

107TH CONGRESS  
2D SESSION

# H. R. 4954

---

---

## AN ACT

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.



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

# H. R. 4954

---

## AN ACT

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

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

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**  
 4 **RITY ACT; REFERENCES TO BIPA AND SEC-**  
 5 **RETARY; TABLE OF CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the  
 7 “Medicare Modernization and Prescription Drug Act of  
 8 2002”.

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

15 (c) BIPA; SECRETARY.—In this Act:

16 (1) BIPA.—The term “BIPA” means the  
 17 Medicare, Medicaid, and SCHIP Benefits Improve-  
 18 ment and Protection Act of 2000, as enacted into  
 19 law by section 1(a)(6) of Public Law 106–554.

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

22 (d) TABLE OF CONTENTS.—The table of contents of  
 23 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.

- 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.
- Sec. 106. GAO study of the effectiveness of the new prescription drug program.

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

### Subtitle A—Medicare+Choice Revitalization

- Sec. 201. Medicare+Choice improvements.
- Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
- Sec. 203. Avoiding duplicative State regulation.
- Sec. 204. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 205. Medicare MSAs.
- Sec. 206. Extension of reasonable cost and SHMO contracts.

### Subtitle B—Medicare+Choice Competition Program

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

## TITLE III—RURAL HEALTH CARE IMPROVEMENTS

- Sec. 301. Reference to full market basket increase for sole community hospitals.
- Sec. 302. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 303. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 304. More frequent update in weights used in hospital market basket.
- Sec. 305. Improvements to critical access hospital program.
- Sec. 306. Extension of temporary increase for home health services furnished in a rural area.
- Sec. 307. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.
- Sec. 308. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.
- Sec. 309. GAO study of geographic differences in payments for physicians' services.
- Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 311. Relief for certain non-teaching hospitals.

## TITLE IV—PROVISIONS RELATING TO PART A

### Subtitle A—Inpatient Hospital Services

- Sec. 401. Revision of acute care hospital payment updates.

- Sec. 402. 2-year increase in level of adjustment for indirect costs of medical education (IME).
- Sec. 403. Recognition of new medical technologies under inpatient hospital PPS.
- Sec. 404. Phase-in of Federal rate for hospitals in Puerto Rico.
- Sec. 405. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 406. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 407. Reference to provision for more frequent updates in the weights used in hospital market basket.
- Sec. 408. Reference to provision making improvements to critical access hospital program.
- Sec. 409. GAO study on improving the hospital wage index.

#### 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.
- Sec. 505. Physician fee schedule wage index revision.

#### 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. Coverage of an initial preventive physical examination.
- Sec. 515. Renal dialysis services.
- Sec. 516. Improved payment for certain mammography services.
- Sec. 517. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 518. Coverage of cholesterol and blood lipid screening.

### TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.
- Sec. 602. Update in home health services.
- Sec. 603. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
- Sec. 604. MedPAC study on medicare margins of home health agencies.
- Sec. 605. Clarification of treatment of occasional absences in determining whether an individual is confined to the home.

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.
- Sec. 624. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

- Sec. 701. Establishment of Medicare Benefits Administration.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

- Sec. 801. Construction; definition of supplier.
- Sec. 802. Issuance of regulations.
- Sec. 803. Compliance with changes in regulations and policies.
- Sec. 804. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

- Sec. 811. Increased flexibility in medicare administration.
- Sec. 812. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

- Sec. 821. Provider education and technical assistance.
- Sec. 822. Small provider technical assistance demonstration program.
- Sec. 823. Medicare provider ombudsman; medicare beneficiary ombudsman.
- Sec. 824. Beneficiary outreach demonstration program.

Subtitle D—Appeals and Recovery

- Sec. 831. Transfer of responsibility for medicare appeals.
- Sec. 832. Process for expedited access to review.
- Sec. 833. Revisions to medicare appeals process.
- Sec. 834. Prepayment review.

- Sec. 835. Recovery of overpayments.  
 Sec. 836. Provider enrollment process; right of appeal.  
 Sec. 837. Process for correction of minor errors and omissions on claims without pursuing appeals process.  
 Sec. 838. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle E—Miscellaneous Provisions

- Sec. 841. Policy development regarding evaluation and management (E & M) documentation guidelines.  
 Sec. 842. Improvement in oversight of technology and coverage.  
 Sec. 843. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.  
 Sec. 844. EMTALA improvements.  
 Sec. 845. Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group.  
 Sec. 846. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.  
 Sec. 847. Application of OSHA bloodborne pathogens standard to certain hospitals.  
 Sec. 848. BIPA-related technical amendments and corrections.  
 Sec. 849. Conforming authority to waive a program exclusion.  
 Sec. 850. Treatment of certain dental claims.  
 Sec. 851. Annual publication of list of national coverage determinations.

TITLE IX—MEDICAID PROVISIONS

- Sec. 901. National Bipartisan Commission on the Future of Medicaid.  
 Sec. 902. Disproportionate share hospital (DSH) payments.  
 Sec. 903. Medicaid pharmacy assistance program.

1                   **TITLE I—MEDICARE**  
 2                   **PRESCRIPTION DRUG BENEFIT**  
 3                   **SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION**  
 4                   **DRUG BENEFIT.**

- 5                   (a) IN GENERAL.—Title XVIII is amended—  
 6                         (1) by redesignating part D as part E; and  
 7                         (2) by inserting after part C the following new  
 8                   part:

1 “PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT  
2 PROGRAM

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

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

11 “(1) MEDICARE+CHOICE PLAN.—If the indi-  
12 vidual is eligible to enroll in a Medicare+Choice plan  
13 that provides qualified prescription drug coverage  
14 under section 1851(j), the individual may enroll in  
15 the plan and obtain coverage through such plan.

16 “(2) PRESCRIPTION DRUG PLAN.—If the indi-  
17 vidual is not enrolled in a Medicare+Choice plan  
18 that provides qualified prescription drug coverage,  
19 the individual may enroll under this part in a pre-  
20 scription drug plan (as defined in section  
21 1860J(a)(5)).

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

24 “(b) GENERAL ELECTION PROCEDURES.—

1           “(1) IN GENERAL.—An individual eligible to  
2           make an election under subsection (a) may elect to  
3           enroll in a prescription drug plan under this part, or  
4           elect the option of qualified prescription drug cov-  
5           erage under a Medicare+Choice plan under part C,  
6           and to change such election only in such manner  
7           and form as may be prescribed by regulations of the  
8           Administrator of the Medicare Benefits Administra-  
9           tion (appointed under section 1808(b)) (in this part  
10          referred to as the ‘Medicare Benefits Administrator’)  
11          and only during an election period prescribed in or  
12          under this subsection.

13           “(2) ELECTION PERIODS.—

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

19                   “(i) annual coordinated election peri-  
20                   ods; and

21                   “(ii) special election periods.

22          In applying the last sentence of section  
23          1851(e)(4) (relating to discontinuance of a  
24          Medicare+Choice election during the first year  
25          of eligibility) under this subparagraph, in the

1 case of an election described in such section in  
2 which the individual had elected or is provided  
3 qualified prescription drug coverage at the time  
4 of such first enrollment, the individual shall be  
5 permitted to enroll in a prescription drug plan  
6 under this part at the time of the election of  
7 coverage under the original fee-for-service plan.

8 “(B) INITIAL ELECTION PERIODS.—

9 “(i) INDIVIDUALS CURRENTLY COV-  
10 ERED.—In the case of an individual who is  
11 entitled to benefits under part A or en-  
12 rolled under part B as of November 1,  
13 2004, there shall be an initial election pe-  
14 riod of 6 months beginning on that date.

15 “(ii) INDIVIDUAL COVERED IN FU-  
16 TURE.—In the case of an individual who is  
17 first entitled to benefits under part A or  
18 enrolled under part B after such date,  
19 there shall be an initial election period  
20 which is the same as the initial enrollment  
21 period under section 1837(d).

22 “(C) ADDITIONAL SPECIAL ELECTION PE-  
23 RIODS.—The Administrator shall establish spe-  
24 cial election periods—

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

4           “(ii) in cases described in section  
5           1837(h) (relating to errors in enrollment),  
6           in the same manner as such section applies  
7           to part B;

8           “(iii) in the case of an individual who  
9           meets such exceptional conditions (includ-  
10          ing conditions provided under section  
11          1851(e)(4)(D)) as the Administrator may  
12          provide; and

13          “(iv) in cases of individuals (as deter-  
14          mined by the Administrator) who become  
15          eligible for prescription drug assistance  
16          under title XIX under section 1935(d).

17          “(3) INFORMATION ON PLANS.—Information  
18          described in section 1860C(b)(1) on prescription  
19          drug plans shall be made available during open en-  
20          rollment periods.

21          “(c) GUARANTEED ISSUE; COMMUNITY RATING; AND  
22          NONDISCRIMINATION.—

23                 “(1) GUARANTEED ISSUE.—

24                         “(A) IN GENERAL.—An eligible individual  
25                         who is eligible to elect qualified prescription

1 drug coverage under a prescription drug plan or  
2 Medicare+Choice plan at a time during which  
3 elections are accepted under this part with re-  
4 spect to the plan shall not be denied enrollment  
5 based on any health status-related factor (de-  
6 scribed in section 2702(a)(1) of the Public  
7 Health Service Act) or any other factor.

8 “(B) MEDICARE+CHOICE LIMITATIONS  
9 PERMITTED.—The provisions of paragraphs (2)  
10 and (3) (other than subparagraph (C)(i), relat-  
11 ing to default enrollment) of section 1851(g)  
12 (relating to priority and limitation on termi-  
13 nation of election) shall apply to PDP sponsors  
14 under this subsection.

15 “(2) COMMUNITY-RATED PREMIUM.—

16 “(A) IN GENERAL.—In the case of an indi-  
17 vidual who maintains (as determined under sub-  
18 paragraph (C)) continuous prescription drug  
19 coverage since the date the individual first  
20 qualifies to elect prescription drug coverage  
21 under this part, a PDP sponsor or  
22 Medicare+Choice organization offering a pre-  
23 scription drug plan or Medicare+Choice plan  
24 that provides qualified prescription drug cov-  
25 erage and in which the individual is enrolled

1 may not deny, limit, or condition the coverage  
2 or provision of covered prescription drug bene-  
3 fits or vary or increase the premium under the  
4 plan based on any health status-related factor  
5 described in section 2702(a)(1) of the Public  
6 Health Service Act or any other factor.

7 “(B) LATE ENROLLMENT PENALTY.—In  
8 the case of an individual who does not maintain  
9 such continuous prescription drug coverage (as  
10 described in subparagraph (C)), a PDP sponsor  
11 or Medicare+Choice organization may (notwith-  
12 standing any provision in this title) adjust the  
13 premium otherwise applicable or impose a pre-  
14 existing condition exclusion with respect to  
15 qualified prescription drug coverage in a man-  
16 ner that reflects additional actuarial risk in-  
17 volved. Such a risk shall be established through  
18 an appropriate actuarial opinion of the type de-  
19 scribed in subparagraphs (A) through (C) of  
20 section 2103(e)(4).

21 “(C) CONTINUOUS PRESCRIPTION DRUG  
22 COVERAGE.—An individual is considered for  
23 purposes of this part to be maintaining contin-  
24 uous prescription drug coverage on and after  
25 the date the individual first qualifies to elect

1 prescription drug coverage under this part if  
2 the individual establishes that as of such date  
3 the individual is covered under any of the fol-  
4 lowing prescription drug coverage and before  
5 the date that is the last day of the 63-day pe-  
6 riod that begins on the date of termination of  
7 the particular prescription drug coverage in-  
8 volved (regardless of whether the individual  
9 subsequently obtains any of the following pre-  
10 scription drug coverage):

11 “(i) COVERAGE UNDER PRESCRIPTION  
12 DRUG PLAN OR MEDICARE+CHOICE  
13 PLAN.—Qualified prescription drug cov-  
14 erage under a prescription drug plan or  
15 under a Medicare+Choice plan.

16 “(ii) MEDICAID PRESCRIPTION DRUG  
17 COVERAGE.—Prescription drug coverage  
18 under a medicaid plan under title XIX, in-  
19 cluding through the Program of All-inclu-  
20 sive Care for the Elderly (PACE) under  
21 section 1934, through a social health main-  
22 tenance organization (referred to in section  
23 4104(c) of the Balanced Budget Act of  
24 1997), or through a Medicare+Choice  
25 project that demonstrates the application

1 of capitation payment rates for frail elderly  
2 medicare beneficiaries through the use of a  
3 interdisciplinary team and through the  
4 provision of primary care services to such  
5 beneficiaries by means of such a team at  
6 the nursing facility involved.

7 “(iii) PRESCRIPTION DRUG COVERAGE  
8 UNDER GROUP HEALTH PLAN.—Any out-  
9 patient prescription drug coverage under a  
10 group health plan, including a health bene-  
11 fits plan under the Federal Employees  
12 Health Benefit Plan under chapter 89 of  
13 title 5, United States Code, and a qualified  
14 retiree prescription drug plan as defined in  
15 section 1860H(f)(1), but only if (subject to  
16 subparagraph (E)(ii)) the coverage pro-  
17 vides benefits at least equivalent to the  
18 benefits under a qualified prescription drug  
19 plan.

20 “(iv) PRESCRIPTION DRUG COVERAGE  
21 UNDER CERTAIN MEDIGAP POLICIES.—  
22 Coverage under a medicare supplemental  
23 policy under section 1882 that provides  
24 benefits for prescription drugs (whether or  
25 not such coverage conforms to the stand-

1 ards for packages of benefits under section  
2 1882(p)(1)), but only if the policy was in  
3 effect on January 1, 2005, and if (subject  
4 to subparagraph (E)(ii)) the coverage pro-  
5 vides benefits at least equivalent to the  
6 benefits under a qualified prescription drug  
7 plan.

8 “(v) STATE PHARMACEUTICAL ASSIST-  
9 ANCE PROGRAM.—Coverage of prescription  
10 drugs under a State pharmaceutical assist-  
11 ance program, but only if (subject to sub-  
12 paragraph (E)(ii)) the coverage provides  
13 benefits at least equivalent to the benefits  
14 under a qualified prescription drug plan.

15 “(vi) VETERANS’ COVERAGE OF PRE-  
16 SCRIPTON DRUGS.—Coverage of prescrip-  
17 tion drugs for veterans under chapter 17  
18 of title 38, United States Code, but only if  
19 (subject to subparagraph (E)(ii)) the cov-  
20 erage provides benefits at least equivalent  
21 to the benefits under a qualified prescrip-  
22 tion drug plan.

23 “(D) CERTIFICATION.—For purposes of  
24 carrying out this paragraph, the certifications  
25 of the type described in sections 2701(e) of the

1 Public Health Service Act and in section  
2 9801(e) of the Internal Revenue Code shall also  
3 include a statement for the period of coverage  
4 of whether the individual involved had prescrip-  
5 tion drug coverage described in subparagraph  
6 (C).

7 “(E) DISCLOSURE.—

8 “(i) IN GENERAL.—Each entity that  
9 offers coverage of the type described in  
10 clause (iii), (iv), (v), or (vi) of subpara-  
11 graph (C) shall provide for disclosure, con-  
12 sistent with standards established by the  
13 Administrator, of whether such coverage  
14 provides benefits at least equivalent to the  
15 benefits under a qualified prescription drug  
16 plan.

17 “(ii) WAIVER OF LIMITATIONS.—An  
18 individual may apply to the Administrator  
19 to waive the requirement that coverage of  
20 such type provide benefits at least equiva-  
21 lent to the benefits under a qualified pre-  
22 scription drug plan, if the individual estab-  
23 lishes that the individual was not ade-  
24 quately informed that such coverage did  
25 not provide such level of benefits.

1           “(F) CONSTRUCTION.—Nothing in this  
2           section shall be construed as preventing the  
3           disenrollment of an individual from a prescrip-  
4           tion drug plan or a Medicare+Choice plan  
5           based on the termination of an election de-  
6           scribed in section 1851(g)(3), including for non-  
7           payment of premiums or for other reasons spec-  
8           ified in subsection (d)(3), which takes into ac-  
9           count a grace period described in section  
10          1851(g)(3)(B)(i).

11          “(3) NONDISCRIMINATION.—A PDP sponsor of-  
12          fering a prescription drug plan shall not establish a  
13          service area in a manner that would discriminate  
14          based on health or economic status of potential en-  
15          rollees.

16          “(d) EFFECTIVE DATE OF ELECTIONS.—

17                 “(1) IN GENERAL.—Except as provided in this  
18                 section, the Administrator shall provide that elec-  
19                 tions under subsection (b) take effect at the same  
20                 time as the Administrator provides that similar elec-  
21                 tions under section 1851(e) take effect under section  
22                 1851(f).

23                 “(2) NO ELECTION EFFECTIVE BEFORE 2005.—  
24                 In no case shall any election take effect before Janu-  
25                 ary 1, 2005.

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

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

6           “(B) termination of elections described in  
7 section 1851(g)(3) (including failure to pay re-  
8 quired premiums).

9 **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**  
10 **TION DRUG COVERAGE.**

11       “(a) REQUIREMENTS.—

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

15           “(A) STANDARD COVERAGE WITH ACCESS  
16 TO NEGOTIATED PRICES.—Standard coverage  
17 (as defined in subsection (b)) and access to ne-  
18 gotiated prices under subsection (d).

19           “(B) ACTUARIALLY EQUIVALENT COV-  
20 ERAGE WITH ACCESS TO NEGOTIATED  
21 PRICES.—Coverage of covered outpatient drugs  
22 which meets the alternative coverage require-  
23 ments of subsection (c) and access to negotiated  
24 prices under subsection (d), but only if it is ap-

1 proved by the Administrator, as provided under  
2 subsection (c).

3 “(2) PERMITTING ADDITIONAL OUTPATIENT  
4 PRESCRIPTION DRUG COVERAGE.—

5 “(A) IN GENERAL.—Subject to subpara-  
6 graph (B), nothing in this part shall be con-  
7 strued as preventing qualified prescription drug  
8 coverage from including coverage of covered  
9 outpatient drugs that exceeds the coverage re-  
10 quired under paragraph (1), but any such addi-  
11 tional coverage shall be limited to coverage of  
12 covered outpatient drugs.

13 “(B) DISAPPROVAL AUTHORITY.—The Ad-  
14 ministrator shall review the offering of qualified  
15 prescription drug coverage under this part or  
16 part C. If the Administrator finds that, in the  
17 case of a qualified prescription drug coverage  
18 under a prescription drug plan or a  
19 Medicare+Choice plan, that the organization or  
20 sponsor offering the coverage is engaged in ac-  
21 tivities intended to discourage enrollment of  
22 classes of eligible medicare beneficiaries obtain-  
23 ing coverage through the plan on the basis of  
24 their higher likelihood of utilizing prescription  
25 drug coverage, the Administrator may termi-

1           nate the contract with the sponsor or organiza-  
2           tion under this part or part C.

3           “(3) APPLICATION OF SECONDARY PAYOR PRO-  
4           VISIONS.—The provisions of section 1852(a)(4) shall  
5           apply under this part in the same manner as they  
6           apply under part C.

7           “(b) STANDARD COVERAGE.—For purposes of this  
8           part, the ‘standard coverage’ is coverage of covered out-  
9           patient drugs (as defined in subsection (f)) that meets the  
10          following requirements:

11           “(1) DEDUCTIBLE.—The coverage has an an-  
12          nual deductible—

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

14                   “(B) for a subsequent year, that is equal  
15                   to the amount specified under this paragraph  
16                   for the previous year increased by the percent-  
17                   age specified in paragraph (5) for the year in-  
18                   volved.

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

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

23                   “(A) IN GENERAL.—The coverage has  
24                   cost-sharing (for costs above the annual deduct-  
25                   ible specified in paragraph (1) and up to the

1 initial coverage limit under paragraph (3)) as  
2 follows:

3 “(i) FIRST COPAYMENT RANGE.—For  
4 costs above the annual deductible specified  
5 in paragraph (1) and up to amount speci-  
6 fied in subparagraph (C), the cost-  
7 sharing—

8 “(I) is equal to 20 percent; or

9 “(II) is actuarially equivalent  
10 (using processes established under  
11 subsection (e)) to an average expected  
12 payment of 20 percent of such costs.

13 “(ii) SECONDARY COPAYMENT  
14 RANGE.—For costs above the amount spec-  
15 ified in subparagraph (C) and up to the  
16 initial coverage limit, the cost-sharing—

17 “(I) is equal to 50 percent; or

18 “(II) is actuarially consistent  
19 (using processes established under  
20 subsection (e)) with an average ex-  
21 pected payment of 50 percent of such  
22 costs.

23 “(B) USE OF TIERED COPAYMENTS.—

24 Nothing in this part shall be construed as pre-  
25 venting a PDP sponsor from applying tiered co-

1 payments, so long as such tiered copayments  
2 are consistent with subparagraph (A).

3 “(C) INITIAL COPAYMENT THRESHOLD.—

4 The amount specified in this subparagraph—

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

6 “(ii) for a subsequent year, is equal to

7 the amount specified in this subparagraph

8 for the previous year, increased by the an-

9 nual percentage increase described in para-

10 graph (5) for the year involved.

11 Any amount determined under clause (ii) that

12 is not a multiple of \$10 shall be rounded to the

13 nearest multiple of \$10.

14 “(3) INITIAL COVERAGE LIMIT.—Subject to

15 paragraph (4), the coverage has an initial coverage

16 limit on the maximum costs that may be recognized

17 for payment purposes—

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

19 “(B) for a subsequent year, that is equal

20 to the amount specified in this paragraph for

21 the previous year, increased by the annual per-

22 centage increase described in paragraph (5) for

23 the year involved.

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

4 “(4) CATASTROPHIC PROTECTION.—

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

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

16 “(i) for 2005, is equal to \$3,700; or

17 “(ii) for a subsequent year, is equal to  
18 the amount specified in this subparagraph  
19 for the previous year, increased by the an-  
20 nual percentage increase described in para-  
21 graph (5) for the year involved.

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

1           “(C) APPLICATION.—In applying subpara-  
2 graph (A)—

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

10           “(ii) such costs shall be treated as in-  
11 curred only if they are paid by the indi-  
12 vidual (or by another individual, such as a  
13 family member, on behalf of the indi-  
14 vidual), under section 1860G, or under  
15 title XIX and the individual (or other indi-  
16 vidual) is not reimbursed through insur-  
17 ance or otherwise, a group health plan, or  
18 other third-party payment arrangement for  
19 such costs.

20           “(5) ANNUAL PERCENTAGE INCREASE.—For  
21 purposes of this part, the annual percentage increase  
22 specified in this paragraph for a year is equal to the  
23 annual percentage increase in average per capita ag-  
24 gregate expenditures for covered outpatient drugs in  
25 the United States for medicare beneficiaries, as de-

1       terminated by the Administrator for the 12-month pe-  
2       riod ending in July of the previous year.

