments are based upon a voucher signed by the certifying employee.

EXPLANATION OF PROVISIONS

The legislation would add Section 1874A to the Social Security Act to permit the Secretary to enter into contracts with any entity to serve as a Medicare administrative contractor. These contractors would perform or secure the performance (through subcontracting) of some or all of the following tasks: determine payment amounts; make payments; educate and assist beneficiaries; provide consultative services; communicate with providers and suppliers; educate and offer technical assistance to providers; and perform additional functions as necessary. An entity eligible to enter into a contract with respect to the performance of a particular function as an entity would (1) have demonstrated capability to carry out such function; (2) comply with conflict of interest standards that are generally applicable under Federal acquisition and procurement; (3) have sufficient assets to financially support the performance of such functions and (4) meet other requirements imposed by the Secretary. The claims processing jurisdiction of Medicare administrative contractor would be determined by the scope of the contract awarded to the entity. Specifically, the Medicare administrative contractor that would perform a particular function is the entity that has the contract to perform that function for any given beneficiary, any given provider or supplier, or class of same.

The Federal Acquisition Rules (FAR) would apply to Medicare administration contracts except to the extent it is inconsistent with a specific Medicare requirement. The Secretary would be required to use competitive procedures when entering into a Medicare administrative contract and would take into account performance quality, price, and other factors. The Secretary would be able to renew a contract for up to five years without regard to statutory requirements concerning competitive contracting if the entity has met or exceeded specified performance standards. The Secretary would be able to transfer functions among contractors consistent with these provisions. The Secretary would be required to (1) ensure that performance quality is considered in such transfers and (2) provide notice of such transfer (in the Federal Register or otherwise) that describes the transferred functions, the affected providers and suppliers, and includes contractor contact information.

The Secretary would be required to (1) provide incentives for the Medicare administrative contractors to provide efficient, high-quality services; and (2) develop performance standards with respect to each of the payment, provider service, and beneficiary service functions required of the contractors. In developing the performance standards, the Secretary would be able to consult with providers and suppliers, organizations representing Medicare beneficiaries, and Medicare contractors. In developing the performance requirements for Medicare administrative contractors, the Secretary may include satisfaction of beneficiaries as a standard for measuring performance. The Secretary would be required to contract only with those entities that will (1) perform efficiently and effectively; (2) meet standards for financial responsibility, legal authority and service quality among other pertinent matters; (3) agree to furnish timely and necessary data; and (4) maintain and provide access to necessary records and data.

The performance requirements would be (1) set forth in the contract between the Secretary and the appropriate Medicare contractor; (2) used to evaluate contractor performance; and (3) consistent with the contract's written statement of work. The statement of work and contract are public documents. A Medicare administrative contract would contain provisions deemed necessary by the Secretary and may provide for advances of Medicare funds for the purposes of making payments to providers and suppliers. In developing contract performance requirements for Medicare administrative contractors, the Secretary would be required to consider the inclusion of the existing standards in effect for timeliness of reviews, reconsiderations and exemption decisions.

The existing MSP provision would apply: the Secretary would not be able to require contractors to match their data with Medicare data for the purposes of the identifying beneficiaries with other insurance coverage. The Secretary would assure that the activities of the Medicare administrative contractors do not duplicate the Medicare Integrity Program (MIP) functions except with respect to the prior authorization of durable medical equipment. An entity with a MIP contract would not be treated as a Medicare administrative contractor, simply because it has a MIP contract.

A Medicare administrative contractor and any of its employees certifying or disbursing payments may be required to provide a surety bond to the United States in an amount established by the Secretary. It is the intent of Congress that the definition of a surety bond in this instance includes fidelity bonds and the Secretary has the authority to request fidelity bonds. The contractor's employee who disburses payments is not liable for erroneous payments in the absence of gross negligence or intent to defraud the United States, if such payments are based upon an authorization from the certifying employee and the authorization meets the internal control standards established by GAO. The contractor is not liable for payments made by its certifying or disbursing officers unless in connection with such payments or in the supervision or selection of such officers the contractor acted with gross negligence.

The Secretary would be able to indemnify a Medicare administrative contractor, subcontractor, or employee who is made a party to any judicial or administrative proceeding arising from the claims administration process to an appropriate extent as determined by the Secretary and specified in the contract. Indemnification in this case may include payment of judgments, certain settlements, awards and costs (including reasonable legal expenses). Settlement proposals would not be negotiated or compromised without prior written approval by the Secretary. The Secretary would not be able to provide any indemnification if the liability arises directly from conduct that is determined in the proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided before such determination is made and the contractor's conduct is found to be, the contractor would reimburse the Secretary for these costs. The provisions would not change common law immunity available to the Medicare contractor or other party, or permit the payment of costs not otherwise allowable, reasonable or allocable under the Federal Acquisition Regulation.

EFFECTIVE DATE

See subsection (d).

REASON FOR CHANGE

Medicare's current contracting represents an antiquated, inefficient, and closed system based on cozy relationships between the government, contractors and providers.

Medicare contracting is antiquated because contractors may not provide service for the entire Medicare program, or particular functions within the program; rather Fiscal Intermediaries administer claims for facilities and carriers administer claims for all other providers. It has failed to keep pace with integrated claims administration practices in the private sector.

Medicare contracting is inefficient because Medicare does not award contracts through competitive procedures, but rather on provider nomination.

Medicare contracting is closed. All but one of the contractors today have been with Medicare since the program's inception 36 years ago, and only insurers can provide contracting services.

This provision permits greater flexibility in contracting for administrative services between the Secretary and the Medicare contractors (entities that process claims under part A and part B of the Medicare program), including the flexibility to separately contract for all or parts of the contractor functions. The Secretary also may contract with a wider range of entities, so that the most efficient and effective contractor can be selected.

These amendments require the Secretary to contract competitively at least once every five years for the administration of benefits under parts A and B. In conjunction with the elimination of cost contracts, it is intended to create incentives for improved service to beneficiaries and to providers of services and suppliers.

(b) Conforming Amendments to Section 1816 (Relating to Fiscal Intermediaries)

CURRENT LAW

Section 1816 of the Social Security Act establishes the provider nomination process, the contracting specifications, and performance standards for fiscal intermediaries that currently contract with Medicare to process claims and perform other related administrative activities for institutional providers.

EXPLANATION OF PROVISIONS

The provisions establish that the activities of fiscal intermediaries in administering Medicare would be conducted through contracts with Medicare administrative contractors as set forth in subsection (a). The provider nomination process and contracting specifications would be repealed. Certain performance standards with respect to the processing of clean claims would be retained. Certain annual reporting requirements concerning the contractor's overpayment recovery efforts would be retained.

EFFECTIVE DATE

See subsection (d).

REASON FOR CHANGE

These amendments provide a basis for a unified contracting system for the administration of parts A and B, identical to the recent Congressionally mandated structure of the Medicare Integrity Program contractors. Consolidation of contracting duties as set forth in this legislation does not constitute consolidation of the Hospital Insurance and Medical Supplementary Insurance Trust Funds, or reflect any position on that issue. In addition, the elimination of provider nomination, which hospitals have rarely been allowed to exercise in recent years, is essential for bringing full and open competition into the contracting functions of the Medicare program.

(c) Conforming Amendments to Section 1842 (Relating to Carriers)

CURRENT LAW

Section 1842 of the Social Security Act establishes that carriers will be used to administer certain Medicare benefits as well as the contracting requirements and certain performance standards for those activities.

EXPLANATION OF PROVISIONS

The provisions would establish that the activities of carriers administering Medicare would be conducted through contracts with Medicare administrative contractors as set forth in subsection (a). Certain instructions including those pertaining to nursing facilities payments, claims assignment, physician participation, overpayment recoveries and billing by suppliers would be retained. Certain performance standards with respect to the processing of clean claims would be retained. Contracting specifications and other conforming changes would be established. The Secretary, not the contractor, would be responsible for taking necessary actions to assure that reasonable payments are made, for those made on both a cost and charge basis. The Secretary, not the contractor, would be responsible for maintaining a toll-free telephone number for beneficiaries to obtain information on participating suppliers. Since the Carrier fair hearing requirement were eliminated in BIPA, the requirements for the hearing are eliminated to conform with existing law. Certain annual reporting requirements concerning the contractor's overpayment recovery efforts would be retained.

The Committee directs the Secretary's attention to the provision of the Balanced Budget Act of 1997 requiring CMS to designate no more than five regional carriers to process laboratory claims. This provision was passed in order to streamline the processing of laboratory claims and was to be implemented by July 1, 1999, but CMS has taken no action to date. In consultation with the clinical laboratory industry, CMS may consider other potential solutions, including the designation of a single contractor to process all claims of laboratory entities operating in more than one state. CMS is directed to report back to the Committee on Ways and Means and

the Committee on Energy and Commerce within three months detailing the action it has taken to implement this directive.

EFFECTIVE DATE

See subsection (d).

REASON FOR CHANGE

The provision establishes a basis for a unified contracting system, identical to the structure implemented for the Medicare Integrity Program contractors. It is important to note, however, that consolidation of contracting duties as set forth in this legislation does not constitute consolidation of the Hospital Insurance and Medical Supplementary Insurance Trust Funds, or reflect any position on that issue. In addition, the Secretary would have the flexibility to choose the best contractor(s) to provide telephone information on suppliers, which is intended to reduce administrative costs and improve quality. Since the carrier fair hearing requirement was eliminated in previous legislation, the requirements for the hearing are eliminated in order to conform with existing law.

(d) Effective Date; Transition Rule

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

Except as otherwise provided in this subsection, the provisions in this section would be effective October 1, 2004. The Secretary would be authorized to take necessary actions prior to that date in order to implement these amendments on a timely basis to transition from the contracts established under sections 1816 and 1842 of the Social Security Act to those established under the new section 1874A created by this legislation. The transition would be consistent with the requirement that the administrative contracts be competitively bid by October 1, 2009. The requirement that MIP contracts be awarded on a competitive basis would continue to apply and would not be affected by the provisions in this section. The MIP contracting exception that allows agreements according to current law would be deemed to be a contract established under the new authority of 1874A and would continue existing activities. The Secretary has the authority to recognize the appropriate termination costs of the current contractors during the transition from cost contracts to competitively bid contracts.

(e) References

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

After this section becomes effective, any reference to fiscal intermediary or carrier would be considered a reference to the appropriate Medicare administrative contractor.

(f) Reports on Implementation

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

The Secretary would submit an implementation plan to Congress and GAO no later than October 1, 2003. GAO would evaluate the plan and include appropriate recommendations no later than six months after the plan is received. No later than October 1, 2007, the Secretary would be required to submit a status report to Congress including (1) the number of contracts that have been competitively bid; (2) the distribution of functions among contracts and contractors; (3) a timeline for complete transition to full competition; and (4) a detailed description of changes to contractor oversight and management.

EFFECTIVE DATES

Upon enactment.

Section 812. Requirements for Information Security

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

Medicare administrative contractors that determine and make payments would be required to implement a contractor-wide information security program that meets the requirements imposed on Federal agencies to ensure the security, integrity, confidentiality, authenticity, and availability of operational data and systems supporting operations. An annual audit of the information security at each Medicare administrative contractor: (1) would be performed by an independent entity that meets the independence requirements specified by the Inspector General (OIG) in HHS; and (2) would test the effectiveness of the information security techniques for an appropriate subset of the contractor's systems. An audit of new contractors (those that have not been fiscal intermediaries or carriers) would be required prior to the start of their performing Medicare payment functions. An audit of existing contractors (those that are now fiscal intermediaries and carriers) would be required to be completed within one year from enactment. The results of the audits would be reported promptly to the OIG, which will submit a report annually to Congress. These provisions would be equally applicable to fiscal intermediaries and carriers as to Medicare administrative contractors.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The increased reliance by the Federal government on the Internet and related telecommunications technologies has resulted in

enhanced inter-connectivity and interdependencies associated with Federal computer systems and between federal and private computer systems. Over the past several years, this inter-connectivity or Anetworking@ has resulted in increased security vulnerabilities that have put at greater risk computer systems and data that are critical to ensuring national and economic security and public health and welfare, including sensitive, non-public information that is collected and maintained by CMS and its business partners.

On May 23, 2001, the Committee on Energy and Commerce held a hearing to investigate the extent to which sensitive, non-public information related to collecting and processing Medicare claims was adequately secure on the computer networks operated by CMS and its business partners, including Medicare contractors. That investigation revealed significant weaknesses, which the agency has been working to address. Some of the computer security concerns identified include weak password management, inadequate access controls, excessive user privileges, improper network configurations, and inadequate testing of critical systems. In addition, the OIG conducted assessments of financial controls—including electronic data processing controls—at CMS and its major Medicare contractors, and, in every year since 1997, the OIG has identified computer security controls to be a material weakness at both CMS and the Medicare contractors reviewed.

Section 812 is intended to assist CMS in identifying and working with contractors to address potential security deficiencies in order to ensure that sensitive, non-public information related to the processing of Medicare claims is adequately secure from unauthorized access, misuse, or destruction.

Subtitle C—Education and Outreach

Section 821. Provider Education and Technical Assistance

(a) Coordination of Education Funding

CURRENT LAW

Medicare's provider education activities are funded through the program management appropriation and through the Education and Training component of the Medicare Integrity Program (MIP). Both claims processing contractors (fiscal intermediaries and carriers) and MIP contractors may undertake provider education activities.

EXPLANATION OF PROVISIONS

The provision would add Section 1889 to the Social Security Act which would require the Secretary to (1) coordinate the educational activities provided through the Medicare administrative and MIP contractors and (2) to submit an evaluation to Congress, no later than October 1, 2003, on actions taken to coordinate the funding of provider education.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

This provision is intended to ensure that federal spending on provider education is coordinated and used as efficiently as possible to maximize the value obtained from the investment. It is not intended to change the proportion of Medicare Integrity Program funds spent on provider education.

(b) Incentives to Improve Contractor Performance

CURRENT LAW

No specific statutory provision. Since FY1996, as part of the audit required by the Chief Financial Officers Act, an estimate of improper payments in Medicare fee-for-service has been established annually. As a recent initiative, CMS is implementing a comprehensive error rate testing program to produce national, contractor specific, benefit category specific and provider specific paid claim error rates.

EXPLANATION OF PROVISIONS

The Secretary would be required to develop and implement a methodology to measure the specific claims payment error rates at each Medicare administrative contractor. This methodology would apply to existing fiscal intermediaries and carriers in the same manner as it applies to Medicare administrative contractors. No later than October 1, 2003, GAO would submit to Congress and to the Secretary a report on the adequacy of the methodology, including recommendations as appropriate. No later than October 1, 2003, the Secretary would be required to report to Congress on (1) the use of the claims error rate methodology in assessing the effectiveness of contractors' provider education and outreach programs and (2) whether methodology should be used as a basis of contractors' performance bonuses.

EFFECTIVE DATE

As specified.

REASON FOR CHANGE

This provision would ensure that the Department monitors contractor performance for claims payment error rates, and it would identify best practices for provider education—all with the goal of reducing payment errors and helping providers and suppliers better comply with program requirements. It is the Committees' intent that, in consultation with representatives of providers and suppliers, the Secretary shall identify and encourage best practices developed by contractors for educating providers and suppliers.

(c) Provision of Access to and Prompt Responses from Medicare Administrative Contractors

CURRENT LAW

No specific statutory provision. Statutory provisions generally instruct carriers to assist providers and others who furnish services in developing procedures relating to utilization practices and to

serve as a channel of communication relating information on program administration. Fiscal intermediaries are generally instructed to (1) provide consultative services to institutions and other agencies to enable them to establish and maintain fiscal records necessary for program participation and payment and (2) serve as a center for any information as well as a channel for communication with providers.

EXPLANATION OF PROVISIONS

The Secretary would be required to develop a communication strategy with beneficiaries, providers and suppliers. Each Medicare administrative contractor would be required to (1) provide general written responses (which may be through electronic transmission) in a clear, concise and accurate manner to written inquiries from beneficiaries, providers and suppliers within 45 business days; (2) provide a toll-free telephone number where these interested parties may obtain billing, coding, claims, coverage and other appropriate Medicare information; (3) maintain a system for identifying which employee provided both the written and oral information; and (4) monitor the accuracy, consistency, and timeliness of the information provided. The Secretary would be required to establish and make public the standards used to monitor the accuracy, consistency, and timeliness of information provided in response to written and telephone inquiries. The standards would be developed in consultation with provider, supplier, and beneficiary organizations and would be consistent with the contractors' performance requirements. The Secretary would be able to directly monitor the quality of the information so provided. These provisions would also apply to existing fiscal intermediaries and carriers.

EFFECTIVE DATE

By October 1, 2003.

REASON FOR CHANGE

This provision is intended to improve contractor accountability to make contractors more responsive to providers and suppliers, and to increase the accuracy and reliability of the information provided in response to the questions received.

(d) Improved Provider Education and Training

CURRENT LAW

In FY2000, $54.8 million was spent on provider education and training activities: about $43 million came from the program management appropriation and about $12 million came from the Provider Education and Training component of MIP. In FY2001, about $57.3 million was budgeted for these activities.

EXPLANATION OF PROVISIONS

The provisions would authorize $25 million in Medicare appropriations in FY2004 and FY2005 and such funds as necessary in subsequent years to increase provider education and training and to improve the accuracy and quality of contractor responses. The

Committees intend for this amount to be provided in addition to current funding levels. Starting on October 1, 2003, the contractors' training activities would accommodate the special needs of small providers and suppliers. The provision defines a small provider as an institution with fewer than 25 full-time equivalents (FTEs) and a non-facility based provider or supplier with fewer than 10 FTEs.

EFFECTIVE DATE

Upon enactment and as specified.

REASON FOR CHANGE

This provision acknowledges that contractors are being instructed to significantly improve their provider education and training efforts, and accordingly authorizes new funds to be available for those purposes.

(e) Requirement to Maintain Internet Sites

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

The Secretary and each contractor would be required to maintain an Internet site that provides answers to frequently asked questions in an easily accessible format as well as other materials published by the contractor.

EFFECTIVE DATE

By October 1, 2003.

REASON FOR CHANGE

This provision will facilitate greater ease of provider and supplier access to information provided by Medicare's contractors.

(f) Additional Provider Education Provisions

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

A Medicare contractor would not be able to use attendance records at educational programs or information gathered during these programs to select or track candidates for audit or prepayment review. Nothing in the proposed legislation would require Medicare administrative contractors to disclose information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

This provision addresses a concern raised by providers and suppliers that their participation in educational forums has been used to trigger audits. Participation in educational forums should be encouraged not discouraged.

Nothing in this section or section 1893(g) shall be construed as preventing the disclosure by a Medicare contractor of information on attendance at education activities for law enforcement purposes. Nothing in this section or section 1893(g) shall be construed as providing for the disclosure by a Medicare contractor of the claims processing screens or computer edits used for identifying claims that will be subject to review.

Section 822. Small Provider Technical Assistance Demonstration Program

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to establish a demonstration program and contract with qualified entities to offer technical assistance, when requested and on a voluntary basis, to small providers or suppliers. Small providers and suppliers would be those institutional providers with less than 25 full-time equivalents (FTEs) or suppliers with less than 10 FTEs. Technical assistance would include direct, in-person examination of billing systems and internal controls by qualified entities such as peer review organizations or other entities. In awarding these contracts, the Secretary would be required to consider any prior investigations of the entity's work by the Office of the Inspector General (OIG) in HHS or the GAO. Participating providers and suppliers would be required to pay an amount estimated and disclosed in advance that would equal 25 percent of the cost of the technical assistance they received. Absent indications of fraud, errors found in the review would not be subject to recovery if the problem is corrected within 30 days of the on-site visit and remains corrected for an appropriate period. However, this protection would only apply to claims filed as part of the demonstration project, would last only for the duration of the project and only as long as the provider or supplier was participating in the project. GAO, in consultation with the OIG, would be required to evaluate and recommend continuation of the demonstration project no later than two years after its implementation. The evaluation would include a determination of whether claims error rates were reduced for providers and suppliers who participated in the program. The provision would authorize $1 million in FY2004 and $6 million in FY2005 of appropriations from the Medicare Trust Funds to carry out demonstration project.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

Many large providers and suppliers have contracts with private consulting firms to help them navigate their interactions with the Medicare program. This type of assistance can be prohibitively expensive for small providers and suppliers—but they too are required to comply with complex program rules and regulations. This provision creates a new demonstration program to facilitate small provider and supplier access to expert technical assistance. The demonstration will also test whether encouraging technical assistance on the front end to help providers and suppliers play by the rules can save the program money in the long term by promoting greater program compliance.

Section 303. Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman.

(a) Medicare Provider Ombudsman

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to appoint a Medicare Provider Ombudsman within HHS to (1) to resolve unclear guidance and provide confidential assistance to providers and suppliers regarding complaints or questions about the Medicare program including peer review and administrative requirements; and (2) recommend changes to improve program administration. The Ombudsman would not advocate any increases in payments or expanded coverage, but would identify issues and problems in current payment and coverage policies.

EFFECTIVE DATE

One year after enactment.

REASON FOR CHANGE

Providers are currently confronted with a morass of bureaucracy and regulation, with no clear individual to assist them. The new ombudsman will help providers navigate Medicare's complicated rules and regulations.

The Medicare Provider Ombudsman shall make recommendations to the Secretary concerning how to respond to recurring patterns of confusion in the Medicare program. Such a recommendation may include calling for the suspension of the imposition of provider sanctions (except those sanctions relating to the quality of care) where there is widespread confusion in program administration. Nothing in this section shall be construed as allowing for the suspension of provider sanctions relating to the quality of care, regardless of whether widespread confusion in the Medicare program exists.

(b) Medicare Beneficiary Ombudsman

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS.

The Secretary would be required to appoint a Medicare Beneficiary Ombudsman within HHS from individuals with health care expertise, advocacy, and education of Medicare beneficiaries. The ombudsman would (1) receive complaints, grievances, and requests for information from Medicare beneficiaries; (2) provide assistance with respect to those complaints, grievances and requests, including assistance to beneficiaries who appeal claims determinations or those affected by the decisions of Medicare+Choice organizations to leave Medicare; and (3) submit an annual report to Congress and the Secretary describing activities and recommending changes to improve program administration. The Ombudsman would not advocate any increases in payments or expanded coverage, but would identify issues and problems in current payment and coverage policies.

To the extent possible, the Beneficiary Ombudsman would work with the Health Insurance Counseling Programs authorized under Section 4360 of OBRA 1990, to facilitate the provision of information to Medicare beneficiaries regarding Medicare+Choice plans and any changes related to those plans. In addition, nothing in this section would preclude further collaboration, as appropriate, between the Beneficiary Ombudsman and these programs.

EFFECTIVE DATE

Once year after enactment.

REASON FOR CHANGE

Beneficiaries confront a morass of bureaucracy and regulation, with no clear individual to assist them. This new ombudsman will help beneficiaries navigate Medicare's complicated rules and regulations.

(c) Funding

CURRENT LAW

No provision

EXPLANATION OF PROVISIONS

The provision would authorize appropriations of necessary sums in FY2003 and subsequently from the appropriate Medicare Trust Funds for the Ombudsman programs.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The Committees acknowledge that implementing these new functions will have a cost and accordingly authorize necessary appropriations.

(d) Use of Central Toll Free Number (1–800 MEDICARE)

CURRENT LAW

The Secretary is required to prepare and distribute an annual notice explaining Medicare benefits and limitations to coverage to Medicare beneficiaries. The Secretary is also required to provide information via a toll-free telephone number.

EXPLANATION OF PROVISIONS

The Secretary would be required to establish a toll-free number (1–800–MEDICARE), which will transfer individuals with questions or seeking help to the appropriate entities. The transfer would occur with no charge. This toll-free number would be the general information and assistance number listed on the annual notice provided to beneficiaries. GAO would be required to (1) monitor the adequacy, accuracy, and consistency of the information provided to Medicare beneficiaries through the toll-free 1–800 MEDICARE number and (2) examine the education and training of those providing the information through the toll-free number. GAO would be required to submit a report to Congress no later than one year from enactment.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The beneficiary handbook currently provides many pages of phone numbers, which can be very confusing for beneficiaries, rather than a single number that then can triage and transfer beneficiaries to the appropriate person or entity. This provision will promote better access to information for beneficiaries.

Section 824. Beneficiary Outreach Demonstration Program

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to establish a 3-year demonstration project where Medicare specialists who are HHS employees are placed in at least six SSA offices to advise and assist Medicare beneficiaries. The SSA offices would be those with a high-volume of visits by Medicare beneficiaries; at least two of which would be in rural areas. In the rural SSA offices, the Secretary would provide for the Medicare specialists to travel among local offices on a scheduled basis. The Secretary would be required to (1) evaluate the project with respect to beneficiary utilization, beneficiary satis-

faction, and cost-effectiveness and (2) recommend whether the demonstration should be established on a permanent basis.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

This provision makes Medicare experts available in six Social Security Administration offices to assist beneficiaries and answer their questions. The demonstration will test whether such outsourced Medicare specialists improve beneficiary utilization and understanding of the program, and beneficiary satisfaction.

Subtitle D—Appeals and Recovery

Section 831. Transfer of Responsibility for Medicare Appeals

CURRENT LAW

Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal claims that are denied or payments that are reduced. Section 1869 of the Social Security Act, which covers the Medicare claims appeals process, was amended by BIPA in its entirety, but the BIPA provisions are not yet effective. Generally, parties who have been denied coverage of an item or service have the right to appeal that decision through a series of administrative appeals and then into federal district court if the amounts of disputed claims in question meet certain thresholds at each step of the appeals process. A hearing by an administrative law judge (ALJ) in the Social Security Administration (SSA) with review by the Department Appeals Board (DAB) are components of the administrative appeals process.

EXPLANATION OF PROVISIONS

By October 1, 2003, the Commissioner of SSA and the Secretary would develop a plan to transfer the functions of the administrative law judges (ALJs) who are responsible for hearing Medicare and Medicare related cases from SSA to HHS. The plan would be transmitted to Congress and GAO no later than October 1, 2003. The GAO would evaluate the plan and submit a report to Congress within 6 months of receiving the plan. The Secretary and the Commissioner of SSA would implement the transition plan and transfer the ALJ functions no earlier than July 1, 2004 and no later than October 1, 2004. The Secretary would (1) assure the ALJ's independence from the Centers of Medicare and Medicaid Services (CMS); and (2) locate the ALJs with an appropriate geographic distribution to ensure access. Subject to appropriations, the Secretary would be permitted to hire ALJs and support staff with priority given to ALJs with experience in handling Medicare appeals. Amounts previously paid to SSA for the ALJs performing the ALJ functions would be payable to the Secretary for the transferred functions. The Secretary would be permitted to enter into arrangements with SSA to share office space, support staff, and other resources with appropriate reimbursement from the Medicare trust funds. Increased appropriations would be permitted to increase the

number of ALJs and support staff; improve education and training for ALJs and their staff; and increase DAB staff.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The Office of Inspector General has identified moving the functions of the Medicare Administrative Law Judges to the Department of Health and Human Services as an important priority in improving the appeals system. This provision makes that transition and increases the emphasis on providing training Administrative Law Judges and their staffs to increase their expertise in Medicare's rules and regulations. The SSA Commissioner and the Secretary are instructed to work together on the transition plans in order to assure that the transition does not adversely affect the SSA ALJ appeals system.

The transition plan shall include information on the following:

- Workload—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes;
- Cost Projections—Funding levels required under this subsection to hear such cases in a timely manner;
- Transition Timetable—A timetable for the transition;
- Regulations—The establishment of specific regulations to govern the appeals process;
- Case Tracking—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the Medicare program;
- Feasibility of Precedential Authority—The feasibility of developing a process to give binding, precedential authority to decisions of the Departmental Appeals Board in the Department of Health and Human Services that address broad legal issues; and,
- Access to Administrative Law Judges—The feasibility of filing appeals with administrative law judges electronically, and the feasibility of conducting hearings using tele- or videoconference technologies.

Section 832. Process for Expedited Access to Judicial Review

(a) Expedited Access to Judicial Review

CURRENT LAW

Section 521 of BIPA (which is not yet implemented) amends Section 1869 to establish deadlines for filing appeals and for making decisions in the Medicare appeals process. Generally, an initial determination is to be completed no later than 45 days from the date a claim for benefits is received; an individual dissatisfied with an initial determination is entitled to a redetermination by a carrier or fiscal intermediary if requested within 120 days of the deter-

mination date. The redetermination is to be completed no later than 30 days from the request date. The Secretary may reopen or revise any initial determination or reconsidered determination under guidelines established by regulation.

An individual dissatisfied with the redetermination is entitled to reconsideration by a qualified independent contractor (QIC) if the request is initiated within 180 days of the notice of the adverse redetermination. With certain exceptions, a QIC reconsideration decision is to be completed within 30 days from the date a timely request has been filed. After a QIC's reconsideration, if the remaining contested amount is greater than $100, an individual is entitled to a hearing by an administrative law judge and then a review by the DAB. Both the ALJ hearing and the DAB review are to be completed within 90 days of a timely filed request for such an action.

If the dispute is not satisfactorily resolved and the contested amounts are greater than $1,000, the individual is entitled to judicial review of the decision. Under certain circumstances, a beneficiary is entitled to an expedited determination with accelerated deadlines. BIPA also provides for an expedited hearing under Section 1869, where the moving party alleges that no material issues of fact are in dispute; the Secretary makes an expedited determination as to whether any such facts are in dispute and, if not, renders a decision expeditiously.

EXPLANATION OF PROVISIONS

The Secretary would establish an appeals process for a provider, supplier, or beneficiary, which permits access to judicial review when a review panel determines that no entity in the administrative appeals process has authority to decide the question of law or regulation in controversy and where material facts are not in dispute. The appellant would be able to make such request only once with respect to a question of law or regulation for a specific dispute. If the appellant requests this determination and submits appropriate supporting documentation, the review panel would make this determination in writing no later than 60 days after the receiving the request. A review panel would consist of a panel of three members who are ALJs, members of the DAB, or qualified individuals associated with a QIC or other independent entity designated by the Secretary to make these determinations. The determination by the review panel would be considered a final decision and not subject to review by the Secretary. Given such a determination or a failure to make the determination within the 60-day deadline, the appellant would be able to request judicial review before a civil court. The filing deadline for this civil action would be within 60 days of the determination or within 60 days of the end of the deadline to make such determination. The venue for judicial review would be the U.S. District Court where the appellant is located, or where the greatest number of appellants are located, or in the district court for the District of Columbia. The amount in controversy would be subject to annual interest beginning on the first day of the first month beginning after the 60-day deadline for filing. Interest would be equal to the rate of interest on obligations issued for purchase by the Medicare trust funds effective for the

month that the civil action is authorized to commence. The interest payments would not be deemed to be Medicare reimbursement.