3       “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A  
4       prescription drug plan or Medicare+Choice plan may pro-  
5       vide a different prescription drug benefit design from the  
6       standard coverage described in subsection (b) so long as  
7       the Administrator determines (based on an actuarial anal-  
8       ysis by the Administrator) that the following requirements  
9       are met and the plan applies for, and receives, the ap-  
10      proval of the Administrator for such benefit design:

11             “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-  
12      ALENT COVERAGE.—

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

18                     “(B) ASSURING EQUIVALENT UNSUB-  
19      SIDIZED VALUE OF COVERAGE.—The unsub-  
20      sidized value of the coverage is at least equal to  
21      the unsubsidized value of standard coverage.  
22      For purposes of this subparagraph, the unsub-  
23      sidized value of coverage is the amount by  
24      which the actuarial value of the coverage (as  
25      determined under subsection (e)) exceeds the

1           actuarial value of the subsidy payments under  
2           section 1860H with respect to such coverage.

3           “(C) ASSURING STANDARD PAYMENT FOR  
4           COSTS AT INITIAL COVERAGE LIMIT.—The cov-  
5           erage is designed, based upon an actuarially  
6           representative pattern of utilization (as deter-  
7           mined under subsection (e)), to provide for the  
8           payment, with respect to costs incurred that are  
9           equal to the initial coverage limit under sub-  
10          section (b)(3), of an amount equal to at least  
11          the sum of the following products:

12                   “(i) FIRST COPAYMENT RANGE.—The  
13                   product of—

14                           “(I) the amount by which the ini-  
15                           tial copayment threshold described in  
16                           subsection (b)(2)(C) exceeds the de-  
17                           ductible described in subsection  
18                           (b)(1); and

19                           “(II) 100 percent minus the cost-  
20                           sharing percentage specified in sub-  
21                           section (b)(2)(A)(i)(I).

22                   “(ii) SECONDARY COPAYMENT  
23                   RANGE.—The product of—

24                           “(I) the amount by which the ini-  
25                           tial coverage limit described in sub-

1 section (b)(3) exceeds the initial co-  
2 payment threshold described in sub-  
3 section (b)(2)(C); and

4 “(II) 100 percent minus the cost-  
5 sharing percentage specified in sub-  
6 section (b)(2)(A)(ii)(I).

7 “(2) CATASTROPHIC PROTECTION.—The cov-  
8 erage provides for beneficiaries the catastrophic pro-  
9 tection described in subsection (b)(4).

10 “(d) ACCESS TO NEGOTIATED PRICES.—

11 “(1) IN GENERAL.—Under qualified prescrip-  
12 tion drug coverage offered by a PDP sponsor or a  
13 Medicare+Choice organization, the sponsor or orga-  
14 nization shall provide beneficiaries with access to ne-  
15 gotiated prices (including applicable discounts) used  
16 for payment for covered outpatient drugs, regardless  
17 of the fact that no benefits may be payable under  
18 the coverage with respect to such drugs because of  
19 the application of cost-sharing or an initial coverage  
20 limit (described in subsection (b)(3)). Insofar as a  
21 State elects to provide medical assistance under title  
22 XIX for a drug based on the prices negotiated by a  
23 prescription drug plan under this part, the require-  
24 ments of section 1927 shall not apply to such drugs.  
25 The prices negotiated by a prescription drug plan

1 under this part, by a Medicare+Choice plan with re-  
2 spect to covered outpatient drugs, or by a qualified  
3 retiree prescription drug plan (as defined in section  
4 1860H(f)(1)) with respect to such drugs on behalf  
5 of individuals entitled to benefits under part A or  
6 enrolled under part B, shall (notwithstanding any  
7 other provision of law) not be taken into account for  
8 the purposes of establishing the best price under sec-  
9 tion 1927(c)(1)(C).

10 “(2) DISCLOSURE.—The PDP sponsor or  
11 Medicare+Choice organization shall disclose to the  
12 Administrator (in a manner specified by the Admin-  
13 istrator) the extent to which discounts or rebates  
14 made available to the sponsor or organization by a  
15 manufacturer are passed through to enrollees  
16 through pharmacies and other dispensers or other-  
17 wise. The provisions of section 1927(b)(3)(D) shall  
18 apply to information disclosed to the Administrator  
19 under this paragraph in the same manner as such  
20 provisions apply to information disclosed under such  
21 section.

22 “(e) ACTUARIAL VALUATION; DETERMINATION OF  
23 ANNUAL PERCENTAGE INCREASES.—

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

4                   “(A) for determining the actuarial valu-  
5                   ation of prescription drug coverage, including—

6                           “(i) an actuarial valuation of standard  
7                           coverage and of the reinsurance subsidy  
8                           payments under section 1860H;

9                           “(ii) the use of generally accepted ac-  
10                          tuarial principles and methodologies; and

11                          “(iii) applying the same methodology  
12                          for determinations of alternative coverage  
13                          under subsection (c) as is used with re-  
14                          spect to determinations of standard cov-  
15                          erage under subsection (b); and

16                          “(B) for determining annual percentage in-  
17                          creases described in subsection (b)(5).

18           “(2) USE OF OUTSIDE ACTUARIES.—Under the  
19           processes under paragraph (1)(A), PDP sponsors  
20           and Medicare+Choice organizations may use actu-  
21           arial opinions certified by independent, qualified ac-  
22           tuaries to establish actuarial values, but the Admin-  
23           istrator shall determine whether such actuarial val-  
24           ues meet the requirements under subsection (c)(1).

25           “(f) COVERED OUTPATIENT DRUGS DEFINED.—

1           “(1) IN GENERAL.—Except as provided in this  
2 subsection, for purposes of this part, the term ‘cov-  
3 ered outpatient drug’ means—

4           “(A) a drug that may be dispensed only  
5 upon a prescription and that is described in  
6 subparagraph (A)(i) or (A)(ii) of section  
7 1927(k)(2); or

8           “(B) a biological product described in  
9 clauses (i) through (iii) of subparagraph (B) of  
10 such section or insulin described in subpara-  
11 graph (C) of such section,

12 and such term includes a vaccine licensed under sec-  
13 tion 351 of the Public Health Service Act and any  
14 use of a covered outpatient drug for a medically ac-  
15 cepted indication (as defined in section 1927(k)(6)).

16           “(2) EXCLUSIONS.—

17           “(A) IN GENERAL.—Such term does not  
18 include drugs or classes of drugs, or their med-  
19 ical uses, which may be excluded from coverage  
20 or otherwise restricted under section  
21 1927(d)(2), other than subparagraph (E) there-  
22 of (relating to smoking cessation agents), or  
23 under section 1927(d)(3).

24           “(B) AVOIDANCE OF DUPLICATE COV-  
25 ERAGE.—A drug prescribed for an individual

1           that would otherwise be a covered outpatient  
2           drug under this part shall not be so considered  
3           if payment for such drug is available under part  
4           A or B for an individual entitled to benefits  
5           under part A and enrolled under part B.

6           “(3) APPLICATION OF FORMULARY RESTRIC-  
7           TIONS.—A drug prescribed for an individual that  
8           would otherwise be a covered outpatient drug under  
9           this part shall not be so considered under a plan if  
10          the plan excludes the drug under a formulary and  
11          such exclusion is not successfully appealed under  
12          section 1860C(f)(2).

13          “(4) APPLICATION OF GENERAL EXCLUSION  
14          PROVISIONS.—A prescription drug plan or  
15          Medicare+Choice plan may exclude from qualified  
16          prescription drug coverage any covered outpatient  
17          drug—

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

20                 “(B) which are not prescribed in accord-  
21                 ance with the plan or this part.

22          Such exclusions are determinations subject to recon-  
23          sideration and appeal pursuant to section 1860C(f).

1 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**  
2 **PRESCRIPTION DRUG COVERAGE.**

3 “(a) **GUARANTEED ISSUE, COMMUNITY-RATED PRE-**  
4 **MIUMS, ACCESS TO NEGOTIATED PRICES, AND NON-**  
5 **DISCRIMINATION.**—For provisions requiring guaranteed  
6 issue, community-rated premiums, access to negotiated  
7 prices, and nondiscrimination, see sections 1860A(c)(1),  
8 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

9 “(b) **DISSEMINATION OF INFORMATION.**—

10 “(1) **GENERAL INFORMATION.**—A PDP sponsor  
11 shall disclose, in a clear, accurate, and standardized  
12 form to each enrollee with a prescription drug plan  
13 offered by the sponsor under this part at the time  
14 of enrollment and at least annually thereafter, the  
15 information described in section 1852(c)(1) relating  
16 to such plan. Such information includes the fol-  
17 lowing:

18 “(A) Access to covered outpatient drugs,  
19 including access through pharmacy networks.

20 “(B) How any formulary used by the spon-  
21 sor functions, including the drugs included in  
22 the formulary.

23 “(C) Co-payments and deductible require-  
24 ments, including the identification of the tiered  
25 or other co-payment level applicable to each  
26 drug (or class of drugs).

1                   “(D) Grievance and appeals procedures.

2           Such information shall also be made available on re-  
3           quest to prospective enrollees during annual open  
4           enrollment periods.

5                   “(2) DISCLOSURE UPON REQUEST OF GENERAL  
6           COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-  
7           TION.—Upon request of an individual eligible to en-  
8           roll under a prescription drug plan, the PDP spon-  
9           sor shall provide the information described in section  
10          1852(e)(2) (other than subparagraph (D)) to such  
11          individual.

12                   “(3) RESPONSE TO BENEFICIARY QUESTIONS.—  
13          Each PDP sponsor offering a prescription drug plan  
14          shall have a mechanism for providing specific infor-  
15          mation to enrollees upon request. The sponsor shall  
16          make available on a timely basis, through an Inter-  
17          net website and in writing upon request, information  
18          on specific changes in its formulary.

19                   “(4) CLAIMS INFORMATION.—Each PDP spon-  
20          sor offering a prescription drug plan must furnish to  
21          enrolled individuals in a form easily understandable  
22          to such individuals an explanation of benefits (in ac-  
23          cordance with section 1806(a) or in a comparable  
24          manner) and a notice of the benefits in relation to  
25          initial coverage limit and annual out-of-pocket

1 threshold for the current year, whenever prescription  
2 drug benefits are provided under this part (except  
3 that such notice need not be provided more often  
4 than monthly).

5 “(c) ACCESS TO COVERED BENEFITS.—

6 “(1) ASSURING PHARMACY ACCESS.—

7 “(A) IN GENERAL.—The PDP sponsor of  
8 the prescription drug plan shall secure the par-  
9 ticipation in its network of a sufficient number  
10 of pharmacies that dispense (other than by mail  
11 order) drugs directly to patients to ensure con-  
12 venient access (as determined by the Adminis-  
13 trator and including adequate emergency ac-  
14 cess) for enrolled beneficiaries, in accordance  
15 with standards established under section  
16 1860D(e) that ensure such convenient access.

17 “(B) USE OF POINT-OF-SERVICE SYS-  
18 TEM.—A PDP sponsor shall establish an op-  
19 tional point-of-service method of operation  
20 under which—

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

24 “(ii) the plan may charge beneficiaries  
25 through adjustments in premiums and co-

1           payments any additional costs associated  
2           with the point-of-service option.

3           The additional copayments so charged shall not  
4           count toward the application of section  
5           1860B(b).

6           “(2) USE OF STANDARDIZED TECHNOLOGY.—

7           “(A) IN GENERAL.—The PDP sponsor of  
8           a prescription drug plan shall issue (and re-  
9           issue, as appropriate) such a card (or other  
10          technology) that may be used by an enrolled  
11          beneficiary to assure access to negotiated prices  
12          under section 1860B(d) for the purchase of  
13          prescription drugs for which coverage is not  
14          otherwise provided under the prescription drug  
15          plan.

16          “(B) STANDARDS.—

17          “(i) DEVELOPMENT.—The Adminis-  
18          trator shall provide for the development of  
19          national standards relating to a standard-  
20          ized format for the card or other tech-  
21          nology referred to in subparagraph (A).  
22          Such standards shall be compatible with  
23          standards established under part C of title  
24          XI.

1                   “(ii) APPLICATION OF ADVISORY TASK  
2                   FORCE.—The advisory task force estab-  
3                   lished under subsection (d)(3)(B)(ii) shall  
4                   provide recommendations to the Adminis-  
5                   trator under such subsection regarding the  
6                   standards developed under clause (i).

7                   “(3) REQUIREMENTS ON DEVELOPMENT AND  
8                   APPLICATION OF FORMULARIES.—If a PDP sponsor  
9                   of a prescription drug plan uses a formulary, the fol-  
10                  lowing requirements must be met:

11                  “(A) PHARMACY AND THERAPEUTIC (P&T)  
12                  COMMITTEE.—The sponsor must establish a  
13                  pharmacy and therapeutic committee that de-  
14                  velops and reviews the formulary. Such com-  
15                  mittee shall include at least one practicing phy-  
16                  sician and at least one practicing pharmacist  
17                  both with expertise in the care of elderly or dis-  
18                  abled persons and a majority of its members  
19                  shall consist of individuals who are a practicing  
20                  physician or a practicing pharmacist (or both).

21                  “(B) FORMULARY DEVELOPMENT.—In de-  
22                  veloping and reviewing the formulary, the com-  
23                  mittee shall base clinical decisions on the  
24                  strength of scientific evidence and standards of  
25                  practice, including assessing peer-reviewed med-

1           ical literature, such as randomized clinical  
2           trials, pharmacoeconomic studies, outcomes re-  
3           search data, and such other information as the  
4           committee determines to be appropriate.

5           “(C) INCLUSION OF DRUGS IN ALL THERA-  
6           PEUTIC CATEGORIES.—The formulary must in-  
7           clude drugs within each therapeutic category  
8           and class of covered outpatient drugs (although  
9           not necessarily for all drugs within such cat-  
10          egories and classes).

11          “(D) PROVIDER EDUCATION.—The com-  
12          mittee shall establish policies and procedures to  
13          educate and inform health care providers con-  
14          cerning the formulary.

15          “(E) NOTICE BEFORE REMOVING DRUGS  
16          FROM FORMULARY.—Any removal of a drug  
17          from a formulary shall take effect only after ap-  
18          propriate notice is made available to bene-  
19          ficiaries and physicians.

20          “(F) GRIEVANCES AND APPEALS RELAT-  
21          ING TO APPLICATION OF FORMULARIES.—For  
22          provisions relating to grievances and appeals of  
23          coverage, see subsections (e) and (f).

1       “(d) COST AND UTILIZATION MANAGEMENT; QUAL-  
2   ITY ASSURANCE; MEDICATION THERAPY MANAGEMENT  
3   PROGRAM.—

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

7           “(A) an effective cost and drug utilization  
8   management program, including medically ap-  
9   propriate incentives to use generic drugs and  
10   therapeutic interchange, when appropriate;

11          “(B) quality assurance measures and sys-  
12   tems to reduce medical errors and adverse drug  
13   interactions, including a medication therapy  
14   management program described in paragraph  
15   (2) and for years beginning with 2006, an elec-  
16   tronic prescription program described in para-  
17   graph (3); and

18          “(C) a program to control fraud, abuse,  
19   and waste.

20       Nothing in this section shall be construed as impair-  
21   ing a PDP sponsor from applying cost management  
22   tools (including differential payments) under all  
23   methods of operation.

24           “(2) MEDICATION THERAPY MANAGEMENT PRO-  
25   GRAM.—

1           “(A) IN GENERAL.—A medication therapy  
2 management program described in this para-  
3 graph is a program of drug therapy manage-  
4 ment and medication administration that is de-  
5 signed to assure, with respect to beneficiaries  
6 with chronic diseases (such as diabetes, asthma,  
7 hypertension, and congestive heart failure) or  
8 multiple prescriptions, that covered outpatient  
9 drugs under the prescription drug plan are ap-  
10 propriately used to achieve therapeutic goals  
11 and reduce the risk of adverse events, including  
12 adverse drug interactions.

13           “(B) ELEMENTS.—Such program may  
14 include—

15           “(i) enhanced beneficiary under-  
16 standing of such appropriate use through  
17 beneficiary education, counseling, and  
18 other appropriate means;

19           “(ii) increased beneficiary adherence  
20 with prescription medication regimens  
21 through medication refill reminders, special  
22 packaging, and other appropriate means;  
23 and

24           “(iii) detection of patterns of overuse  
25 and underuse of prescription drugs.

1           “(C) DEVELOPMENT OF PROGRAM IN CO-  
2           OPERATION WITH LICENSED PHARMACISTS.—  
3           The program shall be developed in cooperation  
4           with licensed and practicing pharmacists and  
5           physicians.

6           “(D) CONSIDERATIONS IN PHARMACY  
7           FEES.—The PDP sponsor of a prescription  
8           drug program shall take into account, in estab-  
9           lishing fees for pharmacists and others pro-  
10          viding services under the medication therapy  
11          management program, the resources and time  
12          used in implementing the program.

13          “(3) ELECTRONIC PRESCRIPTION PROGRAM.—

14                 “(A) IN GENERAL.—An electronic prescrip-  
15                 tion drug program described in this paragraph  
16                 is a program that includes at least the following  
17                 components, consistent with national standards  
18                 established under subparagraph (B):

19                         “(i) ELECTRONIC TRANSMITTAL OF  
20                         PRESCRIPTIONS.—Prescriptions are only  
21                         received electronically, except in emergency  
22                         cases and other exceptional circumstances  
23                         recognized by the Administrator.

24                         “(ii) PROVISION OF INFORMATION TO  
25                         PRESCRIBING HEALTH CARE PROFES-

1           SIONAL.—The program provides, upon  
2           transmittal of a prescription by a pre-  
3           scribing health care professional, for trans-  
4           mittal by the pharmacist to the profes-  
5           sional of information that includes—

6                   “(I) information (to the extent  
7                   available and feasible) on the drugs  
8                   being prescribed for that patient and  
9                   other information relating to the med-  
10                  ical history or condition of the patient  
11                  that may be relevant to the appro-  
12                  priate prescription for that patient;

13                  “(II) cost-effective alternatives (if  
14                  any) for the use of the drug pre-  
15                  scribed; and

16                  “(III) information on the drugs  
17                  included in the applicable formulary.

18           To the extent feasible, such program shall  
19           permit the prescribing health care profes-  
20           sional to provide (and be provided) related  
21           information on an interactive, real-time  
22           basis.

23           “(B) STANDARDS.—

24                   “(i) DEVELOPMENT.—The Adminis-  
25                   trator shall provide for the development of

1 national standards relating to the elec-  
2 tronic prescription drug program described  
3 in subparagraph (A). Such standards shall  
4 be compatible with standards established  
5 under part C of title XI.

6 “(ii) ADVISORY TASK FORCE.—In de-  
7 veloping such standards and the standards  
8 described in subsection (c)(2)(B)(i) the Ad-  
9 ministrator shall establish a task force that  
10 includes representatives of physicians, hos-  
11 pitals, pharmacists, and technology experts  
12 and representatives of the Departments of  
13 Veterans Affairs and Defense and other  
14 appropriate Federal agencies to provide  
15 recommendations to the Administrator on  
16 such standards, including recommenda-  
17 tions relating to the following:

18 “(I) The range of available com-  
19 puterized prescribing software and  
20 hardware and their costs to develop  
21 and implement.

22 “(II) The extent to which such  
23 systems reduce medication errors and  
24 can be readily implemented by physi-  
25 cians and hospitals.

1           “(III) Efforts to develop a com-  
2           mon software platform for computer-  
3           ized prescribing.

4           “(IV) The cost of implementing  
5           such systems in the range of hospital  
6           and physician office settings, includ-  
7           ing hardware, software, and training  
8           costs.

9           “(V) Implementation issues as  
10          they relate to part C of title XI, and  
11          current Federal and State prescribing  
12          laws and regulations and their impact  
13          on implementation of computerized  
14          prescribing.

15          “(iii) DEADLINES.—

16               “(I) The Administrator shall con-  
17               stitute the task force under clause (ii)  
18               by not later than April 1, 2003.

19               “(II) Such task force shall sub-  
20               mit recommendations to Adminis-  
21               trator by not later than January 1,  
22               2004.

23               “(III) The Administrator shall  
24               develop and promulgate the national

1 standards referred to in clause (ii) by  
2 not later than January 1, 2005.

3 “(C) REFERENCE TO AVAILABILITY OF  
4 GRANT FUNDS.—Grant funds are authorized  
5 under section 3990 of the Public Health Serv-  
6 ice Act to provide assistance to health care pro-  
7 viders in implementing electronic prescription  
8 drug programs.

9 “(4) TREATMENT OF ACCREDITATION.—Section  
10 1852(e)(4) (relating to treatment of accreditation)  
11 shall apply to prescription drug plans under this  
12 part with respect to the following requirements, in  
13 the same manner as they apply to Medicare+Choice  
14 plans under part C with respect to the requirements  
15 described in a clause of section 1852(e)(4)(B):

16 “(A) Paragraph (1) (including quality as-  
17 surance), including medication therapy manage-  
18 ment program under paragraph (2).

19 “(B) Subsection (c)(1) (relating to access  
20 to covered benefits).

21 “(C) Subsection (g) (relating to confiden-  
22 tiality and accuracy of enrollee records).

23 “(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL  
24 PRICES FOR EQUIVALENT DRUGS.—Each PDP spon-  
25 sor shall provide that each pharmacy or other dis-

1       penser that arranges for the dispensing of a covered  
2       outpatient drug shall inform the beneficiary at the  
3       time of purchase of the drug of any differential be-  
4       tween the price of the prescribed drug to the enrollee  
5       and the price of the lowest cost generic drug covered  
6       under the plan that is therapeutically equivalent and  
7       bioequivalent.

8       “(e) GRIEVANCE MECHANISM, COVERAGE DETER-  
9       MINATIONS, AND RECONSIDERATIONS.—

10           “(1) IN GENERAL.—Each PDP sponsor shall  
11       provide meaningful procedures for hearing and re-  
12       solving grievances between the organization (includ-  
13       ing any entity or individual through which the spon-  
14       sor provides covered benefits) and enrollees with pre-  
15       scription drug plans of the sponsor under this part  
16       in accordance with section 1852(f).

17           “(2) APPLICATION OF COVERAGE DETERMINA-  
18       TION AND RECONSIDERATION PROVISIONS.—A PDP  
19       sponsor shall meet the requirements of paragraphs  
20       (1) through (3) of section 1852(g) with respect to  
21       covered benefits under the prescription drug plan it  
22       offers under this part in the same manner as such  
23       requirements apply to a Medicare+Choice organiza-  
24       tion with respect to benefits it offers under a  
25       Medicare+Choice plan under part C.