EFFECTIVE DATE

See section (c).

(b) Application to Provider Agreement Determinations

CURRENT LAW

Section 1866(h) of the Social Security Act provides for a hearing and for judicial review of that hearing for any institution or agency dissatisfied with a determination that it is not a provider (or that it can no longer be a provider).

EXPLANATION OF PROVISIONS

An agency or institution's appeal concerning program participation under Section 1866 would have access to expedited judicial review under Section 1869 provisions. This provision would not be construed to affect remedies applied to assure quality of care in skilled nursing facilities (under Section 1819) while such appeals are pending.

(c) Effective Date

EXPLANATION OF PROVISION

Amendments in the section would apply to appeals filed on or after October 1, 2003.

REASON FOR CHANGE

The provisions in 402 (a-c) on expedited access to judicial review ensure that if a review board certifies that there are no material facts in dispute and that the appeals process does not have authority to resolve the question at issue, the provider, supplier, or beneficiary may take their case to court in an expedited manner. This will facilitate more prompt resolution of challenges to the underlying validity of CMS regulations and determinations. To the extent that any part of an appeal poses a factual dispute that is being adjudicated before an administrative tribunal, this provision would not authorize the severance of the legal issues from the underlying factual dispute.

(d) Expedited Review of Certain Provider Agreement Determinations

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

The Secretary would develop and implement a process under 1866(h) to expedite provider agreement determinations including those instances where participation is terminated or other sanctions (including denials of new admissions or appointment of temporary management) against skilled nursing facilities have been imposed. Priority would be given to termination of provider agree-

ments. Increased appropriations from the Medicare trust funds in FY2003 and subsequently would be authorized in order to (1) reduce the average time for administrative determinations on provider participation appeals by 50 percent; (2) increase the number of ALJs and their staff; and (3) educate the ALJs and their staff on long term care issues.

EFFECTIVE DATE

Upon enactment.

Section 833. Revisions to Medicare Appeals Process

(a) Requiring Full and Early Presentation of Evidence

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

A provider or supplier would not be able to introduce evidence that was not presented at reconsideration conducted by the QIC unless a good cause precluded its introduction at or before that reconsideration.

EFFECTIVE DATE

On or before October 1, 2003.

REASON FOR CHANGE

The Office of Inspector General identified this change as a priority to promote more expeditious resolution of appeals of denied claims. This provision requires prompt introduction of evidence relevant to a provider appeal. When deciding whether there is good cause to introduce new evidence, the adjudicator should ensure, after consideration of the totality of the circumstances, that disallowing the introduction of such new evidence would unfairly prejudice the case. The totality of the circumstances may include, but is not limited to, the following: evidence is not yet available; the appellant was not represented at a lower level of appeal; the appellant was not aware of her rights; or the appellant did not understand the proceeding.

(b) Use of Patients' Medical Records

CURRENT LAW

BIPA established QIC reconsiderations as part of the Medicare's administrative review process. To reconsider whether a service is reasonable and necessary, a QIC will employ panel of physicians or other appropriate health care professionals to review the facts and the circumstances of the initial determination. The QIC reconsideration is to be based on applicable information, including clinical experience, and medical, technical, and scientific evidence.

EXPLANATION OF PROVISIONS

Medical records of the individual involved in the appeal would be included as part of the applicable information used by QICs in their reconsideration process.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

In the determination of whether an item or service is reasonable and necessary for an individual, a beneficiary's medical records should be considered with other relevant information.

(c) Notice Requirements for Medicare Appeals

CURRENT LAW

Section 521 of BIPA (which is not yet implemented) amends Section 1869 appeals process in its entirety, but did not establish specific notice requirements for each part of Medicare appeals process.

EXPLANATION OF PROVISIONS

The provisions would establish that a written notice of an initial determination associated with a claims denial be provided. The notice would include: (1) the reason for the denial and, upon request, the policy, manual or regulation used to make the decision; (2) the procedures for obtaining additional information concerning the determination; and (3) the notification of appeal rights and associated instructions.

The provisions would amend the existing requirement that a reconsideration decision be written and establish that the decision would have to be provided in printed form and written in a manner that could be understood by the beneficiary; the notice would include: as appropriate, a summary of the clinical or scientific evidence used to make the decision; upon request, the policy manual or regulation used to make the decision; and a detailed explanation of the decision to the extent appropriate. The requirement that the reconsideration decision include a notice of appeal rights and relevant instructions would also be established.

Comparable requirements would be extended to ALJ decisions. These decisions would have to be written in an understandable manner and include the specific reasons for the decision, an appropriate summary of the evidence, the procedures for obtaining additional information about the decision, and a notification of appeal rights and instructions.

The current requirements that a QIC prepare documentation and an explanation of the issues for an appeal to an ALJ would be modified: a QIC would be required to submit the information required in an appeal of a Medicare contractor's decision to the ALJ.

REASON FOR CHANGE

Currently, Medicare only provides beneficiaries with a brief statement about the initial determination of her claim on the Medicare Summary Notice. This provision provides additional informa-

tion to beneficiaries (or providers who appeal on their behalf) about Medicare's denial of their claim for benefits; the reasons for the denial, and the rights to further appeal so that beneficiaries can have a clear and concise understanding of decisions affecting their medical care.

(d) Qualified Independent Contractors

CURRENT LAW

BIPA established Qualified Independent Contractor (QIC) reconsiderations as part of Medicare's administrative review process. A QIC is an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations and that meets the established requirements for sufficient training and expertise in medical science and legal matters to make such reconsiderations. QIC reviews include consideration of the facts and circumstances by a panel of physicians or appropriate health professionals. No physician or health care professional employed by a QIC may review determinations regarding services provided to a patient, if directly responsible for furnishing the services to that patient. Review of home health care services is also prohibited by physicians and other professionals who have a significant direct or indirect financial interest in the agency or institution providing the care. This prohibition extends to physicians and professionals who have family members with such significant financial interests.

EXPLANATION OF PROVISIONS

To qualify as a QIC, an entity would be required to have sufficient medical, legal and other expertise, including knowledge of the Medicare program as well as sufficient professional qualifications, independence and staffing to make reconsideration decisions. A QIC would be required to assure that reviewers meet qualification and compensation requirements. If a reconsideration request indicates that the item or service was furnished by a physician, each reviewing professional should be a physician. Entities and their professional reviewers would have to meet independence requirements and may not: (1) be a related party; (2) have a material familial, financial, or professional relationships with a related party; or (3) have a conflict of interest with respect to a related party. QIC's compensation would not be contingent on any decision by the QIC or by any reviewing professional. A reviewer's compensation would not be contingent on any decision rendered by the reviewer. In this context, a related party to a Medicare case involving an individual beneficiary is (1) the Secretary, the Medicare administrative contractor involved, any fiduciary, officer, director or employee of HHS or such Medicare contractor; (2) the individual or authorized representative; (3) the health professional, institution or entity that provides or manufactures the item or service involved in the case; and (4) any other party with substantial interest in the case, as defined by regulation.

Individuals affiliated with a fiscal intermediary, carrier or other contractor would be able to act as a QIC reviewer if (1) a individual is not involved with the provision of the item or service of the case;

(2) individual is not an employee of the Medicare contractor and does not provide services exclusively or primarily to or on behalf of the contractor; and (3) the fact of the relationship is disclosed to the Secretary and the Medicare beneficiary or authorized representative who do not object. Individuals with staff privileges at the institution where treatment occurs would be able to serve as a reviewer if the affiliation is disclosed and there is no objection. Each reviewing professional shall be a allopathic or osteopathic physician or health care professional who is legally authorized to furnish items and services that are the subject of review in one or more states; and has medical expertise in the appropriate field for the case.

EFFECTIVE DATE

As if included in BIPA.

REASON FOR CHANGE

The BIPA 2000 law laid out broad provisions for revision of the Medicare appeals process. These provisions strengthen the appeals process by enhancing the criteria related to the independence and expertise of the reviewers and review entities.

Section 834. Prepayment Review

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

Medicare administrative contractors would be able to conduct random prepayment reviews in order to develop contractor-wide or program-wide claims payment error rates or under additional circumstances as established by regulations that are developed in consultation with providers and suppliers. Medicare administrative contractors would be permitted to conduct random prepayment reviews in accordance with a standard protocol developed by the Secretary. The Secretary would not be able to initiate non-random prepayment review based on the initial identification by a provider or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error. The Secretary would be required to issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment reviews. No provision would prevent the denial of payment for claims actually reviewed under random prepayment review. These provisions would be applied to fiscal intermediaries and carriers.

EFFECTIVE DATE

No later than one year from enactment. The Secretary would be required to issue regulations before that deadline; the random prepayment review protocols would apply to reviews after a date specified by the Secretary (but no later than one year from enactment.)

REASON FOR CHANGE

These provisions build greater consistency and predictability into Medicare's rules for prepayment review, while protecting program integrity.

Section 835. Recovery of Overpayments

CURRENT LAW

No provision with respect to repayment plans. Section 1833(j) of the Social Security Act provides that interest accrues on underpayments or overpayments starting within 30 days of the date of the final determination of the accurate payment amount.

EXPLANATION OF PROVISIONS

Subject to certain qualifications, in circumstances where refund of an overpayment within 30 days would constitute a hardship, providers and suppliers on request would be allowed to repay the overpayment amount (by offset or otherwise) over a period of at least six months up to three years when their obligation exceeds a ten percent threshold of their annual payments from Medicare. The Secretary would be able to establish a repayment period of up to five years in cases of extreme hardship. Interest would accrue on the balance through the repayment period. The Secretary would be required to establish a process under which newly-participating providers and suppliers could qualify for a repayment plan under this hardship provision. Previous overpayment amounts already included in an ongoing repayment plans would not be included in the calculation of the hardship threshold. The Secretary would be allowed to seek immediate collection if payments are not made as scheduled. Exceptions to this provision would be permitted in cases where the Secretary has reason to suspect that bankruptcy may be declared or that the provider or supplier may otherwise cease to do business or discontinue participating in the Medicare program, or where fraud or abuse against Medicare is indicated. This provision would not affect the application of existing no-fault provisions, which preclude recovery under certain circumstances where incorrect payment has been made to an individual who is without fault or where the recovery would decrease payments to another person who is without fault.

Upon enactment, the Secretary would not be able to initiate any recovery action if the provider or supplier has sought a reconsideration of the Medicare overpayment by a qualified independent contractor (QIC) until the date of the reconsideration decision. If QIC's are not yet in place, the recovery would not be initiated until the date of a redetermination decision by a fiscal intermediary or a carrier. If monies have been offset or repaid, the Secretary would return those amounts plus applicable interest if the original overpayment determination is reversed. If such an overpayment determination is upheld, interest would accrue beginning on the date of the original overpayment notice; the interest amount would be the rate otherwise applicable for Medicare overpayments.

Not later than one year after enactment, a Medicare contractor would not be able to use extrapolation to make overpayment deter-

minations initiated after the date of enactment, unless, as determined by the Secretary, a sustained or high level of payment error exists or a documented educational intervention did not correct the payment error.

Where providers and suppliers have previously been overpaid, Medicare contractors would be able to require periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that a previous practice has been discontinued.

The Secretary would be able to use a consent settlement to resolve a projected overpayment. Before entering into any consent settlements after the date of enactment, the Secretary would be required to communicate to a provider or supplier that based on a preliminary evaluation of a medical records review, an overpayment may exist; the nature of the identified problems; and the necessary steps to address the problem. The Secretary would provide 45–days where additional information may be submitted concerning the claims for which the medical records have been reviewed. After considering the additional information, the Secretary would provide notice and explanation of any remaining overpayment determination and would offer the opportunity for a statistically valid random sample (which would not waive appeal rights) or a consent settlement (based on a smaller sample with a waiver of appeal rights) to resolve the overpayment amounts.

Not later than one year after enactment, the Secretary would be required to establish, in consultation with health care associations, a process where classes of providers and suppliers are notified that their Medicare contractor has identified specific billing codes that may be over-utilized.

For audits initiated after enactment, Medicare contractors would be required to provide a written notice (which may be in electronic form) of the intent to conduct a post-payment audit to those selected as audit candidates. Medicare contractors would be required to provide those who have been audited a full review and understandable explanation of the findings that: (1) permits the development of an appropriate corrective action plan; (2) provides information on appeal rights as well as consent settlements (which are at the discretion of the Secretary); and (3) provides for an opportunity to supply additional information to the contractor. Medicare contractors would be required to take into account the information provided on a timely basis. The provisions requiring notice of audit and findings would not apply if pending law enforcement activities would be compromised or findings of law enforcement-related audits would be revealed.

Not later than one year after enactment, the Secretary would be required to establish a standard methodology for Medicare contractors to use in selecting a claims sample for a review of abnormal billing patterns.

These provisions would apply to Medicare administrative contractors including fiscal intermediaries and carriers as well as those eligible entities with MIP contracts.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

These provisions build greater consistency and predictability into Medicare's rules for recovery of overpayments, while protecting program integrity.

Section 836. Provider Enrollment Process; Right of Appeal

CURRENT LAW

Providers and, to some extent suppliers, have access to certain appeal mechanisms if their application to participate in Medicare is denied or terminated. Section 1866(h) of the Social Security Act provides for a hearing and for judicial review of that hearing for any institution or agency dissatisfied with a determination that it is not a provider (or that it can no longer be a provider). There is no statutory provision extending such judicial appeal rights to suppliers. Sections 1128(a) and (b) of the Act provide for the exclusion of certain individuals or entities because of the conviction of crimes related to their participation in Medicare; Section 1128(f) provides for hearing and judicial review for exclusions. In 1999, the Health Care Financing Administration (HCFA- now the Centers for Medicare and Medicaid Services or CMS) published a proposed regulation that would revise existing Medicare Part B administrative appeals procedures and extend them to all suppliers not currently covered.

EXPLANATION OF PROVISION

The Secretary would be required to (1) establish by regulation an enrollment process for providers and suppliers which would include deadlines for actions on enrollment applications within six months of enactment; (2) monitor the performance of Medicare administrative contractors in meeting the deadlines: (3) consult with providers and suppliers in making changes to the enrollment forms made on or after January 1, 2003. In establishing an enrollment process for providers and suppliers, the Secretary would build upon existing Medicare practice.

Providers and suppliers whose application to enroll or reenroll has been denied and who are dissatisfied with the determination would be entitled to a hearing and judicial review of the determination under the procedures that currently apply to providers. This provision would apply to denials after a date specified by the Secretary, which could not be later than one year from enactment.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

This provision gives providers and suppliers an opportunity to appeal denials of their applications to participate in the Medicare program.

Section 837. Process for Correction of Minor Errors and Omissions on Claims Without Pursuing Appeals Process

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to develop, in consultation with appropriate Medicare contractors and health care associations, a process where minor claims errors and omissions can be corrected and resubmitted without appealing the claims denial.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

Many of the providers and suppliers who testified before the Subcommittee or contacted members directly emphasized the need to create a process in which they could correct claims that were denied because they were incomplete or contained minor errors without having to pursue a formal appeal. This provision instructs the Secretary to create such a process, which will alleviate pressure on the appeals system. The Committees would be concerned, however, if this process were to become an incentive for providers to knowingly or negligently submit incomplete information.

The Committees intend that the process for correction of minor errors and omissions on claims cover both the submission of prepayment and post-payment review claims. For example, if in the case of a home health claim, the physician has signed the plan of care and/or physician's order but has not dated it, the claim shall be returned to the home health agency and may be resubmitted by the home health agency with any incomplete or missing information without having to appeal the claim.

Section 838. Prior Determination Process for Certain Items and Services; Advance Beneficiary Notices

CURRENT LAW

Medicare law prohibits payment for items and services that are not medically reasonable and necessary for the diagnosis or treatment of an illness or an injury. Under certain circumstances, however, Medicare will pay for noncovered services that have been provided if both the beneficiary and the provider of the services did not know and could not have reasonably been expected to know that Medicare payment would not be made for these services.

However, in most circumstances either the beneficiary or the provider will be liable in the event that Medicare does not cover an item or service. There are detailed rules on beneficiary and provider liability in the statute. A provider may be held liable for providing uncovered services, if, for example, specific requirements are published by the Medicare contractor or the provider has received a denial or reduction of payment on the same or similar service. In cases where the provider believes that the service may not be

covered as reasonable and necessary, the provider may limit his liability by providing an acceptable advance notice of Medicare's possible denial of payment to the patient. The notice must be given in writing, in advance of providing the service; include the patient's name, date and description of service as well as reasons why the service would not be covered; and must be signed and dated by the patient to indicate that the beneficiary will assume financial liability for the service if Medicare payment is denied or reduced. Currently, when there is a question about coverage, there is no way for a beneficiary or provider to find out in advance whether or not Medicare will cover that item or service for that particular beneficiary.

EXPLANATION OF PROVISIONS

The Secretary would be required to establish a process through regulation where physicians and beneficiaries can establish whether Medicare covers certain items and services before such services are provided. An eligible requestor would be either a physician or a Medicare beneficiary who receives an advance beneficiary notice (ABN) from a physician. Eligible items and services for review are those physicians' services under 1848(f)(4)(A) for which a physician may be paid directly. The provisions would establish: (1) such prior determinations would be binding on the Medicare contractor, absent fraud or misrepresentation of facts; (2) the right to redetermination in the case of a denial; (3) the applicability of existing deadlines with respect to those redeterminations; (4) contractors' prior determinations (and redeterminations) are not subject to further administrative or judicial review; and (5) an individual retains all rights to usual administrative or judicial review after receiving the service or receiving a determination that a service would not be covered. This section also requires that whenever a physician requests a pre-service determination (or redetermination), beneficiaries must still receive notices that include information explaining the beneficiary's right to receive the service and request access to the appeals process under section 1869. The calculation of the sustainable growth rate for physician updates is modified so that the increase in utilization from this provision is included. These provisions would not affect a Medicare beneficiary's rights in any future appeal or judicial action. The Secretary must establish the process to allow for the processing of such requests beginning 18 months after enactment. The Secretary would be required to collect data on the advance determinations and to establish a beneficiary and provider outreach and education program. GAO is required to report on the use of the advance beneficiary notice and prior determination process within 18 months of its implementation.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The Committees believe that when there is a question of whether Medicare will cover certain care for a beneficiary, the beneficiary should have the right to find out what will be covered before get-

ting the service and risking financial liability. Doctors also should be able to make such a request on behalf of a particular patient. This provision is particularly important for seniors and disabled individuals who tend to be risk adverse and live on fixed incomes.

Subtitle E—Miscellaneous Provisions

Section 841. Policy Development Regarding Evaluation and Management (E&M) Documentation Guidelines

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would not be permitted to implement any new documentation guidelines on or after enactment for evaluation and management (E&M) physician services unless the guidelines (1) are developed in collaboration with practicing physicians (both generalists and specialists) after assessment by the physician community; (2) based on a plan with deadlines for improving use of E&M codes; (3) are developed after completion of the pilot projects to test modifications to the codes; (4) are found to meet the desired objectives; and (5) are preceded the establishment of an appropriate outreach and education of the physician community. The Secretary would make changes to existing E&M guidelines to reduce paperwork burdens on physicians. The Secretary would be required to modify E&M guidelines to (1) identify clinically relevant documentation: (2) decrease non-clinically pertinent documentation; (3) increase the reviewers' accuracy; and (4) educate the physicians and the reviewers.

The provisions would establish different pilot projects in specified settings that would be (1) conducted on a voluntary basis in consultation with practicing physicians (both generalists and specialists); (2) be of sufficient length to educate physicians and contractors on E&M guidelines and (3) allow for an assessment of E&M guidelines and their use. A range of different projects would be established and include at least one project that (1) uses a physician peer review method; (2) uses an alternative method based on face-to-face encounter time with the patient; (3) is in a rural area; (4) is outside a rural area; and (5) involves physicians billing in a teaching setting and non-teaching setting. The projects would examine the effect of modified E&M guidelines on different types of physician practices in terms of the cost of compliance. Data collected under these projects would not be the basis for overpayment demands or post-payment audits. This protection would apply to claims filed as part of the project, would last the duration of the project., and would last for as long as the provider participated in the project. The Secretary, in consultation with practicing physicians including those in groups practices as well as generalists and specialists, would be required to evaluate the development of alternative E&M documentation systems with respect to administrative simplification requirements and report results of the study to Congress by October 1, 2004. The Medicare Payment Advisory Com-

mission would conduct an analysis of the results of this study and submit a report to Congress.

The Secretary would be required to conduct a study of the appropriate coding of extended office visits where no diagnosis is made and submit a report with recommendations to Congress no later than October 1, 2004.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

This provision is designed to promote greater consultation with practicing physicians with regard to the complicated evaluation and management and coding requirements governing Medicare payment for physician services.

Section 842. Improvement in Oversight of Technology and Coverage

(a) Improved Coordination Between FDA and CMS on Coverage of Breakthrough Medical Devices

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

Upon request and to the extent feasible, the Secretary would be required to ensure that appropriate information from the review for application for premarket approval of class III medical devices conducted by the FDA for coverage decisions. Within 6 months of enactment, the Secretary would be required to submit a report to the appropriate Congressional committees on the implementation plan to shorten the delay between FDA's premarket approval and Medicare's coding and coverage decisions. This provision would not change Medicare's coverage nor FDA's premarket approval criteria. Nothing in this subsection will be construed to lengthen the time for premarket approval under the FFDCA.

EFFECTIVE DATE

Upon enactment

REASON FOR CHANGE.

After the FDA pre-market approval, the Medicare program does a second evaluation of breakthrough technologies to determine effectiveness and cost of those technologies compared to existing technologies. The review is necessary and appropriate, but it can take months between FDA approval and the availability of new technology for Medicare beneficiaries. By coordinating FDA and CMS approval of breakthrough medical devices, where feasible, this provision is intended to facilitate a more efficient process for the coverage of certain new technology by the Medicare program.

(b) Council for Technology and Innovation

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary is required to establish a Council for Technology and Innovation within the Centers for Medicare and Medicaid Services (CMS). The council would be composed of senior CMS staff with an Executive Coordinator, who is designated or appointed by the Secretary and reports to the CMS administrator. The Chairperson would serve as a single point of contact for outside groups and entities regarding Medicare coverage, coding, and payment processes. The Council would coordinate Medicare's coverage, coding, and payment processes as well as information exchange with other entities with respect to new technologies and procedures, including drug therapies.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

CMS personnel responsible for coverage, coding and payment of medical innovation are often not well coordinated. This provision creates a focal point for technology and innovation within the Centers for Medicare and Medicaid Services by creating a Council to coordinate across the different Centers and Offices with responsibilities in this area. The Executive Coordinator also provides a single point of contact for outside groups, similar to recent initiatives launched by the Secretary for specific issues and types of providers.

(c) GAO Study on Improvements in External Data Collection for Use in the Medicare Inpatient Payment System

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

GAO would be required to conduct a study analyzing which external data can be collected by CMS for use in computing Medicare's inpatient hospital payments. The study may include an evaluation of the feasibility and appropriateness of using quarterly samples or special surveys among other methods. The study would include an analysis of whether other agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information. The report would be submitted to Congress no later than October 1, 2003.

EFFECTIVE DATE

Upon enactment.

(d) IOM Study on Local Coverage Determinations

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to arrange for a study by the Institute of Medicine (IOM) that would examine Medicare's local coverage determinations. The study would examine: (1) the consistency of definitions used in the determinations; (2) the types of evidence that are the basis of the determinations; (3) the advantages and disadvantages of local coverage decisionmaking and of maintaining local Medicare contractor advisory committees; and (4) the manner in which local coverage decisions are used to develop data to support national coverage determinations. The IOM study would be due to the Secretary no later than 3 years after enactment when it would be promptly transmitted to Congress.

EFFECTIVE DATE

Upon enactment.

(e) Methods For Determining Payment Basis for New Lab Tests

CURRENT LAW

Outpatient clinical diagnostic laboratory tests are paid on the basis of area wide fee schedules. The law establishes cap on the payment amounts, which is currently set at 74 percent of the median for all fee schedules for that test. The cap is set at 100 percent of the median for tests performed after January 1, 2001 that the Secretary determines are new tests for which no limitation amount has previously been established.

EXPLANATION OF PROVISIONS

The Secretary would be required to establish procedures (by regulation) for determining the basis and amount of payments for new clinical diagnostic laboratory tests. New laboratory tests would be defined as those assigned a new Health Care Procedure Coding System (HCPCS) code on or after January 1, 2004. The Secretary, as part of this procedure, would be required to (1) provide a list (on an Internet site or other appropriate venue) of tests for which payments are being established in that year; (2) publish a notice of a meeting in the Federal Register on the day the list becomes available; (3) hold the public meeting no earlier than 30 days after the notice to receive public comments and recommendations; (4) take into account the comments, recommendations and accompanying data in both proposed and final payment determinations. The Secretary would set forth the criteria for making these determinations; make public the available data considered in making such determinations; and could convene other public meetings as necessary.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

The Secretary of Health and Human Services is required to establish by regulation an open process for any clinical diagnostic laboratory test. Under the regulations, the Secretary shall develop criteria for use in determining whether a laboratory test should be established through gap-filling or cross-walking to an existing code. When existing services are not sufficient and gap filling must be used, the criteria shall explain the basis of the data, the collection of the data, and the methodology for computing the rate.

The intent of Congress is to open the process to allow CMS to have access to information from beneficiaries, physicians, health care experts and laboratories. Using the information it receives through this new process, CMS shall develop and make available to the public the information used to arrive at a final determination. The information will include the rationale for each such determination, the data on which the determination is based, and responses to public comments.

Section 843. Treatment of Hospitals for Certain Services Under the Medicare Secondary Payor (MSP) Provisions

CURRENT LAW

In certain instances when a beneficiary has other insurance coverage, Medicare becomes the secondary insurance. Medicare Secondary Payor is the Medicare program's coordination of benefits with other insurers. Section 1862(b)(6) of the Social Security Act requires an entity furnishing a Part B service to obtain information from the beneficiary on whether other insurance coverage is available.

EXPLANATION OF PROVISION

The Secretary would not require a hospital or a critical access hospital to ask questions or obtain information relating to the Medicare secondary payor provisions in the case of reference laboratory services if the same requirements are not imposed upon those provided by an independent laboratory. Reference laboratory services would be those clinical laboratory diagnostic tests and interpretations of same that are furnished without a face-to-face encounter between the beneficiary and the hospital where the hospital submits a claim for the services.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

Hospitals would not have to directly contact each beneficiary on their retirement date, black lung status and other insurance information for reference laboratory services. While current law provisions for a claim containing valid insurance information are maintained, this provision is intended to reduce the amount of paperwork and regulatory burden related to the provision of these reference laboratory services by hospital-based entities.

Section 844. EMTALA Improvements

CURRENT LAW

Medicare requires participating hospitals that operate an emergency room to provide necessary screening and stabilization services to a patient in order to determine whether an emergency medical situation exist prior to asking about insurance status of the patient.

Hospitals that are found to be in violation of EMTALA requirements may face civil monetary penalties and termination of their provider agreement. After a state investigation of an EMTALA complaint, the CMS Regional Office may ask their local peer review organization (PRO) to perform a 5-day review to obtain additional medical expertise. This review is discretionary. However, prior to imposing a civil monetary penalty, the Secretary is required to request that a PRO assess whether the involved beneficiary had an emergency condition, which had not been stabilized and provide a report on its findings. Except in the case where a delay would jeopardize the health or safety of individuals, the Secretary provides 60-day period for the requested PRO review.

EXPLANATION OF PROVISIONS

Emergency room services provided to screen and stabilize a Medicare beneficiary furnished after January 1, 2003, would be evaluated as reasonable and necessary on the basis of the information available to the treating physician or practitioner at the time the services were ordered; this would include the patient's presenting symptoms or complaint and not the patient's principal diagnosis. The Secretary would not be able to consider the frequency with which the item or service was provided to the patient before the time of admission or visit. The Secretary shall also not count the provision of the item or service during such an admission or visit when considering the frequency with which the item or service is furnished on subsequent occasions.

The Secretary would be required to establish a procedure to notify hospitals and physician when an EMTALA investigation is closed.

Except in the case where a delay would jeopardize the health and safety of individuals, the Secretary would be required to request a PRO review before making a compliance determination that would terminate a hospital's Medicare participation because of EMTALA violation. The current period of review for the discretionary review—5 business days—would apply for such review. The Secretary shall provide a copy of the report on its findings to the hospital or physician, consistent with existing confidentiality requirements. This provision would apply to terminations initiated on or after enactment.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

Providers have reported that some Medicare contractors are looking at final diagnoses (not presenting symptoms) in applying local medical review policies (LMRPs) that match particular tests to particular diagnoses—if a test does not match a listed diagnosis, payment is denied. Other claims are reportedly being denied based on LMRPs that set frequency limits for certain tests—if the test's use in the emergency room exceeds a frequency limit, payment is denied. In its January 2001 report entitled AThe Emergency Medical Treatment and Labor Act: The Enforcement Process,@ the OIG recommended that CMS ensure that peer review occurs before a provider is terminated from the Medicare program for an EMTALA violation. This section implements that recommendation, making the current discretionary PRO review process mandatory in cases that involve a question of medical judgment.

Section 845. Emergency Medical Treatment and Active Labor (EMTALA) Task Force

CURRENT LAW

No provision.

EXPLANATION OF PROVISION

The Secretary would be required to establish a 19-member technical advisory group under specified requirements to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA). The advisory group would be comprised of: the CMS Administrator; the OIG; four hospital representatives who have EMTALA experience, (including one person from a public hospital and two of whom have not experienced EMTALA violations) seven practicing physicians with EMTALA experience; two patient representatives; two regional CMS staff involved in EMTALA investigations; one representative from a State survey organization and one representative from a PRO. The Secretary would select qualified individuals who are nominated by organizations representing providers and patients.

The advisory group would be required to (1) elect a member to serve as chairperson; (2) schedule its first meeting at the direction of the Secretary and meet at least twice a year subsequently; and (3) terminate 30 months after the date of its first meeting. The advisory group would review EMTALA regulations; provide advice and recommendations to the Secretary; solicit public comments from interested parties; and disseminate information on the application of the EMTALA regulations.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

In its January 2001 report entitled The Emergency Medical Treatment and Labor Act: The Enforcement Process, the OIG recommended that CMS establish an EMTALA technical advisory group that includes all EMTALA stakeholders to help the agency

resolve any emerging issues related to implementation of the law. Some of these current issues include specialists who refuse to service on call panels and inconsistencies between Stat and Federal law governing emergency medical services. In its June 2001 report entitled Emergency Care: EMTALA Implementations and Enforcement Issues, the GAO also concluded that the establishment of a technical advisory group could help CMS work with hospitals and physicians to achieve the goals of EMTALA and avoid creating unnecessary burdens for providers. This section implements the OIG recommendation, establishing a 19-member technical advisory group within HHS.

Section 846. Authorizing Use of Arrangements with Other Hospice Programs to Provide the Core Hospice Services in Certain Circumstances

CURRENT LAW

Hospice programs are not permitted to use services provided under arrangement to deliver hospice services. Under arrangement services are permitted for providers delivering Part A and Part B hospital services as well as skilled nursing services. However, the originating hospital or skilled nursing facility is required to bill for the service and be responsible for the quality of care delivered by the subcontractor.

EXPLANATION OF PROVISION

Hospice programs may enter into arrangements with another certified hospice program to provide services. The provision for under arrangement services is limited to extraordinary or non-routine circumstances, such as unanticipated periods of staffing shortages. The originating hospice program continues to bear the legal responsibility for billing and maintaining quality of care.

EFFECTIVE DATE

For hospice care provided after enactment.

REASON FOR CHANGE

Hospice programs would be allowed to use personnel from other hospice programs to provide services to hospice patients. The program is given the flexibility so that a hospice program could continue to serve a patient if he or she was temporarily out of the area due to travel. Otherwise, the provision of the care to the patient might be delayed by the paperwork and requirements in starting up a new service at another agency. It is the intent of Congress that the originating hospice maintains control over the billing and quality of care.

Section 847. Application of OSHA Bloodborne Pathogens Standards to Certain Hospitals

CURRENT LAW

Section 1866 establishes certain conditions of participation that providers must meet in order to participate in Medicare.

EXPLANATION OF PROVISION

Public hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 would be required to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations. A hospital that fails to comply with the requirement would be subject to a civil monetary penalty, but would not be terminated from participating in Medicare.

EFFECTIVE DATE

Applies to hospitals as of July 1, 2003.

REASON FOR CHANGE

Last year, Congress enacted legislation that requires hospitals to utilize safe needles. However, that legislation only applies to non-government hospitals. Twenty-four states have similar requirements on public hospitals. This provision would protect the health and safety of health care workers in those facilities by requiring public hospitals in the other 26 states and the District of Columbia to comply with this important standard.

Section 848. BIPA-Related Technical Amendments and Corrections

CURRENT LAW

BIPA established an advisory process for national coverage determinations where panels of experts formed by advisory committees could forward their recommendations directly to the Secretary without prior approval of the advisory committee or the Executive Committee.

EXPLANATION OF PROVISION

This provision makes technical corrections related to the Medicare Coverage Advisory Committee by transferring the provisions from Title 11 to Title 18 and by removing incorrect cross references to the establishment authority.

EFFECTIVE DATE

As if included in BIPA.

Section 849. Conforming Authority to Waive A Program Exclusion

CURRENT LAW

The Secretary is required to exclude individuals and entities from participation in Federal Health Programs who are (1) convicted of a criminal offense related to health care delivery under Medicare or under State health programs; (2) convicted of a criminal offense related to patient abuse or neglect under Federal or State law; (3) convicted of a felony relating to fraud, theft, or financial misconduct relating to a health care program financed or operated by the Federal, State or local government; or (4) convicted of a felony related to a controlled substance. At the request of a state, the Secretary is permitted to waive a program exclusion with re-

spect to Medicare or Medicaid, but only for exclusions described in (1) above.

EXPLANATION OF PROVISIONS

The Administrator of a Federal health program would be permitted to request a waiver of a program exclusion if the exclusion of a sole community physician or source of specialized services in a community would impose a hardship. This conforming change would extend the same waiver authority currently in Medicare and Medicaid to federal health programs. In addition, waivers could be requested for Medicare, Medicaid, and federal health programs with respect to all exclusions except those related to patient abuse or neglect.

EFFECTIVE DATE

Upon enactment.

REASON FOR CHANGE

This technical correction was requested by the Office of Inspector General.

Section 850. Treatment of Certain Dental Claims

CURRENT LAW

Under current law, providers of services and suppliers submitting claims to Medicare must be enrolled in the Medicare program. However, certain services are specifically excluded from coverage under Medicare. Under current law, no payment may be made under part A or part B of the Medicare program for any services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except in the case of inpatient hospital services associated with the provision of these dental services if the individual's underlying medical condition and clinical status or the severity of the dental service require hospitalization.

EXPLANATION OF PROVISION

This provision would prohibit group health plans from requiring a Medicare claims determination for dental benefits that are specifically excluded from Medicare coverage as a condition of making a determination for coverage under the group health plan. In so doing, this provision would ensure that dentists would not have to submit claims to the Medicare program (and thus enroll in the Medicare program) when the services they are providing are clearly those that are categorically excluded from coverage. In those cases that involve or appear to involve inpatient hospital services or dental services expressly covered by Medicare, a group health plan may require the claim to be first submitted to the Medicare program.

EFFECTIVE DATE

60 days after enactment.

REASON FOR CHANGE

The Committees are concerned about private insurers requiring dentists to submit claims to Medicare for non-covered services before making a determination for coverage under the group health plan. Because of this requirement, dentists have been forced to enroll in the Medicare program to submit claims for services that are categorically excluded from Medicare coverage. Dentists view Medicare's enrollment application process as overly burdensome, particularly in light of the fact that most dental services are not covered by Medicare. This provision would alleviate the enrollment burden placed on dentists providing services clearly excluded from Medicare coverage, consistent with the overarching goal of this legislation to reduce regulatory burdens.

Section 851. Annual Publication of List on National Coverage Determinations

CURRENT LAW

No provision.

EXPLANATION OF PROVISIONS

The Secretary would be required to provide, in an annual report that will be publicly available, a list of Medicare's national coverage determinations made in the previous year and include information on how to learn more about such determinations.

EFFECTIVE DATE

Upon enactment.

Clarifications and Instructions to the Secretary

First, the Committee is pleased that the Secretary has published a notice of proposed rulemaking to provide Medicare payment for clinical psychology internship training programs that would not qualify under Medicare's existing provider-operated criteria. The Committee notes that Congress has consistently urged the Secretary to initiate payment for the training of clinical psychologists since 1997. Supportive language has been included in conference reports accompanying Medicare legislation in 1999 (Report 106–479), and in 2000 (Senate Report 106–293).

The Committee is concerned, however, that a delay in the rule may mean that hospitals and institutions will reduce or eliminate psychology training programs and urges implementation of the rule as soon as possible. The Committee notes that clinical psychologists provide valuable and unique services to Medicare beneficiaries during their training. Regarding their training, clinical psychologists are distinguishable from other health care professionals in that they are the only doctoral level mental health professionals fully participating in Medicare whose clinical training is not currently reimbursed. In addition, their clinical internship training is entirely controlled, administered, supervised, evaluated, and certified by the hospital or institution, separately accredited, and distinct from any university training they receive. Clinical psychologists are hospital-based in the final stages of their training functioning in a

parallel status to medical interns and residents, not medical nursing or health professional students. Where a clinical psychologist has clearly finished their educational curriculum and is training solely in the hospital setting, it is the intention of Congress that the hospital be reimbursed if that training is hospital-based.

Second, Congresses original intent on BIPA section 422(a)(2) on the dialysis composite rate has not been correctly interpreted by CMS. The intent was not to bar end stage renal disease (ESRD) composite rate exception relief for facilities that are not presently being paid under an exception to the composite rate. It is the Committee's expectation that CMS will evaluate ESRD composite rate exception requests submitted in 2002 and subsequent years by new renal dialysis facilities and existing facilities that do not have an exception.

TITLE IX—MEDICAID AND PUBLIC HEALTH ACT

SUBTITLE A—MEDICAID PROVISIONS

Section 901. National Bipartisan Commission on the Future of Medicaid

(a) *Establishment.* This provision establishes the National Bipartisan Commission on the Future of Medicaid.

(b) *Duties of the Commission*. The Commission will analyze the long-term financial condition of the Medicaid program, identify causes and consequences of increasing Medicaid costs, analyze policies to ensure the financial integrity of the Medicaid program and the provision of appropriate benefits under such a program, and make recommendations to promote enhanced efficiencies and for establishing the appropriate balance between benefits, payments, State and Federal contributions, and recipient cost-sharing obligations. The Commission will also make recommendations on the impact of promoting increased utilization of competitive, private enterprise models and the financing of prescription drug benefits currently covered under State Medicaid programs. The Commission will also analyze the impact of impending demographic changes on Medicaid benefits, including long term care, and make recommendations about how best to divide State and Federal responsibilities for funding these benefits.

(c) *Membership.* The Commission will be composed of 17 members. The ability to select appointees will be divided among the President, Senate Majority and Minority leaders, the Speaker of the House and the House Minority leader. The President, Senate Majority Leader and Speaker of the House of Representatives will jointly appoint the Chairman of the Commission. Members of the Commission must be appointed by December 1, 2002.

(d) *Staff and Support Services*. The Chairman will appoint an Executive Director of the Commission, who may appoint such staff as is considered appropriate.

(e) *Powers of Commission.* The Commission may hold hearings, request GAO reports, obtain CBO and CMS Actuary cost estimates, and obtain any information directly from any Federal agency that is necessary to carry out its duties.

(f) *Report.* By March 1, 2004, the Commission shall submit a report to the President and Congress that will contain the recommendations, findings, and conclusions of the Commission.

Section 902. GAO Study on Medicaid Drug Payment System

(a) *Study.* The Comptroller General will conduct a study on the reimbursements under the Medicaid program for covered outpatient drugs. The report shall examine the extent to which reimbursements for drugs exceed their acquisition cost, the services and resources associated with dispensing a prescription, any additional payments available to compensate for these expenses for pharmacy services, and State efforts to modify reimbursements for Medicaid covered drugs.

(b) *Report*. The Comptroller General shall submit a report to Congress within 1 year of enactment, which will include recommendations for legislative or administrative changes regarding Medicaid reimbursements for outpatient prescription drugs.

Subtitle B—Internet Pharmacies

Section 911. Findings

This provision contains findings concerning both the benefits of Internet prescription drug sales and the potential for abuse of consumers by unlawful or unscrupulous parties through Internet prescription drug sales.

Section 912. Amendments to the Federal Food, Drug, and Cosmetic Act

This section requires interstate Internet sellers of prescription drugs to disclose important information on their web sites and to State licensing boards to improve the reliability of consumer transactions and make it easier for State and Federal enforcement officials to patrol for rogue sellers. The failure to post information or for knowingly making a false statement when posting information is prohibited.

Section 913. Public Education

This section requires the Secretary to engage in activities to educate the public about the dangers of purchasing medications from Internet prescription drug sellers who fail to follow the law. The Secretary is also directed to educate the public about effective public and private sector consumer protection efforts, as appropriate.

Section 914. Study Regarding Coordination of Regulatory Activities

Within 180 days of enactment and after consultation with the Attorney General, the Secretary is required to submit to Congress a report providing recommendations for coordinating (1) the activities of federal agencies regarding interstate Internet sellers that operate from foreign countries, and (2) the activities of the Federal Government with the activities of government of foreign countries regarding such interstate Internet sellers.

Section 915. Effective Date

The sections in this subtitle shall take effect 1 year after enactment, except that the authority of the Secretary to commence rulemaking is effective on the date of enactment.

Subtitle C—Promotion of Electronic Prescribing

Section 921. Program of Grants to Health Care Professionals to Implement Electronic Prescription Drug Programs

This section authorizes the Secretary to make grants for the purpose of assisting health care professionals who prescribe drugs and biologicals in implementing electronic prescription programs. Grants may only be made pursuant to a grant application submitted in a time, manner, and form approved by the Secretary. Such sums as are necessary are authorized to be appropriated for FY 2004 to carry out this section.

Subtitle D—Treatment of Rare Diseases

Section 931. NIH Office of Rare Diseases at National Institutes of Health

This section authorizes in statute an Office of Rare Diseases at the National Institutes of Health. Rare diseases are diseases affecting less than 200,000 individuals in the United States. The Director of the Office of Rare Diseases will serve as the principal advisor to the Director of NIH with respect to rare diseases, and shall serve to promote sufficient allocation of NIH resources to rare disease research, and promote and encourage the establishment of a centralized clearinghouse for rare disease information for the benefit of the public, medical professionals, patients, and families. The Director will prepare a biannual report that describes the research and education activities on rare diseases and prepare the NIH Director's annual report to Congress on rare disease research conducted by or supported through the national research institutes and centers. For fiscal years 2003 through 2006, $4 million per year is authorized to be appropriated.

Section 932. Rare Disease Regional Centers of Excellence

This section allows the Director of the Office of Rare Diseases at the NIH to enter into cooperative agreements with, and make grants to, nonprofit entities which will serve as regional centers of excellence supporting clinical research into, training in, and demonstration of diagnostic, prevention, control, and treatment methods for rare diseases. Support for regional centers of excellence may not exceed 5 years, though such period may be extended if the operations of such centers have been reviewed by an appropriate technical and scientific peer review group. For fiscal years 2003 through 2006, $20 million per year is authorized to be appropriated.

Subtitle E—Other Provisions Relating to Drugs

Section 941. Study by General Accounting Office Regarding Direct-to-Consumer Advertising of Prescription Drugs

The Comptroller General is directed to conduct a study to determine whether DTC prescription drug advertising has resulted in increased utilization rates for prescription drugs and, if so, whether, and to what extent, increased utilization has resulted in increased costs to health plans, health insurance, or other health programs. The study will also determine whether DTC prescription drug advertising has resulted in increased consumer education and whether consumers and physicians are satisfied with such advertising. Last, the study will consider whether DTC prescription drug advertising has resulted in lower overall health expenditures for consumers and employers. The Comptroller General will submit to Congress a report on the findings of this study within 2 years of enactment.

Section 942. Certain Health Professions Programs Regarding Practice of Pharmacy

This section grants the Secretary the authority to develop and issue public service announcements to advertise and promote the pharmacist profession. The Secretary may also award grants to State and local governments to conduct public service announcements to promote the pharmacist profession. A demonstration project is established to expand the number of pharmacists who are currently eligible to participate in the National Health Service Corps Loan Repayment Program. It allows pharmacists participating in the program to provide medication therapy management services to assure that patients use medications appropriately. It also grants the Secretary the authority to make grants or contracts available to qualifying schools of pharmacy for the purpose of assisting these schools in acquiring and installing computer-based systems to provide pharmaceutical education. This section authorizes such sums as necessary for fiscal years 2003 through 2006.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill, H.R. 4954.

MOTION TO REPORT THE BILL

The bill, H.R. 4954, as amended, was ordered favorably reported by a roll call vote of 22 yeas to 16 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas	X			Mr. Rangel		X	
Mr. Crane				Mr. Stark		X	
Mr. Shaw	X			Mr. Matsui		X	
Mrs. Johnson	X			Mr. Coyne			
Mr. Houghton	X			Mr. Levin		X	
Mr. Herger	X			Mr. Cardin		X	
Mr. McCrery	X			Mr. McDermott		X	

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp	X			Mr. Kleczka		X	
Mr. Ramstad	X			Mr. Lewis (GA)		X	
Mr. Nussle	X			Mr. Neal		X	
Mr. Johnson	X			Mr. McNulty			
Ms. Dunn	X			Mr. Jefferson		X	
Mr. Collins		X		Mr. Tanner		X	
Mr. Portman	X			Mr. Becerra		X	
Mr. English	X			Mrs. Thurman		X	
Mr. Watkins	X			Mr. Doggett		X	
Mr. Hayworth	X			Mr. Pomeroy		X	
Mr. Weller	X						
Mr. Hulshof	X						
Mr. McInnis	X						
Mr. Lewis (KY)	X						
Mr. Foley	X						
Mr. Brady	X						
Mr. Ryan	X						

VOTES ON AMENDMENTS

A rollcall vote was conducted on the following amendment to the Chairman's amendment in the nature of a substitute.

An amendment to Title I by Mr. Stark on behalf of Mr. Rangel, to strike Title I and replace with a new Title I, was defeated by a roll call vote of 16 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane.		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger				Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty	X		
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title I by Mr. McDermott, which would require all plans to charge a $35 monthly premium, was defeated by a roll call vote of 17 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Houghton		X		Mr. Levin	X		

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Herger				Mr. Cardin	X		
Mr. McCrery.		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty	X		
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title I by Messrs. Cardin and Levin, which would assist high-need beneficiaries to access catastrophic coverage by allowing dollars spent by others (e.g., family members, employer coverage, etc.) to count toward the catastrophic cap, was defeated by a rollcall vote of 16 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty	X		
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett			
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title I by Mr. Becerra, which would provide beneficiaries with 20 percent co-insurance between the $250 deductible and $2900 limit out-of-pocket spending, was defeated by a rollcall vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne	X		

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty	X		
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title I by Mr. Tanner, which sought to ensure that any pharmacy that is willing to accept the negotiated reimbursement rates of a private drug plan should be allowed to participate in the plan network, was defeated by a rollcall vote of 18 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Houghton				Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty	X		
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins.	X			Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title I by Mr. Doggett and Mrs. Thurman, which would require each participating manufacturers of a covered outpatient drug to make available such drugs at a price no greater than the manufacturer's average foreign price, was defeated by a rollcall vote of 16 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin			
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad				Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty			
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins	X			Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title II by Mr. McDermott, which would strike the sections that (1) create a new premium support program (including demonstration), (2) preempt state laws for Medicare+Choice plans, and (3) make changes to Medicare MSA, was defeated by a roll call vote of 15 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui.	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Houghton.		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty			
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner			
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title IV by Messrs. Neal and Rangel, which would ensure providing inpatient PPS hospitals with a full market basket in 2003 and permanently freeze IME at 6.5%, was defeated by a rollcall vote of 16 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne			
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty			
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner			
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley	X						
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title IV by Mr. Pomeroy, which would phase-in the elimination of skilled nursing facility add-on, was defeated by a roll call vote of 15 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne			
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty			
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title VI by Messrs. Jefferson and Levin, which would strike both the new home health co-payment, and the decrease in annual updates to home health agencies for year 2003–2005, was defeated by a roll call vote of 14 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Crane		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne			
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty			
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner	X		
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

An amendment to Title VI by Mr. Levin, which would add several preventive-care services to Medicare's basic benefit package and eliminate coinsurance and deductibles for all new and existing preventive care services, was defeated by a roll call vote of 14 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Thomas		X		Mr. Rangel	X		
Mr. Crane				Mr. Stark	X		
Mr. Shaw		X		Mr. Matsui	X		
Mrs. Johnson		X		Mr. Coyne			
Mr. Houghton		X		Mr. Levin	X		
Mr. Herger		X		Mr. Cardin	X		
Mr. McCrery		X		Mr. McDermott	X		
Mr. Camp		X		Mr. Kleczka	X		
Mr. Ramstad		X		Mr. Lewis (GA)	X		
Mr. Nussle		X		Mr. Neal	X		
Mr. Johnson		X		Mr. McNulty			
Ms. Dunn		X		Mr. Jefferson	X		
Mr. Collins		X		Mr. Tanner			
Mr. Portman		X		Mr. Becerra	X		
Mr. English		X		Mrs. Thurman	X		
Mr. Watkins		X		Mr. Doggett	X		
Mr. Hayworth		X		Mr. Pomeroy	X		
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					
Mr. Brady		X					
Mr. Ryan		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made:

The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO), which is included below. The Committee notes that the CBO score does not include a discussion of the "pharmacy cost management factor," which represents potential savings on total drug expenditures, reflecting changes in price, quantity and mix of drugs compared to what a Medicare beneficiary without drug coverage would otherwise spend. CBO has orally told the Committee that the pharmacy cost management factor for H.R. 4954 is the highest of any bills CBO has evaluated. The Committee believed it achieved this distinction by providing prescription drug plans the both the incentive to control costs and the tools to do so.

In addition, the score does not mention that CBO assumes 96 percent of Medicare seniors would have prescription drug coverage under this legislation. That means CBO believes the benefit will be offered nationwide and will be attractive to virtually all Medicare beneficiaries.

CBO has agreed to provide a subsequent letter to clarify these issues in writing, but that letter was not available at the time this bill was filed.

B. Statement Regarding New Budget Authority and Tax Expenditures

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the Committee bill would result in increased federal direct spending by $4.1 billion in 2003 and by $337 billion over the 2003–2012 period.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office (CBO), the following report prepared by the CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, June 24, 2002.

Hon. William "Bill" M. Thomas,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002, as ordered reported by the Committee on Ways and Means on June 19, 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Julia Christensen.

Sincerely,

Steven Lieberman
(For Dan L. Crippen, Director).

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

H.R. 4954—Medicare Modernization and Prescription Drug Act of 2002

Summary: H.R. 4954 would establish an outpatient prescription drug benefit in Medicare and would modify Medicare's payment rates or coverage rules for many services, including those furnished by hospitals, skilled nursing facilities, home health agencies, physicians, physical and speech therapists, occupational therapists, and managed care plans. CBO estimates those provisions would increase direct spending by $4.1 billion in 2003 and by $337 billion over the 2003–2012 period.

The bill would authorize the collection of civil penalties for the failure of interstate Internet pharmacies to comply with disclosure requirements. Those collections would be classified as revenues (i.e., governmental receipts). However, CBO assumes that there would be substantial compliance with the disclosure requirements and that the effect on revenues would be negligible. Because the bill would affect direct spending and revenues, pay-as-you-go procedures would apply.

The bill would also affect discretionary spending. H.R. 4954 would require the Centers for Medicare and Medicaid Services to modify how Medicare regulations and policies are developed, communicated, and enforced. It would establish a Medicare Benefits Administration to administer the outpatient drug benefit and the Medicare+Choice program, and would require the Social Security Administration (SSA) to determine the eligibility of low-income beneficiaries for the subsidy of the drug benefit. The bill also would establish an Office of Rare Diseases at the National Institutes of Health, require several studies, and authorize several grant programs. CBO has not completed an estimate of the costs of activities subject to appropriation of the necessary amounts.

The bill contains intergovernmental mandates, including a number of preemptions of state law, as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the preemption of state premium taxes would result in revenue losses to states of about $70 million in 2005 (the first year the mandate is effective) increasing to about $100 million in 2009. Those losses would exceed the threshold established in UMRA ($62 million in 2005, adjusted annually for inflation). CBO estimates that other mandates and preemptions in the bill would impose minimal or no costs on state, local, or tribal governments. Provisions of the bill affecting Medicaid would result in net savings to state and local governments of about $46 billion over the 2003–2012 period.

The bill would modify several existing private-sector mandates on insurers that offer Medicare supplemental (medigap) coverage and would impose new requirements on Internet pharmacies and group health plans. CBO estimates that the direct cost of the mandates in the bill would not exceed the threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation).

Estimated cost to the Federal Government: The estimated budgetary impact on H.R. 4954 is summarized in Table 1 and major components of these costs are outlined below. The costs of this leg-

islation fall within budget functions 550 (health) and 570 (Medicare).

Major provisions: The following discussion highlights changes in gross outlays directly attributable to provisions of the act. In addition, the estimate includes three interactions: the effect of changes in Medicare Part B outlays on receipts from Part B premiums, the effect of changes in Part B premiums and cost sharing on federal Medicaid spending, and the effect of changes in Medicare payment rates on federal Medicaid spending subject to the "upper payment limit" (UPL).

About 25 percent of new Part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total $4.3 billion from 2003 through 2012. Such payments would be recorded as offsetting receipts (a credit against direct spending).

Medicaid pays some or all of the premiums and cost sharing for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits. In addition to changing the Part B premium, the bill would change cost sharing for services furnished in hospital outpatient departments and by home health agencies, and would change payment rates for many services (which would affect cost sharing). CBO estimates that the changes in premiums and cost sharing would increase federal Medicaid costs by about $0.2 billion over the 2003–2012 period.

TABLE 1.—ESTIMATED IMPACT ON DIRECT SPENDING OF H.R. 4954, THE MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002, AS ORDERED REPORTED BY THE COMMITTEE ON WAYS AND MEANS ON JUNE 19, 2002

	By fiscal year, outlays in billions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–12
	Medicare Outlays										
Title I: Medicare Prescription Drug Benefit	0	0	22.0	35.8	40.5	45.7	51.3	57.3	64.2	72.2	389.0
Title II: Medicare+Choice:											
201 M+C payment improvements	0.5	1.1	0.5	0	0	0	0	0	0	0	2.2
211 M+C competition program	0	0	0.6	0.9	0.9	0.3	−0.4	−0.6	−0.6	−0.5	0.7
Other provisions	*	*	*	*	*	*	*	*	*	*	0.2
Subtotal, title II	0.5	1.2	1.2	0.9	0.9	0.3	−0.3	−0.6	−0.6	−0.5	3.0
Title III: Rural Health Care Improvements:											
302 Disproportionate share adjustment	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.6
303 Standardized payment amount	0.3	0.6	0.6	0.7	0.7	0.8	0.8	0.9	0.9	1.0	7.2
306 Home Health 10 percent rural add-on	0.1	0.3	0.1	*	0	0	0	0	0	0	0.6
311 Increase for nonteaching hospitals	0.1	0.1	0.1	*	0	0	0	0	0	0	0.4
Other provisions	*	*	*	*	*	*	*	*	*	*	0.1
Subtotal, title III	0.5	1.1	1.0	0.9	0.9	1.0	1.0	1.1	1.2	1.2	9.9
Title IV: Part A:											
401 Hospital update	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	3.6
402 Indirect medical education	0.4	0.3	0	0	0	0	0	0	0	0	0.7
404 Phase-in federal rate in Puerto Rico	*	*	*	*	*	*	*	*	*	*	0.2
411 Skilled nursing facility payment rates	0.6	0.7	0.6	0.1	0	0	0	0	0	0	2.0

TABLE 1.—ESTIMATED IMPACT ON DIRECT SPENDING OF H.R. 4954, THE MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002, AS ORDERED REPORTED BY THE COMMITTEE ON WAYS AND MEANS ON JUNE 19, 2002—Continued

	By fiscal year, outlays in billions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–12
421 Hospice consultation services	0	*	*	*	*	*	*	*	*	*	0.2
Other provisions	*	*	*	*	*	*	0	0	0	0	0.1
Subtotal, title IV	1.3	1.3	0.9	0.5	0.4	0.4	0.4	0.5	0.5	0.5	6.8
Title V: Part B:											
501 Updates for physicians' services	1.6	4.4	6.6	5.7	2.9	−0.4	−2.5	−3.0	−2.5	−1.4	11.5
511 Competitive acquisition	0	−0.2	−0.4	−0.7	−0.8	−0.9	−1.0	−1.1	−1.2	−1.3	−7.7
512 Ambulance	0.2	0.2	0.1	0.1	*	0	0	0	0	0	0.6
513 Therapy cap: 2 year extension of moratorium	0.4	0.5	0.1	*	*	*	*	*	*	*	1.0
514 Hospital outpatient services	0	0.2	0.5	0.7	0.8	0.8	0.8	1.0	1.8	3.1	9.7
515 Routine physical	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.6
516 Renal dialysis services	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Other provisions	*	0.1	0.1	*	*	*	*	*	*	0.1	0.5
Subtotal, title V	2.2	5.4	7.2	6.1	3.1	−0.2	−2.4	−2.8	−1.5	0.8	17.8
Title VI: Parts A and B:											
Home health provisions	0.2	*	−0.3	−0.4	−0.4	−0.5	−0.6	−0.7	−0.7	−0.8	−4.1
611 Limit on high cost medical education programs	*	*	−0.1	−0.2	−0.2	−0.3	−0.3	−0.4	−0.5	−0.5	−2.6
612 Redistribute unused residency positions	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0
Other provisions	0	*	*	*	0	0	0	0	0	0	*
Subtotal, title VI	0.2	*	−0.2	−0.4	−0.5	−0.7	−0.8	−0.9	−1.1	−1.2	−5.7
Title VII: Medicare Benefits Administration	0	0	0	0	0	0	0	0	0	0	0
Title VIII: Regulatory Reform	*	*	*	*	*	*	*	*	*	*	0.1
Title IX: Medicaid, Public Health, and other Provisions	0	0	0	0	0	0	0	0	0	0	0
Subtotal, gross Medicare outlays	4.6	9.0	32.2	43.7	45.2	46.6	49.2	54.5	62.6	73.1	420.8
Premium collections	−0.7	−1.6	−1.9	−1.6	−0.8	0.1	0.7	0.9	0.6	*	−4.3
Subtotal, net Medicare outlays	4.0	7.5	30.2	42.1	44.4	46.7	49.9	55.4	63.2	73.1	416.5
Medicaid Outlays											
Title I: Medicare Prescription Drug Benefit	0	*	−3.8	−8.1	−8.5	−9.2	−10.1	−11.3	−12.7	−14.2	−77.9
Spending subject to upper payment limit	0.1	0.1	0.1	*	*	*	*	*	*	*	0.3
Medicaid payments of Medicare premiums	0.1	0.2	0.2	0.2	0.1	*	−0.1	−0.1	−0.1	−0.1	0.2
Subtotal, Medicaid	0.2	0.3	−3.5	−7.9	−8.5	−9.2	−10.2	−11.4	−12.8	−14.2	−77.4
Other Direct Spending [1]											
Title I: Medicare Prescription Drug Benefit	0	0	−0.1	−0.2	−0.2	−0.2	−0.2	−0.3	−0.3	−0.3	−1.8
Total Changes in Direct Spending											
Estimated outlays	4.1	7.7	26.6	34.0	35.7	37.2	39.5	43.7	50.2	58.5	337.4

[1] Federal savings in the Federal Employees Health Benefits program, Department of Defense spending on health benefits for Medicare-eligible retirees, and spending from the Combined Benefits Funds for the United Mine Workers Association.