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

14          “(f) APPEALS.—

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

23                 “(2) FORMULARY DETERMINATIONS.—An indi-  
24                 vidual who is enrolled in a prescription drug plan of-  
25                 fered by a PDP sponsor may appeal to obtain cov-

1 erage for a covered outpatient drug that is not on  
2 a formulary of the sponsor if the prescribing physi-  
3 cian determines that the formulary drug for treat-  
4 ment of the same condition is not as effective for the  
5 individual or has adverse effects for the individual.

6 “(g) CONFIDENTIALITY AND ACCURACY OF EN-  
7 ROLLEE RECORDS.—A PDP sponsor shall meet the re-  
8 quirements of section 1852(h) with respect to enrollees  
9 under this part in the same manner as such requirements  
10 apply to a Medicare+Choice organization with respect to  
11 enrollees under part C.

12 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**  
13 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**  
14 **LISHMENT OF STANDARDS.**

15 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor  
16 of a prescription drug plan shall meet the following re-  
17 quirements:

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

23 “(2) ASSUMPTION OF FINANCIAL RISK FOR UN-  
24 SUBSIDIZED COVERAGE.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B) and section 1860E(d)(2), the entity  
3 assumes full financial risk on a prospective  
4 basis for qualified prescription drug coverage  
5 that it offers under a prescription drug plan  
6 and that is not covered under section 1860H.

7           “(B) REINSURANCE PERMITTED.—The en-  
8 tity may obtain insurance or make other ar-  
9 rangements for the cost of coverage provided to  
10 any enrolled member under this part.

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

16           “(b) CONTRACT REQUIREMENTS.—

17           “(1) IN GENERAL.—The Administrator shall  
18 not permit the election under section 1860A of a  
19 prescription drug plan offered by a PDP sponsor  
20 under this part, and the sponsor shall not be eligible  
21 for payments under section 1860G or 1860H, unless  
22 the Administrator has entered into a contract under  
23 this subsection with the sponsor with respect to the  
24 offering of such plan. Such a contract with a spon-  
25 sor may cover more than one prescription drug plan.

1 Such contract shall provide that the sponsor agrees  
2 to comply with the applicable requirements and  
3 standards of this part and the terms and conditions  
4 of payment as provided for in this part.

5 “(2) NEGOTIATION REGARDING TERMS AND  
6 CONDITIONS.—The Administrator shall have the  
7 same authority to negotiate the terms and conditions  
8 of prescription drug plans under this part as the Di-  
9 rector of the Office of Personnel Management has  
10 with respect to health benefits plans under chapter  
11 89 of title 5, United States Code. In negotiating the  
12 terms and conditions regarding premiums for which  
13 information is submitted under section 1860F(a)(2),  
14 the Administrator shall take into account the sub-  
15 sidy payments under section 1860H and the ad-  
16 justed community rate (as defined in section  
17 1854(f)(3)) for the benefits covered.

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

24 “(A) MINIMUM ENROLLMENT.—Para-  
25 graphs (1) and (3) of section 1857(b).

1           “(B) CONTRACT PERIOD AND EFFECTIVE-  
2           NESS.—Paragraphs (1) through (3) and (5) of  
3           section 1857(e).

4           “(C) PROTECTIONS AGAINST FRAUD AND  
5           BENEFICIARY PROTECTIONS.—Section 1857(d).

6           “(D) ADDITIONAL CONTRACT TERMS.—  
7           Section 1857(e); except that in applying section  
8           1857(e)(2) under this part—

9                   “(i) such section shall be applied sepa-  
10                   rately to costs relating to this part (from  
11                   costs under part C);

12                   “(ii) in no case shall the amount of  
13                   the fee established under this subpara-  
14                   graph for a plan exceed 20 percent of the  
15                   maximum amount of the fee that may be  
16                   established under subparagraph (B) of  
17                   such section; and

18                   “(iii) no fees shall be applied under  
19                   this subparagraph with respect to  
20                   Medicare+Choice plans.

21           “(E) INTERMEDIATE SANCTIONS.—Section  
22           1857(g).

23           “(F) PROCEDURES FOR TERMINATION.—  
24           Section 1857(h).

1           “(4) RULES OF APPLICATION FOR INTER-  
2           MEDIATE SANCTIONS.—In applying paragraph  
3           (3)(E)—

4                   “(A) the reference in section  
5                   1857(g)(1)(B) to section 1854 is deemed a ref-  
6                   erence to this part; and

7                   “(B) the reference in section  
8                   1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall  
9                   not be applied.

10          “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-  
11          PAND CHOICE.—

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

21                   “(2) GROUNDS FOR APPROVAL.—The grounds  
22                   for approval under this paragraph are the grounds  
23                   for approval described in subparagraph (B), (C),  
24                   and (D) of section 1855(a)(2), and also include the

1 application by a State of any grounds other than  
2 those required under Federal law.

3 “(3) APPLICATION OF WAIVER PROCEDURES.—  
4 With respect to an application for a waiver (or a  
5 waiver granted) under this subsection, the provisions  
6 of subparagraphs (E), (F), and (G) of section  
7 1855(a)(2) shall apply.

8 “(4) LICENSURE DOES NOT SUBSTITUTE FOR  
9 OR CONSTITUTE CERTIFICATION.—The fact that an  
10 entity is licensed in accordance with subsection  
11 (a)(1) does not deem the entity to meet other re-  
12 quirements imposed under this part for a PDP spon-  
13 sor.

14 “(5) REFERENCES TO CERTAIN PROVISIONS.—  
15 For purposes of this subsection, in applying provi-  
16 sions of section 1855(a)(2) under this subsection to  
17 prescription drug plans and PDP sponsors—

18 “(A) any reference to a waiver application  
19 under section 1855 shall be treated as a ref-  
20 erence to a waiver application under paragraph  
21 (1); and

22 “(B) any reference to solvency standards  
23 shall be treated as a reference to solvency  
24 standards established under subsection (d).

1       “(d) SOLVENCY STANDARDS FOR NON-LICENSED  
2 SPONSORS.—

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

9           “(2) COMPLIANCE WITH STANDARDS.—Each  
10 PDP sponsor that is not licensed by a State under  
11 subsection (a)(1) and for which a waiver application  
12 has been approved under subsection (c) shall meet  
13 solvency and capital adequacy standards established  
14 under paragraph (1). The Administrator shall estab-  
15 lish certification procedures for such PDP sponsors  
16 with respect to such solvency standards in the man-  
17 ner described in section 1855(c)(2).

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

23       “(f) RELATION TO STATE LAWS.—

24           “(1) IN GENERAL.—The standards established  
25 under this part shall supersede any State law or reg-

1       ulation (other than State licensing laws or State  
2       laws relating to plan solvency, except as provided in  
3       subsection (d)) with respect to prescription drug  
4       plans which are offered by PDP sponsors under this  
5       part.

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

12 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**  
13 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

14       “(a) IN GENERAL.—The Administrator shall estab-  
15      lish a process for the selection of the prescription drug  
16      plan or Medicare+Choice plan which offer qualified pre-  
17      scription drug coverage through which eligible individuals  
18      elect qualified prescription drug coverage under this part.

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

21               “(1) Annual, coordinated election periods, in  
22      which such individuals can change the qualifying  
23      plans through which they obtain coverage, in accord-  
24      ance with section 1860A(b)(2).

1           “(2) Active dissemination of information to pro-  
2           mote an informed selection among qualifying plans  
3           based upon price, quality, and other features, in the  
4           manner described in (and in coordination with) sec-  
5           tion 1851(d), including the provision of annual com-  
6           parative information, maintenance of a toll-free hot-  
7           line, and the use of non-Federal entities.

8           “(3) Coordination of elections through filing  
9           with a Medicare+Choice organization or a PDP  
10          sponsor, in the manner described in (and in coordi-  
11          nation with) section 1851(c)(2).

12          “(c) MEDICARE+CHOICE ENROLLEE IN PLAN OF-  
13          FERING PRESCRIPTION DRUG COVERAGE MAY ONLY OB-  
14          TAIN BENEFITS THROUGH THE PLAN.—An individual  
15          who is enrolled under a Medicare+Choice plan that offers  
16          qualified prescription drug coverage may only elect to re-  
17          ceive qualified prescription drug coverage under this part  
18          through such plan.

19          “(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED  
20          PRESCRIPTION DRUG COVERAGE.—

21                  “(1) CHOICE OF AT LEAST TWO PLANS IN EACH  
22          AREA.—

23                          “(A) IN GENERAL.—The Administrator  
24                          shall assure that each individual who is entitled  
25                          to benefits under part A or enrolled under part

1           B and who is residing in an area in the United  
2           States has available, consistent with subpara-  
3           graph (B), a choice of enrollment in at least  
4           two qualifying plans (as defined in paragraph  
5           (5)) in the area in which the individual resides,  
6           at least one of which is a prescription drug  
7           plan.

8           “(B) REQUIREMENT FOR DIFFERENT  
9           PLAN SPONSORS.—The requirement in subpara-  
10          graph (A) is not satisfied with respect to an  
11          area if only one PDP sponsor or  
12          Medicare+Choice organization offers all the  
13          qualifying plans in the area.

14          “(2) GUARANTEEING ACCESS TO COVERAGE.—  
15          In order to assure access under paragraph (1) and  
16          consistent with paragraph (3), the Administrator  
17          may provide financial incentives (including partial  
18          underwriting of risk) for a PDP sponsor to expand  
19          the service area under an existing prescription drug  
20          plan to adjoining or additional areas or to establish  
21          such a plan (including offering such a plan on a re-  
22          gional or nationwide basis), but only so long as (and  
23          to the extent) necessary to assure the access guaran-  
24          teed under paragraph (1).

1           “(3) LIMITATION ON AUTHORITY.—In exer-  
2           cising authority under this subsection, the  
3           Administrator—

4                   “(A) shall not provide for the full under-  
5                   writing of financial risk for any PDP sponsor;

6                   “(B) shall not provide for any under-  
7                   writing of financial risk for a public PDP spon-  
8                   sor with respect to the offering of a nationwide  
9                   prescription drug plan; and

10                   “(C) shall seek to maximize the assump-  
11                   tion of financial risk by PDP sponsors or  
12                   Medicare+Choice organizations.

13           “(4) REPORTS.—The Administrator shall, in  
14           each annual report to Congress under section  
15           1808(f), include information on the exercise of au-  
16           thority under this subsection. The Administrator  
17           also shall include such recommendations as may be  
18           appropriate to minimize the exercise of such author-  
19           ity, including minimizing the assumption of financial  
20           risk.

21           “(5) QUALIFYING PLAN DEFINED.—For pur-  
22           poses of this subsection, the term ‘qualifying plan’  
23           means a prescription drug plan or a  
24           Medicare+Choice plan that includes qualified pre-  
25           scription drug coverage.

1 **“SEC. 1860F. SUBMISSION OF BIDS AND PREMIUMS.**

2 “(a) SUBMISSION OF BIDS, PREMIUMS, AND RE-  
3 LATED INFORMATION.—

4 “(1) IN GENERAL.—Each PDP sponsor shall  
5 submit to the Administrator the information de-  
6 scribed in paragraph (2) in the same manner as in-  
7 formation is submitted by a Medicare+Choice orga-  
8 nization under section 1854(a)(1).

9 “(2) INFORMATION SUBMITTED.—The informa-  
10 tion described in this paragraph is the following:

11 “(A) COVERAGE PROVIDED.—Information  
12 on the qualified prescription drug coverage to  
13 be provided.

14 “(B) ACTUARIAL VALUE.—Information on  
15 the actuarial value of the coverage.

16 “(C) BID AND PREMIUM.—Information on  
17 the bid and the premium for the coverage, in-  
18 cluding an actuarial certification of—

19 “(i) the actuarial basis for such bid  
20 and premium;

21 “(ii) the portion of such bid and pre-  
22 mium attributable to benefits in excess of  
23 standard coverage; and

24 “(iii) the reduction in such bid and  
25 premium resulting from the subsidy pay-  
26 ments provided under section 1860H.

1           “(D) ADDITIONAL INFORMATION.—Such  
2           other information as the Administrator may re-  
3           quire to carry out this part.

4           “(3) REVIEW OF INFORMATION AND APPROVAL  
5           OF PREMIUMS.—The Administrator shall review the  
6           information filed under paragraph (2) for the pur-  
7           pose of conducting negotiations under section  
8           1860D(b)(2). The Administrator, using the informa-  
9           tion provided (including the actuarial certification  
10          under paragraph (2)(C)) shall approve the premium  
11          submitted under this subsection only if the premium  
12          accurately reflects both (A) the actuarial value of  
13          the benefits provided, and (B) the 67 percent sub-  
14          sidy provided under section 1860H for the standard  
15          benefit. The Administrator shall apply actuarial  
16          principles to approval of a premium under this part  
17          in a manner similar to the manner in which those  
18          principles are applied in establishing the monthly  
19          part B premium under section 1839.

20          “(b) UNIFORM BID AND PREMIUM.—

21                 “(1) IN GENERAL.—The bid and premium for  
22                 a prescription drug plan under this section may not  
23                 vary among individuals enrolled in the plan in the  
24                 same service area.

1           “(2) CONSTRUCTION.—Nothing in paragraph  
2           (1) shall be construed as preventing the imposition  
3           of a late enrollment penalty under section  
4           1860A(c)(2)(B).

5           “(c) COLLECTION.—

6           “(1) BENEFICIARY’S OPTION OF PAYMENT  
7           THROUGH WITHHOLDING FROM SOCIAL SECURITY  
8           PAYMENT OR USE OF ELECTRONIC FUNDS TRANS-  
9           FER MECHANISM.—In accordance with regulations, a  
10          PDP sponsor shall permit each enrollee, at the en-  
11          rollee’s option, to make payment of premiums under  
12          this part through withholding from benefit payments  
13          in the manner provided under section 1840 with re-  
14          spect to monthly premiums under section 1839 or  
15          through an electronic funds transfer mechanism  
16          (such as automatic charges of an account at a finan-  
17          cial institution or a credit or debit card account) or  
18          otherwise. All such amounts shall be credited to the  
19          Medicare Prescription Drug Trust Fund.

20          “(2) OFFSETTING.—Reductions in premiums  
21          for coverage under parts A and B as a result of a  
22          selection of a Medicare+Choice plan may be used to  
23          reduce the premium otherwise imposed under para-  
24          graph (1).

1           “(3) PAYMENT OF PLANS.—PDP plans shall re-  
2           ceive payment based on bid amounts in the same  
3           manner as Medicare+Choice organizations receive  
4           payment based on bid amounts under section  
5           1853(a)(1)(A)(ii) except that such payment shall be  
6           made from the Medicare Prescription Drug Trust  
7           Fund.

8           “(d) ACCEPTANCE OF BENCHMARK AMOUNT AS  
9           FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVID-  
10          UALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN  
11          AN AREA.—

12           “(1) IN GENERAL.—If there is no standard pre-  
13          scription drug coverage (as defined in paragraph  
14          (2)) offered in an area, in the case of an individual  
15          who is eligible for a premium subsidy under section  
16          1860G and resides in the area, the PDP sponsor of  
17          any prescription drug plan offered in the area (and  
18          any Medicare+Choice organization that offers quali-  
19          fied prescription drug coverage in the area) shall ac-  
20          cept the benchmark bid amount (under section  
21          1860G(b)(2)) as payment in full for the premium  
22          charge for qualified prescription drug coverage.

23           “(2) STANDARD PRESCRIPTION DRUG COV-  
24          ERAGE DEFINED.—For purposes of this subsection,  
25          the term ‘standard prescription drug coverage’

1 means qualified prescription drug coverage that is  
2 standard coverage or that has an actuarial value  
3 equivalent to the actuarial value for standard cov-  
4 erage.

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

7 “(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS  
8 WITH INCOME BELOW 175 PERCENT OF FEDERAL POV-  
9 ERTY LEVEL.—

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

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

21 “(B) subject to subsection (c), to the sub-  
22 stitution for the beneficiary cost-sharing de-  
23 scribed in paragraphs (1) and (2) of section  
24 1860B(b) (up to the initial coverage limit speci-  
25 fied in paragraph (3) of such section) of

1 amounts that do not exceed \$2 for a multiple  
2 source or generic drug (as described in section  
3 1927(k)(7)(A)) and \$5 for a non-preferred  
4 drug.

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

13 “(A) an income-related premium subsidy  
14 determined on a linear sliding scale ranging  
15 from 100 percent of the amount described in  
16 subsection (b)(1) for individuals with incomes  
17 at 150 percent of such level to 0 percent of  
18 such amount for individuals with incomes at  
19 175 percent of such level; and

20 “(B) subject to subsection (c), to the sub-  
21 stitution for the beneficiary cost-sharing de-  
22 scribed in paragraphs (1) and (2) of section  
23 1860B(b) (up to the initial coverage limit speci-  
24 fied in paragraph (3) of such section) of  
25 amounts that do not exceed \$2 for a multiple

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

4 “(3) CONSTRUCTION.—Nothing in this section  
5 shall be construed as preventing a PDP sponsor  
6 from reducing to 0 the cost-sharing otherwise appli-  
7 cable to generic drugs.

8 “(4) DETERMINATION OF ELIGIBILITY.—

9 “(A) SUBSIDY ELIGIBLE INDIVIDUAL DE-  
10 FINED.—For purposes of this section, subject  
11 to subparagraph (D), the term ‘subsidy eligible  
12 individual’ means an individual who—

13 “(i) is eligible to elect, and has elect-  
14 ed, to obtain qualified prescription drug  
15 coverage under this part;

16 “(ii) has income below 175 percent of  
17 the Federal poverty line; and

18 “(iii) meets the resources requirement  
19 described in section 1905(p)(1)(C).

20 “(B) DETERMINATIONS.—The determina-  
21 tion of whether an individual residing in a State  
22 is a subsidy eligible individual and the amount  
23 of such individual’s income shall be determined  
24 under the State medicaid plan for the State  
25 under section 1935(a) or by the Social Security

1 Administration. In the case of a State that does  
2 not operate such a medicaid plan (either under  
3 title XIX or under a statewide waiver granted  
4 under section 1115), such determination shall  
5 be made under arrangements made by the Ad-  
6 ministrator. There are authorized to be appro-  
7 priated to the Social Security Administration  
8 such sums as may be necessary for the deter-  
9 mination of eligibility under this subparagraph.

10 “(C) INCOME DETERMINATIONS.—For pur-  
11 poses of applying this section—

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

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

22 “(D) TREATMENT OF TERRITORIAL RESI-  
23 DENTS.—In the case of an individual who is not  
24 a resident of the 50 States or the District of  
25 Columbia, the individual is not eligible to be a

1           subsidy eligible individual but may be eligible  
2           for financial assistance with prescription drug  
3           expenses under section 1935(e).

4           “(E) TREATMENT OF CONFORMING  
5           MEDIGAP POLICIES.—For purposes of this sec-  
6           tion, the term ‘qualified prescription drug cov-  
7           erage’ includes a medicare supplemental policy  
8           described in section 1860H(b)(4).

9           “(5) INDEXING DOLLAR AMOUNTS.—

10           “(A) FOR 2006.—The dollar amounts ap-  
11           plied under paragraphs (1)(B) and (2)(B) for  
12           2006 shall be the dollar amounts specified in  
13           such paragraph increased by the annual per-  
14           centage increase described in section  
15           1860B(b)(5) for 2006.

16           “(B) FOR SUBSEQUENT YEARS.—The dol-  
17           lar amounts applied under paragraphs (1)(B)  
18           and (2)(B) for a year after 2006 shall be the  
19           amounts (under this paragraph) applied under  
20           paragraph (1)(B) or (2)(B) for the preceding  
21           year increased by the annual percentage in-  
22           crease described in section 1860B(b)(5) (relat-  
23           ing to growth in medicare prescription drug  
24           costs per beneficiary) for the year involved.

25           “(b) PREMIUM SUBSIDY AMOUNT.—

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

8           “(2) BENCHMARK BID AMOUNT DEFINED.—For  
9 purposes of this subsection, the term ‘benchmark bid  
10 amount’ means, with respect to qualified prescrip-  
11 tion drug coverage offered under—

12                   “(A) a prescription drug plan that—

13                           “(i) provides standard coverage (or al-  
14 ternative prescription drug coverage the  
15 actuarial value is equivalent to that of  
16 standard coverage), the bid amount for en-  
17 rollment under the plan under this part  
18 (determined without regard to any subsidy  
19 under this section or any late enrollment  
20 penalty under section 1860A(c)(2)(B)); or

21                           “(ii) provides alternative prescription  
22 drug coverage the actuarial value of which  
23 is greater than that of standard coverage,  
24 the bid amount described in clause (i) mul-  
25 tiplied by the ratio of (I) the actuarial

1 value of standard coverage, to (II) the ac-  
2 tuarial value of the alternative coverage; or  
3 “(B) a Medicare+Choice plan, the portion  
4 of the bid amount that is attributable to statu-  
5 tory drug benefits (described in section  
6 1853(a)(1)(A)(ii)(II)).

7 “(c) RULES IN APPLYING COST-SHARING SUB-  
8 SIDIES.—

9 “(1) IN GENERAL.—In applying subsections  
10 (a)(1)(B) and (a)(2)(B), nothing in this part shall  
11 be construed as preventing a plan or provider from  
12 waiving or reducing the amount of cost-sharing oth-  
13 erwise applicable.

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

18 “(3) APPLICATION OF INDEXING RULES.—The  
19 provisions of subsection (a)(4) shall apply to the dol-  
20 lar amount specified in paragraph (2) in the same  
21 manner as they apply to the dollar amounts specified  
22 in subsections (a)(1)(B) and (a)(2)(B).

23 “(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The  
24 Administrator shall provide a process whereby, in the case  
25 of an individual who is determined to be a subsidy eligible

1 individual and who is enrolled in prescription drug plan  
2 or is enrolled in a Medicare+Choice plan under which  
3 qualified prescription drug coverage is provided—

4 “(1) the Administrator provides for a notifica-  
5 tion of the PDP sponsor or Medicare+Choice orga-  
6 nization involved that the individual is eligible for a  
7 subsidy and the amount of the subsidy under sub-  
8 section (a);

9 “(2) the sponsor or organization involved re-  
10 duces the premiums or cost-sharing otherwise im-  
11 posed by the amount of the applicable subsidy and  
12 submits to the Administrator information on the  
13 amount of such reduction; and

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

17 The reimbursement under paragraph (3) with respect to  
18 cost-sharing subsidies may be computed on a capitated  
19 basis, taking into account the actuarial value of the sub-  
20 sidies and with appropriate adjustments to reflect dif-  
21 ferences in the risks actually involved.

22 “(e) RELATION TO MEDICAID PROGRAM.—

23 “(1) IN GENERAL.—For provisions providing  
24 for eligibility determinations, and additional financ-  
25 ing, under the medicaid program, see section 1935.