[2] Notes:
*=Between −$50 million and $50 million.
Numbers may not add up to totals because of rounding.

State Medicaid programs use Medicare payment rates to calculate the maximum amount, known as the upper payment limit, that they can pay for services furnished by hospitals and nursing homes. In recent years, many states have increased their Medicaid payments up to the UPL in order to draw down additional federal

funds. The bill would raise Medicare payment rates for services furnished by hospitals and skilled nursing facilities, thus boosting the UPL and allowing states to receive additional Medicaid funds. CBO estimates that the bill would increase federal Medicaid spending subject to the UPL by $0.3 billion over the 2003–2012 period.

Title I—Medicare Outpatient Prescription Drug Benefit

Title I would create a voluntary outpatient prescription drug benefit, beginning in 2005, under a new Part D of the Medicare program. The prescription drug benefit would be offered by competing private drug plans that would be at financial risk for covering the cost of the benefit. Premiums would be charged to participating beneficiaries and subsidized, in part, by the Medicare program. The bill would establish a program to subsidize premiums and cost sharing for certain low-income beneficiaries, and would reduce federal Medicaid payments to states through 2012 by a proportion of the spending for subsidized premiums and cost sharing attributed to Medicare enrollees who are entitled to prescription drug coverage under Medicaid.

CBO estimates that the Part D provisions would increase direct spending by about $309 billion over the 2003–2012 period (see Table 2). Of that 10-year total, $294 billion represents outlays for federal payments to plans offering qualified prescription drug coverage and $97 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by $96 billion in federal savings associated with the new drug program, because Part D would replace or supplement drug coverage that some Medicare enrollees obtain through Medicaid, the Federal Employees Health Benefits program, the Department of Defense, or the Combined Benefits Funds of the United Mine Workers Association. Other effects of the program—largely the result of increased Medicare enrollees in Medicaid, offset, in part, by the reduction through 2012 in federal Medicaid payments in states—would increase federal spending by $14 billion through 2012, CBO estimates.

TABLE 2.—EFFECT ON DIRECT SPENDING OF ESTABLISHING A PRESCRIPTION DRUG BENEFIT IN MEDICARE: TITLE I OF H.R. 4954, THE MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002

	By fiscal year, outlays in billions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–12
Changes in Direct Spending											
Medicare spending on prescription drugs	0	0	18	29	31	35	38	43	47	53	294
Spending by Medicaid and other programs on drugs for Medicare enrollees	0	0	−4	−9	−10	−11	−13	−14	−16	−18	−96
Low-income subsidy	0	0	4	8	10	12	13	15	16	18	97
Other direct spending [1]	0	*	*	*	1	1	2	3	3	4	14
Total changes	0	*	18	27	32	36	41	46	51	58	309
Memorandum											
Monthly premium	n.a.	n.a.	$35	$37	$40	$44	$47	$52	$57	$62	.....
Deductible	n.a.	n.a.	$250	$276	$303	$332	$364	$398	$434	$474	.....

[1] Other direct spending includes changes in Medicare and Medicaid spending associated with increases in the number of Medicare beneficiaries enrolled in Medicaid and reductions in federal Medicaid payments to states.

Notes:
*=Costs or savings of less than $500 million.
n.a.=not applicable because the benefit would not take effect until 2005.
Numbers may not add up to totals because of rounding.

Under the prescription drug benefit, plan sponsors would offer either "standard coverage" or actuarially equivalent coverage, if approved by the Medicare Benefits Administration. For 2005, standard coverage would have a $250 deductible; 20 percent cost sharing for costs between $250 and $1,000; and 50 percent cost sharing for costs between $1,000 and $2,000. Beneficiaries would be responsible for 100 percent of costs above $2,000 until the beneficiary reaches the catastrophic limit at $3,800 in out-of-pocket spending. In subsequent years, those amounts would be increased by the percentage change in per-capita spending for outpatient prescription drugs among the Medicare population.

The beneficiary would stop paying for covered prescription drugs after reaching the catastrophic limit (out-of-pocket spending of $3,800 in 2005). However, only payments made by the beneficiary, the low-income subsidy, or by Medicaid would count toward that catastrophic limit; payments or reimbursements made by other insurance or third-party payers would not count toward that limit.

Each plan would establish its own premium. CBO estimates that premiums would average about $35 in 2005, increasing to $62 in 2012.

The Medicaid program would subsidize the drug benefit through two payments to plans: reimbursement of 35 percent of the plan's spending for the standard benefit and "individual reinsurance" payments for high-cost beneficiaries that, in aggregate, equal 30 percent of total spending for standard benefits.

Individuals with incomes below 150 percent of the federal poverty level would be eligible for a full subsidy of the lowest premium in the market and the cost sharing for drug spending below $2,000. For individuals with incomes between 150 percent and 175 percent of the federal poverty level, there would be a full subsidy of cost sharing for costs below $2,000 and there would be a sliding-scale subsidy of the lowest premium in the market. (In 2002, the federal poverty level is $8,860 for an individual and $11,940 for a couple.) The bill would require the SSA to determine the eligibility of low-income beneficiaries for the subsidy of the drug benefit.

Title II—Medicare+Choice Revitalization and Competition

Title II would increase rates paid to Medicare+Choice plans in calendar years 2003 and 2004, and would establish a new Medicare+Choice payment system based competitive bidding, beginning in 2005. The bill would also extend several expiring programs and demonstration programs involving group plans. CBO estimates the provisions in title II would increase direct spending by $0.5 billion in 2003 and by $3.0 billion over the 2003–2012 period.

CBO estimates that a requirement in current law will hold increases in rates paid to nearly all Medicare+Choice plans to 2 percent in both 2003 and 2004. H.R. 4954 would eliminate that requirement and modify the payment formula to pay the largest of four amounts: a minimum payment amount, a blend of local and national amounts based on inflated historical per-capita costs in the fee-for-service sector, estimated current per-capita costs in the

fee-for-service sector, and a minimum increase of 3 percent. (The minimum payment amounts would be $425 in most counties and $525 in counties in a metropolitan area with a population greater than 250,000, updated from 2001 by the increase in per-capita spending in the Medicare program.) That provision would affect spending during fiscal years 2003 through 2005, increasing outlays by $0.5 billion in 2003 and by a cumulative total of $2.2 billion.

H.R. 4954 would establish a competitive bidding program for Medicare+Choice plans, beginning in 2005. Under the program, plans would submit bids for the cost of providing standard benefits under Parts A and B of Medicare and the standard drug benefit under Part D. Those bids for standard Part A and Part B benefits would be compared to a benchmark amount, which in 2005 through 2007 would be the larger of the minimum payment amount and estimated current per-capita costs in the fee-for-service sector. Beginning in 2008, the benchmark amount would be the larger of the minimum payment amount and 95 percent of per-capita costs in the fee-for-service sector. If a plan were to bid below the benchmark amount, Medicare would pay the plan the bid plus an amount that would approximate 75 percent of the difference between the bid and the benchmark amount (after adjusting for differences in risk attributable to the health status of the plan's enrollees). The plans could rebate that additional payment to Medicare enrollees, or could use it to pay for additional benefits. CBO estimates that the competition program would increase spending during the 2005–2008 period and reduce spending beginning in 2009, with spending through 2012 increasing by a total of $0.7 billion.

Title III—Rural Health Care Improvements

Title III would increase payment rates for inpatient service furnished by hospitals in rural areas or metropolitan area with a population under one million, and for services furnished by home health agencies located in rural areas. CBO estimates these provisions would increase spending by $0.5 billion in 2003 and by about $10 billion through 2012 Two provisions—increasing the standardized payment amount and increasing payments to hospitals that qualify for a payment adjustment as a disproportionate share hospital—account for $8.8 billion of that 10-year total.

Title IV—Provisions Relating to Medicare Part A

Title IV would increase payment rates for inpatient services furnished by hospitals, skilled nursing facilities, and hospices. CBO estimates the provisions in title IV would increase spending by $1.3 billion in 2003 and by $6.8 billion over the 2003–2012 period.

H.R. 4954 would increase the 2003 update to payment rates for hospital inpatient services paid under the prospective pay system from 0.55 percentage points below the "market basket index" measure of changes in hospital input prices go 0.25 percentage points below that index. Hospitals designated as sole community hospitals would receive an update in 2003 equal to the market basket index. CBO estimates that provision would increase spending by $0.3 billion in 2003 and $3.6 billion over the 2003–2012 period.

Temporary increases in payments to teaching hospitals and skilled nursing facilities account for most of the remaining costs of title IV. Teaching hospitals would receive higher payments for two years, at an estimated cumulative cost of $0.7 billion, and skilled nursing facilities would receive higher payment rates for three years, at accumulative cost of $2.0 billion.

Title V—Provisions Relating to Medicare Part B

CBO estimates that the provisions of title V would increase Medicare spending by $2.2 billion in 2003 and $17.8 billion over the 2003–1012 period. The provisions with the largest budgetary effects include changes in payments or physicians' services, assumption of some cost sharing for services furnished by hospital outpatient departments, establishment of a competitive acquisition program for durable medical equipment and certain orthotics, coverage of some routine physical examinations, and two-year delay in the implementation of caps on payments for certain therapy services.

Compared to current law, CBO estimates that H.R. 4954 would increase payments for services paid under the physican fee schedule during 2003 through 2007, without outlays increasing by $1.6 billion in 2003 and by $21.3 billion though 2007. However, the bill would reduce payments for these services in 2008 and subsequent years, with a net increase in spending during the 2003–2012 period of $11.5 billion.

Before the Balanced Budget Act of 1997 (BBA), beneficiaries paid cost sharing of 20 percent of charge for hospital outpatient services and the program paid 80 percent of allowed charges. Allowed charges generally were a much lower amount than charges. As a result beneficiaries, on average, were paying about half of payments to hospitals for outpatient services. The BBA and subsequent legislation are phasing in increases in payments for outpatient services while limiting cost sharing, with the objective of reducing the share paid by beneficiaries to 20 percent. H.R. 4954 would accelerate the Medicare program's assumption of cost sharing in excess of 20 percent, beginning in 2004. CBO estimates that provision would increase spending by $9.7 billion over the 2003–2012 period.

The bill would expand and make permanent a demonstration project in which certain durable medical equipment and orthotics are acquired through competitive bidding instead of paying on the basis of a fee schedule. CBO estimates that provision would reduce spending by $7.7 billion through 2012.

Beginning in 2004, the bill would require Medicare to pay for a routine physical examination, and association services, when furnished within six months of when a beneficiary first enrolls in Medicare. The bill would waive cost sharing for those services. Beneficiaries already enrolled in Medicare would not be eligible for this benefit. CBO estimates this provision would cost $1.6 billion over the 2003–2012 period.

Title VI—Provisions Relating to Medicare Parts A and B

Title VI would modify payment rates for home health services, limit subsidies to hospitals with graduate medical education (GME)

programs and permit redistribution of subsidized GME slots, and establish several demonstration programs. CBO estimates that the provisions of title VI would increase Medicare spending by $0.2 billion in 2003 and would reduce spending by $5.7 billion over the 2003–2012 period.

Under current law, there will be a so-called "15 percent" reduction in 2003 in rates paid for services to furnished by home health agencies (the actual reduction would be about 7 percent). H.R. 4954 would eliminate the reduction, but would provide for smaller annual updates to payment rates in subsequent years. In addition, the bill would impose cost sharing on beneficiaries of 1.5 percent of the average per-episode payment amount. CBO estimates those provisions would increase federal spending by $0.2 billion in 2003 and reduce spending by $4.1 billion over the 2003–2012 period.

Under current law, a limit on subsidies for GME programs—at 140 percent of the adjusted national average per-resident amount—would expire at the end of 2002. The bill would extend that limit through 2012, reducing federal spending by about $2.6 billion over the 2003–2012 period. Current law caps the number of residency slots at each teaching hospital that are eligible for GME subsidies. The bill would permit unused residency slots to be redistributed to hospitals that have reached their caps. CBO estimates that provision would increase spending by $1 billion over the 2003–2012 period.

Title VII—Medicare Benefits Administration

H.R. 4954 would establish a Medicare Benefits Administration within the Department of Health and Human Services to administer the Medicare+Choice competition program and the prescription drug benefit. CBO estimates that title VII would have no effect on direct spending.

Title VIII—Regulatory Reduction and Contracting Reform

Title VIII would establish a procedure for obtaining a determination before a service is furnished whether Medicare will pay for that service. CBO estimates that provision would increase direct spending by about $0.1 billion over the 2003–2012 period.

Title IX—Medicaid, Public Health, and Other Health Provisions

CBO estimates that the provisions of title IX would have no effect on direct spending.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By fiscal year, in millions of dollars—										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in outlays	0	4,100	7,700	26,000	34,000	35,700	37,200	39,500	43,700	50,200	58,500
Changes in receipts	0	0	0	0	0	0	0	0	0	0	0

Estimated impact on state, local, and tribal governments: The bill contains intergovernmental mandates, including a number of preemptions of state law, as defined in the Unfunded Mandates Reform Act. CBO estimates that the preemption of state premium taxes would result in revenue losses to states of about $70 million in 2005 (the first year the mandate is effective) increasing to about $100 million in 2009. Those losses would exceed the threshold established in UMRA ($62 million in 2005, adjusted annually for inflation). CBO estimates that other mandates and preemptions in the bill would impose minimal or no costs on state, local, or tribal governments. Provisions of the bill affecting Medicaid would result in net savings to state and local governments of about $64 billion over the 2003–2012 period.

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs), and this prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs would result in a shift away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues. CBO estimates that approximately 10 million people would change their insurance coverage for prescription drugs from taxable plans to PDPs. As a result, states would be unable to collect premium taxes (ranging from 0.2 percent to 3.0 percent of premiums) on those plans. CBO estimates that state losses of premium tax revenue as a result of this preemption would range from about $70 million in 2005 to $100 million in 2009.

The bill also would allow the Secretary of Health and Human Services to waive state licensure requirements for PDPs in cases where a state fails to act on a license application within 90 days or where a state denial is based on discriminatory treatment or solvency requirements that differ from those in the bill. In cases where the Secretary waives licensure requirements, states would lose fees associated with those licenses. CBO cannot estimate the magnitude of such losses because we have no basis for predicting the number of cases where a waiver would be possible or would be granted.

Health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, would be required to disclose whether the coverage they offer provides benefits at least equivalent to the benefits under the PDP. That disclosure requirement would be an intergovernmental mandate as defined by UMRA; however CBO estimates that the costs of the mandate would be minimal.

The bill would preempt state solvency standards for PDP sponsors and would supercede all state laws governing Medicare+Choice plans, with the exception of licensing or solvency requirements. While these preemptions would limit the application of state laws, they would impose no duties on states that would result in additional spending.

Other Impacts

The net effect of the bill on state Medicaid spending is expected to be savings totaling about $46 billion over the 2003–2012 period. On the one hand, state Medicaid programs would benefit as coverage responsibility for individuals that are dually eligible for Medicaid and Medicare shift from Medicaid to Medicare. However, some of these savings would be offset by new prescription drug spending for new enrollees who are fully eligible for both Medicare and Medicaid. CBO estimates that savings to states from these provisions would total about $58 billion over the 2003–2012 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state savings over the same period by about $12 billion.

States would be required to determine the eligibility of individuals for premium and cost-sharing assistance under the Medicare drug benefit. (Medicare beneficiaries may also apply for these benefits through the Social Security Administration.) The costs associated with this additional requirement would decrease over time because the matching rate from the federal government would increase annually until 2014 when it would equal 100 percent. Because states may alter their programmatic and financial responsibilities to offset the costs of this new requirement, it would not be an intergovernmental mandate as defined in UMRA.

State and local governments that provide health insurance to their employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in their health plans for retirees. Because CBO cannot predict how states might restructure the prescription drug component of their health plans, we cannot estimate the size of any federal reinsurance payments that would accrue to those governments.

Estimated impact on the private sector: The bill would modify or create a number of mandates on private-sector entities. CBO estimates that the direct cost of the mandates in the bill would not exceed the threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation).

Section 104 of the bill would modify several existing private-sector mandates on insurers that offer Medicare supplemental (medigap) coverage. One change would bar insurers from offering policies that include prescription drug coverage (policy categories H, I, and J) except to beneficiaries currently enrolled in the plans. However, insurers would be allowed to offer to beneficiaries who enroll in the Part D program two new medigap policies whose coverage would complement the Part D coverage. In addition, insurers who sell medigap policies without prescription drug coverage (policy categories A–G) would have to make those policies available, on a similar basis as they do to beneficiaries newly eligible to purchase medigap coverage, to any beneficiary who enrolls in the new Medicare Part D program and who, at the time of enrollment in Part D, held an H, I, or J policy.

CBO estimates that most Medicare beneficiaries who would purchase medigap plans with prescription drug coverage under current

law would joint the new Part D program under the bill and would also purchase one of the two new medigap drug plans. As a result, nearly all of the profits lost by insurers due to restrictions on current medigap plans would be offset by profits earned on the new drug plans.

The bill would also impose three new private-sector mandates. Section 1860A would require health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, to certify that the coverage they offer provides benefits at least equivalent to the benefits under Part D. Such a certification would be needed by enrollees who wanted to enter the Medicare drug benefit late because they had previously obtained coverage from the certifying plan. Section 850 would bar group health plans from requiring dental providers to obtain a claims determination from Medicare for dental benefits specifically excluded from Medicare coverage as a condition for obtaining a claims determination for such benefits under the group health plan. Section 912 would require pharmacies operating on the Internet to disclose their existence to state licensing boards and to post certain information on their web sites. CBO estimates that the direct cost of these mandates would be small.

Estimate prepared by: Federal Costs: Medicare outpatient prescription drug benefit—Julia Christensen, Jeanne De Sa, and Eric Rollins; Rachel Schmidt and Sarah Thomas. Medicare+Choice Competition—Niall Brennan. Other provisions—Alexis Ahlstrom, Charles Betley, Niall Brennan, Julia Christensen, Jeanne De Sa, Eric Rollins, Christopher Topoleski. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

V. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Subcommittee on Health. The hearings were as follows:

The Subcommittee on Health held a series of hearings on Medicare Reform during the 107th Congress to examine the implications of different proposals aimed at helping seniors gain more affordable access to prescription drugs. A list of these hearings may be found in this report in Section I. Introduction, Part C. Legislative History (Page 4).

B. Summary of General Performance Goals and Objectives

In compliance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee states that the primary purpose of H.R. 4954 is to create a prescription drug benefit into the Medicare program while modernizing other aspects of the program.

C. Constitutional Authority Statement

In compliance with clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, relating to constitutional Authority, the Committee states that the Committee's action in reporting the bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have power to lay and collect taxes, duties, imposts, and excises, to pay the debts and to provide for * * * the General Welfare of the United States * * *").

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

Part A—General Provisions

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.

(a) * * *

* * * * * * *

(f) Subject to subsection (g) *and section 1935(e)(1)(B)*, the total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

(1) * * *

* * * * * * *

APPOINTMENT OF ADVISORY COUNCIL AND OTHER ADVISORY GROUPS

SEC. 1114. (a) * * *

* * * * * * *

[(i)(1) Any advisory committee appointed under subsection (f) to advise the Secretary on matters relating to the interpretation, application, or implementation of section 1862(a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

[(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5, United States Code, by reason of subsection (b)(4) of such section (relating to trade secrets); or

[(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

[(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.]

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) * * *

* * * * * * *

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) * * *

* * * * * * *

(3)(A) * * *

(B) [Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of a State, the Secretary may waive the exclusion under subsection (a)(1) in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.] *Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.* The Secretary's decision whether to waive the exclusion shall not be reviewable.

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *

(b)(1) * * *

* * * * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) * * *

* * * * * * *

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987; [and]

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination

thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide[.]*;*

(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII; and

(H) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.

* * * * * * *

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

* * * * * * *

(e)(1) * * *

[(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative).]

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

NOTICE OF MEDICARE BENEFITS; MEDICARE AND MEDIGAP INFORMATION

SEC. 1804. (a) * * *

(b) The Secretary shall provide information via a toll-free telephone number on the programs under this title. *The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.*

* * * * * * *

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) * * *

(b) DUTIES.—

(1) * * *

(2) SPECIFIC TOPICS TO BE REVIEWED.—

(A) * * *

(B) ORIGINAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for *the efficient provision of* services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

* * * * * * *

(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.

* * * * * * *

MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

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

(1) to endorse prescription drug discount card programs that meet the requirements of this section; and

(2) to make available to medicare beneficiaries information regarding such endorsed programs.

(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary may not endorse a prescription drug discount card program under this section unless the program meets the following requirements:

(1) SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

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

(3) BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

(4) INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

(5) DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

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

(7) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

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

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

(2) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the discounts and services provided.

(3) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-medicare toll free telephone number for the receipt and response to inquiries and complaints concerning the program and programs endorsed under this section.

(4) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary shall revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

(5) ENROLLMENT PRACTICES.—A medicare beneficiary may not be enrolled in more than one endorsed program at any time.

(d) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the program under this section at the time prescription drug benefits first become available under part D.

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

MEDICARE BENEFITS ADMINISTRATION

SEC. 1808. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF ACTUARY.—

(1) ADMINISTRATOR.—

(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an administrator to be known as the "Medicare Benefits Administrator" (in this section referred to as the "Administrator") who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except as specified in this section.

(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

(2) DEPUTY ADMINISTRATOR.—

(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

(3) CHIEF ACTUARY.—

(A) IN GENERAL.—There is established in the Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

(B) COMPENSATION.—The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

(C) DUTIES.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

(4) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

(1) DUTIES.—

(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

(C) PRESCRIPTION DRUG CARD.—The Administrator shall carry out section 1807 (relating to the medicare prescription drug discount card endorsement program).

(D) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

(E) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

(2) STAFF.—

(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3110 and 3112, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of the enactment of this Act.

(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

(d) OFFICE OF BENEFICIARY ASSISTANCE.—

(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of medicare beneficiaries under this title, including the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate, directly or through contract, to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through a toll-free telephone number, information with respect to the following:

(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and

the Voluntary Prescription Drug Benefit Program under part D.

(e) MEDICARE POLICY ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the "Board"). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

(2) REPORTS.—

(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Ad-

ministration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

(4) MEMBERSHIP.—

(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of seven members to be appointed as follows:

(i) Three members shall be appointed by the President.

(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairmen and the ranking minority members of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(6) TERMS OF OFFICE.—

(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

(i) one shall be appointed for a term of 1 year;

(ii) three shall be appointed for terms of 2 years; and

(iii) three shall be appointed for terms of 3 years.

(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than three times during each fiscal year.

(9) DIRECTOR AND STAFF.—

(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.

MEDICARE BENEFICIARY OMBUDSMAN

SEC. 1809. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) * * *

* * * * * * *

(3) for individuals not enrolled in part B, home health services, and for individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness; **[**and**]**

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1)**[**.**]***; and*

(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

(A) an evaluation of the individual's need for pain and symptom management;

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

(C) advising the individual regarding advanced care planning.

* * * * * * *

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) * * *

* * * * * * *

(5)(A)(i) Subject to clause (ii), the amount payable for home health services furnished to the individual under this title for each episode of care beginning in a year (beginning with 2003) shall be reduced by a copayment equal to the copayment amount specified in subparagraph (B)(ii) such year.

(ii) The copayment under clause (i) shall not apply—

(I) in the case of an individual who has been determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)) or otherwise to be entitled to medical assistance under section 1902(a)(10)(A) or 1902(a)(10)(C); and

(II) in the case of an episode of care which consists of 4 or fewer visits.

(B)(i) The Secretary shall estimate, before the beginning of each year (beginning with 2003), the national average payment under this title per episode for home health services projected for the year involved.

(ii) For each year the copayment amount under this clause is equal to 1.5 percent of the national average payment estimated for the year involved under clause (i). Any amount determined under the preceding sentence which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

(iii) There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of average payment under clause (i).

* * * * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) * * *

* * * * * * *

Payment for Hospice Care

(i)(1)(A) * * *

* * * * * * *

(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such care shall be increased by 10 percent. For purposes of this subparagraph, the term 'frontier area' means a county in which the population density is less than 7 persons per square mile.

* * * * * * *

(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of mod-

erate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.

(5) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

* * * * * * *

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

* * * * * * *

(e)(1) * * *

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986) with respect to—

(A) * * *

* * * * * * *

(C) extended care services; [and]

(D) hospice care; *and*

(E) inpatient critical access hospital services;

if the provider of such services elects to receive, and qualifies for, such payments.

[USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES]

PROVISIONS RELATING TO THE ADMINISTRATION OF PART A

SEC. 1816. [(a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e)), and for the making of such payments by such agency or organization to such providers (and to providers assigned to such agency or organization under subsection (e)). Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers

to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection. As used in this title and part B of title XI, the term "fiscal intermediary" means an agency or organization with a contract under this section.

[(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

[(1) he finds—

[(A) after applying the standards, criteria, and procedures developed under subsection (f), that to do so is consistent with the effective and efficient administration of this part, and

[(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance; and

[(2) such agency or organization agrees—

[(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

[(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.]

(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.

(c)[(1) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement. The Secretary shall provide that in determining the necessary and proper cost of administration, the Secretary shall, with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used. The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1871, that a fiscal intermediary match data obtained other

than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1862(b) may apply.]

(2)(A) Each [agreement under this section] *contract under section 1874A that provides for making payments under this part* shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this title—

(i) * * *

* * * * * * *

(3)(A) Each [agreement under this section] *contract under section 1874A that provides for making payments under this part* shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

* * * * * * *

[(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

[(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

[(2) Notwithstanding subsections (a) and (d), the Secretary may (subject to the provisions of paragraph (4)) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

[(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii)

such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

[(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

[(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title. By not later than July 1, 1987, the Secretary shall limit the number of such regional agencies or organizations to not more than ten.

[(5) Notwithstanding any other provision of this title, the Secretary shall designate the agency or organization which has entered into an agreement under this section to perform functions under such an agreement with respect to each hospice program, except that with respect to a hospice program which is a subdivision of a provider of services (and such hospice program and provider of services are under common control) due regard shall be given to the agency or organization which performs the functions under this section for the provider of services.

[(f)(1) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (A) overall performance of claims processing (including the agency's or organization's success in recovering payments made under this title for services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A))) and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (B) performance of such functions with respect to specific providers of services, and the Secretary shall establish standards and criteria with respect to the ef-

ficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.

[(2) The standards and criteria established under paragraph (1) shall include—

[(A) with respect to claims for services furnished under this part by any provider of services other than a hospital—

[(i) whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days, and

[(ii) the extent to which such agency's or organization's determinations are reversed on appeal; and

[(B) with respect to applications for an exemption from or exception or adjustment to the target amount applicable under section 1886(b) to a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B))—

[(i) if such agency or organization receives a completed application, whether such agency or organization is able to process such application not later than 75 days after the application is filed, and

[(ii) if such agency or organization receives an incomplete application, whether such agency or organization is able to return the application with instructions on how to complete the application not later than 60 days after the application is filed.

[(g) An agreement with the Secretary under this section may be terminated—

[(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

[(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after applying the standards, criteria, and procedures developed under subsection (f) and after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

[(h) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

[(i)(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

[(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

[(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).]

(j) [An agreement with an agency or organization under this section] *A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part* shall require that, with respect to a claim for home health services, extended care services, or post-hospital extended care services submitted by a provider to [such agency or organization] *such medicare administrative contractor* that is denied, [such agency or organization] *such medicare administrative contractor*—

(1) * * *

* * * * * * *

(k) [An agreement with an agency or organization under this section] *A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part* shall require that [such agency or organization] *such medicare administrative contractor* submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

[(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.]

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, [and the Secretary of Health and Human Services, all ex officio,] *the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,* and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the ear-

lier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) * * *

* * * * * * *

MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

SEC. 1820. (a) * * *

* * * * * * *

(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

(1) * * *

(2) STATE DESIGNATION OF FACILITIES.—

(A) * * *

(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

(i) * * *

* * * * * * *

(iii) provides *subject to paragraph (3)* not more than 15 (or, in the case of a facility under an agreement described in subsection (f), 25) acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

* * * * * * *

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

(A) IN GENERAL.—In the case of a hospital that demonstrates that it meets the standards established under subparagraph (B), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).

* * * * * * *

(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agree-

ment between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted. *The limitations in numbers of beds under the first sentence are subject to adjustment under subsection (c)(3).*

* * * * * * *

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through **[**2002**]** *2007*.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which

payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent *(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))* of the payment basis determined under sec-

tion 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent *(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))* of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services, (S) with respect to drugs and biologicals not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o), (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, and (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895 *less the copayment amount applicable under section 1813(a)(5)*;

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991 and $100 for 1991 and subsequent years; except that (1) such total amount shall not include expenses incurred for items

and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), **[**and**]** (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)), *and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))*. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year.

(g)(1) * * *

* * * * * * *

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, **[**and 2002**]** *2002, 2003, and 2004*.

(h)(1) * * *

* * * * * * *

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2004 (in this paragraph referred to as 'new tests').

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such

test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term "HCPCS" refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be "substantially revised" if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) * * *

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) * * *

* * * * * * *

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) *and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography*.

* * * * * * *

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) * * *

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy **[**or temperature monitored cryoablation**]**, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

* * * * * * *

(8) COPAYMENT AMOUNT.—

(A) * * *

* * * * * * *

(C) LIMITATION ON COPAYMENT AMOUNT.—

(i) * * *

(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) * * *

* * * * * * *

[(III) For procedures performed in 2004, 50 percent.

[(IV) For procedures performed in 2005, 45 percent.

[(V) For procedures performed in 2006 and thereafter, 40 percent.**]**

(III) For procedures performed in 2004, 45 percent.

(IV) For procedures performed in 2005, 40 percent.

(V) For procedures performed in 2006, 2007, 2008 and 2009, 35 percent.

(VI) For procedures performed in 2010, 30 percent.

(VII) For procedures performed in 2011, 25 percent.

(VIII) For procedures performed in 2012 and thereafter, 20 percent.

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SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) * * *

* * * * * * *

(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) * * *

(2) ELECTION OF COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

(A) * * *

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.

* * * * * * *

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) * * *

(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

(A) * * *

* * * * * * *

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner *consistent with paragraph (10)*, except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by

carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

* * * * * * *

[(8)] *(9)* TRANSITIONAL ASSISTANCE FOR RURAL PROVIDERS.—In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year before January 1, 2007, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

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

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

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

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

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2003, and before January 1, 2008, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile

rate otherwise established shall be increased by 1/4 of the payment per mile otherwise applicable to such miles.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), and (f)**[**, and to reflect 80 percent of any reduction elected under section 1854(f)(1)(E).**]**.

* * * * * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837) and not pursuant to a special enrollment period under section 1837(i)(4), the monthly premium determined under subsection (a) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iii)). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. *No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, or 2003, and who demonstrates to the Secretary before December 31, 2003, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.*

* * * * * * *

(h)(1) In the case of an individual who resides in a competitive-demonstration area designated under section 1851(k)(1) and who is not enrolled in a Medicare+Choice plan under part C, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this sub-

section) shall be adjusted as follows: If the fee-for-service area-specific non-drug bid (as defined in section 1853(k)(6)) for the Medicare+Choice area in which the individual resides for a month—

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

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

(i) the sum of the amount of the adjusted premium and the choice non-drug benchmark for the area, is equal to

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

(2) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

(3) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

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

(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

* * * * * * *

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. (a) * * *

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, Secretary of the Treasury, the Secretary of Labor, [and the Secretary of Health and Human Services, all ex officio,] *the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,* and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nomi-

nated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) * * *

* * * * * * *

[USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS]

PROVISIONS RELATING TO THE ADMINISTRATION OF PART B

SEC. 1842. [(a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

[(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

[(B) receive, disburse, and account for funds in making such payments; and

[(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

[(2)(A) determine compliance with the requirements of section 1861(k) as to utilization review; and

[(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization;

[(3) serve as a channel of communication of information relating to the administration of this part; and

[(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.]

(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.

(b)[(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.]

(2)[(A) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The Secretary shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. In establishing such standards and criteria, the Secretary shall provide a system to measure a carrier's performance of responsibilities described in paragraph (3)(H), subsection (h), and section 1845(e)(2). The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.

[(B) The Secretary shall establish standards for evaluating carriers' performance of reviews of initial carrier determinations and of fair hearings under paragraph (3)(C), under which a carrier is expected—

[(i) to complete such reviews, within 45 days after the date of a request by an individual enrolled under this part for such a review, in 95 percent of such requests, and

[(ii) to make a final determination, within 120 days after the date of receipt of a request by an individual enrolled under this part for a fair hearing under paragraph (3)(C), in 90 percent of such cases.]

(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct [carriers] *medicare administrative contractors* to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term "team" refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.

[(D) In addition to any other standards and criteria established by the Secretary for evaluating carrier performance under this paragraph relating to avoiding erroneous payments, the carrier shall be subject to standards and criteria relating to the carrier's success in recovering payments made under this part for items or

services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

[(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 4611 of the Balanced Budget Act of 1997, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.]

(3) [Each such contract shall provide that the carrier] *The Secretary—*

(A) [will] *shall* take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) [will] *shall* take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, [to the policyholders and subscribers of the carrier] *to the policyholders and subscribers of the medicare administrative contractor*, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) * * *

* * * * * * *

[(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is at least $100, but less than $500, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

[(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part;

[(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;]

(F) [will] *shall* take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

(G) [will] *shall*, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1848(g)—

(i) * * *

* * * * * * *

(H) [if it makes determinations or payments with respect to physicians' services, will] *shall* implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the [carrier] *medicare administrative contractor*, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

* * * * * * *

[(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)); and]

(L) [will] *shall* monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality[;].

[and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate.] In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12-month period ending on the June 30 last preceding the start of the calendar year in which the service is rendered. In the case of physicians' services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, or (with respect to physicians' services furnished in a year after 1987) the level determined under this sentence (or under any other provision of law affecting the prevailing charge level) for the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (in-

cluding equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (I) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, *medicare administrative contractor,* or agent of the Department of Health and Human Services performing functions under this title and acting within the scope of his or its authority, and (II) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975, and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861(v)(1)(K), and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility.

* * * * * * *

[(5) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.**]**

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment

may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1861(s)(2)(K), payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1861(aa)(2)) for a continuous period beginning prior to the date of the enactment of the Balanced Budget Act of 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1861(aa)(2), payment may be made directly to the physician assistant, (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the ⟦carrier⟧ *medicare administrative contractor* for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician, (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished by, or under arrangements made by, a skilled nursing facility to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility, (F) in the case of home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise), and (G) in the case of services in a hospital or clinic to which section 1880(e) applies, payment shall be made to such hospital or clinic. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant

to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.

(7)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), [the carrier] *the Secretary* shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(i) * * *

* * * * * * *

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), [the carrier] *the Secretary* shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, [the carrier] *the Secretary* shall base payment under this title on the greatest of—

(I) * * *

* * * * * * *

(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, [the carrier] *the Secretary* shall provide for payment for such services under this part

on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).

* * * * * * *

(c)[(1) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract. The Secretary shall provide that in determining a carrier's necessary and proper cost of administration, the Secretary shall, with respect to each contract, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier in carrying out the terms of its contract. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for carriers under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.]

(2)(A) Each [contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),] *contract under section 1874A that provides for making payments under this part* shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

(i) * * *

* * * * * * *

(3)(A) Each contract under this section which provides for the disbursement of funds, as described in [subsection (a)(1)(B)] *section 1874A(a)(3)(B)*, shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

(4) Neither a [carrier] *medicare administrative contractor* nor the Secretary may impose a fee under this title—

(A) * * *

* * * * * * *

[(5) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(15)(C).

[(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

[(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

[(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

[(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

[(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

[(f) For purposes of this part, the term "carrier" means—

[(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

[(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.]

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a [carrier or carriers] *medicare administrative contractor or contractors* to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 226(a) of this Act and section 7(d) of the Railroad Retirement Act of 1974.

(h)(1) * * *

(2) [Each carrier having an agreement with the Secretary under subsection (a)] *The Secretary* shall maintain a toll-free telephone number or numbers at which individuals enrolled under this part may obtain the names, addresses, specialty, and telephone numbers of participating physicians and suppliers and may request a copy of an appropriate directory published under paragraph (4). [Each such carrier] *The Secretary* shall, without charge, mail a copy of such directory upon such a request.

(3)(A) In any case in which [a carrier having an agreement with the Secretary under subsection (a)] *medicare administrative contractor having a contract under section 1874A that provides for making payments under this part* is able to develop a system for the electronic transmission to [such carrier] *such contractor* of bills for services, such carrier shall establish direct lines for the electronic receipt of claims from participating physicians and suppliers.

(B) The Secretary shall establish a procedure whereby an individual enrolled under this part may assign, in an appropriate manner on the form claiming a benefit under this part for an item or service furnished by a participating physician or supplier, the individual's rights of payment under a medicare supplemental policy (described in section 1882(g)(1)) in which the individual is enrolled. In the case such an assignment is properly executed and a payment determination is made by [a carrier] *a medicare administrative contractor* with a contract under this section, [the carrier] *the contractor* shall transmit to the private entity issuing the medicare supplemental policy notice of such fact and shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order to enable the entity to decide whether (and the amount of) any payment is due under the policy. The Secretary may enter into agreements for the transmittal of such information to entities electronically. The Secretary shall impose user fees for the transmittal of information under this subparagraph by [a carrier] *a medicare administrative contractor*, whether electronically or otherwise, and such user fees shall be collected and retained by [the carrier] *the contractor*.

* * * * * * *

(5)(A) The Secretary shall promptly notify individuals enrolled under this part through an annual mailing of the participation program under this subsection and the publication and availability of the directories and shall make the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of [carriers] *medicare administrative contractors*, and to senior citizen organizations.

(B) The annual notice provided under subparagraph (A) shall include—

(i) * * *

(iii) an explanation of the assistance offered by [carriers] *medicare administrative contractors* in obtaining the names of participating physicians and suppliers, and

* * * * * * *

(l)(1)(A) Subject to subparagraph (C), if—

(i) * * *

* * * * * * *

(iii)(I) a [carrier] *medicare administrative contractor* determines under this part or a peer review organization determines under part B of title XI that payment may not be made by reason of section 1862(a)(1) because a service otherwise covered under this title is not reasonable and necessary under the standards described in that section or (II) payment under this title for such services is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B), and

* * * * * * *

(2) Each [carrier] *medicare administrative contractor* with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not re-

quested on an assignment-related basis to the physician and the individual involved.

* * * * * * *

(p)(1) * * *

* * * * * * *

(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a [carrier] *medicare administrative contractor*, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

* * * * * * *

(q)(1)(A) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all [carrier] localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

* * * * * * *

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) * * *

* * * * * * *

(c) The Secretary shall determine the Government contribution under subparagraphs (A) and (B) of subsection (a)(1) without regard to any premium reduction resulting from an election under section 1854(f)(1)(E) *and without regard to any premium adjustment effected under section 1839(h)*.

* * * * * * *

[SEC. 1847. DEMONSTRATION PROJECTS FOR COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

[(a) ESTABLISHMENT OF DEMONSTRATION PROJECT BIDDING AREAS.—

[(1) IN GENERAL.—The Secretary shall implement not more than 5 demonstration projects under which competitive acquisition areas are established for contract award purposes for the furnishing under this part of the items and services described in subsection (d).

[(2) PROJECT REQUIREMENTS.—Each demonstration project under paragraph (1)—

[(A) shall include such group of items and services as the Secretary may prescribe,

[(B) shall be conducted in not more than 3 competitive acquisition areas, and

[(C) shall be operated over a 3-year period.

[(3) CRITERIA FOR ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—Each competitive acquisition area established under a demonstration project implemented under paragraph (1)—

[(A) shall be, or shall be within, a metropolitan statistical area (as defined by the Secretary of Commerce), and

[(B) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in such area.

[(b) AWARDING OF CONTRACTS IN AREAS.—

[(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under a demonstration project implemented under subsection (a).

[(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary and that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

[(3) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

[(4) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

[(c) EXPANSION OF PROJECTS.—

[(1) EVALUATIONS.—The Secretary shall evaluate the impact of the implementation of the demonstration projects on medicare program payments, access, diversity of product selection, and quality. The Secretary shall make annual reports to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate on the results of the evaluation described in the preceding sentence and a final report not later than 6 months after the termination date specified in subsection (e).

[(2) EXPANSION.—If the Secretary determines from the evaluations under paragraph (1) that there is clear evidence that any demonstration project—

[(A) results in a decrease in Federal expenditures under this title, and

[(B) does not reduce program access, diversity of product selection, and quality under this title,

the Secretary may expand the project to additional competitive acquisition areas.

[(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part

(except for physicians' services as defined in section 1861(s)(1)) that the Secretary may specify. At least one demonstration project shall include oxygen and oxygen equipment.

[(e) TERMINATION.—Notwithstanding any other provision of this section, all projects under this section shall terminate not later than December 31, 2002.**]**

COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

(1) IMPLEMENTATION OF PROGRAMS.—

(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

(i) at least 1/3 of such areas in 2004; and

(ii) at least 2/3 of such areas in 2005.

(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

(A) DURABLE MEDICAL EQUIPMENT AND INHALATION DRUGS USED IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

(3) EXEMPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

(A) areas that are not competitive due to low population density; and

(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

(b) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

(2) CONDITIONS FOR AWARDING CONTRACT.—

(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

(i) The entity meets quality and financial standards specified by the Secretary or developed by accreditation entities or organizations recognized by the Secretary.

(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

(iii) Beneficiary access to a choice of multiple suppliers in the area is maintained.

(iv) Beneficiary liability is limited to the applicable percentage of contract award price.

(B) QUALITY STANDARDS.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, and suppliers to review (and advise the Secretary concerning) such quality standards.

(3) CONTENTS OF CONTRACT.—

(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

(B) TERM OF CONTRACTS.—The Secretary shall rebid contracts under this section not less often than once every 3 years.

(4) LIMIT ON NUMBER OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

(B) MULTIPLE WINNERS.—The Secretary shall award contracts to more than one entity submitting a bid in each area for an item or service.

(5) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) fur-

nished by a contractor and for which competition is conducted under this section unless—

(A) the contractor has submitted a bid for such items and services under this section; and

(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries with respect to the program.

(c) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction.

(d) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

(B) which are furnished without a face-to-face encounter between the individual and the hospital or physician ordering the tests.

(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

(3) REPORT.—The Secretary shall submit to Congress—

(A) an initial report on the project not later than December 31, 2004; and

(B) such progress and final reports on the project after such date as the Secretary determines appropriate.

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

* * * * * * *

(d) CONVERSION FACTORS.—

(1) * * *

* * * * * * *

(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

(A) * * *

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D) *and paragraph (6)*, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) * * *

* * * * * * *

(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under [subparagraph (A)—

[(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

[(ii) for 2005 of +0.8 percent.] *subparagraph (A), for each of 2001 and 2002, of −0.2 percent.*

(5) UPDATE FOR 2003.—The update to the single conversion factor established in paragraph (1)(C) for 2003 is 2 percent.

(6) SPECIAL RULES FOR UPDATE FOR 2004 AND 2005.—The following rules apply in determining the update adjustment factors under paragraph (4)(B) for 2004 and 2005:

(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

(i) The reference in clause (ii)(I) of such paragraph to April 1, 1996, is deemed to be a reference to January 1, 2002.

(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, and 2005 is deemed to be increased by 1 percentage point.

* * * * * * *

(f) SUSTAINABLE GROWTH RATE.—

(1) * * *

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 shall be equal to the product of—

(A) * * *

* * * * * * *

(C) 1 plus the Secretary's estimate of the [projected] *annual average* percentage growth in real gross domestic product per capita (divided by 100) [from the previous applicable period to the applicable period involved] *during the 10-year period ending with the applicable period involved*, and

* * * * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

* * * * * * *

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A),

(2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), *(2)(W),* (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) such other items and services as the Secretary may specify).

* * * * * * *

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits *(other than qualified prescription drug benefits)* under this title—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part**[**.**]**,

and may elect qualified prescription drug coverage in accordance with section 1860A.

(2) TYPES OF MEDICARE+CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1855(d)), and preferred provider organization plans. *Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.*

* * * * * * *

(b) SPECIAL RULES.—

(1) * * *

* * * * * * *

(4) COVERAGE UNDER MSA PLANS **[**ON A DEMONSTRATION BASIS**]**.—

(A) IN GENERAL.—**[**An individual is not eligible to enroll in an MSA plan under this part—

[(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

[(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.**]**

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA

plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

* * * * * * *

(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). **[**The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).**]**

* * * * * * *

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) * * *

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans *to the extent such information is available at the time of preparation of materials for the mailing*. Such information shall be presented in a comparative form.

* * * * * * *

(e) COVERAGE ELECTION PERIODS.—

(1) * * *

* * * * * * *

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) * * *

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term "annual, coordinated election period" means, with respect to a year before 2003 **[**and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005**]**, *the month of November before such year and with respect to 2003 and any subsequent year*, the period beginning on November 15 and ending on December 31 of the year before such year.

* * * * * * *

(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), *or*

(ii) an annual, coordinated election period described in paragraph (3)(B)[, or]*;*

[(iii) the month of November 1998;]

* * * * * * *

(g) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection *and section 1860A(c)(2)(B)*, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

* * * * * * *

(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

(1) * * *

* * * * * * *

(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1856. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise *except as provided under section 1854(b)(1)(C)*, and

* * * * * * *

(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

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

(i) requiring a Medicare+Choice plan to include coverage of qualified prescription drug coverage; or

(ii) permitting a Medicare+Choice organization from providing such coverage to an individual who has not elected such coverage under section 1860A(b).

For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860A(b) shall be treated as being ineligible to enroll in a Medicare+Choice plan under this part that offers such coverage.

(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements re-

lating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860F(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

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

(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

(B) providing a Medicare+Choice organization with direct and insurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2005 shall be the 6-month period beginning with November 2004.

(5) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms "qualified prescription drug coverage" and "standard coverage" have the meanings given such terms in section 1860B.

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) * * *

(2) SATISFACTION OF REQUIREMENT.—

(A) * * *

* * * * * * *

(C) ELECTION OF UNIFORM COVERAGE [POLICY] *DETERMINATION*.—In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage [policy] *determination* is applied with respect to different parts of the area, the organization may elect to have the local coverage [policy] *determination* for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

* * * * * * *

[(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of

providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

[(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

[(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Health Care Financing Administration of the actuarial costs associated with the coverage determination or legislative change in benefits.]

(5) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall only implement a national coverage determination that will result in a significant change in the costs to a Medicare+Choice organization in a prospective manner that applies to announcements made under section 1853(b) after the date of the implementation of the determination.

(b) ANTIDISCRIMINATION.—

(1) BENEFICIARIES.—

(A) IN GENERAL.—A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act. *The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare+Choice eligible individuals with the organization.*

* * * * * * *

(c) DISCLOSURE REQUIREMENTS.—

(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) * * *

* * * * * * *

(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e) *if required under such section*.

* * * * * * *

(e) QUALITY ASSURANCE PROGRAM.—

(1) IN GENERAL.—Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans *(other than MSA plans)* of the organization.

* * * * * * *

(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1851(a)(2)(A) *or with an organization offering a MSA plan* shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

* * * * * * *

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e), (g), and (i) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, **[**in an amount equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.**]** *in an amount determined as follows:*

(i) PAYMENT BEFORE 2005.—For years before 2005, the payment amount shall be equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iii).

(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2005.—For years beginning with 2005—

(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) (or, in the case of a competitive-demonstration area, described in section 1854(b)(4)), the payment under this subsection is equal to the unadjusted non-drug monthly bid amount (or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount), adjusted under clause (iii), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C) (or, in the case of a competitive-demonstration area, described in section 1854(b)(4)), the payment amount under this subsection is equal to the fee-for-service area-specific non-drug benchmark amount, adjusted under clause (iii).

(iii) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted non-drug monthly bid amount under clause (ii)(I), and the fee-for-service area-specific non-drug benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

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

* * * * * * *

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) for years before 2004 [and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005] *not later than March 1 before the calendar year concerned and for 2004 and each subsequent year* not later than the second Monday in May before [the respective calendar year—

[(A) the annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year, and

[(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.] *the calendar year concerned with respect to each Medicare+Choice payment area, the following:*

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

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

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

(B) COMPETITION INFORMATION.—For years beginning with 2005, the following:

(i) BENCHMARKS.—The fee-for-service area-specific non-drug benchmark under section 1853(j) and, if applicable, the choice non-drug benchmark under section 1853(k)(2), for the year involved and, if applicable, the national fee-for-service market share percentage.

(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iii) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).

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

(iv) INDIVIDUALS.—The number of individuals counted under subsection (k)(4)(B) and enrolled in each Medicare+Choice plan in the area.

* * * * * * *

(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement [in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization].

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), [or (C)] *(C), or (D)*:

(A) BLENDED CAPITATION RATE.—The sum of—

(i) * * *

* * * * * * *

multiplied *(for a year before 2003)* by the budget neutrality adjustment factor determined under paragraph (5).

* * * * * * *

(C) MINIMUM PERCENTAGE INCREASE.—

(i) * * *

* * * * * * *

[(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.]

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

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

(vi) For 2005 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

(i) IN GENERAL.—For 2003 and 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

* * * * * * *

(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to [subparagraph (B)] *subparagraphs (B) and (E)*, the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) * * *

* * * * * * *

(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation

rate under subparagraph (A) for a year (beginning with 2003), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

(A) * * *

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the "national standardized annual Medicare+Choice capitation rate" for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries *who (with respect to determinations for 2003 and for 2004) are enrolled in a Medicare+Choice plan* residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

* * * * * * *

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year *(before 2003)*, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(d) MEDICARE+CHOICE PAYMENT AREA DEFINED.—

(1) * * *

* * * * * * *

(3) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1)—

[(i) to a single statewide Medicare+Choice payment area,**]**

(i) to a single statewide Medicare+Choice payment area,

* * * * * * *

[(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.]

(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Medicare Benefits Administrator shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

* * * * * * *

(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term "fee-for-service area-specific non-drug benchmark amount" means, with respect to a Medicare+Choice payment area for a month in a year, an amount equal to the greater of the following (but in no case less than 1/12 of the rate computed under subsection (c)(1), without regard to subparagraph (A), for the year):

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

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

(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRATION PROGRAM.—

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

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

(i) LIMITATION ON NUMBER OF AREAS THAT MAY BE DESIGNATED.—The Administrator may not designate more than 4 areas as competitive-demonstration areas.

(ii) LIMITATION ON PERIOD OF DESIGNATION OF ANY AREA.—The Administrator may not designate any area as a competitive-demonstration area for a period of more than 2 years.

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

(B) QUALIFICATIONS FOR DESIGNATION.—For purposes of this title, a Medicare+Choice area (which is a metropolitan statistical area or other area with a substantial number of Medicare+Choice enrollees) may not be designated as a "competitive-demonstration area" for a 2-year period beginning with a year unless the Administrator determines, by such date before the beginning of the year as the Administrator determines appropriate, that—

(i) there will be offered during the open enrollment period under this part before the beginning of the year at least 2 Medicare+Choice plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare+Choice organization; and

(ii) during March of the previous year at least 50 percent of the number of Medicare+Choice eligible individuals who reside in the area were enrolled in a Medicare+Choice plan.

(2) CHOICE NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term "choice non-drug benchmark amount" means, with respect to a Medicare+Choice payment area for a month in a year, the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive-demonstration area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2005) in which it is designated as such an area.

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

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

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

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

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

(i) NATIONAL MEDICARE+CHOICE MARKET SHARE.—1 minus the national fee-for-service market share percentage for the year.

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

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

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

(i) PROPORTION OF EACH PLAN'S ENROLLEES IN THE AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare+Choice plans described in subparagraph (C) for that area and year.

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

(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare+Choice plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare+Choice plans described in this subparagraph are plans that are offered in the area and year and were offered in the area in March of the previous year.

(5) COMPUTATION OF NATIONAL FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year, the proportion (in this subsection referred to as the "national fee-for-service market share percentage") of Medicare+Choice eligible individuals who during March of the previous year were not enrolled in a Medicare+Choice plan.

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

PREMIUMS *AND BID AMOUNTS*.

SEC. 1854. (a) SUBMISSION OF PROPOSED PREMIUMS *AND BID AMOUNTS* AND RELATED INFORMATION.—

(1) IN GENERAL.—Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year),

each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year—

[(A)] *(A)(i) if the following year is before 2005,* the information described in paragraph (2), (3), or (4) for the type of plan involved *or (ii) if the following year is 2005 or later, the information described in paragraph (6)(A)*; and

* * * * * * *

(5) REVIEW.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under *paragraphs (2), (3), and (4) of* this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

* * * * * * *

(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.

(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

(i) The term "statutory non-drug benefits" means benefits under parts A and B.

(ii) The term "statutory prescription drug benefits" means benefits under part D.

(iii) The term "statutory benefits" means statutory prescription drug benefits and statutory non-drug benefits.

(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)). The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

(b) MONTHLY PREMIUM CHARGED.—

(1) IN GENERAL.—

(A) * * *

* * * * * * *

(C) BENEFICIARY REBATE RULE.—

(i) REQUIREMENT FOR NON-COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is not a competitive-demonstration area designated under section 1853(k)(1), the Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

(ii) REQUIREMENT FOR COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is designated as a competitive-demonstration area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (4) for a Medicare+Choice plan and year, the Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings.

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

(I) through the crediting of the amount of the rebate towards the Medicare+Choice monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.

(2) PREMIUM TERMINOLOGY DEFINED.—For purposes of this part:

[(A) THE MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly basic beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(1) for the plan, or, in the case of a Medicare+Choice private fee-for-service plan, the amount filed under subsection (a)(4)(A)(ii).

[(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly supplemental beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(2) for the plan or, in the case

of a MSA plan or Medicare+Choice private fee-for-service plan, the amount filed under paragraph (3)(B) or (4)(B) of subsection (a).]

(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly basic beneficiary premium" means, with respect to a Medicare+Choice plan—

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

(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted non-drug monthly bid amount exceeds the fee-for-service area-specific non-drug benchmark amount.

(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly supplemental beneficiary premium" means, with respect to a Medicare+Choice plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.

(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year is computed as follows:

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

(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2005), for each State the average of the risk adjustment factors to be applied to enrollees under section 1853(a)(1)(A) in that State. In the case of a State in which a Medicare+Choice plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare+Choice plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare+Choice plan offered in a State, the Administrator shall—

(i) adjust the fee-for-service area-specific non-drug benchmark amount by the applicable average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings de-

scribed in this subparagraph is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

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

(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.

(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the fee-for-service area-specific non-drug benchmark amount in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the choice non-drug benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).

[(c) UNIFORM PREMIUM.—The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.**]**

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

(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide*, except as provided under subsection (b)(1)(C) and subsection (b)(1)(D),* for cash or other monetary rebates as an inducement for enrollment or otherwise.

[(e) LIMITATION ON ENROLLEE LIABILITY.—

[(1) FOR BASIC AND ADDITIONAL BENEFITS.—In no event may—

[(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1851(a)(2)(A) of an organization with respect to required benefits described in section 1852(a)(1)(A) and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

[(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to in-

dividuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

[(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1851(a)(2)(A) with respect to supplemental benefits described in section 1852(a)(3), the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

[(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

[(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

[(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in section 1852(a)(1), exceed

[(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

[(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

[(1) REQUIREMENT.—

[(A) IN GENERAL.—Each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

[(B) EXCESS AMOUNT.—For purposes of this paragraph, the "excess amount", for an organization for a plan, is the amount (if any) by which—

[(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

[(ii) the actuarial value of the required benefits described in section 1852(a)(1)(A) under the plan for individuals under this part, as determined based upon

an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

[(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the "adjusted excess amount", for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

[(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

[(E) PREMIUM REDUCTIONS.—

[(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1853(a)(1)(A) with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

[(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

[(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

[(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

[(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

[(2) STABILIZATION FUND.—A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

[(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term "adjusted community rate" for a service or services means, at the election of a Medicare+Choice organization, either—

[(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

[(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

[(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.]

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ESTABLISHMENT OF STANDARDS

SEC. 1856. (a) * * *

(b) ESTABLISHMENT OF OTHER STANDARDS.—

(1) * * *

* * * * * * *

[(3) RELATION TO STATE LAWS.—

[(A) IN GENERAL.—The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

[(B) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this paragraph:

[(i) Benefit requirements (including cost-sharing requirements).

[(ii) Requirements relating to inclusion or treatment of providers.

[(iii) Coverage determinations (including related appeals and grievance processes).

[(iv) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.]

(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part.

* * * * * * *

DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) * * *

(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

(1) * * *

* * * * * * *

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

(A) IN GENERAL.—The term "specialized Medicare+Choice plan for special needs beneficiaries" means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

(B) SPECIAL NEEDS BENEFICIARY.—The term "special needs beneficiary" means a Medicare+Choice eligible individual who—

(i) is institutionalized (as defined by the Secretary);

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

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

* * * * * * *

(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.

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), the individual may enroll in the plan and obtain coverage through such plan.

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

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

(b) GENERAL ELECTION PROCEDURES.—

(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1808(b)) (in this part referred to as the "Medicare Benefits Administrator") and only during an election period prescribed in or under this subsection.

(2) ELECTION PERIODS.—

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

(i) annual coordinated election periods; and

(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

(B) INITIAL ELECTION PERIODS.—

(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2004, there shall be an initial election period of 6 months beginning on that date.

(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

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

(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

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

(1) GUARANTEED ISSUE.—

(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

(2) COMMUNITY-RATED PREMIUM.—

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

(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) adjust the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

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

(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

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

(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at

least equivalent to the benefits under a qualified prescription drug plan.

(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

(E) DISCLOSURE.—

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

(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

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

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

(d) EFFECTIVE DATE OF ELECTIONS.—

(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

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

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

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

(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) REQUIREMENTS.—

(1) IN GENERAL.—For purposes of this part and part C, the term "qualified prescription drug coverage" means either of the following:

(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

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

(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

(b) STANDARD COVERAGE.—For purposes of this part, the "standard coverage" is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

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

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

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

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(2) LIMITS ON COST-SHARING.—

(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph

(1) and up to the initial coverage limit under paragraph (3)) as follows:

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

(I) is equal to 20 percent; or

(II) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

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

(I) is equal to 50 percent; or

(II) is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

(B) USE OF TIERED COPAYMENTS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

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

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

(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes—

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

(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

(4) CATASTROPHIC PROTECTION.—

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

(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For purposes of this part, the "annual out-of-pocket threshold" specified in this subparagraph—

(i) for 2005, is equal to $3,800; or

(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

(C) APPLICATION.—In applying subparagraph (A)—

(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

(ii) such costs shall be treated as incurred only if they are paid by the individual, under section 1860G, or under title XIX and the individual is not reimbursed (through insurance or otherwise) by another person for such costs.

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

(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860H with respect to such coverage.

(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the sum of the following products:

(i) FIRST COPAYMENT RANGE.—The product of—

(I) the amount by which the initial copayment threshold described in subsection (b)(2)(C) exceeds the deductible described in subsection (b)(1); and

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

(ii) SECONDARY COPAYMENT RANGE.—The product of—

(I) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the initial copayment threshold described in subsection (b)(2)(C); and

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

(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

(d) ACCESS TO NEGOTIATED PRICES.—

(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated by a prescription drug plan under this part, by a Medicare+Choice plan with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

(2) DISCLOSURE.—The PDP sponsor or Medicare+Choice organization shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

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

(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

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

(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

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

(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

(f) COVERED OUTPATIENT DRUGS DEFINED.—

(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term "covered outpatient drug" means—

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

(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

(2) EXCLUSIONS.—

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

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

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

(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

(A) for which payment would not be made if section 1862(a) applied to part D; or

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

(b) DISSEMINATION OF INFORMATION.—

(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

(A) Access to covered outpatient drugs, including access through pharmacy networks.

(B) How any formulary used by the sponsor functions.

(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

(D) Grievance and appeals procedures.