1 this part, the Administrator shall provide in accordance  
2 with this section for payment to a qualifying entity (as  
3 defined in subsection (b)) of the following subsidies:

4           “(1) DIRECT SUBSIDY.—In the case of an indi-  
5 vidual enrolled in a prescription drug plan,  
6 Medicare+Choice plan that provides qualified pre-  
7 scription drug coverage, or qualified retiree prescrip-  
8 tion drug plan, a direct subsidy equal to 37 percent  
9 of the total payments made by a qualifying entity  
10 for standard coverage under the respective plan.

11           “(2) SUBSIDY THROUGH REINSURANCE.—The  
12 reinsurance payment amount (as defined in sub-  
13 section (c)), which in the aggregate is 30 percent of  
14 such total payments, for excess costs incurred in  
15 providing qualified prescription drug coverage—

16           “(A) for individuals enrolled with a pre-  
17 scription drug plan under this part;

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

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

23 This section constitutes budget authority in advance of ap-  
24 propriations Acts and represents the obligation of the Ad-

1 administrator to provide for the payment of amounts pro-  
2 vided under this section.

3 “(b) QUALIFYING ENTITY DEFINED.—For purposes  
4 of this section, the term ‘qualifying entity’ means any of  
5 the following that has entered into an agreement with the  
6 Administrator to provide the Administrator with such in-  
7 formation as may be required to carry out this section:

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

10 “(2) A Medicare+Choice organization that pro-  
11 vides qualified prescription drug coverage under a  
12 Medicare+Choice plan under part C.

13 “(3) The sponsor of a qualified retiree prescrip-  
14 tion drug plan (as defined in subsection (f)).

15 “(c) REINSURANCE PAYMENT AMOUNT.—

16 “(1) IN GENERAL.—Subject to subsection  
17 (d)(1)(B) and paragraph (4), the reinsurance pay-  
18 ment amount under this subsection for a qualifying  
19 covered individual (as defined in subsection (g)(1))  
20 for a coverage year (as defined in subsection (g)(2))  
21 is equal to the sum of the following:

22 “(A) For the portion of the individual’s  
23 gross covered prescription drug costs (as de-  
24 fined in paragraph (3)) for the year that ex-  
25 ceeds the initial copayment threshold specified

1 in section 1860B(b)(2)(C), but does not exceed  
2 the initial coverage limit specified in section  
3 1860B(b)(3), an amount equal to 30 percent of  
4 the allowable costs (as defined in paragraph  
5 (2)) attributable to such gross covered prescrip-  
6 tion drug costs.

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

14 “(2) ALLOWABLE COSTS.—For purposes of this  
15 section, the term ‘allowable costs’ means, with re-  
16 spect to gross covered prescription drug costs under  
17 a plan described in subsection (b) offered by a quali-  
18 fying entity, the part of such costs that are actually  
19 paid (net of average percentage rebates) under the  
20 plan, but in no case more than the part of such  
21 costs that would have been paid under the plan if  
22 the prescription drug coverage under the plan were  
23 standard coverage.

24 “(3) GROSS COVERED PRESCRIPTION DRUG  
25 COSTS.—For purposes of this section, the term

1 ‘gross covered prescription drug costs’ means, with  
2 respect to an enrollee with a qualifying entity under  
3 a plan described in subsection (b) during a coverage  
4 year, the costs incurred under the plan (including  
5 costs attributable to administrative costs) for cov-  
6 ered prescription drugs dispensed during the year,  
7 including costs relating to the deductible, whether  
8 paid by the enrollee or under the plan, regardless of  
9 whether the coverage under the plan exceeds stand-  
10 ard coverage and regardless of when the payment  
11 for such drugs is made.

12 “(4) INDEXING DOLLAR AMOUNTS.—

13 “(A) AMOUNTS FOR 2005.—The dollar  
14 amounts applied under paragraph (1) for 2005  
15 shall be the dollar amounts specified in such  
16 paragraph.

17 “(B) FOR 2006.—The dollar amounts ap-  
18 plied under paragraph (1) for 2006 shall be the  
19 dollar amounts specified in such paragraph in-  
20 creased by the annual percentage increase de-  
21 scribed in section 1860B(b)(5) for 2006.

22 “(C) FOR SUBSEQUENT YEARS.—The dol-  
23 lar amounts applied under paragraph (1) for a  
24 year after 2006 shall be the amounts (under  
25 this paragraph) applied under paragraph (1)

1 for the preceding year increased by the annual  
2 percentage increase described in section  
3 1860B(b)(5) (relating to growth in medicare  
4 prescription drug costs per beneficiary) for the  
5 year involved.

6 “(D) ROUNDING.—Any amount, deter-  
7 mined under the preceding provisions of this  
8 paragraph for a year, which is not a multiple of  
9 \$10 shall be rounded to the nearest multiple of  
10 \$10.

11 “(d) ADJUSTMENT OF PAYMENTS.—

12 “(1) ADJUSTMENT OF REINSURANCE PAY-  
13 MENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY  
14 THROUGH REINSURANCE.—

15 “(A) ESTIMATION OF PAYMENTS.—The  
16 Administrator shall estimate—

17 “(i) the total payments to be made  
18 (without regard to this subsection) during  
19 a year under subsections (a)(2) and (c);  
20 and

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

1           “(B) ADJUSTMENT.—The Administrator  
2           shall proportionally adjust the payments made  
3           under subsections (a)(2) and (c) for a coverage  
4           year in such manner so that the total of the  
5           payments made under such subsections for the  
6           year is equal to 30 percent of the total pay-  
7           ments described in subparagraph (A)(ii).

8           “(2) RISK ADJUSTMENT FOR DIRECT SUB-  
9           SIDIES.—To the extent the Administrator deter-  
10          mines it appropriate to avoid risk selection, the pay-  
11          ments made for direct subsidies under subsection  
12          (a)(1) are subject to adjustment based upon risk  
13          factors specified by the Administrator. Any such risk  
14          adjustment shall be designed in a manner as to not  
15          result in a change in the aggregate payments made  
16          under such subsection.

17          “(e) PAYMENT METHODS.—

18                 “(1) IN GENERAL.—Payments under this sec-  
19                 tion shall be based on such a method as the Admin-  
20                 istrator determines. The Administrator may estab-  
21                 lish a payment method by which interim payments  
22                 of amounts under this section are made during a  
23                 year based on the Administrator’s best estimate of  
24                 amounts that will be payable after obtaining all of  
25                 the information.

1           “(2) SOURCE OF PAYMENTS.—Payments under  
2 this section shall be made from the Medicare Pre-  
3 scription Drug Trust Fund.

4           “(f) QUALIFIED RETIREE PRESCRIPTION DRUG  
5 PLAN DEFINED.—

6           “(1) IN GENERAL.—For purposes of this sec-  
7 tion, the term ‘qualified retiree prescription drug  
8 plan’ means employment-based retiree health cov-  
9 erage (as defined in paragraph (3)(A)) if, with re-  
10 spect to an individual enrolled (or eligible to be en-  
11 rolled) under this part who is covered under the  
12 plan, the following requirements are met:

13           “(A) ASSURANCE.—The sponsor of the  
14 plan shall annually attest, and provide such as-  
15 surances as the Administrator may require,  
16 that the coverage meets or exceeds the require-  
17 ments for qualified prescription drug coverage.

18           “(B) AUDITS.—The sponsor (and the plan)  
19 shall maintain, and afford the Administrator  
20 access to, such records as the Administrator  
21 may require for purposes of audits and other  
22 oversight activities necessary to ensure the ade-  
23 quacy of prescription drug coverage, and the ac-  
24 curacy of payments made.

1           “(C) PROVISION OF CERTIFICATION OF  
2           PRESCRIPTION DRUG COVERAGE.—The sponsor  
3           of the plan shall provide for issuance of certifi-  
4           cations of the type described in section  
5           1860A(c)(2)(D).

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

11                   “(A) enrolled under this part;

12                   “(B) is covered under the plan; and

13                   “(C) is eligible to obtain qualified prescrip-  
14           tion drug coverage under section 1860A but did  
15           not elect such coverage under this part (either  
16           through a prescription drug plan or through a  
17           Medicare+Choice plan).

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

19                   “(A) EMPLOYMENT-BASED RETIREE  
20           HEALTH COVERAGE.—The term ‘employment-  
21           based retiree health coverage’ means health in-  
22           surance or other coverage of health care costs  
23           for individuals enrolled under this part (or for  
24           such individuals and their spouses and depend-

1           ents) based on their status as former employees  
2           or labor union members.

3           “(B) SPONSOR.—The term ‘sponsor’  
4           means a plan sponsor, as defined in section  
5           3(16)(B) of the Employee Retirement Income  
6           Security Act of 1974.

7           “(g) GENERAL DEFINITIONS.—For purposes of this  
8           section:

9           “(1) QUALIFYING COVERED INDIVIDUAL.—The  
10          term ‘qualifying covered individual’ means an indi-  
11          vidual who—

12                 “(A) is enrolled with a prescription drug  
13                 plan under this part;

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

17                 “(C) is enrolled for benefits under this title  
18                 and is covered under a qualified retiree pre-  
19                 scription drug plan.

20           “(2) COVERAGE YEAR.—The term ‘coverage  
21           year’ means a calendar year in which covered out-  
22           patient drugs are dispensed if a claim for payment  
23           is made under the plan for such drugs, regardless of  
24           when the claim is paid.

1 **“SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.**

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

15       “(b) PAYMENTS FROM TRUST FUND.—

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

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

22                       “(B) payments under section 1860H (re-  
23 lating to subsidy payments); and

24                       “(C) payments with respect to administra-  
25 tive expenses under this part in accordance with  
26 section 201(g).

1           “(2) TRANSFERS TO MEDICAID ACCOUNT FOR  
2 INCREASED ADMINISTRATIVE COSTS.—The Man-  
3 aging Trustee shall transfer from time to time from  
4 the Trust Fund to the Grants to States for Medicaid  
5 account amounts the Administrator certifies are at-  
6 tributable to increases in payment resulting from the  
7 application of a higher Federal matching percentage  
8 under section 1935(b).

9           “(c) DEPOSITS INTO TRUST FUND.—

10           “(1) LOW-INCOME TRANSFER.—There is hereby  
11 transferred to the Trust Fund, from amounts appro-  
12 priated for Grants to States for Medicaid, amounts  
13 equivalent to the aggregate amount of the reductions  
14 in payments under section 1903(a)(1) attributable to  
15 the application of section 1935(c).

16           “(2) APPROPRIATIONS TO COVER GOVERNMENT  
17 CONTRIBUTIONS.—There are authorized to be appro-  
18 priated from time to time, out of any moneys in the  
19 Treasury not otherwise appropriated, to the Trust  
20 Fund, an amount equivalent to the amount of pay-  
21 ments made from the Trust Fund under subsection  
22 (b), reduced by the amount transferred to the Trust  
23 Fund under paragraph (1).

24           “(d) RELATION TO SOLVENCY REQUIREMENTS.—  
25 Any provision of law that relates to the solvency of the

1 Trust Fund under this part shall take into account the  
2 Trust Fund and amounts receivable by, or payable from,  
3 the Trust Fund.

4 **“SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES**  
5 **TO PROVISIONS IN PART C.**

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

7 “(1) COVERED OUTPATIENT DRUGS.—The term  
8 ‘covered outpatient drugs’ is defined in section  
9 1860B(f).

10 “(2) INITIAL COVERAGE LIMIT.—The term ‘ini-  
11 tial coverage limit’ means such limit as established  
12 under section 1860B(b)(3), or, in the case of cov-  
13 erage that is not standard coverage, the comparable  
14 limit (if any) established under the coverage.

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

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

23 “(5) PRESCRIPTION DRUG PLAN.—The term  
24 ‘prescription drug plan’ means health benefits cov-  
25 erage that—

1           “(A) is offered under a policy, contract, or  
2           plan by a PDP sponsor pursuant to, and in ac-  
3           cordance with, a contract between the Adminis-  
4           trator and the sponsor under section 1860D(b);

5           “(B) provides qualified prescription drug  
6           coverage; and

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

9           “(6) QUALIFIED PRESCRIPTION DRUG COV-  
10          ERAGE.—The term ‘qualified prescription drug cov-  
11          erage’ is defined in section 1860B(a).

12          “(7) STANDARD COVERAGE.—The term ‘stand-  
13          ard coverage’ is defined in section 1860B(b).

14          “(b) APPLICATION OF MEDICARE+CHOICE PROVI-  
15          SIONS UNDER THIS PART.—For purposes of applying pro-  
16          visions of part C under this part with respect to a pre-  
17          scription drug plan and a PDP sponsor, unless otherwise  
18          provided in this part such provisions shall be applied as  
19          if—

20                 “(1) any reference to a Medicare+Choice plan  
21                 included a reference to a prescription drug plan;

22                 “(2) any reference to a provider-sponsored or-  
23                 ganization included a reference to a PDP sponsor;

1           “(3) any reference to a contract under section  
2 1857 included a reference to a contract under sec-  
3 tion 1860D(b); and

4           “(4) any reference to part C included a ref-  
5 erence to this part.”.

6           (b) ADDITIONAL CONFORMING CHANGES.—

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

13           (2) CONFORMING AMENDMENT PERMITTING  
14 WAIVER OF COST-SHARING.—Section 1128B(b)(3)  
15 (42 U.S.C. 1320a-7b(b)(3)) is amended—

16           (A) by striking “and” at the end of sub-  
17 paragraph (E);

18           (B) by striking the period at the end of  
19 subparagraph (F) and inserting “; and”; and

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

22           “(G) the waiver or reduction of any cost-shar-  
23 ing imposed under part D of title XVIII.”.

24           (3) SUBMISSION OF LEGISLATIVE PROPOSAL.—

25           Not later than 6 months after the date of the enact-



1 coverage (other than that required under parts  
2 A and B) to an enrollee under a  
3 Medicare+Choice plan unless such drug cov-  
4 erage is at least qualified prescription drug cov-  
5 erage and unless the requirements of this sub-  
6 section with respect to such coverage are met.

7 “(B) CONSTRUCTION.—Nothing in this  
8 subsection shall be construed as—

9 “(i) requiring a Medicare+Choice  
10 plan to include coverage of qualified pre-  
11 scription drug coverage; or

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

16 For purposes of this part, an individual who  
17 has not elected qualified prescription drug cov-  
18 erage under section 1860A(b) shall be treated  
19 as being ineligible to enroll in a  
20 Medicare+Choice plan under this part that of-  
21 fers such coverage.

22 “(2) COMPLIANCE WITH ADDITIONAL BENE-  
23 FICIARY PROTECTIONS.—With respect to the offer-  
24 ing of qualified prescription drug coverage by a  
25 Medicare+Choice organization under a

1 Medicare+Choice plan, the organization and plan  
2 shall meet the requirements of section 1860C, in-  
3 cluding requirements relating to information dis-  
4 semination and grievance and appeals, in the same  
5 manner as they apply to a PDP sponsor and a pre-  
6 scription drug plan under part D and shall submit  
7 to the Administrator the information described in  
8 section 1860F(a)(2). The Administrator shall waive  
9 such requirements to the extent the Administrator  
10 determines that such requirements duplicate require-  
11 ments otherwise applicable to the organization or  
12 plan under this part.

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

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

21 “(B) providing a Medicare+Choice organi-  
22 zation with direct and insurance subsidy pay-  
23 ments for providing qualified prescription drug  
24 coverage under this part, see section 1860H.

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

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

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

13           (1) in subsection (a)(1)—

14                   (A) by inserting “(other than qualified pre-  
15                   scription drug benefits)” after “benefits”;

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

18                   (C) by adding after and below subpara-  
19                   graph (B) the following:

20                   “and may elect qualified prescription drug coverage  
21                   in accordance with section 1860A.”; and

22           (2) in subsection (g)(1), by inserting “and sec-  
23           tion 1860A(e)(2)(B)” after “in this subsection”.

1 (c) EFFECTIVE DATE.—The amendments made by  
 2 this section apply to coverage provided on or after January  
 3 1, 2005.

4 **SEC. 103. MEDICAID AMENDMENTS.**

5 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-  
 6 COME SUBSIDIES.—

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

9 (A) by striking “and” at the end of para-  
 10 graph (64);

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

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

15 “(66) provide for making eligibility determina-  
 16 tions under section 1935(a).”.

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

19 (A) by redesignating section 1935 as sec-  
 20 tion 1936; and

21 (B) by inserting after section 1934 the fol-  
 22 lowing new section:

23 “SPECIAL PROVISIONS RELATING TO MEDICARE  
 24 PRESCRIPTION DRUG BENEFIT

25 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGI-  
 26 BILITY DETERMINATIONS FOR LOW-INCOME SUB-

1 SIDIES.—As a condition of its State plan under this title  
2 under section 1902(a)(66) and receipt of any Federal fi-  
3 nancial assistance under section 1903(a), a State shall—

4 “(1) make determinations of eligibility for pre-  
5 mium and cost-sharing subsidies under (and in ac-  
6 cordance with) section 1860G;

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

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

13 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE  
14 COSTS.—

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

24 “(A) For expenditures attributable to costs  
25 incurred during 2005, the otherwise applicable

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

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

11 “(ii) For purposes of clause (i), the ‘appli-  
12 cable percent’ for—

13 “(I) 2006 is 20 percent; or

14 “(II) a subsequent year is the applica-  
15 ble percent under this clause for the pre-  
16 vious year increased by 10 percentage  
17 points.

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

22 “(2) COORDINATION.—The State shall provide  
23 the Administrator with such information as may be  
24 necessary to properly allocate administrative expend-

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

3 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID  
4 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-  
5 SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

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

11 (2) AMOUNT DESCRIBED.—Section 1935, as in-  
12 serted by subsection (a)(2), is amended by adding at  
13 the end the following new subsection:

14 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-  
15 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-  
16 FICIARIES.—

17 “(1) IN GENERAL.—For purposes of section  
18 1903(a)(1), for a State that is one of the 50 States  
19 or the District of Columbia for a calendar quarter  
20 in a year (beginning with 2005) the amount com-  
21 puted under this subsection is equal to the product  
22 of the following:

23 “(A) MEDICARE SUBSIDIES.—The total  
24 amount of payments made in the quarter under  
25 section 1860G (relating to premium and cost-

1 sharing prescription drug subsidies for low-in-  
2 come medicare beneficiaries) that are attrib-  
3 utable to individuals who are residents of the  
4 State and are entitled to benefits with respect  
5 to prescribed drugs under the State plan under  
6 this title (including such a plan operating under  
7 a waiver under section 1115).

8 “(B) STATE MATCHING RATE.—A propor-  
9 tion computed by subtracting from 100 percent  
10 the Federal medical assistance percentage (as  
11 defined in section 1905(b)) applicable to the  
12 State and the quarter.

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

16 “(2) PHASE-OUT PROPORTION.—For purposes  
17 of paragraph (1)(C), the ‘phase-out proportion’ for  
18 a calendar quarter in—

19 “(A) 2005 is 90 percent;

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

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

1 (c) MEDICAID PROVIDING WRAP-AROUND BENE-  
2 FITS.—Section 1935, as so inserted and amended, is fur-  
3 ther amended by adding at the end the following new sub-  
4 section:

5 “(d) ADDITIONAL PROVISIONS.—

6 “(1) MEDICAID AS SECONDARY PAYOR.—In the  
7 case of an individual who is entitled to qualified pre-  
8 scription drug coverage under a prescription drug  
9 plan under part D of title XVIII (or under a  
10 Medicare+Choice plan under part C of such title)  
11 and medical assistance for prescribed drugs under  
12 this title, medical assistance shall continue to be pro-  
13 vided under this title for prescribed drugs to the ex-  
14 tent payment is not made under the prescription  
15 drug plan or the Medicare+Choice plan selected by  
16 the individual.

17 “(2) CONDITION.—A State may require, as a  
18 condition for the receipt of medical assistance under  
19 this title with respect to prescription drug benefits  
20 for an individual eligible to obtain qualified prescrip-  
21 tion drug coverage described in paragraph (1), that  
22 the individual elect qualified prescription drug cov-  
23 erage under section 1860A.”.

24 (d) TREATMENT OF TERRITORIES.—

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

3           (A) in subsection (a) in the matter pre-  
4 ceding paragraph (1), by inserting “subject to  
5 subsection (e)” after “section 1903(a)”;

6           (B) in subsection (c)(1), by inserting “sub-  
7 ject to subsection (e)” after “1903(a)(1)”; and

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

10       “(e) TREATMENT OF TERRITORIES.—

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

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

16           “(B) if the State establishes a plan de-  
17 scribed in paragraph (2) (for providing medical  
18 assistance with respect to the provision of pre-  
19 scription drugs to medicare beneficiaries), the  
20 amount otherwise determined under section  
21 1108(f) (as increased under section 1108(g))  
22 for the State shall be increased by the amount  
23 specified in paragraph (3).

24           “(2) PLAN.—The plan described in this para-  
25 graph is a plan that—

1           “(A) provides medical assistance with re-  
2 spect to the provision of covered outpatient  
3 drugs (as defined in section 1860B(f)) to low-  
4 income medicare beneficiaries; and

5           “(B) assures that additional amounts re-  
6 ceived by the State that are attributable to the  
7 operation of this subsection are used only for  
8 such assistance.

9           “(3) INCREASED AMOUNT.—

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

13           “(i) the aggregate amount specified in  
14 subparagraph (B); and

15           “(ii) the amount specified in section  
16 1108(g)(1) for that State, divided by the  
17 sum of the amounts specified in such sec-  
18 tion for all such States.

19           “(B) AGGREGATE AMOUNT.—The aggre-  
20 gate amount specified in this subparagraph  
21 for—

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

23           “(ii) a subsequent year, is equal to the  
24 aggregate amount specified in this sub-  
25 paragraph for the previous year increased

1 by annual percentage increase specified in  
2 section 1860B(b)(5) for the year involved.

3 “(4) REPORT.—The Administrator shall submit  
4 to Congress a report on the application of this sub-  
5 section and may include in the report such rec-  
6 ommendations as the Administrator deems appro-  
7 priate.”.

8 (2) CONFORMING AMENDMENT.—Section  
9 1108(f) (42 U.S.C. 1308(f)) is amended by inserting  
10 “and section 1935(e)(1)(B)” after “Subject to sub-  
11 section (g)”.

12 (e) AMENDMENT TO BEST PRICE.—Section  
13 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is  
14 amended—

15 (1) by striking “and” at the end of subclause  
16 (III);

17 (2) by striking the period at the end of sub-  
18 clause (IV) and inserting “; and”; and

19 (3) by adding at the end the following new sub-  
20 clause:

21 “(V) any prices charged which  
22 are negotiated by a prescription drug  
23 plan under part D of title XVIII, by  
24 a Medicare+Choice plan under part C  
25 of such title with respect to covered

1 outpatient drugs, or by a qualified re-  
2 tiree prescription drug plan (as de-  
3 fined in section 1860H(f)(1)) with re-  
4 spect to such drugs on behalf of indi-  
5 viduals entitled to benefits under part  
6 A or enrolled under part B of such  
7 title.”.