(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket threshold for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

(c) ACCESS TO COVERED BENEFITS.—

(1) ASSURING PHARMACY ACCESS.—

(A) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access.

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

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

(ii) the plan may charge beneficiaries through adjustments in premiums and copayments any additional costs associated with the point-of-service option.

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

(2) USE OF STANDARDIZED TECHNOLOGY.—

(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

(B) STANDARDS.—

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

(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one physician and at least one pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a pharmacist (or both).

(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs

(although not necessarily for all drugs within such categories and classes).

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

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

(F) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

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

(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

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

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

Nothing in this section shall be construed as impairing a PDP sponsor from applying cost management tools (including differential payments) under all methods of operation.

(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

(B) ELEMENTS.—Such program may include—

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

(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

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

(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

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

(3) ELECTRONIC PRESCRIPTION PROGRAM.—

(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with national standards established under subparagraph (B):

(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Administrator.

(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

(I) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

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

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

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

(B) STANDARDS.—

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

(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

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

(II) The extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals.

(III) Efforts to develop a common software platform for computerized prescribing.

(IV) The cost of implementing such systems in the range of hospital and physician office settings, including hardware, software, and training costs.

(V) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

(iii) DEADLINES.—

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

(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2004.

(III) The Administrator shall develop and promulgate the national standards referred to in clause (ii) by not later than January 1, 2005.

(C) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 399O of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

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

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

(B) Subsection (c)(1) (relating to access to covered benefits).

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

(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

(e) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

(1) IN GENERAL.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with pre-

scription drug plans of the sponsor under this part in accordance with section 1852(f).

(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

(f) APPEALS.—

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

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

(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

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

(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

(2) ASSUMPTION OF FINANCIAL RISK.—

(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860H.

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

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

(b) CONTRACT REQUIREMENTS.—

(1) IN GENERAL.—The Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

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

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

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

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

(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

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

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

(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

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

(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

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

(1) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) has been met.

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

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

(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

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

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

(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2003, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

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

(e) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP

sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2003.

(f) RELATION TO STATE LAWS.—

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

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

SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

(b) ELEMENTS.—Such process shall include the following:

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

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

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

(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

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

(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or

Medicare+Choice organization offers all the qualifying plans in the area.

(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

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

(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1808(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term "qualifying plan" means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

SEC. 1860F. SUBMISSION OF BIDS.

(a) SUBMISSION OF BIDS AND RELATED INFORMATION.—

(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

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

(B) Information on the actuarial value of the coverage.

(C) Information on the bid for the coverage, including an actuarial certification of—

(i) the actuarial basis for such bid;

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

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

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

(3) REVIEW.—The Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

(b) UNIFORM BID.—

(1) IN GENERAL.—The bid for a prescription drug plan under this section may not vary among individuals enrolled in the plan in the same service area.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860A(c)(2)(B).

(c) COLLECTION.—

(1) USE AT BENEFICIARY'S OPTION OF WITHHOLDING FROM SOCIAL SECURITY PAYMENT AND USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a PDP sponsor shall permit each enrollee, at the enrollee's option, to make payment of premiums through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839. In the case in which an enrollee does not elect such option, a PDP sponsor may, in accordance with regulations, encourage enrollees to make payment of the premium established by the plan under this part through an electronic funds transfer mechanism, such as automatic charges of an account at a financial institution or a credit or debit card account. All such amounts shall be credited to the Medicare Prescription Drug Trust Fund.

(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a Medicare+Choice plan may be used to reduce the premium otherwise imposed under paragraph (1).

(3) PAYMENT OF PLANS.—PDP plans shall receive payment based on bid amounts in the same manner as Medicare+Choice organizations receive payment based on bid amounts under section 1853(a)(1)(A)(ii) except that such payment shall be made from the Medicare Prescription Drug Trust Fund.

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

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

(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term "standard prescription drug coverage" means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 175 PERCENT OF FEDERAL POVERTY LEVEL.—

(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as

defined in paragraph (4)) who is determined to have income that does not exceed 150 percent of the Federal poverty level, the individual is entitled under this section—

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

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

(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 150 percent, but does not exceed 175 percent, of the Federal poverty level, the individual is entitled under this section to—

(A) an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 150 percent of such level to 0 percent of such amount for individuals with incomes at 175 percent of such level; and

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

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

(4) DETERMINATION OF ELIGIBILITY.—

(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term "subsidy eligible individual" means an individual who—

(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

(ii) has income below 175 percent of the Federal poverty line; and

(iii) meets the resources requirement described in section 1905(p)(1)(C).

(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator. There are authorized to be appropriated to the So-

cial Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

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

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

(ii) the term "Federal poverty line" means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

(E) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term "qualified prescription drug coverage" includes a medicare supplemental policy described in section 1860H(b)(4).

(5) INDEXING DOLLAR AMOUNTS.—

(A) FOR 2006.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1)(B) or (2)(B) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

(b) PREMIUM SUBSIDY AMOUNT.—

(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark bid amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term "benchmark bid amount" means, with respect to qualified prescription drug coverage offered under—

(A) a prescription drug plan that—

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

(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the bid amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

(B) a Medicare+Choice plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

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

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

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

(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(4) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B) and (a)(2)(B).

(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

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

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

(e) RELATION TO MEDICAID PROGRAM.—

(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

(3) COORDINATION.—The Administrator shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to in-

suring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level of 65 percent, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

(1) DIRECT SUBSIDY.—In the case of an individual enrolled in a prescription drug plan, Medicare+Choice plan that provides qualified prescription drug coverage, or qualified retiree prescription drug plan, a direct subsidy equal to 35 percent of the total payments made by a qualifying entity for standard coverage under the respective plan.

(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of such total payments, for excess costs incurred in providing qualified prescription drug coverage—

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

(B) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage; and

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

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term "qualifying entity" means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

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

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

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

(c) REINSURANCE PAYMENT AMOUNT.—

(1) IN GENERAL.—Subject to subsection (d)(1)(B) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial copayment threshold specified in section 1860B(b)(2)(C), but does not exceed the initial coverage limit specified in section 1860B(b)(3), an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860B(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

(2) ALLOWABLE COSTS.—For purposes of this section, the term "allowable costs" means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term "gross covered prescription drug costs" means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

(4) INDEXING DOLLAR AMOUNTS.—

(A) AMOUNTS FOR 2005.—The dollar amounts applied under paragraph (1) for 2005 shall be the dollar amounts specified in such paragraph.

(B) FOR 2006.—The dollar amounts applied under paragraph (1) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

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

(d) ADJUSTMENT OF PAYMENTS.—

(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—

(A) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

(i) the total payments to be made (without regard to this subsection) during a year under subsections (a)(2) and (c); and

(ii) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments made under such subsection.

(e) PAYMENT METHODS.—

(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

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

(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term "qualified retiree prescription drug plan" means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, and the accuracy of payments made.

(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual

who is enrolled under a qualified retiree prescription drug plan unless the individual is—

(A) enrolled under this part;

(B) is covered under the plan; and

(C) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

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

(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term "employment-based retiree health coverage" means health insurance or other coverage of health care costs for individuals enrolled under this part (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

(B) SPONSOR.—The term "sponsor" means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(g) GENERAL DEFINITIONS.—For purposes of this section:

(1) QUALIFYING COVERED INDIVIDUAL.—The term "qualifying covered individual" means an individual who—

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

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

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

(2) COVERAGE YEAR.—The term "coverage year" means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.

(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the "Medicare Prescription Drug Trust Fund" (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

(b) PAYMENTS FROM TRUST FUND.—

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

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

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

(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from

time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

(c) DEPOSITS INTO TRUST FUND.—

(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

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

(1) COVERED OUTPATIENT DRUGS.—The term "covered outpatient drugs" is defined in section 1860B(f).

(2) INITIAL COVERAGE LIMIT.—The term "initial coverage limit" means such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term "Medicare Prescription Drug Trust Fund" means the Trust Fund created under section 1860I(a).

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

(5) PRESCRIPTION DRUG PLAN.—The term "prescription drug plan" means health benefits coverage that—

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

(B) provides qualified prescription drug coverage; and

(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term "qualified prescription drug coverage" is defined in section 1860B(a).

(7) STANDARD COVERAGE.—The term "standard coverage" is defined in section 1860B(b).

(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this

part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

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

(4) any reference to part C included a reference to this part.

PART [D] *E*—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Supplier

(d) The term "supplier" means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) * * *

(2)(A) * * *

* * * * * * *

(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes; [and]

(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

(i) * * *

* * * * * * *

(iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;

(W) an initial preventive physical examination (as defined in subsection (ww)); and

(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));

* * * * * * *

Hospice Care; Hospice Program

(dd)(1) * * *

(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals *and services described in section 1812(a)(5)*,

* * * * * * *

(5)(A) * * *

* * * * * * *

(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

* * * * * * *

Initial Preventive Physical Examination

(ww) The term "initial preventive physical examination" means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services specified by the Secretary in regulations.

Cholesterol and Other Blood Lipid Screening Test

(xx)(1) The term "cholesterol and other blood lipid screening test" means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d), **[**and**]**

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation**[**;**]**,

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

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

* * * * * * *

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and subparagraph (B), (F), (G), [or (H)] *(H), or (J)* of paragraph (1));

* * * * * * *

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B). In making a national coverage determination (as defined in paragraph (1)(B) of section 1869(f)) the Secretary shall ensure that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees [established under section 1114(f)] with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

* * * * * * *

(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

* * * * * * *

(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a

condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

* * * * * * *

[(i)**]** *(j)*(1) Any advisory committee appointed **[**under subsection (f)**]** to advise the Secretary on matters relating to the interpretation, application, or implementation of **[**section 1862(a)(1)**]** *subsection (a)(1)* shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5, United States Code, by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES*; ENROLLMENT PROCESSES*

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification, **[**and**]**

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) * * *

* * * * * * *

(iii) the percentage of such individuals who received such services from such provider (or another such provider)[.], *and*

(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction [or coinsurance], *coinsurance, or copayment* amount imposed pursuant to section 1813(a)(1), (a)(3), [or (a)(4)] *(a)(4), or (a)(5)*, section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5). In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

* * * * * * *

(b)(1) * * *

* * * * * * *

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

* * * * * * *

(h)(1)*(A)* Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.

* * * * * * *

(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) ENROLLMENT PROCESS.—

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance

of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

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EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

SEC. 1867. (a) * * *

* * * * * * *

(d) ENFORCEMENT.—

(1) * * *

* * * * * * *

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS.—In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) *or in terminating a hospital's participation under this title*, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. *Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.*

(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

PRACTICING PHYSICIANS ADVISORY COUNCIL*; MEDICARE PROVIDER OMBUDSMAN*

SEC. 1868. (a) *PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)* The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this [section] *subsection* referred to as the "Council") to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

[(b)] *(2)* The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

[(c)] *(3)* Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this title.

(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as "CMS").

(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.

DETERMINATIONS; APPEALS

SEC. 1869. (a) INITIAL DETERMINATIONS.—

(1) * * *

* * * * * * *

(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall include—

(A) the specific reasons for the determination, including—

(i) upon request, the provision of the policy, manual, or regulation used in making the determination; and

(ii) as appropriate in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination;

(B) the procedures for obtaining additional information concerning the determination or redetermination; and

(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.

The written notice on a redetermination shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both.

(b) APPEAL RIGHTS.—

(1) IN GENERAL.—

(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a)(1) shall be

entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and*, subject to paragraph (2),* to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). For purposes of the preceding sentence, any reference to the "Commissioner of Social Security" or the "Social Security Administration" in subsection (g) or (l) of section 205 shall be considered a reference to the "Secretary" or the "Department of Health and Human Services", respectively.

* * * * * * *

(F) EXPEDITED [PROCEEDINGS.—

[(i) EXPEDITED DETERMINATION] *DETERMINATIONS AND RECONSIDERATIONS*.—In the case of an individual who has received notice from a provider of services that such provider plans—

[(I)] *(i)* to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

[(II)] *(ii)* to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

[(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.]

* * * * * * *

(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the ap-

propriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

(C) ACCESS TO JUDICIAL REVIEW.—

(i) IN GENERAL.—If the appropriate review panel—

(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

(D) REVIEW PANELS.—For purposes of this subsection, a "review panel" is a panel consisting of 3 members (who

shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.

(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.

* * * * * * *

(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

(1) * * *

* * * * * * *

(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet all of the following requirements:

(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required by the Secretary to carry out the provisions of this subsection, and shall have [sufficient training and expertise in medical science and legal matters] *sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing* to make reconsiderations under this subsection.

(B) RECONSIDERATIONS.—

(i) IN GENERAL.—The qualified independent contractor shall review initial determinations. Where an initial determination is made with respect to whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)), such review shall include consideration of the facts and circumstances of the initial determination by a panel of physicians or other appropriate health care professionals and any decisions with respect to the reconsideration shall be based on applicable information, including clinical experience *(including the medical records of the individual involved)* and medical, technical, and scientific evidence.

* * * * * * *

[(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

[(i) PHYSICIANS AND HEALTH CARE PROFESSIONAL.—No physician or health care professional under the employ of a qualified independent contractor may review—

[(I) determinations regarding health care services furnished to a patient if the physician or health care professional was directly responsible for furnishing such services; or

[(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the family of the physician or health care professional has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

[(ii) FAMILY DESCRIBED.—For purposes of this paragraph, the family of a physician or health care professional includes the spouse (other than a spouse who is legally separated from the physician or health care professional under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents of the physician or health care professional.]

(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).

(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing, *be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)* and shall include a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision, *and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section* and in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical and scientific rationale for the decision.

* * * * * * *

(I) DATA COLLECTION.—

(i) * * *

(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

(I) * * *

* * * * * * *

(III) Situations suggesting the need for changes in national or local coverage [policy] *determination*.

(IV) Situations suggesting the need for changes in local [medical review policies] *coverage determinations*.

(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) [prepare] *submit* such information as is required for an appeal of a decision of the contractor [with respect to a reconsideration to the Secretary for a hearing, including as necessary, explanations of issues involved in the decision and relevant policies], and (ii) participate in such hearings as required by the Secretary.

(K) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

(I) is not a related party (as defined in subsection (g)(5));

(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

(III) does not otherwise have a conflict of interest with such a party.

(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.

* * * * * * *

(d) DEADLINES FOR HEARINGS BY THE SECRETARY*; NOTICE*.—

(1) * * *

* * * * * * *

(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the decision; and

(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.

* * * * * * *

(f) REVIEW OF COVERAGE DETERMINATIONS.—

(1) * * *

(2) LOCAL COVERAGE DETERMINATION.—

(A) IN GENERAL.—Review of any local coverage determination shall be subject to the following limitations:

(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge [of the Social Security Administration]. The administrative law judge—

(I) * * *

* * * * * * *

(4) PENDING NATIONAL COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an aggrieved person (as described in paragraph (5)) may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request (notwithstanding the receipt by the Secretary of new evidence (if any) during such 90-day period), the Secretary shall take one of the following actions:

(i) * * *

* * * * * * *

(iv) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in [subclause (I), (II), or (III)] *clause (i), (ii), or (iii)*.

(B) DEEMED ACTION BY THE SECRETARY.—In the case of an action described in [clause (i)(IV)] *subparagraph (A)(iv)*, if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in [clause (i)(III)] *subparagraph (A)(iii)* as of the deadline.

(C) EXPLANATION OF DETERMINATION.—When issuing a determination under [clause (i)] *subparagraph (A)*, the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than [subclause (IV)] *clause (iv)*) is deemed to be a national coverage determination for purposes of review under [subparagraph (A)] *paragraph (1)(A)*.

* * * * * * *

(g) QUALIFICATIONS OF REVIEWERS.—

(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

(A) each individual conducting a review shall meet the qualifications of paragraph (2);

(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a "reviewing professional"), each reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

(2) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

(i) not be a related party (as defined in paragraph (5));

(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

(iii) not otherwise have a conflict of interest with such a party.

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

(I) the individual is not involved in the provision of items or services in the case under review;

(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term "participation agreement" means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

(5) RELATED PARTY DEFINED.—For purposes of this section, the term "related party" means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

(B) The individual (or authorized representative).

(C) The health care professional that provides the items or services involved in the case.

(D) The institution at which the items or services (or treatment) involved in the case are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

(F) Any other party determined under any regulations to have a substantial interest in the case involved.

(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

(1) ESTABLISHMENT OF PROCESS.—

(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be

paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

(3) REQUEST FOR PRIOR DETERMINATION.—

(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

(4) RESPONSE TO REQUEST.—

(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

(i) the item or service is so covered;

(ii) the item or service is not so covered; or

(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to

whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

(5) EFFECT OF DETERMINATIONS.—

(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

(6) LIMITATION ON FURTHER REVIEW.—

(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

(i) decides not to seek a prior determination under this subsection with respect to items or services; or

(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services,

there shall be no prior determination under this subsection with respect to such items or services.

* * * * * * *

REGULATIONS

SEC. 1871. (a)(1) * * *

* * * * * * *

(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.

(4) If the Secretary publishes notice of proposed rulemaking relating to a regulation (including an interim final regulation), insofar as such final regulation includes a provision that is not a logical outgrowth of such notice of proposed rulemaking, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

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(d)(1) Subject to paragraph (2), the Secretary shall issue proposed or final (including interim final) regulations to carry out this title only on one business day of every month.

(2) The Secretary may issue a proposed or final regulation described in paragraph (1) on any other day than the day described in paragraph (1) if the Secretary—

(A) finds that issuance of such regulation on another day is necessary to comply with requirements under law; or

(B) finds that with respect to that regulation the limitation of issuance on the date described in paragraph (1) is contrary to the public interest.

If the Secretary makes a finding under this paragraph, the Secretary shall include such finding, and brief statement of the reasons for such finding, in the issuance of such regulation.

(3) The Secretary shall coordinate issuance of new regulations described in paragraph (1) relating to a category of provider of services or suppliers based on an analysis of the collective impact of regulatory changes on that category of providers or suppliers.

(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.

(2)(A) If—

(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any

amount) if the provider of services or supplier reasonably relied on such guidance.

(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.

(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

(2) In preparing a report under paragraph (1), the Secretary shall collect—

(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

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CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

SEC. 1874A. (a) AUTHORITY.—

(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

(A) the entity has demonstrated capability to carry out such function;

(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(C) the entity has sufficient assets to financially support the performance of such function; and

(D) the entity meets such other requirements as the Secretary may impose.

(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

(A) IN GENERAL.—The term "medicare administrative contractor" means an agency, organization, or other person with a contract under this section.

(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the "appropriate" medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

(5) RELATIONSHIP TO MIP CONTRACTS.—

(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5)

(relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

(b) CONTRACTING REQUIREMENTS.—

(1) USE OF COMPETITIVE PROCEDURES.—

(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

(3) PERFORMANCE REQUIREMENTS.—

(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements,

the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

(B) CONSULTATION.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

(ii) shall be used for evaluating contractor performance under the contract; and

(iii) shall be consistent with the written statement of work provided under the contract.

(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(c) TERMS AND CONDITIONS.—

(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by the individual under this section.

(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless in connection with such payment or in the supervision of or selection of such officer the medicare administrative contractor acted with gross negligence.

(4) INDEMNIFICATION BY SECRETARY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.

(e) REQUIREMENTS FOR INFORMATION SECURITY.—

(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under section 3534(b)(2) of title 44, United States Code (other than requirements under subparagraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

(2) INDEPENDENT AUDITS.—

(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

(ii) test the effectiveness of information security control techniques for an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines.

(B) DEADLINE FOR INITIAL EVALUATION.—

(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent

evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

(C) REPORTS ON EVALUATIONS.—

(i) TO THE INSPECTOR GENERAL.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services.

(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations.

(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

(4) MONITORING OF CONTRACTOR RESPONSES.—

(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

(B) DEVELOPMENT OF STANDARDS.—

(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

(h) CONDUCT OF PREPAYMENT REVIEW.—

(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term "random prepayment review" means a demand for the production of records or documentation absent cause with respect to a claim.

(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by

that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

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PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

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(h)(1) * * *

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(5)(A) * * *

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(C)*(i)* The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2004*, except (subject to clause (ii)) in the case of a contract for an area which is not covered in the service area of 1 or more coordinated care Medicare+Choice plans under part C.*

(ii) In the case in which—

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

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

(III) all Medicare+Choice plans subsequently terminate coverage in such area;

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

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MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

(b)(1) * * *

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(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility

or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities. [The Secretary] *Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary* shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) * * *

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CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

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(v) COVERAGE OF PRESCRIPTION DRUGS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

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

(A) IN GENERAL.—The issuer of a medicare supplemental policy—

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

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

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

(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as "H", "I", or "J" under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Modernization and Prescription Drug Act of 2002, with respect to policies issued to individuals who are enrolled under part D, the changes in standards shall only provide for substituting for the benefit packages that included coverage for prescription drugs two benefit packages that may provide for coverage of cost-sharing with respect to qualified prescription drug coverage under such part, except that such coverage may not cover the prescription drug deductible under such part. The two benefit packages shall be consistent with the following:

(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

(i) Coverage of 50 percent of the cost-sharing otherwise applicable, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

(ii) No coverage of the part B deductible.

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

(iv) A limitation on annual out-of-pocket expenditures to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

(i) Substitute "75 percent" for "50 percent" in clause (i) of such subparagraph.

(ii) Substitute "$2,000" for "$4,000" in clause (iv) of such subparagraph.

(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

(b)(1) * * *

* * * * * * *

(3)(A) * * *

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) * * *

* * * * * * *

[(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas, and]

(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and

* * * * * * *

(d)(1) * * *

* * * * * * *

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hos-

pitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) * * *

* * * * * * *

[(iv) For discharges] *(iv)(I) Subject to the succeeding provisions of this clause, for discharges* occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring during fiscal year 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the average standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area within the United States and within each region equal to the average standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i).

* * * * * * *

(5)(A) * * *

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) * * *

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) − 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. For discharges occurring—

(I) * * *

* * * * * * *

(VI) during fiscal year 2002, "c" is equal to 1.6; [and]

(VII) during fiscal year 2003, "c" is equal to 1.47;

(VIII) during fiscal year 2004, "c" is equal to 1.45; and

[(VII)] *(IX)* on or after October 1, [2002] *2004*, "c" is equal to 1.35.

* * * * * * *

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. *The provisions of clause (i) of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection, but the provisions of clause (ii) of such subparagraph shall not apply.*

* * * * * * *

(F)(i) * * *

* * * * * * *

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) * * *

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, *subject to clause (xiv) and* for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

* * * * * * *

(viii) [The formula] *Subject to clause (xiv), the formula* used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula:(P–30)(.6) + 4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

* * * * * * *

(x) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xi) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xii) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xiii) [For purposes] *Subject to clause (xiv), for purposes* of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) * * *

* * * * * * *

(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

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

(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 80 percent, for each subsequent year (through 2006) is the old blend proportion under this subclause for the previous year minus 20 percentage points, and for each year beginning with 2007 is 0 percent.

* * * * * * *

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). *Such mechanism shall be modified to meet the requirements of clause (viii).*

(ii) The mechanism established pursuant to clause (i) shall—

(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate *(applying a threshold specified by the Secretary that is the lesser of 50 percent of the national average standardized amount for operating costs of inpatient hospital services for all hospitals and all diagnosis-related groups or one standard deviation for the diagnosis-related group involved)*;

* * * * * * *

(III) subject to paragraph (4)(C)(iii), provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology *(based on the marginal rate applied to costs under subparagraph (A))*; and

* * * * * * *

(vi)*(I)* For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a "new medical service or technology" if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of a significant sample of specific discharges in which the service or technology has been used.

(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 or 526 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or

is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act.

(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, no add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

* * * * * * *

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) [for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)] *the applicable Puerto Rico percentage (specified in subparagraph (E))* of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

(ii) [for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)] *the applicable Federal percentage (specified in subparagraph (E))* of the discharge-weighted average of—

(I) * * *

* * * * * * *

(E) For purposes of subparagraph (A), for discharges occurring—

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

(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 45 percent and the applicable Federal percentage is 55 percent;

(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 40 percent and the applicable Federal percentage is 60 percent;

(v) during fiscal year 2006, the applicable Puerto Rico percentage is 35 percent and the applicable Federal percentage is 65 percent;

(vi) during fiscal year 2007, the applicable Puerto Rico percentage is 30 percent and the applicable Federal percentage is 70 percent; and

(vii) on or after October 1, 2007, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.

* * * * * * *

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) * * *

* * * * * * *

(D) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—

(i) * * *

* * * * * * *

(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

(I) FREEZE FOR FISCAL YEARS 2001 [AND 2002] *THROUGH 2012*.—For a cost reporting period beginning [during fiscal year 2001 or fiscal year 2002] *during the period beginning with fiscal year 2001*

and ending with fiscal year 2012, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, [subject to subclause (III),] the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

[(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.—For a cost reporting period beginning during fiscal year 2003, fiscal year 2004, or fiscal year 2005, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.]

[(III)] *(II)* NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) [or (II)] reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

* * * * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—

(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, *subject to subparagraph (I),* the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

* * * * * * *

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G), *subject to subparagraph (I),* prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

* * * * * * *

(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

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

(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

(II) REFERENCE PERIODS DEFINED.—In this clause, the term "reference periods" means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

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

(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

(ii) REDISTRIBUTION.—

(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an in-

crease under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

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

(I) RESIDENT LEVEL.—The term "resident level" means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and

(H) on the resident level for the hospital determined without regard to this subparagraph.

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

* * * * * * *

(e) PROSPECTIVE PAYMENT.—

(1) * * *

* * * * * * *

[(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

[(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

[(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

[(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

[(ii) is a hospital-based facility; and

[(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

[(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

[(i) is entitled to benefits under part A; and

[(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.]

(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.

PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.

(b) ENHANCED EDUCATION AND TRAINING.—

(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2004 and 2005 and such sums as may be necessary for succeeding fiscal years.

(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

(1) provides answers in an easily accessible format to frequently asked questions, and

(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).

(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

(g) DEFINITIONS.—For purposes of this section, the term "medicare contractor" includes the following:

(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.

* * * * * * *

MEDICARE INTEGRITY PROGRAM

SEC. 1893. (a) * * *

* * * * * * *

(f) RECOVERY OF OVERPAYMENTS.—

(1) USE OF REPAYMENT PLANS.—

(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

(B) HARDSHIP.—

(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

(ii) there is an indication of fraud or abuse committed against the program.

(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

(2) LIMITATION ON RECOUPMENT.—

(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term "medicare contractor" has the meaning given such term in section 1889(g).

(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may

request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5) CONSENT SETTLEMENT REFORMS.—

(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

(i) communicate to the provider of services or supplier—

(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

(II) the nature of the problems identified in such evaluation; and

(III) the steps that the provider of services or supplier should take to address the problems; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term "consent settlement" means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases

in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

(7) PAYMENT AUDITS.—

(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

* * * * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) * * *

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT BASIS.—

[(A) INITIAL BASIS.—

[(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

[(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect.

[(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).

[(III) For periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

[(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 2000.]

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

(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

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

(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(B) ANNUAL UPDATE.—

(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for ⟦each fiscal year (beginning with fiscal year 2002)⟧ *fiscal year 2002 and for each subsequent year (beginning with 2003)* in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year *or year* involved.

(ii) HOME HEALTH APPLICABLE INCREASE PERCENTAGE.—For purposes of this subparagraph, the term "home health applicable increase percentage" means, with respect to—

(I) ⟦each of fiscal years 2002 and 2003⟧ *fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;*

(II) 2003, ⟦the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points⟧ *2.0 percentage points*; ⟦or⟧

(III) 2004, 1.1 percentage points;

(IV) 2005, 2.7 percentage points; or

⟦(II)⟧ *(V)* any subsequent ⟦fiscal⟧ year, the home health market basket percentage increase.

(iii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term "home health market basket percentage increase" means, with respect to a fiscal year *or year*, a percentage (estimated by the Secretary before the beginning of the fiscal year *or year*) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year *or year*.

(iv) ADJUSTMENT FOR CASE MIX CHANGES.—Insofar as the Secretary determines that the adjustments

under paragraph (4)(A)(i) for a previous fiscal year *or year* (or estimates that such adjustments for a future fiscal year *or year*) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year *or year* that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years *or years* so as to eliminate the effect of such coding or classification changes.

* * * * * * *

(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year *or year* may not exceed **[**5**]** *3* percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title; **[**and**]**

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

(A) * * *

* * * * * * *

(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section**[**.**]***; and*

(66) provide for making eligibility determinations under section 1935(a).

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this

title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance

under the State plan, *reduced by the amount computed under section 1935(c)(1) for the State and the quarter*; plus

* * * * * * *

SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a) subject to subsection (e), a State shall—

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

(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

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

(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

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

(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

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

(ii) For purposes of clause (i), the "applicable percent" for—

(I) 2006 is 20 percent; or

(II) a subsequent year is the applicable percent under this clause for the previous year increased by 10 percentage points.

(C) For expenditures attributable to costs incurred after 2013, the otherwise applicable Federal matching rate shall be increased to 100 percent.

(2) COORDINATION.—The State shall provide the Administrator with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.

(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

(1) IN GENERAL.—For purposes of section 1903(a)(1) subject to subsection (e), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

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

(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the "phase-out proportion" for a calendar quarter in—

(A) 2005 is 90 percent;

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

(C) a year after 2013 is 0 percent.

(d) ADDITIONAL PROVISIONS.—

(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.

(e) TREATMENT OF TERRITORIES.—

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

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

(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as

increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

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

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

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

(3) INCREASED AMOUNT.—

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

(i) the aggregate amount specified in subparagraph (B); and

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

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

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

(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860B(b)(5) for the year involved.

(4) REPORT.—The Administrator shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Administrator deems appropriate.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1935.] *1936.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) * * *

* * * * * * *

SECTION 4018 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

SEC. 4018. SPECIAL RULES.

(a) * * *

(b) EXTENSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—

(1) The Secretary of Health and Human Services shall extend without interruption, through [the date that is 30 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997] *December 31, 2004*, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions

(other than duration of the project) established under that section (as amended by paragraph (2) of this subsection).