8 **SEC. 104. MEDIGAP TRANSITION.**

9 (a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss)  
10 is amended by adding at the end the following new sub-  
11 section:

12 “(v) COVERAGE OF PRESCRIPTION DRUGS.—

13 “(1) IN GENERAL.—Notwithstanding any other  
14 provision of law, except as provided in paragraph (3)  
15 no new medicare supplemental policy that provides  
16 coverage of expenses for prescription drugs may be  
17 issued under this section on or after January 1,  
18 2005, to an individual unless it replaces a medicare  
19 supplemental policy that was issued to that indi-  
20 vidual and that provided some coverage of expenses  
21 for prescription drugs.

22 “(2) ISSUANCE OF SUBSTITUTE POLICIES IF  
23 OBTAIN PRESCRIPTION DRUG COVERAGE UNDER  
24 PART D.—

1           “(A) IN GENERAL.—The issuer of a medi-  
2           care supplemental policy—

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

11                  “(ii) may not discriminate in the prie-  
12                  ing of such policy, because of health sta-  
13                  tus, claims experience, receipt of health  
14                  care, or medical condition; and

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

18                  in the case of an individual described in sub-  
19                  paragraph (B) who seeks to enroll under the  
20                  policy not later than 63 days after the date of  
21                  the termination of enrollment described in such  
22                  paragraph and who submits evidence of the  
23                  date of termination or disenrollment along with  
24                  the application for such medicare supplemental  
25                  policy.

1           “(B) INDIVIDUAL COVERED.—An indi-  
2           vidual described in this subparagraph is an in-  
3           dividual who—

4                   “(i) enrolls in a prescription drug plan  
5                   under part D; and

6                   “(ii) at the time of such enrollment  
7                   was enrolled and terminates enrollment in  
8                   a medicare supplemental policy which has  
9                   a benefit package classified as ‘H’, ‘I’, or  
10                  ‘J’ under the standards referred to in sub-  
11                  paragraph (A)(i) or terminates enrollment  
12                  in a policy to which such standards do not  
13                  apply but which provides benefits for pre-  
14                  scription drugs.

15           “(C) ENFORCEMENT.—The provisions of  
16           paragraph (4) of subsection (s) shall apply with  
17           respect to the requirements of this paragraph in  
18           the same manner as they apply to the require-  
19           ments of such subsection.

20           “(3) NEW STANDARDS.—In applying subsection  
21           (p)(1)(E) (including permitting the NAIC to revise  
22           its model regulations in response to changes in law)  
23           with respect to the change in benefits resulting from  
24           title I of the Medicare Modernization and Prescrip-  
25           tion Drug Act of 2002, with respect to policies

1 issued to individuals who are enrolled under part D,  
2 the changes in standards shall only provide for sub-  
3 stituting for the benefit packages that included cov-  
4 erage for prescription drugs two benefit packages  
5 that may provide for coverage of cost-sharing with  
6 respect to qualified prescription drug coverage under  
7 such part, except that such coverage may not cover  
8 the prescription drug deductible under such part.  
9 The two benefit packages shall be consistent with  
10 the following:

11 “(A) FIRST NEW POLICY.—The policy de-  
12 scribed in this subparagraph has the following  
13 benefits, notwithstanding any other provision of  
14 this section relating to a core benefit package:

15 “(i) Coverage of 50 percent of the  
16 cost-sharing otherwise applicable, except  
17 coverage of 100 percent of any cost-shar-  
18 ing otherwise applicable for preventive ben-  
19 efits.

20 “(ii) No coverage of the part B de-  
21 ductible.

22 “(iii) Coverage for all hospital coin-  
23 surance for long stays (as in the current  
24 core benefit package).

1           “(iv) A limitation on annual out-of-  
2           pocket expenditures to \$4,000 in 2005 (or,  
3           in a subsequent year, to such limitation for  
4           the previous year increased by an appro-  
5           priate inflation adjustment specified by the  
6           Secretary).

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

11                  “(i) Substitute ‘75 percent’ for ‘50  
12                  percent’ in clause (i) of such subpara-  
13                  graph.

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

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

21 **SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT**  
22 **CARD ENDORSEMENT PROGRAM.**

23          (a) IN GENERAL.—Title XVIII is amended by insert-  
24          ing after section 1806 the following new sections:

1 “MEDICARE PRESCRIPTION DRUG DISCOUNT CARD  
2 ENDORSEMENT PROGRAM

3 “SEC. 1807. (a) IN GENERAL.—The Secretary (or  
4 the Medicare Benefits Administrator pursuant to section  
5 1808(c)(3)(C)) shall establish a program—

6 “(1) to endorse prescription drug discount card  
7 programs that meet the requirements of this section;  
8 and

9 “(2) to make available to medicare beneficiaries  
10 information regarding such endorsed programs.

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

15 “(1) SAVINGS TO MEDICARE BENEFICIARIES.—  
16 The program passes on to medicare beneficiaries  
17 who enroll in the program discounts on prescription  
18 drugs, including discounts negotiated with manufac-  
19 turers.

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

23 “(3) BENEFICIARY SERVICES.—The program  
24 provides pharmaceutical support services, such as

1 education and counseling, and services to prevent  
2 adverse drug interactions.

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

11 “(5) DEMONSTRATED EXPERIENCE.—The enti-  
12 ty operating the program has demonstrated experi-  
13 ence and expertise in operating such a program or  
14 a similar program.

15 “(6) QUALITY ASSURANCE.—The entity has in  
16 place adequate procedures for assuring quality serv-  
17 ice under the program.

18 “(7) OPERATION OF ASSISTANCE PROGRAM.—  
19 The entity meets such requirements relating to sol-  
20 vency, compliance with financial reporting require-  
21 ments, audit compliance, and contractual guarantees  
22 as the Secretary finds necessary for the participation  
23 of the sponsor in the low-income assistance program  
24 under section 1807A.

1           “(8) ENROLLMENT FEES.—The program may  
2           charge an annual enrollment fee, but the amount of  
3           such annual fee may not exceed \$25.

4           “(9) ADDITIONAL BENEFICIARY PROTEC-  
5           TIONS.—The program meets such additional require-  
6           ments as the Secretary identifies to protect and pro-  
7           mote the interest of medicare beneficiaries, including  
8           requirements that ensure that beneficiaries are not  
9           charged more than the lower of the negotiated retail  
10          price or the usual and customary price.

11          The prices negotiated by a prescription drug discount card  
12          program endorsed under this section shall (notwith-  
13          standing any other provision of law) not be taken into ac-  
14          count for the purposes of establishing the best price under  
15          section 1927(c)(1)(C).

16          “(c) PROGRAM OPERATION.—The Secretary shall op-  
17          erate the program under this section consistent with the  
18          following:

19                 “(1) PROMOTION OF INFORMED CHOICE.—In  
20                 order to promote informed choice among endorsed  
21                 prescription drug discount card programs, the Sec-  
22                 retary shall provide for the dissemination of infor-  
23                 mation which compares the prices and services of  
24                 such programs in a manner coordinated with the

1 dissemination of educational information on  
2 Medicare+Choice plans under part C.

3 “(2) OVERSIGHT.—The Secretary shall provide  
4 appropriate oversight to ensure compliance of en-  
5 dored programs with the requirements of this sec-  
6 tion, including verification of the discounts and serv-  
7 ices provided.

8 “(3) USE OF MEDICARE TOLL-FREE NUMBER.—  
9 The Secretary shall provide through the 1-800-medi-  
10 care toll free telephone number for the receipt and  
11 response to inquiries and complaints concerning the  
12 program and programs endorsed under this section.

13 “(4) SANCTIONS FOR ABUSIVE PRACTICES.—  
14 The Secretary may implement intermediate sanc-  
15 tions or may revoke the endorsement of a program  
16 in the case of a program that the Secretary deter-  
17 mines no longer meets the requirements of this sec-  
18 tion or that has engaged in false or misleading mar-  
19 keting practices.

20 “(5) ENROLLMENT PRACTICES.—A medicare  
21 beneficiary may not be enrolled in more than one en-  
22 dored program at any time. A medicare beneficiary  
23 may change the endorsed program in which the ben-  
24 eficiary is enrolled, but may not make such change  
25 until the beneficiary has been enrolled in a program

1 for a minimum period of time specified by the Sec-  
2 retary.

3 “(d) TRANSITION.—The Secretary shall provide for  
4 an appropriate transition and discontinuation of the pro-  
5 gram under this section at the time prescription drug ben-  
6 efits first become available under part D.

7 “(e) ENDORSEMENT CONDITION.—The Secretary  
8 shall require, as condition of endorsement under of a pre-  
9 scription drug discount card program under this section  
10 that the program implement policies and procedures to  
11 safeguard the use and disclosure of program beneficiaries’  
12 individually identifiable health information in a manner  
13 consistent with the Federal regulations (concerning the  
14 privacy of individually identifiable health information) pro-  
15 mulgated under section 264(c) of the Health Insurance  
16 Portability and Accountability Act of 1996.

17 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
18 are authorized to be appropriated such sums as may be  
19 necessary to carry out the program under this section and  
20 section 1807A.

21 “TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE  
22 PROGRAM FOR LOW-INCOME BENEFICIARIES

23 “SEC. 1807A. (a) PURPOSE.—The purpose of this  
24 section is to provide low-income medicare beneficiaries  
25 with immediate assistance in the purchase of covered out-

1 patient prescription drugs during the period before the  
2 program under part D becomes effective.

3 “(b) FUNDS AVAILABLE; ALLOTMENTS.—

4 “(1) APPROPRIATIONS; TOTAL ALLOTMENTS.—

5 “(A) APPROPRIATIONS.—For the purpose  
6 of carrying out this section, there is appro-  
7 priated, out of any money in the Treasury not  
8 otherwise appropriated—

9 “(i) for fiscal year 2003,  
10 \$300,000,000;

11 “(ii) for fiscal year 2004,  
12 \$2,100,000,000; and

13 “(iii) for fiscal year 2005,  
14 \$500,000,000.

15 “(2) ALLOTMENTS.—

16 “(A) AMONG RESIDENTS OF 50 STATES  
17 AND THE DISTRICT OF COLUMBIA.—Subject to  
18 subparagraph (B), the amount appropriated  
19 under subparagraph (A) for each fiscal year  
20 shall be allotted among the 50 States and the  
21 District of Columbia based upon the Secretary’s  
22 estimate of each State’s or District’s proportion  
23 of the total number of medicare beneficiaries  
24 with income below 175 percent of the Federal  
25 poverty line residing in all such States and the

1 District. The Secretary shall determine the  
2 amount of the allotment for each such State  
3 and District not later than July 1, 2003.

4 “(B) AMONG RESIDENTS OF TERRI-  
5 TORIES.—Of the amount appropriated under  
6 subparagraph (A) for a fiscal year, the Sec-  
7 retary shall allot a percentage (determined con-  
8 sistent with the allotment provided to territories  
9 under the State children’s health insurance pro-  
10 gram under section 2104(c)) among the com-  
11 monwealths and territories described in section  
12 2104(c)(3) in the same proportion as the allot-  
13 ment proportion under such program is allowed  
14 among such commonwealths and territories.

15 “(3) AVAILABILITY OF AMOUNTS ALLOTTED.—  
16 Amounts allotted with respect to a State pursuant to  
17 this subsection for a fiscal year shall remain avail-  
18 able for expenditure through the end of the fiscal  
19 year in which benefits are first available under part  
20 D. Any funds allotted to States that are not obli-  
21 gated revert to the General Fund of the Treasury.

22 “(4) LIMITATION.—In no case shall the total  
23 amount of payments for assistance to eligible indi-  
24 viduals (and administrative costs) in a State for a  
25 fiscal year (and previous fiscal years) under this sec-

1       tion exceed the amount of the allotments with re-  
2       spect to that State in that year (and previous fiscal  
3       years). Nothing in this section shall be construed as  
4       preventing a State from providing, with its own  
5       funds, pharmaceutical assistance that is in addition  
6       to the assistance funded under this section.

7       “(c) ELIGIBILITY.—

8             “(1) IN GENERAL.—Taking into account the  
9       amounts allotted with respect to each State under  
10      subsection (b) and the minimum dollar value on as-  
11      sistance per eligible individual specified by the Sec-  
12      retary under subsection (d)(3), the Secretary shall  
13      establish guidelines for the establishment by each  
14      State of eligibility standards consistent with para-  
15      graph (2).

16            “(2) ELIGIBILITY RESTRICTIONS.—In no case  
17      shall an individual residing in a State be eligible for  
18      assistance under this section unless the individual—

19             “(A) is entitled to benefits under part A or  
20             enrolled under part B;

21             “(B) has income that is at or below a per-  
22             centage (specified under the State eligibility  
23             plan under paragraph (1), but not to exceed  
24             175 percent) of the Federal poverty line; and

1           “(C) meets the resources requirement de-  
2           scribed in section 1905(p)(1)(C);

3           “(D) is enrolled under a prescription drug  
4           discount card program (or under an alternative  
5           program authorized under subsection  
6           (d)(1)(B)); and

7           “(E) is not eligible for coverage of, or as-  
8           sistance for, outpatient prescription drugs  
9           under any of the following:

10           “(i) A medicaid plan under title XIX  
11           (including under any waiver approved  
12           under section 1115).

13           “(ii) Enrollment under a group health  
14           plan or health insurance coverage.

15           “(iii) Enrollment under a medicare  
16           supplemental insurance policy.

17           “(iv) Chapter 55 of title 10, United  
18           States Code (relating to medical and den-  
19           tal care for members of the uniformed  
20           services).

21           “(v) Chapter 17 of title 38, United  
22           States Code (relating to Veterans’ medical  
23           care).

24           “(vi) Enrollment under a plan under  
25           chapter 89 of title 5, United States Code

1 (relating to the Federal employees' health  
2 benefits program).

3 “(vii) The Indian Health Care Im-  
4 provement Act (25 U.S.C. 1601 et seq.).

5 “(3) INCOME DETERMINATIONS.—The provi-  
6 sions of section 1860G(4)(C) shall apply for pur-  
7 poses of applying this subsection.

8 “(d) FORM OF ASSISTANCE AND AMOUNT OF BENE-  
9 FITS.—

10 “(1) IN GENERAL.—

11 “(A) THROUGH PROGRAM SPONSOR.—Sub-  
12 ject to subparagraph (B), the assistance under  
13 this section to an eligible individual shall be in  
14 the form of a discount (as identified by the  
15 sponsor to the Secretary) provided by the spon-  
16 sor of a prescription drug discount card pro-  
17 gram to eligible individuals who are enrolled in  
18 such program.

19 “(B) THROUGH ALTERNATIVE STATE PRO-  
20 GRAM.—A State may apply to the Secretary for  
21 authorization to provide the assistance under  
22 this section to an eligible individual through a  
23 State pharmaceutical assistance program or pri-  
24 vate program of pharmaceutical assistance. The  
25 Secretary shall not authorize the use of such a

1 program unless the Secretary finds that the  
2 program—

3 “(i) was in existence before the date  
4 of the enactment of this section; and

5 “(ii) is reasonably designed to provide  
6 for pharmaceutical assistance for a number  
7 of individuals, and in a scope, that is not  
8 less than the number of individuals, and  
9 minimum required amount, that would  
10 occur if the provisions of this subpara-  
11 graph had not applied in the State.

12 “(2) GUIDANCE; MINIMUM LEVEL OF ASSIST-  
13 ANCE.—The Secretary shall establish guidelines for  
14 how the program under this section will operate.  
15 Based upon the aggregate amount appropriated in  
16 each fiscal year and other relevant factors, the Sec-  
17 retary shall establish a minimum amount of assist-  
18 ance that is available, subject to paragraph (4)(B),  
19 to each eligible individual for each calendar quarter  
20 (or other period specified by the Secretary) and pro-  
21 vide guidance to sponsors regarding how assistance  
22 funds may be provided to eligible individuals con-  
23 sistent with such amount and funding limitations.

24 “(3) RELATIONSHIP TO DISCOUNTS.—The as-  
25 sistance provided under this section is in addition to

1 the discount otherwise available to individuals en-  
2 rolled in prescription drug discount card programs  
3 who are not eligible individuals.

4 “(4) LIMITATION ON ASSISTANCE.—

5 “(A) IN GENERAL.—The assistance under  
6 this section for an eligible individual shall be  
7 limited to assistance—

8 “(i) for covered outpatient drugs (as  
9 defined in section 1860B(f)) and for en-  
10 rollment fees imposed under prescription  
11 drug discount card programs; and

12 “(ii) for expenses incurred—

13 “(I) on and after the date the in-  
14 dividual is both enrolled in the pre-  
15 scription drug discount card program  
16 and determined to be an eligible indi-  
17 vidual under this section; and

18 “(II) before the date benefits are  
19 first available under the program  
20 under part D.

21 “(B) AUTHORITY.—The Secretary shall  
22 take such steps as may be necessary to assure  
23 compliance with the expenditure limitations de-  
24 scribed in subsection (b)(4).

1       “(e) PAYMENT OF FEDERAL SUBSIDY TO SPON-  
2 SORS.—

3           “(1) IN GENERAL.—The Secretary shall make  
4 payment (within the allotments for each State, less  
5 the administrative payments made subsection (f)(2)  
6 to each State) to the sponsor of the prescription  
7 drug discount card program (or to a State or other  
8 entity operating a program under subsection  
9 (d)(1)(B)) in which an eligible individual is enrolled  
10 of the amount of the assistance provided by the  
11 sponsor pursuant to this section.

12           “(2) PERIODIC PAYMENTS.—Payments under  
13 this subsection (and subsection (f)(2)) shall be made  
14 on a monthly or other periodic installment basis,  
15 based upon estimates of the Secretary and shall be  
16 reduced or increased to the extent of any overpay-  
17 ment or underpayment which the Secretary deter-  
18 mines was made under this section for any prior pe-  
19 riod and with respect to which adjustment has not  
20 already been made under this paragraph.

21       “(f) STATE RESPONSIBILITIES.—

22           “(1) ELIGIBILITY DETERMINATIONS.—As a  
23 condition for the payment of Federal financial par-  
24 ticipation to a State under section 1903(a) for peri-  
25 ods during which assistance is available under this

1 section, the State must submit to the Secretary an  
2 eligibility plan under which the State—

3 “(A) establishes eligibility standards con-  
4 sistent with the provisions of this section;

5 “(B) conducts determinations of eligibility  
6 and income in the same manner as the State is  
7 required to make eligibility and income deter-  
8 minations described in section 1860G(a)(4);  
9 and

10 “(C) communicates to the Secretary (or  
11 the Secretary’s designee) determinations of eli-  
12 gibility or discontinuation of eligibility under  
13 this section.

14 The Secretary shall provide a method for commu-  
15 nicating with sponsors concerning the identity of eli-  
16 gible individuals.

17 “(2) COVERAGE OF ADMINISTRATIVE COSTS.—

18 Of the amount allotted with respect to a State under  
19 subsection (b), the Secretary shall pay to the State  
20 the amount of its administrative costs in carrying  
21 out this subsection, but not to exceed 10 percent of  
22 the amount of such allotment to the State. The pro-  
23 visions of subsection (e)(2) shall apply to such pay-  
24 ments.

25 “(g) DEFINITIONS.—For purposes of this section:

1           “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
2 individual’ means an individual who is determined by  
3 a State to be eligible for assistance under this sec-  
4 tion.

5           “(2) PRESCRIPTION DRUG DISCOUNT CARD  
6 PROGRAM.—The term ‘prescription drug discount  
7 card program’ means such a program that is en-  
8 dorsed under section 1807.

9           “(3) SPONSOR.—The term ‘sponsor’ means the  
10 sponsor of a prescription drug discount card pro-  
11 gram, or, in the case of a program authorized under  
12 subsection (d)(1)(B), the State or other entity oper-  
13 ating the program.

14           “(4) STATE.—The term ‘State’ has the mean-  
15 ing given such term for purposes of title XIX.”.

16       (b)       CONFORMING       AMENDMENT.—Section  
17 1927(c)(1)(C)(i)(V) (42 U.S.C. 1396r–8(c)(1)(C)(i)(V)),  
18 as added by section 103(e), is amended by striking “or  
19 by a qualified retiree prescription drug plan (as defined  
20 in section 1860H(f)(1))” and inserting “by a qualified re-  
21 tiree prescription drug plan (as defined in section  
22 1860H(f)(1)), or by a prescription drug discount card pro-  
23 gram endorsed under section 1807”.

1 **SEC. 106. GAO STUDY OF THE EFFECTIVENESS OF THE NEW**  
2 **PRESCRIPTION DRUG PROGRAM.**

3 (a) STUDY.—The Comptroller General of the United  
4 States shall conduct a study on the effectiveness of the  
5 prescription drug program provided under part D of title  
6 XVIII of the Social Security Act. Such study shall—

7 (1) report—

8 (A) the percentage of eligible individuals  
9 who enrolled in the program;

10 (B) the demographic characteristics (in-  
11 cluding health status) of such enrollees;

12 (C) the number and type of qualified pre-  
13 scription drug coverage available to such indi-  
14 viduals; and

15 (D) the premiums imposed for enrollment  
16 in different areas;

17 (2) evaluate the processes and methods devel-  
18 oped by the Administrator and the decisions reached  
19 by outside actuaries to determine the actuarial valu-  
20 ation of prescription drug coverage; and

21 (3) assess whether the subsidy payments under  
22 such part accomplished its stated goals of reducing  
23 premium levels for all beneficiaries, reducing adverse  
24 selection, and promoting participation of PDP spon-  
25 sors.

1 (b) REPORT.—Not later January 1, 2006, the Comp-  
2 troller General shall submit a report to Congress on the  
3 study conducted under subsection (a).

4 **TITLE II—MEDICARE+CHOICE**  
5 **REVITALIZATION AND**  
6 **MEDICARE+CHOICE COM-**  
7 **PETITION PROGRAM**  
8 **Subtitle A—Medicare+Choice**  
9 **Revitalization**

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

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

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

16 “(D) BASED ON 100 PERCENT OF FEE-  
17 FOR-SERVICE COSTS.—

18 “(i) IN GENERAL.—For 2003 and  
19 2004, the adjusted average per capita cost  
20 for the year involved, determined under  
21 section 1876(a)(4) for the  
22 Medicare+Choice payment area for serv-  
23 ices covered under parts A and B for indi-  
24 viduals entitled to benefits under part A  
25 and enrolled under part B who are not en-

1 rolled in a Medicare+Choice plan under  
2 this part for the year, but adjusted to ex-  
3 clude costs attributable to payments under  
4 section 1886(h).

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

19 (2) CONFORMING AMENDMENT.—Such section  
20 is further amended, in the matter before subpara-  
21 graph (A), by striking “or (C)” and inserting “(C),  
22 or (D)”.