* * * * * * *

SECTION 9215 OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

SEC. 9215. EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

(a) The Secretary of Health and Human Services shall extend through December 31, 1997, approval of four municipal health services demonstration projects (located in Baltimore, Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967. The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, costs to the medicaid program and other payers, access to care, outcomes, beneficiary satisfaction, utilization differences among the different populations served by the projects, and such other factors as may be appropriate. Subject to subsection (c), the Secretary may further extend such demonstration projects through **[**December 31, 2004, but only with respect to individuals who received at least one service during the period beginning on January 1, 1996, and ending on the date of the enactment of the Balanced Budget Act of 1997.**]** *December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.*

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MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

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TITLE III—PROVISIONS RELATING TO PART A

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Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

* * * * * * *

SEC. 312. INCREASE IN NURSING COMPONENT OF PPS FEDERAL RATE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall increase by 16.66 percent the nursing component of the casemix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed.

Reg. 46770) and as subsequently updated, effective for services furnished on or after April 1, 2001, and before October 1, 2002. *The Secretary of Health and Human Services shall increase by 12, 10, and 8 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770) and as subsequently updated under section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effective for services furnished during fiscal years 2003, 2004, and 2005, respectively.*

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TITLE IV—PROVISIONS RELATING TO PART B

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Subtitle C—Other Services

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SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) UPDATE.—

(1) * * *

(2) PROHIBITION ON EXCEPTIONS.—

(A) IN GENERAL.—Subject to subparagraphs (B) [and (C)]*, (C), and (D)*, the Secretary of Health and Human Services may not provide for an exception under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) on or after December 31, 2000.

(B) DEADLINE FOR NEW APPLICATIONS.—[In the case] *Subject to subparagraph (D), in the case* of a facility that during 2000 did not file for an exception rate under such section, the facility may submit an application for an exception rate by not later than July 1, 2001.

* * * * * * *

(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term "pediatric facility" means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.

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TITLE V—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

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SEC. 508. TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) [24-MONTH INCREASE BEGINNING APRIL 1, 2001] *IN GENERAL*.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after April 1, 2001, and before [April 1, 2003] *January 1, 2005*, the Secretary of Health and Human Services shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

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Subtitle E—Other Provisions

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SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

(a) * * *

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(c) EFFECTIVE DATE.—This section shall apply to services furnished during the [2-year period] *3-year period* beginning on January 1, 2001.

* * * * * * *

SEC. 547. CLARIFICATION OF APPLICATION OF TEMPORARY PAYMENT INCREASES FOR 2001.

(a) * * *

* * * * * * *

(c) HOME HEALTH SERVICES.—

(1) * * *

(2) TEMPORARY INCREASE FOR RURAL HOME HEALTH SERVICES.—The payment increase provided under section 508(a) for [the period beginning on April 1, 2001, and ending on September 30, 2002,] *a period under such section* shall not apply to episodes and visits ending after such period, and shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

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TITLE 5, UNITED STATES CODE

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PART III—EMPLOYEES

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Subpart D—Pay and Allowances

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CHAPTER 53—PAY RATES AND SYSTEMS

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SUBCHAPTER II—EXECUTIVE SCHEDULE PAY RATES

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§ 5314. Positions at level III

Level III of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

Solicitor General of the United States.

Under Secretary of Commerce, Under Secretary of Commerce for Economic Affairs, Under Secretary of Commerce for Export Administration and Under Secretary of Commerce for Travel and Tourism.

* * * * * * *

Administrator of the Centers for Medicare & Medicaid Services .

Administrator of the Medicare Benefits Administration.

§ 5315. Positions at level IV

Level IV of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

Deputy Administrator of General Services.

* * * * * * *

[Administrator of the Health Care Financing Administration.**]**

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FEDERAL FOOD, DRUG, AND COSMETIC ACT

* * * * * * *

CHAPTER III—PROHIBITED ACTS AND PENALTIES

PROHIBITED ACTS

SEC. 301. The following acts and the causing thereof are hereby prohibited:

(a) * * *

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(bb) The failure to post information required under section 503B(b)(2) or for knowingly making a materially false statement when posting such information as required under such section or violating section 503B(b)(4).

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CHAPTER V—DRUGS AND DEVICES

SUBCHAPTER A—DRUGS AND DEVICES

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SEC. 503B. INTERNET PRESCRIPTION DRUG SALES.

(a) DEFINITIONS.—For purposes of this section:

(1) CONSUMER.—The term "consumer" means a person (other than an entity licensed or otherwise authorized under Federal or State law as a pharmacy or to dispense or distribute prescription drugs) that purchases or seeks to purchase prescription drugs through the Internet.

(2) HOME PAGE.—The term "home page" means the entry point or main web page for an Internet site.

(3) INTERNET.—The term "Internet" means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio, including electronic mail.

(4) INTERSTATE INTERNET SELLER.—

(A) IN GENERAL.—The term "interstate Internet seller" means a person whether in the United States or abroad, that engages in, offers to engage in, or causes the delivery or sale of a prescription drug through the Internet and has such drug delivered directly to the consumer via the Postal Service, or any private or commercial interstate carrier to a consumer in the United States who is residing in a State other than the State in which the seller's place of business is located. This definition excludes a person who only delivers a prescription drug to a consumer, such as an interstate carrier service.

(B) EXEMPTION.—With respect to the consumer involved, the term "interstate Internet seller" does not include a person described in subparagraph (A) whose place of business is located within 75 miles of the consumer.

(5) LINK.—The term "link" means either a textual or graphical marker on a web page that, when clicked on, takes the consumer to another part of the Internet, such as to another web page or a different area on the same web page, or from an electronic message to a web page.

(6) PHARMACY.—The term "pharmacy" means any place licensed or otherwise authorized as a pharmacy under State law.

(7) PRESCRIBER.—The term "prescriber" means an individual, licensed or otherwise authorized under applicable Federal and State law to issue prescriptions for prescription drugs.

(8) PRESCRIPTION DRUG.—The term "prescription drug" means a drug under section 503(b)(1).

(9) VALID PRESCRIPTION.—The term "valid prescription" means a prescription that meets the requirements of section 503(b)(1) and other applicable Federal and State law.

(10) WEB SITE; SITE.—The terms "web site" and "site" mean a specific location on the Internet that is determined by Internet protocol numbers or by a domain name.

(b) REQUIREMENTS FOR INTERSTATE INTERNET SELLERS.—

(1) IN GENERAL.—Each interstate Internet seller shall comply with the requirements of this subsection with respect to the sale of, or the offer to sell, prescription drugs through the Internet and shall at all times display on its web site information in accordance with paragraph (2).

(2) WEB SITE DISCLOSURE INFORMATION.—An interstate Internet seller shall post in a visible and clear manner (as determined by regulation) on the home page of its web site, or on a page directly linked to such home page—

(A) the street address of the interstate Internet seller's place of business, and the telephone number of such place of business;

(B) each State in which the interstate Internet seller is licensed or otherwise authorized as a pharmacy, or if the interstate Internet seller is not licensed or otherwise authorized by a State as a pharmacy, each State in which the interstate Internet seller is licensed or otherwise authorized to dispense prescription drugs, and the type of State license or authorization;

(C) in the case of an interstate Internet seller that makes referrals to or solicits on behalf of a prescriber, the name of each prescriber, the street address of each such prescriber's place of business, the telephone number of such place of business, each State in which each such prescriber is licensed or otherwise authorized to prescribe prescription drugs, and the type of such license or authorization; and

(D) a statement that the interstate Internet seller will dispense prescription drugs only upon a valid prescription.

(3) DATE OF POSTING.—Information required to be posted under paragraph (2) shall be posted by an interstate Internet seller—

(A) not later than 90 days after the effective date of this section if the web site of such seller is in operation as of such date; or

(B) on the date of the first day of operation of such seller's web site if such site goes into operation after such date.

(4) QUALIFYING STATEMENTS.—An interstate Internet seller shall not indicate in any manner that posting disclosure information on its web site signifies that the Federal Government has made any determination on the legitimacy of the interstate Internet seller or its business.

(5) DISCLOSURE TO STATE LICENSING BOARDS.—An interstate Internet seller licensed or otherwise authorized to dispense prescription drugs in accordance with applicable State law shall notify each State entity that granted such licensure or authorization that it is an interstate Internet seller, the name of its business, the Internet address of its business, the street address of its place of business, and the telephone number of such place of business.

(6) REGULATIONS.—The Secretary is authorized to promulgate such regulations as are necessary to carry out the provisions of this subsection. In issuing such regulations, the Secretary—

(A) shall take into consideration disclosure formats used by existing interstate Internet seller certification programs; and

(B) shall in defining the term "place of business" include provisions providing that such place is a single location at which employees of the business perform job functions, and not a post office box or similar locale.

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PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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PART P—ADDITIONAL PROGRAMS

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SEC. 399O. GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS.

(a) IN GENERAL.—The Secretary is authorized to make grants for the purpose of assisting health care providers who prescribe drugs and biologicals in implementing electronic prescription programs described in section 1860C(d)(3) of the Social Security Act.

(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal year 2004, such sums as may be appropriate to carry out this section.

TITLE IV—NATIONAL RESEARCH INSTITUTES

PART A—NATIONAL INSTITUTES OF HEALTH

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OFFICE OF RARE DISEASES

SEC. 404F. (a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of

Rare Diseases (in this section referred to as the "Office"), which shall be headed by a Director (in this section referred to as the "Director"), appointed by the Director of NIH.

(b) DUTIES.—

(1) IN GENERAL.—The Director of the Office shall carry out the following:

(A) The Director shall recommend an agenda for conducting and supporting research on rare diseases through the national research institutes and centers. The agenda shall provide for a broad range of research and education activities, including scientific workshops and symposia to identify research opportunities for rare diseases.

(B) The Director shall, with respect to rare diseases, promote coordination and cooperation among the national research institutes and centers and entities whose research is supported by such institutes.

(C) The Director, in collaboration with the directors of the other relevant institutes and centers of the National Institutes of Health, may enter into cooperative agreements with and make grants for regional centers of excellence on rare diseases in accordance with section 404G.

(D) The Director shall promote the sufficient allocation of the resources of the National Institutes of Health for conducting and supporting research on rare diseases.

(E) The Director shall promote and encourage the establishment of a centralized clearinghouse for rare and genetic disease information that will provide understandable information about these diseases to the public, medical professionals, patients and families.

(F) The Director shall biennially prepare a report that describes the research and education activities on rare diseases being conducted or supported through the national research institutes and centers, and that identifies particular projects or types of projects that should in the future be conducted or supported by the national research institutes and centers or other entities in the field of research on rare diseases.

(G) The Director shall prepare the NIH Director's annual report to Congress on rare disease research conducted by or supported through the national research institutes and centers.

(2) PRINCIPAL ADVISOR REGARDING ORPHAN DISEASES.—With respect to rare diseases, the Director shall serve as the principal advisor to the Director of NIH and shall provide advice to other relevant agencies. The Director shall provide liaison with national and international patient, health and scientific organizations concerned with rare diseases.

(c) DEFINITION.—For purposes of this section, the term "rare disease" means any disease or condition that affects less than 200,000 persons in the United States.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as already have been appropriated for fiscal year 2002, and $4,000,000 for each of the fiscal years 2003 through 2006.

RARE DISEASE REGIONAL CENTERS OF EXCELLENCE

SEC. 404G. (a) COOPERATIVE AGREEMENTS AND GRANTS.—

(1) IN GENERAL.—The Director of the Office of Rare Diseases (in this section referred to as the "Director"), in collaboration with the directors of the other relevant institutes and centers of the National Institutes of Health, may enter into cooperative agreements with and make grants to public or private nonprofit entities to pay all or part of the cost of planning, establishing, or strengthening, and providing basic operating support for regional centers of excellence for clinical research into, training in, and demonstration of diagnostic, prevention, control, and treatment methods for rare diseases.

(2) POLICIES.—A cooperative agreement or grant under paragraph (1) shall be entered into in accordance with policies established by the Director of NIH.

(b) COORDINATION WITH OTHER INSTITUTES.—The Director shall coordinate the activities under this section with similar activities conducted by other national research institutes, centers and agencies of the National Institutes of Health and by the Food and Drug Administration to the extent that such institutes, centers and agencies have responsibilities that are related to rare diseases.

(c) USES FOR FEDERAL PAYMENTS UNDER COOPERATIVE AGREEMENTS OR GRANTS.—Federal payments made under a cooperative agreement or grant under subsection (a) may be used for—

(1) staffing, administrative, and other basic operating costs, including such patient care costs as are required for research;

(2) clinical training, including training for allied health professionals, continuing education for health professionals and allied health professions personnel, and information programs for the public with respect to rare diseases; and

(3) clinical research and demonstration programs.

(d) PERIOD OF SUPPORT; ADDITIONAL PERIODS.—Support of a center under subsection (a) may be for a period of not to exceed 5 years. Such period may be extended by the Director for additional periods of not more than 5 years if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period should be extended.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as already have been appropriated for fiscal year 2002, and $20,000,000 for each of the fiscal years 2003 through 2006.

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TITLE VII—HEALTH PROFESSIONS EDUCATION

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PART E—HEALTH PROFESSIONS AND PUBLIC HEALTH WORKFORCE

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Subpart 3—Pharmacist Workforce Programs

SEC. 771. PUBLIC SERVICE ANNOUNCEMENTS.

(a) PUBLIC SERVICE ANNOUNCEMENTS.—

(1) IN GENERAL.—The Secretary shall develop and issue public service announcements that advertise and promote the pharmacist profession, highlight the advantages and rewards of being a pharmacist, and encourage individuals to enter the pharmacist profession.

(2) METHOD.—The public service announcements described in subsection (a) shall be broadcast through appropriate media outlets, including television or radio, in a manner intended to reach as wide and diverse an audience as possible.

(b) STATE AND LOCAL PUBLIC SERVICE ANNOUNCEMENTS.—

(1) IN GENERAL.—The Secretary shall award grants to entities to support State and local advertising campaigns through appropriate media outlets to promote the pharmacist profession, highlight the advantages and rewards of being a pharmacist, and encourage individuals to enter the pharmacist profession.

(2) USE OF FUNDS.—An entity that receives a grant under subsection (a) shall use funds received through such grant to acquire local television and radio time, place advertisements in local newspapers, and post information on billboards or on the Internet, in order to—

(A) advertise and promote the pharmacist profession;

(B) promote pharmacist education programs;

(C) inform the public of public assistance regarding such education programs;

(D) highlight individuals in the community that are presently practicing as pharmacists to recruit new pharmacists; and

(E) provide any other information to recruit individuals for the pharmacist profession.

(3) METHOD.—The campaigns described in subsection (a) shall be broadcast on television or radio, placed in newspapers as advertisements, or posted on billboards or the Internet, in a manner intended to reach as wide and diverse an audience as possible.

SEC. 772. DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall establish a demonstration project to enhance the participation of individuals who are pharmacists in the National Health Service Corps Loan Repayment Program described in section 338B.

(b) SERVICES.—Services that may be provided by pharmacists pursuant to the demonstration project established under this section include medication therapy management services to assure that medications are used appropriately by patients, to enhance patients' understanding of the appropriate use of medications, to increase pa-

tients' adherence to prescription medication regimens, to reduce the risk of adverse events associated with medications, and to reduce the need for other costly medical services through better management of medication therapy. Such services may include case management, disease management, drug therapy management, patient training and education, counseling, drug therapy problem resolution, medication administration, the provision of special packaging, or other services that enhance the use of prescription medications.

(c) PROCEDURE.—The Secretary may not provide assistance to an individual under this section unless the individual agrees to comply with all requirements described in sections 338B and 338D.

(d) LIMITATIONS.—The demonstration project described in this section shall provide for the participation of—

(1) individuals to provide services in rural and urban areas; and

(2) enough individuals to allow the Secretary to properly analyze the effectiveness of such project.

(e) DESIGNATIONS.—The demonstration project described in this section, and any pharmacists who are selected to participate in such project, shall not be considered by the Secretary in the designation of a health professional shortage area under section 332 during fiscal years 2003 through 2005.

(f) RULE OF CONSTRUCTION.—This section shall not be construed to require any State to participate in the project described in this section.

(g) REPORT.—The Secretary shall prepare and submit a report on the project to—

(1) the Committee on Health, Education, Labor, and Pensions of the Senate;

(2) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the Senate;

(3) the Committee on Energy and Commerce of the House of Representatives; and

(4) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the House of Representatives.

SEC. 773. INFORMATION TECHNOLOGY.

(a) GRANTS AND CONTRACTS.—The Secretary may make awards of grants or contracts to qualifying schools of pharmacy for the purpose of assisting such schools in acquiring and installing computer-based systems to provide pharmaceutical education. Education provided through such systems may be graduate education, professional education, or continuing education. The computer-based systems may be designed to provide on-site education, or education at remote sites (commonly referred to as distance learning), or both.

(b) QUALIFYING SCHOOL OF PHARMACY.—For purposes of this section, the term "qualifying school of pharmacy" means a school of pharmacy (as defined in section 799B) that requires students to serve in a clinical rotation in which pharmacist services are part of the curriculum.

SEC. 774. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out this subpart, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2003 through 2006.

DISSENTING VIEWS

The bill ordered reported from this Committee solely by its Republican Members is a political placebo designed to provide political cover to politicians instead of prescription drug coverage to Medicare beneficiaries. This legislation is little more than a $310 billion give-away to the private insurance industry and pharmaceutical companies.

The Republican bill falls far short of what is needed to provide meaningful prescription drug coverage to the nation's 40 million senior citizens and individuals with disabilities who depend on Medicare. The Congressional Budget Office estimates that drug spending on behalf of beneficiaries will total $1.6 trillion between 2005—the first year of the Republican drug benefit proposal—and 2012. Yet the $310 billion Committee-passed bill covers only 19 percent of the anticipated spending during that time period. This means that most Medicare beneficiaries will continue to pay far more for prescription drugs than they can afford.

Republicans claim that they can't afford to do more. They criticize our proposal for costing too much. Don't be fooled. It's a matter of priorities. Last year, they squandered the surplus on tax breaks for the wealthy, and they're at it again this year. In 2012 alone, the tax cut would cost $229 billion—more than three times the amount that Republican are willing to dedicate to prescription drugs.

The Republican drug proposal is nothing more than an empty promise and campaign rhetoric. It doesn't guarantee any specific benefit. It gives private plans free reign to charge beneficiaries whatever they want for premiums. It has a gaping hole in coverage that would force approximately half of all beneficiaries—including millions of low-income senior citizens and individuals with disabilities—to pay 100 percent of their drug costs at a time when their needs are increasing. It uses a cynical, technical calculation of out-of-pocket costs that will prevent family members from helping beneficiaries pay for needed medications and discourage employers from offering wrap-around coverage. It fails to assure access to needed medications by allowing private drug plans to decide which drugs to cover, and it allows the private drug plans to exclude neighborhood pharmacies.

The Committee bill also lays the groundwork for the Republicans' ultimate goal to privatize Medicare. The new drug program relies on a risky, untested private insurance scheme that sets the stage for broader changes in Medicare. It moves Medicare+Choice to a competition-based program in 2005, and conducts a premium-support demonstration under which fee-for-service premiums could rise dramatically. Finally, it creates a new bureaucracy to regulate the Medicare+Choice and private drug plans that both disadvantages

the agency which oversees traditional fee-for-service Medicare and stacks the deck at the new agency in favor of the private plans.

The Democratic plan: Real choices real coverage

By rejecting the Democratic substitute, the Committee missed its opportunity to provide an affordable, comprehensive prescription medicine benefit under Medicare. We urge the House to take a different position and pass the Democratic alternative.

Our plan is an entitlement that would guarantee all beneficiaries the option to purchase affordable, dependable, comprehensive prescription drug coverage at a uniform price. The program would be administered and managed through pharmacy contractors, much like carriers and fiscal intermediaries do for the rest of Medicare today. Starting in 2005, under our plan, beneficiaries would pay a $25 monthly premium, $100 annual deductible and not more than 20 percent co-insurance until they spend $2,000, the government would pay 100 percent of the drug costs. This benefit minimizes beneficiary costs. [Chart 1]

Low-income beneficiaries receive additional assistance under our proposal. Those with incomes up to 150% of poverty ($13,290 for one person) will pay nothing. Those with incomes between 150–175% ($13,290–$15,505 for a single person) of poverty will pay premiums on a sliding scale.

The Democratic substitute also substantially reduces the soaring costs that seniors currently pay for prescription drugs. Under our plan, the Secretary would leverage the collective bargaining power of 40 million beneficiaries to negotiate with manufacturers for lower drug prices. Secretary Thompson recently demonstrated the effectiveness of similar bargaining power when he negotiated an 80 percent discount off the list price of the antibiotic Cipro during the anthrax scare last year. Pharmacy contractors would also negotiate additional savings. The savings from these negotiations would be required to be directly passed on to beneficiaries through lower prices.

The Democratic substitute guarantees senior citizens and those with disabilities the choices that matter—choice of drugs and choice of pharmacy. Under our plan Medicare would pay toward the cost of every prescription drug. The Democratic substitute also assures access to pharmacies by prohibiting pharmacy contractors from refusing to contract with a pharmacy that agreed to meet its standards. These are the choices people want and need.

Most importantly unlike the Republican plan, our plan will never force seniors into an HMO or similar private plan in order to get a prescription drug benefit. That's why the leading consumer organizations back the Democratic substitute. [See letters attached.]

The Republican plan: Let the buyer beware

Under the legislation reported out of Committee, virtually all of the important decisions are left to the private drug plans—the amounts paid by beneficiaries for premiums and cost-sharing, which specific drugs are covered, and the number and location of participating pharmacies. The motto of the free market approach in the Republican bill is caveat emptor: Let the buyer aware.

Rather than pursue negotiations to define on a bipartisan basis the best path to provide a good Medicare drug benefit, the Republican majority has chosen instead to push for a complex plan that puts the interests of HMOs and the drug industry ahead of the interests of benefiaries. Its key flaws are:

No guaranteed premium. Insurers can charge whatever they want for premiums. While Republicans claim that the premium will be $35, which is 40 percent higher than the premium in the Democratic plan, there is nothing in the legislation to support that claim. In fact, there are no limits or guidelines regarding the setting of the premium. Under this proposal, premiums will vary by plan and place. In addition, the Republican plan does not provide any direct premium subsidies to beneficiaries with incomes in excess of 175 percent of poverty. Yet middle income seniors are finding their retirement security undermined by the high cost of pharmaceuticals, too.

Subsidies to HMOs, not beneficiaries. The Republican legislation provides premium subsidies to insurance companies and HMOs, but not to beneficiaries. And nothing in the legislation requires the HMOs and insurers to pass on the subsidies to beneficiaries.

Pay more and get less. For most seniors in the Republican plan, the more you spend, the less coverage you get. Inexplicably, the design of the Committee bill forces the elderly to pay a higher percentage of costs as their needs increase. Once the initial $250 deductible is met, beneficiaries have to pay 20 percent of the cost until there has been $1000 in drug spending. Then the co-insurance increases to 50 percent for spending between $1000 and $2000. And it increases again to 100 percent—no government contribution whatsoever—after $2000 in drug spending. Beneficiares are forced to pay all of their drug costs for spending between $2000 and $4900, while continuing to pay premiums. (NOTE: The Republican $3800 out-of-pocket cap translates into $4900 in spending.)

In fact, under the Committee bill, America's senior citizens and individuals with disabilities will spend $4,220 to get $4900 worth of drugs; in contrast, under the Democratic plan, beneficiaries would pay just $1,360. [CHART 2]

No standard benefit. The benefits described above are merely suggestions. Private plans can vary cost-sharing levers in both the standard coverage option and in the alternative coverage option. This is an invitation for plans to design benefits that "cherry pick" low-cost, healthy enrollees. It is a recipe for beneficiary confusion. This model represents a retreat from the Medigap reforms of the early 1990s that standardized benefits, thus ensuring that plans compete on price and quality and not on consumer confusion.

Not a real entitlement. Despite Republican claims to the contrary, the Republican bill is not a true Medicare entitlement. Under Medicare today, beneficiares are entitled to a set of benefits defined in law, regardless of where they live or what it costs to deliver the benefits. For example, beneficiaries in Milwaukee and Miami pay a $100 deductible for Part B and 20% co-insurance for Part B services. Beneficiaries in Bakersfield and Boston are guaranteed the same coverage for hospital care and home health services. Under the Republican plan, there is no such entitlement. Instead, Republicans guarantee hundreds of billions of taxpayer dollars in federal

subsidies to their friends in the private insurance and pharmaceutical industries.

Limits access to specific drugs and pharmacies. Under the Republican plan, private plans can refuse to cover needed medications. The private plans decide what specific drugs are on their formulary; beneficiaries who need prescription drugs that are not on the formulary are out-of-luck. Plans are not required to disclose the formulatory to prospective enrollees, and plans are allowed to change the formulary during the year with "adequate" notice. Private plans also pick and choose with pharmacies are in their network. Private plans could also change their pharmacy networks mid-year. And, because the Republican plan uses the Medicare+Choice enrollment procedures, beneficiaries will be locked into the private plan for the entire year—even if the plan drops a needed drug or local pharmacy.

Hidden hatchet. Crafted behind closed doors and without public hearing, the legislation has a hidden hatchet designed to artifically depress its aggregate cost and undermine its already paltry benefit. It strictly limits the dollars that count toward the out-of-pocket cap by specifying that only costs which are paid by the individual and are "not reimbursed (through insurance or otherwise) by another person" count toward the out-of-pocket limot. In other words, if a beneficiary receives any assistance—other than low-income assistance—with his or her drug costs, those costs do not count toward the $3,800 limit. This means beneficiaries who pay for supplemental coverage or who get help from family members might never qualify for the catastrophic coverage. Perhaps more importantly, this new notion of "true" out-of-pocket costs put employers, unions, and others who provide retiree coverage in a bind. Employers are already steadily reducing their retiree benefits. [Chart 3] Unfortunately, the Republican bill moves in the wrong direction by providing employers with an incentive to either cap their retiree prescription drug benefits or drop them entirely. Committee counsel for the majority indicated in the mark-up that eliminating this gimmick would increase the cost of their bill by $120 billion.

Flawed private-market model. There is no guarantee that any private plans will even agree to participate, as drug-only risk-bearing insurance plans don't currently exist. For two years, the insurance industry has expressed skepticism about the Republican plan, which relies exclusively on the participation of private insurers. The Health Insurance Association of America recently wrote to the Chairman that there is a "better chance" now than before that their companies will participate, but that's hardly a guarantee. That said, relying on a private insurance system will increase the costs to the beneficiary and the government due to the additional expenses related to product development, marketing, administration and profit. Developing a new private insurance product market would be difficult in sparsely populated rural areas, where the need is greatest, risk pools are smaller and costs often higher.

Risk-bearing requirement is bad news for beneficiaries. Because the Republican plan would require the private insurers to be financially "at-risk" for the utilization of the benefit, the Congressional Budget Office assumes that these organizations will aggressively use every tool at their disposal to limit their financial exposure.

This means they will deny or otherwise limit access to needed medications, set up very restrictive formularies, limit pharmacy networks and take other steps to keep claims low.

Government "bribe." To entice plans to participate, the Committee-reported bill authorizes the Secretary to pay virtually any price, provided the entity is still "partially" at-risk. Thus, the Secretary could subsidize 99.99% of the risk. How much more will taxpayers pay for wasted overhead? How much more will beneficiaries pay? Will the market be stable and certain? Or will private plans be able to come and go as they wish? Will the drug coverage be available and affordable to all beneficiaries? Or only to a select few?

Medicare+Choice all over again. Even if coverage were offered, insurers would be likely to come in and out of the market, move to profitable areas and significantly modify benefit design from year-to-year based on the prior year's experience. This could easily result in the same pull-outs and churning seen in the Medicare+Choice plans—except that the M+C program affects just 14 percent of beneficiaries.

Prescription drug card: The placebo effect

The Committee legislation authorizes the Administration's prescription drug discount card program, but fails to require the cards to provide any minimum discount. These cards are currently available on the market, and they are clearly not the answer to beneficiaries' needs. We are concerned about the potential that this program has to tarnish Medicare's good name.

The real Republican agenda: Privatization of Medicare

This legislation takes the first steps needed to pursue the majority's privatization agenda. It creates a private-sector based drug benefit. It moves Medicare+Choice to a competition-based system in 2005. And it creates a premium support demonstration program under which fee-for-service premiums could rise dramatically. Make no mistake: The long march to privatization is beginning in this bill.

Republican plan: Creates new bureaucracy, adds inefficiency and expense

Ironically, the Committee-reported bill creates a new agency within the Department of Health and Human Services. The new Medicare Benefits Administration (MBA) would be exempt from normal Civil Service pay scales and the conflict of interest rules that govern the civil service. The MBA would regulate Medicare+Choice plans and the prescription drug plans, though the Administrator would be forbidden from "interfering" with negotiations and performing other important oversight duties. Predictably, this new agency is stacked in favor of the plans, and will drain needed resources from the Centers for Medicare and Medicaid Services.

A matter of priorities: Democrats support a Medicare prescription drug benefit, while Republicans prefer to focus on tax breaks for the wealthy

We admit that the cost of our Medicare program expansion to seniors and the disabled is likely to be more than twice the cost of the Republican gift to drug companies and HMOs. But that's because we provide a much more generous benefit—e.g., beneficiaries save three times more under our plan [Chart 4]—and we don't include any hidden hatchets or other gimmicks or gaps to shift costs elsewhere. Under the Democratic plan, what you see is what you get.

We are proud to be doing more for the most vulnerable in our society. The Democratic Medicare prescription drug benefit will make a real difference in the lives of America's seniors and their families both by lowering drug prices and giving them substantial assistance in paying for them. But you simply cannot do a meaningful prescription drug benefit on the cheap.

Help for Medicare providers

While we have grave concerns about the feasibility, advisability and scope of benefits under the Republican drug plan in Title I and the steps toward competitive bidding in Title II, we are largely supportive of the package of provider payment relief in Titles II, III, IV, V, and VI of the Committee-passed bill. We would strongly prefer to consider the provider-related pieces on their own merits, and not as part of a larger more controversial debate.

Conclusion

Medicare's promise of health and financial security will not be fulfill until a prescription drug benefit is enacted. The Republican scheme is a prescription for failure. [Chart 5] Many Democratic amendments were offered in repeated attempts to fix its many flaws or, in some cases, simply live up to Republican rhetoric. All were rejected on virtually party-line votes.

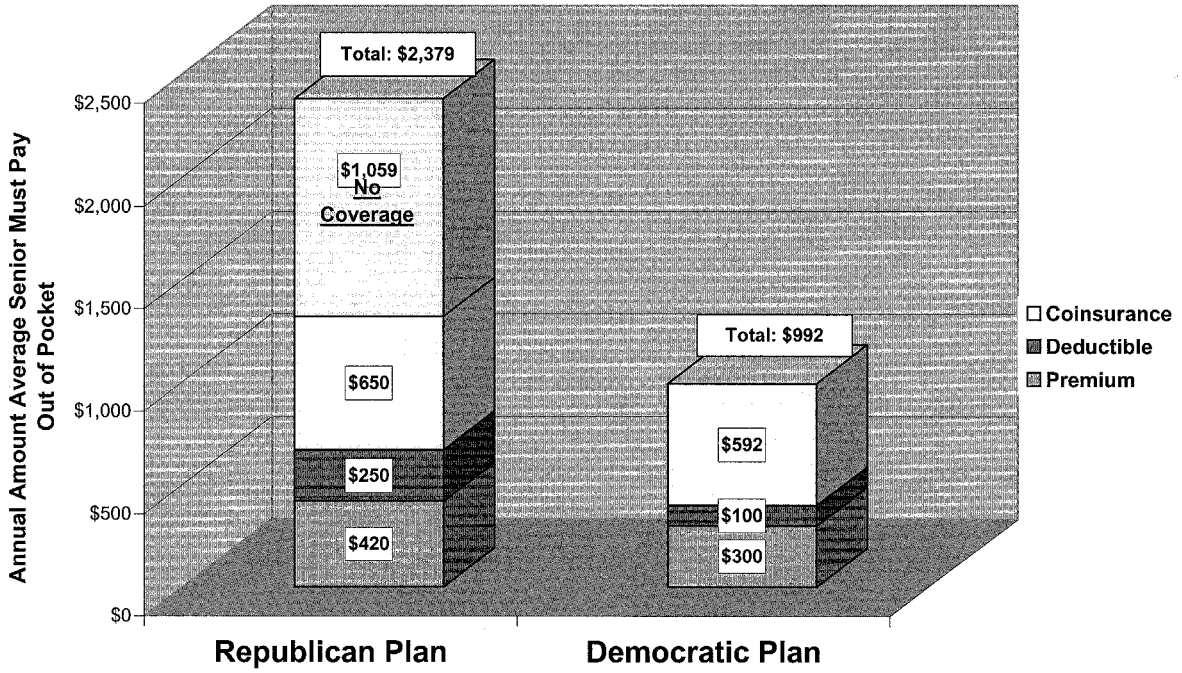
Seniors need and deserve stability, equity, continuity and predictability in their health care plans. They do not get this from for-profit HMOs in the M+C program. And they will not get it from private drug plans with variable premiums, co-insurance and benefits.

Members of Congress should defeat the Republican drug hoax and vote for a real, defined benefit in Medicare. They should enact the Democratic substitute.

C.B. RANGEL.
WILLIAM J. COYNE.
BEN CARDIN.
JIM MCDERMOTT.
JERRY KLECZKA.
WILLIAM J. JEFFERSON.
JOHN TANNER.
MICHAEL R. MCNULTY.
PETE STARK.
SANDER M. LEVIN.
ROBERT T. MATSUI.

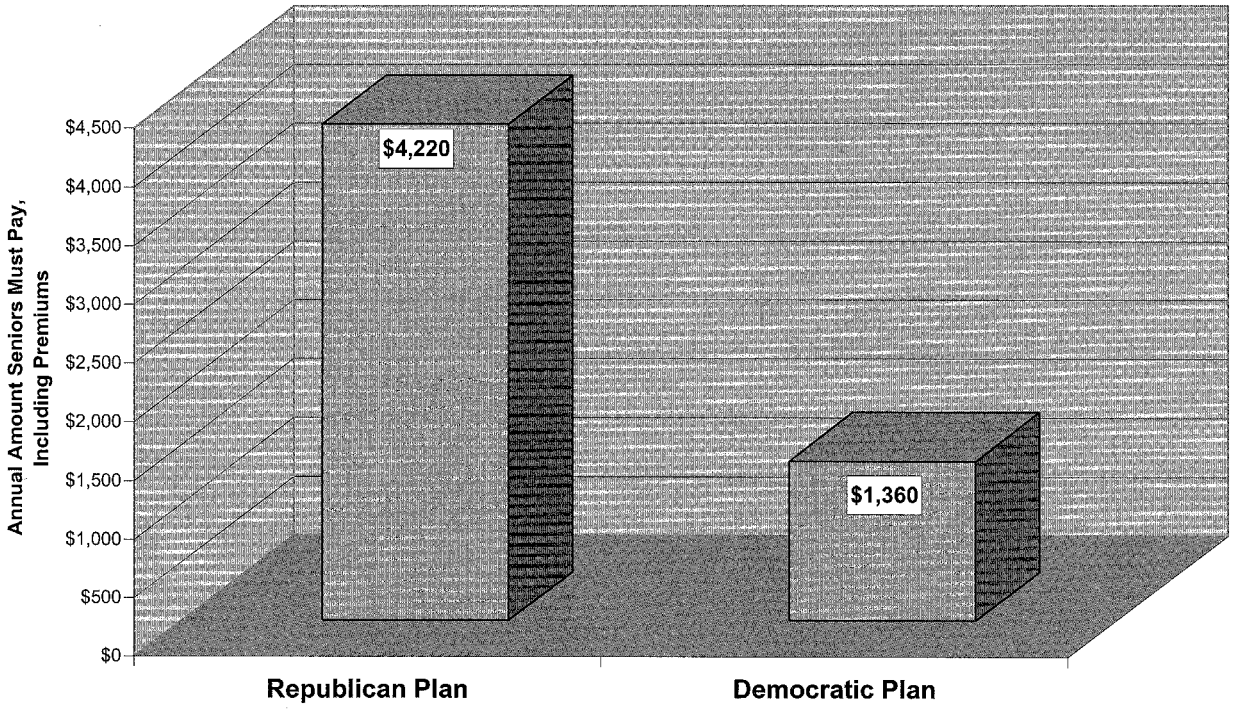
JOHN LEWIS.
KAREN L. THURMAN.
RICHARD E. NEAL.
XAVIER BECERRA.

CHART 1
How Much Would the Average Senior Pay?



Average beneficiary spending on prescription drugs at the start of the benefit (2005) = $3,059. (CBO March 2002 Baseline)

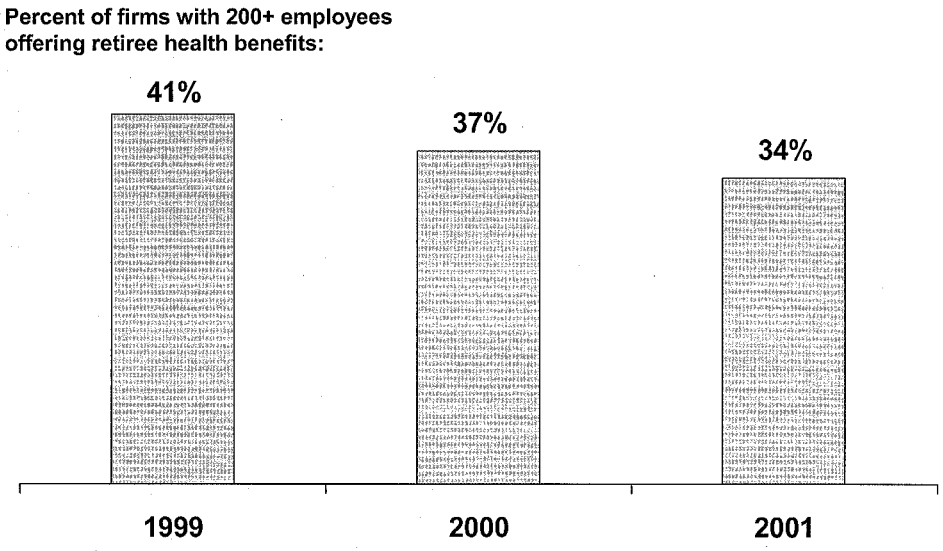
CHART 2
How Much Must Seniors Pay for $4,900* Worth of Medicines?



* House GOP plan stop-loss applies at $3,800 in out-of-pocket spending, which translates into $4,900 worth of medicines.

Figure 3

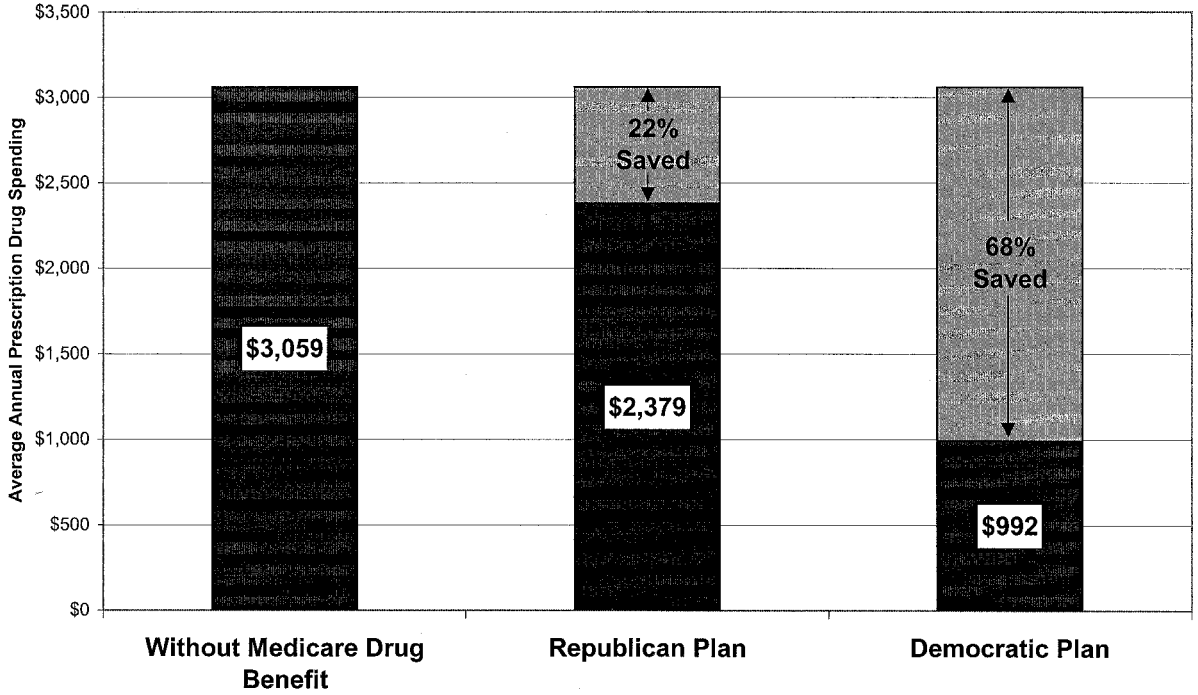
The share of employers offering retiree health benefits is declining



Source: Kaiser/HRET/Commonwealth Fund, April 2002.

THE HENRY J. KAISER FAMILY FOUNDATION

CHART 4
Beneficiaries Save Three Times More Under Democratic Plan



Without a Medicare drug benefit, CBO projects the average senior will spend $3,059 on prescription drugs in 2005. (CBO March 2002 Baseline) To get $3,059 worth of prescription drugs, a senior would have to spend $2,379 under the Republican plan and $992 under the Democratic plan.

CHART 5

Medicare Prescription Drug Benefit: Republican v. Democratic Proposals

Plan Element	Republican Proposal	Democratic Proposal
Guaranteed Minimum Benefit	NO Beneficiaries must obtain coverage through private insurers, who may not participate and can offer vastly different benefits and premiums.	YES Medicare covers prescription drugs like other Medicare benefits, with guaranteed benefits, premiums, and cost sharing for all beneficiaries.
Guaranteed Fair Drug Prices	NO Private insurers negotiate separately on behalf of subsets of the Medicare population, diminishing the program's group negotiating power.	YES The Secretary of HHS uses the collective bargaining clout of all 40 million Medicare beneficiaries to negotiate fair drug prices. These reduced prices will be passed on to beneficiaries.
Premium	Not specified. It is estimated to be: $35/month $420/year[1]	Specified in statute. $25/month $300/year
Deductible	$250/year[1]	$100/year
Co-insurance	20% for first $1,000 50% for next $1,000 100% for all remaining spending up to the out-of-pocket maximum[1]	20%
Out-of-Pocket Maximum	$3,800/year[1]	$2,000/year
Coverage Gaps	YES Beneficiaries who need more than $2,000 worth of drugs must pay 100% out-of-pocket (and keep paying premiums) until they reach the $3,800 out-of-pocket cap.	NO Beneficiaries always have coverage, with no gaps.
Access to Local Pharmacies	LIMITED Private plans can limit which pharmacies participate in their network.	BROAD Any willing pharmacy must be included in the network.
Access to Prescribed Medicines	LIMITED Private insurers can establish strict formularies and deny any coverage for off-formulary drugs.	BROAD Beneficiaries have coverage for any drug their doctor prescribes.
Low-Income Protections	WEAK Low-income beneficiaries may have to pay $2 or $5 co-pays and 100% of costs in the coverage gap. Drugs may be denied if the beneficiary can't afford this cost sharing.	STRONG No cost sharing or premiums up to 150% of poverty; sliding scale premiums phased in between 150% and 175% of poverty.

[1] Cost sharing amounts shown are benchmarks only. Actual cost sharing amounts will vary depending on the private plan the beneficiary chooses (assuming one is available).

Jun-21-2002 01:57pm From- T-049 P.002/002 F-690

National Committee to Preserve Social Security and Medicare

Twentieth

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June 12, 2002

The Honorable Charles Rangel
Rayburn House Office Building 2354
Washington, DC 20515

Dear Congressman Rangel:

On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I write in strong support of the Democratic substitute bill offered in the Ways and Means committee. Your Medicare prescription drug legislation will provide much needed relief to seniors. Your bill contains all of the elements that seniors need in a comprehensive drug benefit under Medicare. Your bill is universal, voluntary, and affordable, not means tested and most importantly, is a defined benefit, so that seniors can plan accordingly. Prescription drug prices are increasing over 17% per year (faster than inflation) and seniors are spending more on out-of-pocket drug expenditures than ever. The time is now to enact a drug benefit that will provide the Medicare beneficiary with meaningful assistance.

We are pleased that your plan would be available for seniors, no matter where they live. It provides seamless coverage. Our members have also expressed to us that a prescription drug benefit must be affordable.

We applaud you for your leadership in this area. We look forward to working with you to ensure enactment on this critical issue of prescription drug coverage for seniors.

Sincerely,

Barbara B. Kennelly

Barbara Kennelly
President

10 G Street, NE, Suite 600 • Washington, DC 20002-4215 • 202-216-0420 • www.ncpssm.org

LEGACY 2002 CAMPAIGN: Protect the Legacy of Social Security and Medicare...Vote November 5, 2002

President
George J. Kourpias

Secretary-Treasurer
Ruben Burks

June 18, 2002

The Honorable Charles Rangel
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rangel:

The Alliance for Retired Americans, on behalf of its 2.5 million members across the nation, endorses the Democratic substitute to H.R. 4954.

While more than 13 million older Americans and persons with disabilities have no prescription drug coverage at all, the coverage other Medicare beneficiaries have is often very expensive, inadequate and unreliable. Passage of this legislation will provide needed and substantial protection for all Medicare beneficiaries

The Democratic substitute measures up to our principles:

- **Coverage must be universal and comprehensive.** This Act covers all who qualify for Medicare benefits and includes a range of current and effective treatments.
- **Benefits must be defined and affordable with protections for low-income persons but no means-testing.** The premiums, deductibles, co-insurance and out-of-pocket cap in this Act are consistent with the Alliance's recommendations. In addition, there are provisions for covering all or most costs for beneficiaries below 175% of poverty and there is no assets test.
- **Enrollment must be voluntary and provide incentives for employers to maintain and expand their level of coverage.** This Act allows for those who have superior benefits to remain in their plans and it also provides employer incentives for continuing coverage.
- **Pharmaceutical prices for all consumers must be brought under some system of control.** This Act provides for the Health and Human Services Secretary to bring about lower prices through the government's negotiating power.

We will do all that we can to work with you toward achieving passage of your substitute.

Sincerely,

Edward F. Coyle
Executive Director

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June 20, 2002

Dear Congressmen:

The National Senior Citizens Law Center is pleased to endorse the Democratic Prescription Drug Substitute in Committee introduced by Congressmen Dingell and Rangel. This measure, alone among those pending in the House, meets our key principles for a meaningful prescription drug benefit.

- **The Dingell-Rangel measure provides for a voluntary drug benefit that includes reliable coverage as part of Medicare's defined benefit package.** The measure does not rely on participation by private insurance companies, which can and do make business decisions to enter and exit markets or scale back benefits. Because the drug benefit is incorporated into Medicare, the measure provides for stable, predictable coverage and prevents significant variations in premiums, deductibles and co-payments from region to region.

- **The drug benefit is comprehensive, shielding beneficiaries from burdensome out-of-pocket expenses and steep cost-sharing.** The benefit has an affordable premium and coinsurance of no more than 20 percent for preferred drugs, and for non-preferred when medically necessary. The benefit does not require beneficiaries to pay the full cost of prescription drugs once they have reached a capped amount and does not contain major gaps in coverage.

- **The drug benefit protects the integrity of the current Medicare benefit.** The measure does not force older people and people with disabilities into an HMO to get drug coverage. Nor does it impose new, increased co-payments for current Medicare benefits, such as home health, in exchange for a drug benefit.

- **The measure provides protection for low-income Medicare beneficiaries, regardless of age and where they live.** The measure provides full cost-sharing for Medicare beneficiaries with incomes up to 150 percent of poverty and premium assistance to persons with incomes up to 175 percent of poverty, and removes the asset test for eligibility.

- **The measure focuses on improving the traditional Medicare program and eschews radical Medicare restructuring proposals that would weaken the traditional program.** The measure does not include reforms that would increase the role of competition and private insurance in the Medicare program and cost-sharing for beneficiaries. Private insurance has failed to meet the needs of elders and persons with disabilities, has not achieved savings for the federal government and will not fund and make available to all beneficiaries the additional benefits, such as prescription drugs, that they want and need.

In sum, we enthusiastically support the Dingell-Rangel Prescription Drug measure because it provides a guaranteed, universal, voluntary and affordable benefit that is part of the Medicare program. We thank you for your leadership on this issue and look forward to working with you to ensure enactment of this measure.

Sincerely yours,

Edward C. King
Executive Director
NSCLC

Kim Glaun
Staff Attorney
NSCLC

THE NATIONAL COUNCIL
ON THE AGING

409 Third Street SW Washington, DC 20024 TEL 202 479-1200 TDD 202 479-6674 FAX 202 479-0735 http://www.ncoa.org

June 12, 2002

The Honorable Charles Rangel
Ranking Member
House Ways and Means Committee
2354 Rayburn House Office Building
Washington, D.C. 20515

The Honorable John Dingell
Ranking Member
House Energy and Commerce Committee
2328 Rayburn House Office Building
Washington, D.C. 20515

Dear Representatives Rangel and Dingell:

On behalf of the National Council on the Aging (NCOA) – the nation's first organization formed to represent America's seniors and those who serve them – I write to commend and thank you for your proposal to provide comprehensive prescription drug coverage to Medicare beneficiaries across the nation. The proposal would provide the level of coverage that the vast majority of America's seniors want and are familiar with.

According to the Congressional Budget Office (CBO), over the next ten years, Medicare beneficiaries will spend almost $1.8 trillion out-of-pocket on prescription drugs. This means, for example, that a $350 billion drug benefit would cover, on average, less than two out of ten dollars beneficiaries will spend on prescription drugs. In our view, allocating only $350 billion for prescription drugs is inadequate. Recent survey data indicated that such an amount would result in poor coverage under a plan in which few beneficiaries would participate. This in turn would result in serious adverse selection problems. We can afford to do much better.

Some critics claim that we cannot afford the comprehensive Medicare drug coverage provided under your proposal. But America has the strongest economy in the world and can find the resources if we want to. It is simply a matter of setting the right priorities. It is not unreasonable that America's seniors should receive prescription drug coverage as generous as that received by members of Congress, or under employer policies provided to younger Americans.

When the President and the Congress identify a clear priority to help Americans in need, the dollars to pay for it have always been found. Money was found last year to pass a $1.7 trillion tax cut. Last December, the Administration and the House found the money to support a stimulus package that cost an estimated $220 billion in the first three years. The House recently voted to make last year's tax cuts permanent, which would cost an estimated $373 billion for just two years (2011 and 2012). Congress also recently found the money to pay for $190 billion in farm subsidies, increasing spending for existing programs by almost 80 percent.

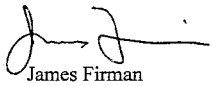
NCOA is particularly pleased that your legislation would provide prescription drug coverage that is universal, voluntary, reliable, and continuous. Other proposals being offered include significant coverage gaps and would fail to solve the problem. Under such bills, a significant

number of beneficiaries would not want to participate in the program, and many of those who do participate would continue to be forced to choose between buying food and essential medicines.

We are also pleased that your proposal would provide strong low-income protections for our most vulnerable seniors. By providing protections up to 175 percent of the poverty line and eliminating the onerous, irrational asset test as a condition for receiving such protections, your proposal would assure that those in greatest need would be able to obtain the medications they are prescribed. The asset requirement in other current Medicare low-income protection programs has not been adjusted for inflation for over 20 years and serves as a major barrier to eligibility for low-income seniors.

Sufficient funds must be allocated to provide access to a continuous, reliable prescription drug benefit for all Medicare beneficiaries, with affordable premiums and coinsurance and no major gaps in coverage. In November 2000, the Administration and Congress promised that meaningful, affordable prescription drug coverage would finally be made available under Medicare. Medicare beneficiaries can no longer afford to wait. We appreciate your efforts to deliver on this promise.

Sincerely,



James Firman
President and CEO

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

815 SIXTEENTH STREET, N.W.
WASHINGTON, D.C. 20006

LEGISLATIVE ALERT!

(202) 637-5090

JOHN J. SWEENEY
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RICHARD L. TRUMKA
SECRETARY-TREASURER

LINDA CHAVEZ-THOMPSON
EXECUTIVE VICE-PRESIDENT

June 13, 2002

The Honorable John Dingell
The Honorable Charles Rangel
United States House of Representatives
Washington, D.C. 20515

Dear Representatives Dingell and Rangel:

On behalf of the 13 million members of the AFL-CIO, I am writing to commend you for your efforts to provide much-needed relief to Medicare beneficiaries. Your proposal to create a voluntary drug benefit within the Medicare program represents an encouraging and solid step toward enacting the one reform most urgently needed for Medicare.

Seniors need a real benefit that provides comprehensive, continuous and certain coverage. Your proposal provides that benefit, giving seniors coverage without gimmicks or gaps. A Medicare drug benefit must also be affordable for beneficiaries living on fixed incomes. The $25 monthly premium, coverage for 80 percent of the cost of prescription drugs and low deductible and out-of-pocket limit put prescription drugs well within the reach of seniors who too often have to make difficult choices between their health care and other basic needs. And providing this benefit within the Medicare program – and not through private HMOs – means seniors can count on the coverage being there.

In addition, your proposal would not put at risk those retirees who currently have some prescription drug coverage through an employer. Retiree health care is the primary source of prescription drug coverage for seniors, and your proposal rightly provides some relief for employers that choose to continue that coverage.

A proposal widely reported under consideration by House Republican leaders offers only unreliable, expensive and unworkable coverage through private plans, with an enormous gap in coverage that leaves seniors without any coverage at all for drug costs between $2000 and $4500. And the only relief for employers is if they drop the coverage they now offer. Such a proposal will not move us any closer to a real benefit.

As this debate moves forward, we want to work with you to enact the best possible Medicare drug benefit. We appreciate your role in advancing that process.

Sincerely,

William Samuel, Director
DEPARTMENT OF LEGISLATION

June 13, 2002

The Honorable Richard A. Gephardt
Minority Leader
H-204 Capitol Building
Washington, D.C. 20515

The Honorable John D. Dingell
U. S. House of Representatives
2329 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Pete Stark
U. S. House of Representatives
239 Cannon House Office Building
Washington, D.C. 20515

Dear Representatives Gephardt, Dingell and Stark:

On behalf of the more than one million members of the American Federation of Teachers (AFT), I am writing to offer our strong support for your legislation to provide a much needed and realistic prescription drug benefit within the Medicare system.

A prescription drug benefit within Medicare is needed now. The dramatic increase in the cost and use of essential drugs means that many retirees must spend over 20% of their retirement income to pay for prescriptions, forcing many elderly Americans to choose between eating and taking the medications they need to survive. Second, while many retirees have some private prescription drug insurance coverage, such insurance is becoming unaffordable. Finally, and perhaps most important, 11 million elderly Americans have no prescription drug coverage at all.

The need for legislation is clear. Your bill adopts the right approach to this serious problem by providing a voluntary prescription drug benefit that is within the Medicare system and does not rely on the private insurance market. Private insurers, as we know, can unilaterally change benefits, increase co-payments and even refuse coverage. For this reason, it is imperative that the benefit be part of the Medicare system.

Your legislation also establishes benefits at a realistic cost to retirees by providing an affordable $25 monthly premium, a 20% co-payment for all prescriptions and catastrophic coverage after $2,000 in out of pocket expenses. Further, the maintenance of effort provisions included in your legislation will provide an important incentive for employers who already provide their retirees' prescription drug coverage to continue to do so.

Our nation's elderly need your Medicare prescription drug benefit. The AFT is happy to support your legislation and to work toward its enactment.

Sincerely,

Charlotte J. Fraas, Director
Department of Legislation

CJF:cmw
opeiu#2afl-cio
House Democratic Medicare Prescription Drug

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June 10, 2002

Honorable Charles B. Rangel
Honorable John D. Dingell
House of Representatives
Washington, D.C. 20515

BY FAX: (202) 225-5288

Dear Congressmen Rangel and Dingell:

The Center for Medicare Advocacy, Inc, is a private, non-profit organization which provides education, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. We are very pleased to endorse your Medicare prescription drug proposal.

Your proposal meets all of our principles for a meaningful, universal, affordable prescription drug benefit. In particular, we are pleased that, under your proposal:

- The drug benefit will be part of the Medicare program and administered in the same way that benefits under Medicare Parts A and B are administered.
- Beneficiaries will not be forced into an HMO in order to get prescription drug coverage.
- Beneficiaries will pay no more than 20% for any prescription, regardless of the amount they spend on drugs.
- Beneficiaries will have continuous coverage. They will not have to pay the full cost of any drugs after the deductible is met, regardless of the amount they spend on drugs.
- Beneficiaries will not be forced to pay higher co-payments for current Medicare benefits such as home health services in exchange for a Medicare drug benefit.
- Low-income Medicare beneficiaries will be protected, regardless of their age and where they live.

The Center for Medicare Advocacy appreciates the efforts you have taken to support the needs of elders and people with disabilities. We look forward to working with you to enact a Medicare prescription drug benefit that meets the needs of Medicare beneficiaries, the people the Medicare statute was designed to protect. Thank you.

Sincerely,

Judith A. Stein,
Executive Director

FamiliesUSA
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1982
2002

June 20, 2002

Congressman Charles Rangel
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Congressman Rangel:

We congratulate you and Congressman Dingell on offering the Democratic substitute that provides a prescription drug benefit for Medicare beneficiaries.

This is an issue of utmost importance to all Americans who need prescription drugs, especially to seniors and people with disabilities. As you well know, seniors' ability to afford prescription drugs is a particularly difficult problem today. In our 2001 report entitled, "Enough to Make You Sick: Prescription Drug Prices for the Elderly," we concluded that the 50 top drugs used by seniors rose 2.3 times the rate of inflation between 2000 and 2001. We are in the process of updating this report for last year, and our preliminary data shows that this devastating rate of price increases continues. Millions of seniors have limited income and no, or limited, drug coverage and will find themselves deciding whether to buy drugs or to pay for other essentials.

Your substitute addresses many of the issues we care about. Beneficiaries will be very grateful that the benefit is the same as in the rest of Medicare, in that the beneficiary only pays 20 percent of the cost of the drug. Additionally, every Medicare beneficiary can benefit from this comprehensive benefit. Beneficiaries across the country will be confident that they will have access to this benefit in the same way they get the rest of their Medicare benefits. Low-income people get extra assistance. Also, there are provisions to assure that costs will be contained and quality maintained.

Please let us know how we can assist you to move toward our mutual goal of providing all Medicare beneficiaries access to the prescription drugs they need.

Sincerely,

Ron Pollack

Ronald F. Pollack
Executive Director

1334 G Street, NW ■ Washington, DC 20005 ■ 202-628-3030 ■ Fax 202-347-2417
E-Mail: info@familiesusa.org ■ Web site: www.familiesusa.org

06/21/02 FRI 14:51 FAX 202 347 2417 FAMILIES USA 002

ADDITIONAL VIEWS OF CONGRESSMAN EARL POMEROY

While I have great concerns about the total cost of the Minority alternative prescription drug package, I firmly believe that it uses the best and most appropriate delivery mechanism—an entitlement provided directly through Medicare. The underlying bill, on the other hand, proposes to deliver the benefit through private insurance companies. The argument made by the Majority that this method of delivery is superior and will result in greater savings is not substantial and relies on blind faith in the insurance industry. In my eight years as Insurance Commissioner for the State of North Dakota, it became apparent that this is simply an unproven theory. One need not look any further than the Medicare+Choice experience in North Dakota as evidence. In our state, we witnessed all three plans that tested the market fail and ultimately pull out. Today there are not available M+C plans in the state because a market-driven approach clearly does not work for providing coverage to our seniors under Medicare.

However, I am compelled to remind my colleagues that Congress has a critical responsibility to address the prescription drug needs of seniors sooner rather than later, and I am committed to working to keep this legislation moving forward. As the process continues, it is my hope that we can work in a bipartisan manner to correct the deficiencies in this bill, beginning with changing the delivery mechanism to utilize the proven, successful elements of the existing Medicare program.

EARL POMEROY.

○