23 (b) REVISION OF BLEND.—

24 (1) REVISION OF NATIONAL AVERAGE USED IN  
25 CALCULATION OF BLEND.—Section

1 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-  
2 23(c)(4)(B)(i)(II)) is amended by inserting “who  
3 (with respect to determinations for 2003 and for  
4 2004) are enrolled in a Medicare+Choice plan”  
5 after “the average number of medicare bene-  
6 ficiaries”.

7 (2) CHANGE IN BUDGET NEUTRALITY.—Section  
8 1853(c) (42 U.S.C. 1395w-23(c)) is amended—

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

11 (B) in paragraph (5), by inserting “(before  
12 2003)” after “for each year”.

13 (c) REVISION IN MINIMUM PERCENTAGE INCREASE  
14 FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C.  
15 1395w-23(c)(1)(C)) is amended by striking clause (iv)  
16 and inserting the following:

17 “(iv) For 2002, 102 percent of the  
18 annual Medicare+Choice capitation rate  
19 under this paragraph for the area for  
20 2001.

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

1                   “(vi) For 2005 and each succeeding  
2                   year, 102 percent of the annual  
3                   Medicare+Choice capitation rate under  
4                   this paragraph for the area for the pre-  
5                   vious year.”.

6           (d) INCLUSION OF COSTS OF DOD AND VA MILI-  
7 TARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENE-  
8 FICIARIES IN CALCULATION OF MEDICARE+CHOICE PAY-  
9 MENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-  
10 23(c)(3)) is amended—

11           (1) in subparagraph (A), by striking “subpara-  
12           graph (B)” and inserting “subparagraphs (B) and  
13           (E)”, and

14           (2) by adding at the end the following new sub-  
15           paragraph:

16                   “(E) INCLUSION OF COSTS OF DOD AND  
17                   VA MILITARY FACILITY SERVICES TO MEDICARE-  
18                   ELIGIBLE BENEFICIARIES.—In determining the  
19                   area-specific Medicare+Choice capitation rate  
20                   under subparagraph (A) for a year (beginning  
21                   with 2003), the annual per capita rate of pay-  
22                   ment for 1997 determined under section  
23                   1876(a)(1)(C) shall be adjusted to include in  
24                   the rate the Secretary’s estimate, on a per cap-  
25                   ita basis, of the amount of additional payments

1           that would have been made in the area involved  
2           under this title if individuals entitled to benefits  
3           under this title had not received services from  
4           facilities of the Department of Defense or the  
5           Department of Veterans Affairs.”.

6           (e)           ANNOUNCEMENT           OF           REVISED  
7   MEDICARE+CHOICE PAYMENT RATES.—Within 4 weeks  
8   after the date of the enactment of this Act, the Secretary  
9   shall determine, and shall announce (in a manner intended  
10  to provide notice to interested parties) Medicare+Choice  
11  capitation rates under section 1853 of the Social Security  
12  Act (42 U.S.C. 1395w–23) for 2003, revised in accordance  
13  with the provisions of this section.

14          (f)   MEDPAC STUDY OF AAPCC.—

15               (1)   STUDY.—The Medicare Payment Advisory  
16   Commission shall conduct a study that assesses the  
17   method used for determining the adjusted average  
18   per capita cost (AAPCC) under section 1876(a)(4)  
19   of the Social Security Act (42 U.S.C.  
20   1395mm(a)(4)). Such study shall examine—

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

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

4 (C) the accuracy of risk adjustment meth-  
5 ods in reflecting differences in costs of pro-  
6 viding care to different groups of beneficiaries  
7 served under such program.

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

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

1 **SEC. 202. MAKING PERMANENT CHANGE IN**  
2 **MEDICARE+CHOICE REPORTING DEADLINES**  
3 **AND ANNUAL, COORDINATED ELECTION PE-**  
4 **RIOD.**

5 (a) CHANGE IN REPORTING DEADLINE.—Section  
6 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by  
7 section 532(b)(1) of the Public Health Security and Bio-  
8 terrorism Preparedness and Response Act of 2002, is  
9 amended by striking “2002, 2003, and 2004 (or July 1  
10 of each other year)” and inserting “2002 and each subse-  
11 quent year (or July 1 of each year before 2002)”.

12 (b) DELAY IN ANNUAL, COORDINATED ELECTION  
13 PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–  
14 21(e)(3)(B)), as amended by section 532(c)(1)(A) of the  
15 Public Health Security and Bioterrorism Preparedness  
16 and Response Act of 2002, is amended by striking “and  
17 after 2005, the month of November before such year and  
18 with respect to 2003, 2004, and 2005” and inserting “,  
19 the month of November before such year and with respect  
20 to 2003 and any subsequent year”.

21 (c) ANNUAL ANNOUNCEMENT OF PAYMENT  
22 RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–  
23 23(b)(1)), as amended by section 532(d)(1) of the Public  
24 Health Security and Bioterrorism Preparedness and Re-  
25 sponse Act of 2002, is amended by striking “and after  
26 2005 not later than March 1 before the calendar year con-

1 cerned and for 2004 and 2005” and inserting “not later  
2 than March 1 before the calendar year concerned and for  
3 2004 and each subsequent year”.

4 (d) **REQUIRING PROVISION OF AVAILABLE INFORMA-**  
5 **TION COMPARING PLAN OPTIONS.**—The first sentence of  
6 section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w-  
7 21(d)(2)(A)(ii)) is amended by inserting before the period  
8 the following: “to the extent such information is available  
9 at the time of preparation of materials for the mailing”.

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

11 (a) **IN GENERAL.**—Section 1856(b)(3) (42 U.S.C.  
12 1395w-26(b)(3)) is amended to read as follows:

13 “(3) **RELATION TO STATE LAWS.**—The stand-  
14 ards established under this subsection shall super-  
15 sede any State law or regulation (other than State  
16 licensing laws or State laws relating to plan sol-  
17 vency) with respect to Medicare+Choice plans which  
18 are offered by Medicare+Choice organizations under  
19 this part.”.

20 (b) **EFFECTIVE DATE.**—The amendment made by  
21 subsection (a) shall take effect on the date of the enact-  
22 ment of this Act.

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

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

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

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

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

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

23 “(i) is institutionalized (as defined by  
24 the Secretary);

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

1                   “(iii) meets such requirements as the  
2                   Secretary may determine would benefit  
3                   from enrollment in such a specialized  
4                   Medicare+Choice plan described in sub-  
5                   paragraph (A) for individuals with severe  
6                   or disabling chronic conditions.”.

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

10           “(f) RESTRICTION ON ENROLLMENT FOR SPECIAL-  
11   IZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS  
12   BENEFICIARIES.—In the case of a specialized  
13   Medicare+Choice plan (as defined in subsection (b)(4)),  
14   notwithstanding any other provision of this part and in  
15   accordance with regulations of the Secretary and for peri-  
16   ods before January 1, 2007, the plan may restrict the en-  
17   rollment of individuals under the plan to individuals who  
18   are within one or more classes of special needs bene-  
19   ficiaries.”.

20           (d) REPORT TO CONGRESS.—Not later than Decem-  
21   ber 31, 2005, the Medicare Benefits Administrator shall  
22   submit to Congress a report that assesses the impact of  
23   specialized Medicare+Choice plans for special needs bene-  
24   ficiaries on the cost and quality of services provided to  
25   enrollees. Such report shall include an assessment of the

1 costs and savings to the medicare program as a result of  
2 amendments made by subsections (a), (b), and (c).

3 (e) EFFECTIVE DATES.—

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

7 (2) DEADLINE FOR ISSUANCE OF REQUIRE-  
8 MENTS FOR SPECIAL NEEDS BENEFICIARIES; TRAN-  
9 SITION.—No later than 6 months after the date of  
10 the enactment of this Act, the Secretary of Health  
11 and Human Services shall issue final regulations to  
12 establish requirements for special needs beneficiaries  
13 under section 1859(b)(4)(B)(iii) of the Social Secu-  
14 rity Act, as added by subsection (b).

15 **SEC. 205. MEDICARE MSAS.**

16 (a) EXEMPTION FROM REPORTING ENROLLEE EN-  
17 COUNTER DATA.—

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

22 (2) CONFORMING AMENDMENTS.—Section 1852  
23 (42 U.S.C. 1395w–22) is amended—

1 (A) in subsection (c)(1)(I), by inserting be-  
2 fore the period at the end the following: “if re-  
3 quired under such section”; and

4 (B) in subparagraphs (A) and (B) of sub-  
5 section (e)(2), by striking “, a non-network  
6 MSA plan,” and “, NON-NETWORK MSA  
7 PLANS,” each place it appears.

8 (b) MAKING PROGRAM PERMANENT AND ELIMI-  
9 NATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w-  
10 21(b)(4)) is amended—

11 (1) in the heading, by striking “ON A DEM-  
12 ONSTRATION BASIS”;

13 (2) by striking the first sentence of subpara-  
14 graph (A); and

15 (3) by striking the second sentence of subpara-  
16 graph (C).

17 (c) APPLYING LIMITATIONS ON BALANCE BILL-  
18 ING.—Section 1852(k)(1) (42 U.S.C. 1395w-22(k)(1)) is  
19 amended by inserting “or with an organization offering  
20 a MSA plan” after “section 1851(a)(2)(A)”.

21 (d) ADDITIONAL AMENDMENT.—Section  
22 1851(e)(5)(A) (42 U.S.C. 1395w-21(e)(5)(A)) is  
23 amended—

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

- 1           (2) by striking “, or” at the end of clause (ii)  
2           and inserting a semicolon; and  
3           (3) by striking clause (iii).

4 **SEC. 206. EXTENSION OF REASONABLE COST AND SHMO**  
5 **CONTRACTS.**

6           (a) REASONABLE COST CONTRACTS.—

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

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

10                   (B) by inserting before the period the fol-  
11                   lowing: “, except (subject to clause (ii)) in the  
12                   case of a contract for an area which is not cov-  
13                   ered in the service area of 1 or more coordi-  
14                   nated care Medicare+Choice plans under part  
15                   C”; and

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

18           “(ii) In the case in which—

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

22                   “(II) such area is no longer included in such  
23                   service area after such date by reason of the oper-  
24                   ation of clause (i) because of the inclusion of such

1 area within the service area of a Medicare+Choice  
2 plan; and

3 “(III) all Medicare+Choice plans subsequently  
4 terminate coverage in such area;  
5 such reasonable cost reimbursement contract may be ex-  
6 tended and renewed to cover such area (so long as it is  
7 not included in the service area of any Medicare+Choice  
8 plan).”.

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

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

24 (1) IN GENERAL.—Section 4018(b)(1) of the  
25 Omnibus Budget Reconciliation Act of 1987 is

1 amended by striking “the date that is 30 months  
2 after the date that the Secretary submits to Con-  
3 gress the report described in section 4014(c) of the  
4 Balanced Budget Act of 1997” and inserting “De-  
5 cember 31, 2004”.

6 (2) SHMOS OFFERING MEDICARE+CHOICE  
7 PLANS.—Nothing in such section 4018 shall be con-  
8 strued as preventing a social health maintenance or-  
9 ganization from offering a Medicare+Choice plan  
10 under part C of title XVIII of the Social Security  
11 Act.

## 12 **Subtitle B—Medicare+Choice** 13 **Competition Program**

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

15 (a) SUBMISSION OF BID AMOUNTS.—Section 1854  
16 (42 U.S.C. 1395w–24) is amended—

17 (1) in the heading by inserting “AND BID  
18 AMOUNTS” after “PREMIUMS”;

19 (2) in subsection (a)(1)(A)—

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

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

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

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

5           “(A) INFORMATION TO BE SUBMITTED.—

6           The information described in this subparagraph  
7 is as follows:

8           “(i) The monthly aggregate bid  
9 amount for provision of all items and serv-  
10 ices under this part and the actuarial basis  
11 for determining such amount.

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

14           “(I) the provision of statutory  
15 non-drug benefits (such portion re-  
16 ferred to in this part as the  
17 ‘unadjusted non-drug monthly bid  
18 amount’);

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

21           “(III) the provision of non-statu-  
22 tory benefits;

23           and the actuarial basis for determining  
24 such proportions.

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

5           “(B) STATUTORY BENEFITS DEFINED.—  
6           For purposes of this part:

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

10          “(ii) The term ‘statutory prescription  
11          drug benefits’ means benefits under part  
12          D.

13          “(iii) The term ‘statutory benefits’  
14          means statutory prescription drug benefits  
15          and statutory non-drug benefits.

16          “(C) ACCEPTANCE AND NEGOTIATION OF  
17          BID AMOUNTS.—The Administrator has the au-  
18          thority to negotiate regarding monthly bid  
19          amounts submitted under subparagraph (A)  
20          (and the proportion described in subparagraph  
21          (A)(ii)). The Administrator may reject such a  
22          bid amount or proportion if the Administrator  
23          determines that such amount or proportion is  
24          not supported by the actuarial bases provided  
25          under subparagraph (A).”.

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

3 (1) IN GENERAL.—Section 1854(b) (42 U.S.C.  
4 1395w–24(b)) is amended—

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

7 “(C) BENEFICIARY REBATE RULE.—

8 “(i) REQUIREMENT.—The  
9 Medicare+Choice plan shall provide to the  
10 enrollee a monthly rebate equal to 75 per-  
11 cent of the average per capita savings (if  
12 any) described in paragraph (3) applicable  
13 to the plan and year involved.

14 “(iii) FORM OF REBATE.—A rebate  
15 required under this subparagraph shall be  
16 provided—

17 “(I) through the crediting of the  
18 amount of the rebate towards the  
19 Medicare+Choice monthly supple-  
20 mentary beneficiary premium or the  
21 premium imposed for prescription  
22 drug coverage under part D;

23 “(II) through a direct monthly  
24 payment (through electronic funds  
25 transfer or otherwise); or

1                   “(III) through other means ap-  
2                   proved by the Medicare Benefits Ad-  
3                   ministrators,

4                   or any combination thereof.”; and

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

7                   “(3) COMPUTATION OF AVERAGE PER CAPITA  
8                   MONTHLY SAVINGS.—For purposes of paragraph  
9                   (1)(C)(i), the average per capita monthly savings re-  
10                  ferred to in such paragraph for a Medicare+Choice  
11                  plan and year is computed as follows:

12                  “(A) DETERMINATION OF STATE-WIDE AV-  
13                  ERAGE RISK ADJUSTMENT.—

14                  “(i) IN GENERAL.—The Medicare  
15                  Benefits Administrator shall determine, at  
16                  the same time rates are promulgated under  
17                  section 1853(b)(1) (beginning with 2005),  
18                  for each State the average of the risk ad-  
19                  justment factors to be applied to enrollees  
20                  under section 1853(a)(1)(A) in that State.  
21                  In the case of a State in which a  
22                  Medicare+Choice plan was offered in the  
23                  previous year, the Administrator may com-  
24                  pute such average based upon risk adjust-

1           ment factors applied in that State in a pre-  
2           vious year.

3           “(ii) TREATMENT OF NEW STATES.—

4           In the case of a State in which no  
5           Medicare+Choice plan was offered in the  
6           previous year, the Administrator shall esti-  
7           mate such average. In making such esti-  
8           mate, the Administrator may use average  
9           risk adjustment factors applied to com-  
10          parable States or applied on a national  
11          basis.

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

16                 “(i) adjust the fee-for-service area-  
17                 specific non-drug benchmark amount by  
18                 the applicable average risk adjustment fac-  
19                 tor computed under subparagraph (A); and

20                 “(ii) adjust the unadjusted non-drug  
21                 monthly bid amount by such applicable av-  
22                 erage risk adjustment factor.

23          “(C) DETERMINATION OF AVERAGE PER  
24          CAPITA MONTHLY SAVINGS.—The average per  
25          capita monthly savings described in this sub-

1 paragraph is equal to the amount (if any) by  
2 which—

3 “(i) the risk-adjusted benchmark  
4 amount computed under subparagraph  
5 (B)(i), exceeds

6 “(ii) the risk-adjusted bid computed  
7 under subparagraph (B)(ii).

8 “(D) AUTHORITY TO DETERMINE RISK AD-  
9 JUSTMENT FOR AREAS OTHER THAN STATES.—  
10 The Administrator may provide for the deter-  
11 mination and application of risk adjustment  
12 factors under this paragraph on the basis of  
13 areas other than States.”.

14 (2) COMPUTATION OF FEE-FOR-SERVICE AREA-  
15 SPECIFIC NON-DRUG BENCHMARK.—Section 1853  
16 (42 U.S.C. 1395w-23) is amended by adding at the  
17 end the following new subsection:

18 “(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPE-  
19 CIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes  
20 of this part, the term ‘fee-for-service area-specific non-  
21 drug benchmark amount’ means, with respect to a  
22 Medicare+Choice payment area for a month in a year,  
23 an amount equal to the greater of the following (but in  
24 no case less than  $\frac{1}{12}$  of the rate computed under sub-

1 section (c)(1), without regard to subparagraph (A), for the  
2 year):

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

22           “(2) MINIMUM MONTHLY AMOUNT.—The min-  
23 imum amount specified in this paragraph is the  
24 amount specified in subsection (c)(1)(B)(iv) for the  
25 year involved.”.

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

2 (1) IN GENERAL.—Section 1853(a)(1)(A) (42  
3 U.S.C. 1395w-23) is amended by striking “in an  
4 amount” and all that follows and inserting the fol-  
5 lowing: “in an amount determined as follows:

6 “(i) PAYMENT BEFORE 2005.—For  
7 years before 2005, the payment amount  
8 shall be equal to  $\frac{1}{12}$  of the annual  
9 Medicare+Choice capitation rate (as cal-  
10 culated under subsection (c)) with respect  
11 to that individual for that area, reduced by  
12 the amount of any reduction elected under  
13 section 1854(f)(1)(E) and adjusted under  
14 clause (iii).

15 “(ii) PAYMENT FOR STATUTORY NON-  
16 DRUG BENEFITS BEGINNING WITH 2005.—  
17 For years beginning with 2005—

18 “(I) PLANS WITH BIDS BELOW  
19 BENCHMARK.—In the case of a plan  
20 for which there are average per capita  
21 monthly savings described in section  
22 1854(b)(3)(C), the payment under  
23 this subsection is equal to the  
24 unadjusted non-drug monthly bid  
25 amount, adjusted under clause (iii),

1 plus the amount of the monthly rebate  
2 computed under section  
3 1854(b)(1)(C)(i) for that plan and  
4 year.

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

14 “(iii) DEMOGRAPHIC ADJUSTMENT,  
15 INCLUDING ADJUSTMENT FOR HEALTH  
16 STATUS.—The Administrator shall adjust  
17 the payment amount under clause (i), the  
18 unadjusted non-drug monthly bid amount  
19 under clause (ii)(I), and the fee-for-service  
20 area-specific non-drug benchmark amount  
21 under clause (ii)(II) for such risk factors  
22 as age, disability status, gender, institu-  
23 tional status, and such other factors as the  
24 Administrator determines to be appro-  
25 priate, including adjustment for health sta-

1           tus under paragraph (3), so as to ensure  
2           actuarial equivalence. The Administrator  
3           may add to, modify, or substitute for such  
4           adjustment factors if such changes will im-  
5           prove the determination of actuarial  
6           equivalence.

7           “(iv) REFERENCE TO SUBSIDY PAY-  
8           MENT FOR STATUTORY DRUG BENEFITS.—  
9           In the case in which an enrollee is enrolled  
10          under part D, the Medicare+Choice orga-  
11          nization also is entitled to a subsidy pay-  
12          ment amount under section 1860H.”.

13       (d) CONFORMING AMENDMENTS.—

14           (1) PROTECTION AGAINST BENEFICIARY SELEC-  
15          TION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w-  
16          22(b)(1)(A)) is amended by adding at the end the  
17          following: “The Administrator shall not approve a  
18          plan of an organization if the Administrator deter-  
19          mines that the benefits are designed to substantially  
20          discourage enrollment by certain Medicare+Choice  
21          eligible individuals with the organization.”.

22           (2) CONFORMING AMENDMENT TO PREMIUM  
23          TERMINOLOGY.—Subparagraphs (A) and (B) of sec-  
24          tion 1854(b)(2) (42 U.S.C. 1395w-24(b)(2)) are  
25          amended to read as follows:

1           “(A) MEDICARE+CHOICE MONTHLY BASIC  
2 BENEFICIARY PREMIUM.—The term  
3 ‘Medicare+Choice monthly basic beneficiary  
4 premium’ means, with respect to a  
5 Medicare+Choice plan—

6           “(i) described in section  
7 1853(a)(1)(A)(ii)(I) (relating to plans pro-  
8 viding rebates), zero; or

9           “(ii) described in section  
10 1853(a)(1)(A)(ii)(II), the amount (if any)  
11 by which the unadjusted non-drug monthly  
12 bid amount exceeds the fee-for-service  
13 area-specific non-drug benchmark amount.

14           “(B) MEDICARE+CHOICE MONTHLY SUP-  
15 PLEMENTAL BENEFICIARY PREMIUM.—The  
16 term ‘Medicare+Choice monthly supplemental  
17 beneficiary premium’ means, with respect to a  
18 Medicare+Choice plan, the portion of the ag-  
19 gregate monthly bid amount submitted under  
20 clause (i) of subsection (a)(6)(A) for the year  
21 that is attributable under such section to the  
22 provision of nonstatutory benefits.”.

23           (3) REQUIREMENT FOR UNIFORM BID  
24 AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w-  
25 24(c)) is amended to read as follows:

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

6               (4) PERMITTING BENEFICIARY REBATES.—

7                       (A) Section 1851(h)(4)(A) (42 U.S.C.  
8 1395w–21(h)(4)(A)) is amended by inserting  
9 “except as provided under section  
10 1854(b)(1)(C)” after “or otherwise”.

11                      (B) Section 1854(d) (42 U.S.C. 1395w–  
12 24(d)) is amended by inserting “, except as pro-  
13 vided under subsection (b)(1)(C),” after “and  
14 may not provide”.

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

18 **SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-**

19 **DEMONSTRATION AREAS.**

20       (a) IDENTIFICATION OF COMPETITIVE-DEMONSTRA-  
21 TION AREAS FOR DEMONSTRATION PROGRAM; COMPUTA-  
22 TION OF CHOICE NON-DRUG BENCHMARKS.—Section  
23 1853, as amended by section 211(b)(2), is amended by  
24 adding at the end the following new subsection:

1       “(k) ESTABLISHMENT OF COMPETITIVE DEM-  
2 ONSTRATION PROGRAM.—

3               “(1) DESIGNATION OF COMPETITIVE-DEM-  
4 ONSTRATION AREAS AS PART OF PROGRAM.—

5               “(A) IN GENERAL.—For purposes of this  
6 part, the Administrator shall establish a dem-  
7 onstration program under which the Adminis-  
8 trator designates Medicare+Choice areas as  
9 competitive-demonstration areas consistent with  
10 the following limitations:

11               “(i) LIMITATION ON NUMBER OF  
12 AREAS THAT MAY BE DESIGNATED.—The  
13 Administrator may not designate more  
14 than 4 areas as competitive-demonstration  
15 areas.

16               “(ii) LIMITATION ON PERIOD OF DES-  
17 IGNATION OF ANY AREA.—The Adminis-  
18 trator may not designate any area as a  
19 competitive-demonstration area for a pe-  
20 riod of more than 2 years.

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

1           “(B) QUALIFICATIONS FOR DESIGNA-  
2           TION.—For purposes of this title, a  
3           Medicare+Choice area (which is a metropolitan  
4           statistical area or other area with a substantial  
5           number of Medicare+Choice enrollees) may not  
6           be designated as a ‘competitive-demonstration  
7           area’ for a 2-year period beginning with a year  
8           unless the Administrator determines, by such  
9           date before the beginning of the year as the Ad-  
10          ministrator determines appropriate, that—

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

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

23           “(2) CHOICE NON-DRUG BENCHMARK  
24           AMOUNT.—For purposes of this part, the term  
25           ‘choice non-drug benchmark amount’ means, with

1 respect to a Medicare+Choice payment area for a  
2 month in a year, the sum of the 2 components de-  
3 scribed in paragraph (3) for the area and year. The  
4 Administrator shall compute such benchmark  
5 amount for each competitive-demonstration area be-  
6 fore the beginning of each annual, coordinated elec-  
7 tion period under section 1851(e)(3)(B) for each  
8 year (beginning with 2005) in which it is designated  
9 as such an area.

10 “(3) 2 COMPONENTS.—For purposes of para-  
11 graph (2), the 2 components described in this para-  
12 graph for an area and a year are the following:

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

16 “(i) NATIONAL FEE-FOR-SERVICE  
17 MARKET SHARE.—The national fee-for-  
18 service market share percentage (deter-  
19 mined under paragraph (5)) for the year.

20 “(ii) FEE-FOR-SERVICE AREA-SPE-  
21 CIFIC NON-DRUG BID.—The fee-for-service  
22 area-specific non-drug bid (as defined in  
23 paragraph (6)) for the area and year.

1           “(B) M+C COMPONENT WEIGHTED BY NA-  
2           TIONAL MEDICARE+CHOICE MARKET SHARE.—

3           The product of the following:

4                   “(i) NATIONAL MEDICARE+CHOICE  
5                   MARKET SHARE.—1 minus the national  
6                   fee-for-service market share percentage for  
7                   the year.

8                   “(ii) WEIGHTED AVERAGE OF PLAN  
9                   BIDS IN AREA.—The weighted average of  
10                  the plan bids for the area and year (as de-  
11                  termined under paragraph (4)(A)).

12           “(4) DETERMINATION OF WEIGHTED AVERAGE  
13           BIDS FOR AN AREA.—

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

20                           “(i) PROPORTION OF EACH PLAN’S  
21                           ENROLLEES IN THE AREA.—The number  
22                           of individuals described in subparagraph  
23                           (B), divided by the total number of such  
24                           individuals for all Medicare+Choice plans

1 described in subparagraph (C) for that  
2 area and year.

3 “(ii) MONTHLY NON-DRUG BID  
4 AMOUNT.—The unadjusted non-drug  
5 monthly bid amount.

6 “(B) COUNTING OF INDIVIDUALS.—The  
7 Administrator shall count, for each  
8 Medicare+Choice plan described in subpara-  
9 graph (C) for an area and year, the number of  
10 individuals who reside in the area and who were  
11 enrolled under such plan under this part during  
12 March of the previous year.

13 “(C) EXCLUSION OF PLANS NOT OFFERED  
14 IN PREVIOUS YEAR.—For an area and year, the  
15 Medicare+Choice plans described in this sub-  
16 paragraph are plans that are offered in the area  
17 and year and were offered in the area in March  
18 of the previous year.

19 “(5) COMPUTATION OF NATIONAL FEE-FOR-  
20 SERVICE MARKET SHARE PERCENTAGE.—The Ad-  
21 ministrator shall determine, for a year, the propor-  
22 tion (in this subsection referred to as the ‘national  
23 fee-for-service market share percentage’) of  
24 Medicare+Choice eligible individuals who during

1 March of the previous year were not enrolled in a  
2 Medicare+Choice plan.

3 “(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-  
4 DRUG BID.—For purposes of this part, the term  
5 ‘fee-for-service area-specific non-drug bid’ means, for  
6 an area and year, the amount described in section  
7 1853(j)(1) for the area and year, except that any  
8 reference to a percent of less than 100 percent shall  
9 be deemed a reference to 100 percent.”.

10 (b) APPLICATION OF CHOICE NON-DRUG BENCH-  
11 MARK IN COMPETITIVE-DEMONSTRATION AREAS.—

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

13 (A) in subsection (b)(1)(C)(i), as added by  
14 section 211(b)(1)(A), by striking “(i) REQUIRE-  
15 MENT.—The” and inserting “(i) REQUIREMENT  
16 FOR NON-COMPETITIVE-DEMONSTRATION  
17 AREAS.—In the case of a Medicare+Choice  
18 payment area that is not a competitive-dem-  
19 onstration area designated under section  
20 1853(k)(1), the”;

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

24 “(ii) REQUIREMENT FOR COMPETI-  
25 TIVE-DEMONSTRATION AREAS.—In the

1 case of a Medicare+Choice payment area  
2 that is designated as a competitive-dem-  
3 onstration area under section 1853(k)(1),  
4 if there are average per capita monthly  
5 savings described in paragraph (4) for a  
6 Medicare+Choice plan and year, the  
7 Medicare+Choice plan shall provide to the  
8 enrollee a monthly rebate equal to 75 per-  
9 cent of such savings.”;

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

13 “(4) COMPUTATION OF AVERAGE PER CAPITA  
14 MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRA-  
15 TION AREAS.—For purposes of paragraph (1)(C)(ii),  
16 the average per capita monthly savings referred to  
17 in such paragraph for a Medicare+Choice plan and  
18 year shall be computed in the same manner as the  
19 average per capita monthly savings is computed  
20 under paragraph (3) except that the reference to the  
21 fee-for-service area-specific non-drug benchmark  
22 amount in paragraph (3)(B)(i) (or to the benchmark  
23 amount as adjusted under paragraph (3)(C)(i)) is  
24 deemed to be a reference to the choice non-drug

1 benchmark amount (or such amount as adjusted in  
2 the manner described in paragraph (3)(B)(i).”; and

3 (D) in subsection (d), as amended by sec-  
4 tion 211(d)(4), by inserting “and subsection  
5 (b)(1)(D)” after “subsection (b)(1)(C)”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) PAYMENT OF PLANS.—Section  
8 1853(a)(1)(A)(ii), as amended by section  
9 211(c)(1), is amended—

10 (i) in subclause (I), by inserting “(or,  
11 in the case of a competitive-demonstration  
12 area, the choice non-drug benchmark  
13 amount)” after “unadjusted non-drug  
14 monthly bid amount”; and

15 (ii) in subclauses (I) and (II), by in-  
16 sserting “(or, in the case of a competitive-  
17 demonstration area, described in section  
18 1854(b)(4))” after “section  
19 1854(b)(3)(C)”.

20 (B) DEFINITION OF MONTHLY BASIC PRE-  
21 MIUM.—Section 1854(b)(2)(A)(ii), as amended  
22 by section 211(d)(2), is amended by inserting  
23 “(or, in the case of a competitive-demonstration  
24 area, the choice non-drug benchmark amount)”  
25 after “benchmark amount”.

1 (c) PREMIUM ADJUSTMENT.—Section 1839 (42  
2 U.S.C. 1395r) is amended by adding at the end the fol-  
3 lowing new subsection:

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

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

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

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

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

7           “(2) Nothing in this subsection shall be construed as  
8           preventing a reduction under paragraph (1)(A) in the pre-  
9           mium otherwise applicable under this part to zero or from  
10          requiring the provision of a rebate to the extent such pre-  
11          mium would otherwise be required to be less than zero.

12          “(3) The adjustment in the premium under this sub-  
13          section shall be effected in such manner as the Medicare  
14          Benefits Administrator determines appropriate.

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

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

1           “(B) periodically throughout the year, informa-  
2           tion to update the information previously trans-  
3           mitted under this paragraph for the year.”.

4           (d) CONFORMING AMENDMENT.—Section 1844(c)  
5           (42 U.S.C. 1395w(e)) is amended by inserting “and with-  
6           out regard to any premium adjustment effected under sec-  
7           tion 1839(h)” before the period at the end.

8           (e) REPORT ON DEMONSTRATION PROGRAM.—Not  
9           later than 6 months after the date on which the designa-  
10          tion of the 4th competitive-demonstration area under sec-  
11          tion 1851(k)(1) of the Social Security Act ends, the Medi-  
12          care Payment Advisory Commission shall submit to Con-  
13          gress a report on the impact of the demonstration pro-  
14          gram under the amendments made by this section, includ-  
15          ing such impact on premiums of medicare beneficiaries,  
16          savings to the medicare program, and on adverse selection.

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

20       **SEC. 213. CONFORMING AMENDMENTS.**

21          (a) CONFORMING AMENDMENTS RELATING TO  
22          BIDS.—

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

1 (A) in the heading of subsection (a), by in-  
2 serting “AND BID AMOUNTS” after “PRE-  
3 MIUMS”; and

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

7 (b) ADDITIONAL CONFORMING AMENDMENTS.—

8 (1) ANNUAL DETERMINATION AND ANNOUNCE-  
9 MENT OF CERTAIN FACTORS.—Section 1853(b) (42  
10 U.S.C. 1395w–23(b)) is amended—

11 (A) in paragraph (1), by striking “the re-  
12 spective calendar year” and all that follows and  
13 inserting the following: “the calendar year con-  
14 cerned with respect to each Medicare+Choice  
15 payment area, the following:

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

18 “(i) MEDICARE+CHOICE CAPITATION  
19 RATES.—The annual Medicare+Choice  
20 capitation rate for each Medicare+Choice  
21 payment area for the year.

22 “(ii) ADJUSTMENT FACTORS.—The  
23 risk and other factors to be used in adjust-  
24 ing such rates under subsection (a)(1)(A)  
25 for payments for months in that year.

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

3           “(i) BENCHMARKS.—The fee-for-serv-  
4 ice area-specific non-drug benchmark  
5 under section 1853(j) and, if applicable,  
6 the choice non-drug benchmark under sec-  
7 tion 1853(k)(2), for the year involved and,  
8 if applicable, the national fee-for-service  
9 market share percentage.

10          “(ii) ADJUSTMENT FACTORS.—The  
11 adjustment factors applied under section  
12 1853(a)(1)(A)(iii) (relating to demographic  
13 adjustment), section 1853(a)(1)(B) (relat-  
14 ing to adjustment for end-stage renal dis-  
15 ease), and section 1853(a)(3) (relating to  
16 health status adjustment).

17          “(iii) PROJECTED FEE-FOR-SERVICE  
18 BID.—In the case of a competitive area,  
19 the projected fee-for-service area-specific  
20 non-drug bid (as determined under sub-  
21 section (k)(6)) for the area.

22          “(iv) INDIVIDUALS.—The number of  
23 individuals counted under subsection  
24 (k)(4)(B) and enrolled in each  
25 Medicare+Choice plan in the area.”; and

1 (B) in paragraph (3), by striking “in suffi-  
2 cient detail” and all that follows up to the pe-  
3 riod at the end.

4 (2) REPEAL OF PROVISIONS RELATING TO AD-  
5 JUSTED COMMUNITY RATE (ACR).—

6 (A) IN GENERAL.—Subsections (e) and (f)  
7 of section 1854 (42 U.S.C. 1395w–24) are re-  
8 pealed.

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

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

17 “(5) PROSPECTIVE IMPLEMENTATION OF NA-  
18 TIONAL COVERAGE DETERMINATIONS.—The Sec-  
19 retary shall only implement a national coverage de-  
20 termination that will result in a significant change  
21 in the costs to a Medicare+Choice organization in a  
22 prospective manner that applies to announcements  
23 made under section 1853(b) after the date of the  
24 implementation of the determination.”.

1           (4) PERMITTING GEOGRAPHIC ADJUSTMENT TO  
2           CONSOLIDATE MULTIPLE MEDICARE+CHOICE PAY-  
3           MENT AREAS IN A STATE INTO A SINGLE STATEWIDE  
4           MEDICARE+CHOICE PAYMENT AREA.—Section  
5           1853(d)(3) (42 U.S.C. 1395w-23(e)(3)) is  
6           amended—

7                   (A) by amending clause (i) of subpara-  
8                   graph (A) to read as follows:

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

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

13                           “(B) BUDGET NEUTRALITY ADJUST-  
14                           MENT.—In the case of a State requesting an  
15                           adjustment under this paragraph, the Medicare  
16                           Benefits Administrator shall initially (and an-  
17                           nually thereafter) adjust the payment rates oth-  
18                           erwise established under this section for  
19                           Medicare+Choice payment areas in the State in  
20                           a manner so that the aggregate of the pay-  
21                           ments under this section in the State shall not  
22                           exceed the aggregate payments that would have  
23                           been made under this section for  
24                           Medicare+Choice payment areas in the State in

1 the absence of the adjustment under this para-  
2 graph.”.

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

## 6 **TITLE III—RURAL HEALTH CARE** 7 **IMPROVEMENTS**

### 8 **SEC. 301. REFERENCE TO FULL MARKET BASKET INCREASE** 9 **FOR SOLE COMMUNITY HOSPITALS.**

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

### 13 **SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOS-** 14 **PITAL (DSH) TREATMENT FOR RURAL HOS-** 15 **PITALS AND URBAN HOSPITALS WITH FEWER** 16 **THAN 100 BEDS.**

17 (a) BLENDING OF PAYMENT AMOUNTS.—

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

21 “(xiv)(I) In the case of discharges in a fiscal year  
22 beginning on or after October 1, 2002, subject to sub-  
23 clause (II), there shall be substituted for the dispro-  
24 tionate share adjustment percentage otherwise determined  
25 under clause (iv) (other than subclause (I)) or under

1 clause (viii), (x), (xi), (xii), or (xiii), the old blend propor-  
2 tion (specified under subclause (III)) of the dispropor-  
3 tionate share adjustment percentage otherwise determined  
4 under the respective clause and 100 percent minus such  
5 old blend proportion of the disproportionate share adjust-  
6 ment percentage determined under clause (vii) (relating  
7 to large, urban hospitals).

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

12 “(III) For purposes of subclause (I), the old blend  
13 proportion for fiscal year 2003 is 80 percent, for each sub-  
14 sequent year (through 2006) is the old blend proportion  
15 under this subclause for the previous year minus 20 per-  
16 centage points, and for each year beginning with 2007 is  
17 0 percent.”.

18 (2) CONFORMING AMENDMENTS.—Section  
19 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
20 amended—

21 (A) in each of subclauses (II), (III), (IV),  
22 (V), and (VI) of clause (iv), by inserting “sub-  
23 ject to clause (xiv) and” before “for discharges  
24 occurring”;

1 (B) in clause (viii), by striking “The for-  
 2 mula” and inserting “Subject to clause (xiv),  
 3 the formula”; and

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

7 (b) EFFECTIVE DATE.—The amendments made by  
 8 this section shall apply with respect to discharges occur-  
 9 ring on or after October 1, 2002.

10 **SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARD-**  
 11 **IZED AMOUNT IN RURAL AND SMALL URBAN**  
 12 **AREAS TO ACHIEVE A SINGLE, UNIFORM**  
 13 **STANDARDIZED AMOUNT.**

14 Section 1886(d)(3)(A)(iv) (42 U.S.C.  
 15 1395ww(d)(3)(A)(iv)) is amended—

16 (1) by striking “(iv) For discharges” and in-  
 17 serting “(iv)(I) Subject to the succeeding provisions  
 18 of this clause, for discharges”; and

19 (2) by adding at the end the following new sub-  
 20 clauses:

21 “(II) For discharges occurring during fiscal  
 22 year 2003, the average standardized amount for hos-  
 23 pitals located other than in a large urban area shall  
 24 be increased by  $\frac{1}{2}$  of the difference between the av-  
 25 erage standardized amount determined under sub-

1 clause (I) for hospitals located in large urban areas  
2 for such fiscal year and such amount determined  
3 (without regard to this subclause) for other hospitals  
4 for such fiscal year.

5 “(III) For discharges occurring in a fiscal year  
6 beginning with fiscal year 2004, the Secretary shall  
7 compute an average standardized amount for hos-  
8 pitals located in any area within the United States  
9 and within each region equal to the average stand-  
10 arized amount computed for the previous fiscal  
11 year under this subparagraph for hospitals located  
12 in a large urban area (or, beginning with fiscal year  
13 2005, for hospitals located in any area) increased by  
14 the applicable percentage increase under subsection  
15 (b)(3)(B)(i).”.

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

18 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After  
19 revising the weights used in the hospital market basket  
20 under section 1886(b)(3)(B)(iii) of the Social Security Act  
21 (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most cur-  
22 rent data available, the Secretary shall establish a fre-  
23 quency for revising such weights in such market basket  
24 to reflect the most current data available more frequently  
25 than once every 5 years.

1 (b) REPORT.—Not later than October 1, 2003, the  
2 Secretary shall submit a report to Congress on the fre-  
3 quency established under subsection (a), including an ex-  
4 planation of the reasons for, and options considered, in  
5 determining such frequency.

6 **SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**  
7 **PROGRAM.**

8 (a) REINSTATEMENT OF PERIODIC INTERIM PAY-  
9 MENT (PIP).—Section 1815(e)(2) (42 U.S.C.  
10 1395g(e)(2)) is amended—

11 (1) by striking “and” at the end of subpara-  
12 graph (C);

13 (2) by adding “and” at the end of subpara-  
14 graph (D); and

15 (3) by inserting after subparagraph (D) the fol-  
16 lowing new subparagraph:

17 “(E) inpatient critical access hospital services;”.

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

22 “The Secretary may not require, as a condition for  
23 applying subparagraph (B) with respect to a critical  
24 access hospital, that each physician providing profes-  
25 sional services in the hospital must assign billing

1 rights with respect to such services, except that such  
2 subparagraph shall not apply to those physicians  
3 who have not assigned such billing rights.”.

4 (c) FLEXIBILITY IN BED LIMITATION FOR HOS-  
5 PITALS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

6 (1) in subsection (c)(2)(B)(iii), by inserting  
7 “subject to paragraph (3)” after “(iii) provides”;

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

10 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS  
11 FOR HOSPITALS WITH STRONG SEASONAL CENSUS  
12 FLUCTUATIONS.—

13 “(A) IN GENERAL.—Subject to subpara-  
14 graph (C), in the case of a hospital that dem-  
15 onstrates that it meets the standards estab-  
16 lished under subparagraph (B) and has not  
17 made the election described in subsection  
18 (f)(2)(A), the bed limitations otherwise applica-  
19 ble under paragraph (2)(B)(iii) and subsection  
20 (f) shall be increased by 5 beds.

21 “(B) STANDARDS.—The Secretary shall  
22 specify standards for determining whether a  
23 critical access hospital has sufficiently strong  
24 seasonal variations in patient admissions to jus-

1           tify the increase in bed limitation provided  
2           under subparagraph (A).”; and

3           (3) in subsection (f)—

4                   (A) by inserting “(1)” after “(f)”; and

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

7           “(2)(A) A hospital may elect to treat the reference  
8           in paragraph (1) to ‘15 beds’ as a reference to ‘25 beds’,  
9           but only if no more than 10 beds in the hospital are at  
10          any time used for non-acute care services. A hospital that  
11          makes such an election is not eligible for the increase pro-  
12          vided under subsection (c)(3)(A).

13          “(B) The limitations in numbers of beds under the  
14          first sentence of paragraph (1) are subject to adjustment  
15          under subsection (c)(3).”.

16          (d) 5-YEAR EXTENSION OF THE AUTHORIZATION  
17          FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section  
18          1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking  
19          “through 2002” and inserting “through 2007”.

20          (e) PROHIBITION OF RETROACTIVE RECOUPMENT.—  
21          The Secretary shall not recoup (or otherwise seek to re-  
22          cover) overpayments made for outpatient critical access  
23          hospital services under part B of title XVIII of the Social  
24          Security Act, for services furnished in cost reporting peri-  
25          ods that began before October 1, 2002, insofar as such

1 overpayments are attributable to payment being based on  
2 80 percent of reasonable costs (instead of 100 percent of  
3 reasonable costs minus 20 percent of charges).

4 (f) EFFECTIVE DATES.—

5 (1) REINSTATEMENT OF PIP.—The amend-  
6 ments made by subsection (a) shall apply to pay-  
7 ments made on or after January 1, 2003.

8 (2) PHYSICIAN PAYMENT ADJUSTMENT CONDI-  
9 TION.—The amendment made by subsection (b)  
10 shall be effective as if included in the enactment of  
11 section 403(d) of the Medicare, Medicaid, and  
12 SCHIP Balanced Budget Refinement Act of 1999  
13 (113 Stat. 1501A–371).

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

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

22 (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.  
23 2763A–533) is amended—

1           (1) by striking “24-MONTH INCREASE BEGIN-  
2           NING APRIL 1, 2001” and inserting “IN GENERAL”;  
3           and

4           (2) by striking “April 1, 2003” and inserting  
5           “January 1, 2005”.

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

11 **SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAY-**  
12 **MENT FOR HOSPICE CARE FURNISHED IN A**  
13 **FRONTIER AREA AND RURAL HOSPICE DEM-**  
14 **ONSTRATION PROJECT.**

15 For—

16           (1) provision of 10 percent increase in payment  
17 for hospice care furnished in a frontier area, see sec-  
18 tion 422; and

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

1 **SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LO-**  
2 **CATED IN RURAL OR SMALL URBAN AREAS IN**  
3 **REDISTRIBUTION OF UNUSED GRADUATE**  
4 **MEDICAL EDUCATION RESIDENCIES.**

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

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

10 (a) STUDY.—The Comptroller General of the United  
11 States shall conduct a study of differences in payment  
12 amounts under the physician fee schedule under section  
13 1848 of the Social Security Act (42 U.S.C. 1395w–4) for  
14 physicians' services in different geographic areas. Such  
15 study shall include—

16 (1) an assessment of the validity of the geo-  
17 graphic adjustment factors used for each component  
18 of the fee schedule;

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

21 (3) an evaluation of the methods used to deter-  
22 mine professional liability insurance costs used in  
23 computing the malpractice component, including a  
24 review of increases in professional liability insurance  
25 premiums and variation in such increases by State  
26 and physician specialty and methods used to update

1 the geographic cost of practice index and relative  
2 weights for the malpractice component.

3 (b) REPORT.—Not later than 1 year after the date  
4 of the enactment of this Act, the Comptroller General shall  
5 submit to Congress a report on the study conducted under  
6 subsection (a). The report shall include recommendations  
7 regarding the use of more current data in computing geo-  
8 graphic cost of practice indices as well as the use of data  
9 directly representative of physicians’ costs (rather than  
10 proxy measures of such costs).

11 **SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COL-**  
12 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**  
13 **CALLY UNDERSERVED POPULATIONS.**

14 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
15 1320a–7(b)(3)), as amended by section 101(b)(2), is  
16 amended—

17 (1) in subparagraph (F), by striking “and”  
18 after the semicolon at the end;

19 (2) in subparagraph (G), by striking the period  
20 at the end and inserting “; and”; and

21 (3) by adding at the end the following new sub-  
22 paragraph:

23 “(H) any remuneration between a public  
24 or nonprofit private health center entity de-  
25 scribed under clause (i) or (ii) of section

1           1905(l)(2)(B) and any individual or entity pro-  
2           viding goods, items, services, donations or  
3           loans, or a combination thereof, to such health  
4           center entity pursuant to a contract, lease,  
5           grant, loan, or other agreement, if such agree-  
6           ment contributes to the ability of the health  
7           center entity to maintain or increase the avail-  
8           ability, or enhance the quality, of services pro-  
9           vided to a medically underserved population  
10          served by the health center entity.”.

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

13                 (1) ESTABLISHMENT.—

14                         (A) IN GENERAL.—The Secretary of  
15                         Health and Human Services (in this subsection  
16                         referred to as the “Secretary”) shall establish,  
17                         on an expedited basis, standards relating to the  
18                         exception described in section 1128B(b)(3)(H)  
19                         of the Social Security Act, as added by sub-  
20                         section (a), for health center entity arrange-  
21                         ments to the antikickback penalties.

22                         (B) FACTORS TO CONSIDER.—The Sec-  
23                         retary shall consider the following factors,  
24                         among others, in establishing standards relating

1 to the exception for health center entity ar-  
2 rangements under subparagraph (A):

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

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

12 (iii) Whether the arrangement be-  
13 tween the health center entity and the  
14 other party protects a health care profes-  
15 sional's independent medical judgment re-  
16 garding medically appropriate treatment.

17 The Secretary may also include other standards  
18 and criteria that are consistent with the intent  
19 of Congress in enacting the exception estab-  
20 lished under this section.

21 (2) INTERIM FINAL EFFECT.—No later than  
22 180 days after the date of enactment of this Act, the  
23 Secretary shall publish a rule in the Federal Reg-  
24 ister consistent with the factors under paragraph  
25 (1)(B). Such rule shall be effective and final imme-

1 diately on an interim basis, subject to such change  
2 and revision, after public notice and opportunity (for  
3 a period of not more than 60 days) for public com-  
4 ment, as is consistent with this subsection.

5 **SEC. 311. RELIEF FOR CERTAIN NON-TEACHING HOS-**  
6 **PITALS.**

7 (a) IN GENERAL.—In the case of a non-teaching hos-  
8 pital that meets the condition of subsection (b), in each  
9 of fiscal years 2003, 2004, and 2005 the amount of pay-  
10 ment made to the hospital under section 1886(d) of the  
11 Social Security Act for discharges occurring during such  
12 fiscal year only shall be increased as though the applicable  
13 percentage increase (otherwise applicable to discharges oc-  
14 ccurring during such fiscal year under section  
15 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C.  
16 1395ww(b)(3)(B)(i)) had been increased by 5 percentage  
17 points. The previous sentence shall be applied for each  
18 such fiscal year separately without regard to its applica-  
19 tion in a previous fiscal year and shall not affect payment  
20 for discharges for any hospital occurring during a fiscal  
21 year after fiscal year 2005.

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

24 (1) it is located in a rural area and the amount  
25 of the aggregate payments under subsection (d) of

1 section 1886 of the Social Security Act for hospitals  
2 located in rural areas in the State for their cost re-  
3 porting periods beginning during fiscal year 1999 is  
4 less than the aggregate allowable operating costs of  
5 inpatient hospital services (as defined in subsection  
6 (a)(4) of such section) for all subsection (d) hos-  
7 pitals in such areas in such State with respect to  
8 such cost reporting periods; or

9 (2) it is located in an urban area and the  
10 amount of the aggregate payments under subsection  
11 (d) of such section for hospitals located in urban  
12 areas in the State for their cost reporting periods  
13 beginning during fiscal year 1999 is less than 103  
14 percent of the aggregate allowable operating costs of  
15 inpatient hospital services (as defined in subsection  
16 (a)(4) of such section) for all subsection (d) hos-  
17 pitals in such areas in such State with respect to  
18 such cost reporting periods.

19 The amounts under paragraphs (1) and (2) shall be deter-  
20 mined by the Secretary of Health and Human Services  
21 based on data of the Medicare Payment Advisory Commis-  
22 sion.

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

24 (1) NON-TEACHING HOSPITAL.—The term  
25 “non-teaching hospital” means, for a cost reporting

1 period, a subsection (d) hospital (as defined in sub-  
2 section (d)(1)(B) of section 1886 of the Social Secu-  
3 rity Act, 42 U.S.C. 1395ww)) that is not receiving  
4 any additional payment under subsection (d)(5)(B)  
5 of such section or a payment under subsection (h)  
6 of such section for discharges occurring during the  
7 period. A subsection (d) hospital that receives addi-  
8 tional payments under subsection (d)(5)(B) or (h) of  
9 such section shall, for purposes of this section, also  
10 be treated as a non-teaching hospital unless a chair-  
11 man of a department in the medical school with  
12 which the hospital is affiliated is serving or has been  
13 appointed as a clinical chief of service in the hos-  
14 pital.

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

1                   **TITLE IV—PROVISIONS**  
2                   **RELATING TO PART A**  
3           **Subtitle A—Inpatient Hospital**  
4                   **Services**

5   **SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT**  
6                   **UPDATES.**

7           Subclause (XVIII) of section 1886(b)(3)(B)(i) (42  
8   U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as fol-  
9   lows:

10                   “(XVIII) for fiscal year 2003, the market bas-  
11           ket percentage increase for sole community hospitals  
12           and such increase minus 0.25 percentage points for  
13           other hospitals, and”.

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

17           Section       1886(d)(5)(B)(ii)       (42       U.S.C.  
18   1395ww(d)(5)(B)(ii)) is amended—

19                   (1) in subclause (VI) by striking “and” at the  
20           end;

21                   (2) by redesignating subclause (VII) as sub-  
22           clause (IX);

23                   (3) in subclause (IX) as so redesignated, by  
24           striking “2002” and inserting “2004”; and

1 (4) by inserting after subclause (VI) the fol-  
2 lowing new subclause:

3 “(VII) during fiscal year 2003, ‘c’ is equal  
4 to 1.47;

5 “(VIII) during fiscal year 2004, ‘c’ is  
6 equal to 1.45; and”.

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

9 (a) IMPROVING TIMELINESS OF DATA COLLEC-  
10 TION.—Section 1886(d)(5)(K) (42 U.S.C.  
11 1395ww(d)(5)(K)) is amended by adding at the end the  
12 following new clause:

13 “(vii) Under the mechanism under this subpara-  
14 graph, the Secretary shall provide for the addition of new  
15 diagnosis and procedure codes in April 1 of each year, but  
16 the addition of such codes shall not require the Secretary  
17 to adjust the payment (or diagnosis-related group classi-  
18 fication) under this subsection until the fiscal year that  
19 begins after such date.”.

20 (b) ELIGIBILITY STANDARD.—

21 (1) MINIMUM PERIOD FOR RECOGNITION OF  
22 NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi)  
23 (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

24 (A) by inserting “(I)” after “(vi)”; and

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

3 “(II) Under such criteria, a service or technology  
4 shall not be denied treatment as a new service or tech-  
5 nology on the basis of the period of time in which the serv-  
6 ice or technology has been in use if such period ends before  
7 the end of the 2-to-3-year period that begins on the effec-  
8 tive date of implementation of a code under ICD–9–CM  
9 (or a successor coding methodology) that enables the iden-  
10 tification of a significant sample of specific discharges in  
11 which the service or technology has been used.”.

12 (2) ADJUSTMENT OF THRESHOLD.—Section  
13 1886(d)(5)(K)(ii)(I) (42 U.S.C.  
14 1395ww(d)(5)(K)(ii)(I)) is amended by inserting  
15 “(applying a threshold specified by the Secretary  
16 that is the lesser of 50 percent of the national aver-  
17 age standardized amount for operating costs of inpa-  
18 tient hospital services for all hospitals and all diag-  
19 nosis-related groups or one standard deviation for  
20 the diagnosis-related group involved)” after “is inad-  
21 equate”.

22 (3) CRITERION FOR SUBSTANTIAL IMPROVE-  
23 MENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C.  
24 1395ww(d)(5)(K)(vi)), as amended by paragraph

1 (1), is further amended by adding at the end the fol-  
2 lowing subclause:

3 “(III) The Secretary shall by regulation provide for  
4 further clarification of the criteria applied to determine  
5 whether a new service or technology represents an advance  
6 in medical technology that substantially improves the diag-  
7 nosis or treatment of beneficiaries. Under such criteria,  
8 in determining whether a new service or technology rep-  
9 resents an advance in medical technology that substan-  
10 tially improves the diagnosis or treatment of beneficiaries,  
11 the Secretary shall deem a service or technology as meet-  
12 ing such requirement if the service or technology is a drug  
13 or biological that is designated under section 506 or 526  
14 of the Federal Food, Drug, and Cosmetic Act, approved  
15 under section 314.510 or 601.41 of title 21, Code of Fed-  
16 eral Regulations, or designated for priority review when  
17 the marketing application for such drug or biological was  
18 filed or is a medical device for which an exemption has  
19 been granted under section 520(m) of such Act, or for  
20 which priority review has been provided under section  
21 515(d)(5) of such Act.”.

22 (4) PROCESS FOR PUBLIC INPUT.—Section  
23 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as  
24 amended by paragraph (1), is amended—

1 (A) in clause (i), by adding at the end the  
2 following: “Such mechanism shall be modified  
3 to meet the requirements of clause (viii).”; and

4 (B) by adding at the end the following new  
5 clause:

6 “(viii) The mechanism established pursuant to clause  
7 (i) shall be adjusted to provide, before publication of a  
8 proposed rule, for public input regarding whether a new  
9 service or technology not described in the second sentence  
10 of clause (vi)(III) represents an advance in medical tech-  
11 nology that substantially improves the diagnosis or treat-  
12 ment of beneficiaries as follows:

13 “(I) The Secretary shall make public and peri-  
14 odically update a list of all the services and tech-  
15 nologies for which an application for additional pay-  
16 ment under this subparagraph is pending.

17 “(II) The Secretary shall accept comments, rec-  
18 ommendations, and data from the public regarding  
19 whether the service or technology represents a sub-  
20 stantial improvement.

21 “(III) The Secretary shall provide for a meeting  
22 at which organizations representing hospitals, physi-  
23 cians, medicare beneficiaries, manufacturers, and  
24 any other interested party may present comments,  
25 recommendations, and data to the clinical staff of

1 the Centers for Medicare & Medicaid Services before  
2 publication of a notice of proposed rulemaking re-  
3 garding whether service or technology represents a  
4 substantial improvement.”.

5 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—  
6 Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is  
7 further amended by adding at the end the following new  
8 clause:

9 “(ix) Before establishing any add-on payment under  
10 this subparagraph with respect to a new technology, the  
11 Secretary shall seek to identify one or more diagnosis-re-  
12 lated groups associated with such technology, based on  
13 similar clinical or anatomical characteristics and the cost  
14 of the technology. Within such groups the Secretary shall  
15 assign an eligible new technology into a diagnosis-related  
16 group where the average costs of care most closely approx-  
17 imate the costs of care of using the new technology. In  
18 such case, no add-on payment under this subparagraph  
19 shall be made with respect to such new technology and  
20 this clause shall not affect the application of paragraph  
21 (4)(C)(iii).”.

22 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-  
23 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.  
24 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after  
25 “the estimated average cost of such service or technology”

1 the following: “(based on the marginal rate applied to  
2 costs under subparagraph (A))”.

3 (e) EFFECTIVE DATE.—

4 (1) IN GENERAL.—The Secretary shall imple-  
5 ment the amendments made by this section so that  
6 they apply to classification for fiscal years beginning  
7 with fiscal year 2004.

8 (2) RECONSIDERATIONS OF APPLICATIONS FOR  
9 FISCAL YEAR 2003 THAT ARE DENIED.—In the case  
10 of an application for a classification of a medical  
11 service or technology as a new medical service or  
12 technology under section 1886(d)(5)(K) of the Social  
13 Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was  
14 filed for fiscal year 2003 and that is denied—

15 (A) the Secretary shall automatically re-  
16 consider the application as an application for  
17 fiscal year 2004 under the amendments made  
18 by this section; and

19 (B) the maximum time period otherwise  
20 permitted for such classification of the service  
21 or technology shall be extended by 12 months.

22 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN**  
23 **PUERTO RICO.**

24 Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is  
25 amended—

1 (1) in subparagraph (A)—

2 (A) in clause (i), by striking “for dis-  
3 charges beginning on or after October 1, 1997,  
4 50 percent (and for discharges between October  
5 1, 1987, and September 30, 1997, 75 percent)”  
6 and inserting “the applicable Puerto Rico per-  
7 centage (specified in subparagraph (E))”; and

8 (B) in clause (ii), by striking “for dis-  
9 charges beginning in a fiscal year beginning on  
10 or after October 1, 1997, 50 percent (and for  
11 discharges between October 1, 1987, and Sep-  
12 tember 30, 1997, 25 percent)” and inserting  
13 “the applicable Federal percentage (specified in  
14 subparagraph (E))”; and

15 (2) by adding at the end the following new sub-  
16 paragraph:

17 “(E) For purposes of subparagraph (A), for dis-  
18 charges occurring—

19 “(i) between October 1, 1987, and September  
20 30, 1997, the applicable Puerto Rico percentage is  
21 75 percent and the applicable Federal percentage is  
22 25 percent;

23 “(ii) on or after October 1, 1997, and before  
24 October 1, 2003, the applicable Puerto Rico percent-

1 age is 50 percent and the applicable Federal per-  
2 centage is 50 percent;

3 “(iii) during fiscal year 2004, the applicable  
4 Puerto Rico percentage is 45 percent and the appli-  
5 cable Federal percentage is 55 percent;

6 “(iv) during fiscal year 2005, the applicable  
7 Puerto Rico percentage is 40 percent and the appli-  
8 cable Federal percentage is 60 percent;

9 “(v) during fiscal year 2006, the applicable  
10 Puerto Rico percentage is 35 percent and the appli-  
11 cable Federal percentage is 65 percent;

12 “(vi) during fiscal year 2007, the applicable  
13 Puerto Rico percentage is 30 percent and the appli-  
14 cable Federal percentage is 70 percent; and

15 “(vii) on or after October 1, 2007, the applica-  
16 ble Puerto Rico percentage is 25 percent and the ap-  
17 plicable Federal percentage is 75 percent.”.

18 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**  
19 **HANCED DISPROPORTIONATE SHARE HOS-**  
20 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**  
21 **PITALS AND URBAN HOSPITALS WITH FEWER**  
22 **THAN 100 BEDS.**

23 For provision enhancing disproportionate share hos-  
24 pital (DSH) treatment for rural hospitals and urban hos-  
25 pitals with fewer than 100 beds, see section 302.

1 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR**  
2 **PHASED-IN INCREASE IN THE STANDARDIZED**  
3 **AMOUNT IN RURAL AND SMALL URBAN**  
4 **AREAS TO ACHIEVE A SINGLE, UNIFORM**  
5 **STANDARDIZED AMOUNT.**

6 For provision phasing in over a 2-year period an in-  
7 crease in the standardized amount for rural and small  
8 urban areas to achieve a single, uniform, standardized  
9 amount, see section 303.

10 **SEC. 407. REFERENCE TO PROVISION FOR MORE FRE-**  
11 **QUENT UPDATES IN THE WEIGHTS USED IN**  
12 **HOSPITAL MARKET BASKET.**

13 For provision providing for more frequent updates in  
14 the weights used in hospital market basket, see section  
15 304.

16 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**  
17 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**  
18 **GRAM.**

19 For provision providing making improvements to crit-  
20 ical access hospital program, see section 305.

21 **SEC. 409. GAO STUDY ON IMPROVING THE HOSPITAL WAGE**  
22 **INDEX.**

23 (a) STUDY.—

24 (1) IN GENERAL.—The Comptroller General of  
25 the United States shall conduct a study on the im-  
26 provements that can be made in the measurement of

1 regional differences in hospital wages reflected in the  
2 hospital wage index under section 1886(d) of the So-  
3 cial Security Act (42 U.S.C. 1395ww(d)).

4 (2) EXAMINATION OF USE OF METROPOLITAN  
5 STATISTICAL AREAS (MSAS).—The study shall spe-  
6 cifically examine the use of metropolitan statistical  
7 areas for purposes of computing and applying the  
8 wage index and whether the boundaries of such  
9 areas accurately reflect local labor markets. In addi-  
10 tion, the study shall examine whether regional in-  
11 equities are created as a result of infrequent updates  
12 of such boundaries and policies of the Bureau of the  
13 Census relating to commuting criteria.

14 (3) WAGE DATA.—The study shall specifically  
15 examine the portions of the hospital cost reports re-  
16 lating to wages, and methods for improving the ac-  
17 curacy of the wage data and for reducing inequities  
18 resulting from differences among hospitals in the re-  
19 porting of wage data.

20 (b) CONSULTATION WITH OMB.—The Comptroller  
21 General shall consult with the Director of Office of Man-  
22 agement and Budget in conducting the study under sub-  
23 section (a)(2).

24 (c) REPORT.—Not later than May 1, 2003, the  
25 Comptroller General shall submit to Congress a report on

1 the study conducted under subsection (a) and shall include  
 2 in the report such recommendations as may be appropriate  
 3 on—

4 (1) changes in the definition of labor market  
 5 areas used for purposes of the area wage index  
 6 under section 1886 of the Social Security Act; and

7 (2) improvements in methods for the collection  
 8 of wage data.

9 **Subtitle B—Skilled Nursing**  
 10 **Facility Services**

11 **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FA-**  
 12 **CILITY SERVICES.**

13 (a) TEMPORARY INCREASE IN NURSING COMPONENT  
 14 OF PPS FEDERAL RATE.—Section 312(a) of BIPA is  
 15 amended by adding at the end the following new sentence:  
 16 “The Secretary of Health and Human Services shall in-  
 17 crease by 12, 10, and 8 percent the nursing component  
 18 of the case-mix adjusted Federal prospective payment rate  
 19 specified in Tables 3 and 4 of the final rule published in  
 20 the Federal Register by the Health Care Financing Ad-  
 21 ministration on July 31, 2000 (65 Fed. Reg. 46770) and  
 22 as subsequently updated under section 1888(e)(4)(E)(ii)  
 23 of the Social Security Act (42 U.S.C.  
 24 1395yy(e)(4)(E)(ii)), effective for services furnished dur-  
 25 ing fiscal years 2003, 2004, and 2005, respectively.”.

1 (b) ADJUSTMENT TO RUGS FOR AIDS RESI-  
2 DENTS.—

3 (1) IN GENERAL.—Paragraph (12) of section  
4 1888(e) (42 U.S.C. 1395yy(e)) is amended to read  
5 as follows:

6 “(12) ADJUSTMENT FOR RESIDENTS WITH  
7 AIDS.—

8 “(A) IN GENERAL.—Subject to subpara-  
9 graph (B), in the case of a resident of a skilled  
10 nursing facility who is afflicted with acquired  
11 immune deficiency syndrome (AIDS), the per  
12 diem amount of payment otherwise applicable  
13 shall be increased by 128 percent to reflect in-  
14 creased costs associated with such residents.

15 “(B) SUNSET.—Subparagraph (A) shall  
16 not apply on and after such date as the Sec-  
17 retary certifies that there is an appropriate ad-  
18 justment in the case mix under paragraph  
19 (4)(G)(i) to compensate for the increased costs  
20 associated with residents described in such sub-  
21 paragraph.”.

22 (2) EFFECTIVE DATE.—The amendment made  
23 by paragraph (1) shall apply to services furnished on  
24 or after October 1, 2003.



1 (b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i))  
2 is amended by adding at the end the following new para-  
3 graph:

4 “(4) The amount paid to a hospice program with re-  
5 spect to the services under section 1812(a)(5) for which  
6 payment may be made under this part shall be equal to  
7 an amount equivalent to the amount established for an  
8 office or other outpatient visit for evaluation and manage-  
9 ment associated with presenting problems of moderate se-  
10 verity under the fee schedule established under section  
11 1848(b), other than the portion of such amount attrib-  
12 utable to the practice expense component.”.

13 (c) CONFORMING AMENDMENT.—Section  
14 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is  
15 amended by inserting before the comma at the end the  
16 following: “and services described in section 1812(a)(5)”.

17 (d) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to services provided by a hospice  
19 program on or after January 1, 2004.

20 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**  
21 **PICE CARE FURNISHED IN A FRONTIER AREA.**

22 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.  
23 1395f(i)(1)) is amended by adding at the end the following  
24 new subparagraph:

1       “(D) With respect to hospice care furnished in a fron-  
2 tier area on or after January 1, 2003, and before January  
3 1, 2008, the payment rates otherwise established for such  
4 care shall be increased by 10 percent. For purposes of this  
5 subparagraph, the term ‘frontier area’ means a county in  
6 which the population density is less than 7 persons per  
7 square mile.”.

8       (b) REPORT ON COSTS.—Not later than January 1,  
9 2007, the Comptroller General of the United States shall  
10 submit to Congress a report on the costs of furnishing  
11 hospice care in frontier areas. Such report shall include  
12 recommendations regarding the appropriateness of extend-  
13 ing, and modifying, the payment increase provided under  
14 the amendment made by subsection (a).

15 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

16       (a) IN GENERAL.—The Secretary shall conduct a  
17 demonstration project for the delivery of hospice care to  
18 medicare beneficiaries in rural areas. Under the project  
19 medicare beneficiaries who are unable to receive hospice  
20 care in the home for lack of an appropriate caregiver are  
21 provided such care in a facility of 20 or fewer beds which  
22 offers, within its walls, the full range of services provided  
23 by hospice programs under section 1861(dd) of the Social  
24 Security Act (42 U.S.C. 1395x(dd)).

1 (b) SCOPE OF PROJECT.—The Secretary shall con-  
2 duct the project under this section with respect to no more  
3 than 3 hospice programs over a period of not longer than  
4 5 years each.

5 (c) COMPLIANCE WITH CONDITIONS.—Under the  
6 demonstration project—

7 (1) the hospice program shall comply with oth-  
8 erwise applicable requirements, except that it shall  
9 not be required to offer services outside of the home  
10 or to meet the requirements of section  
11 1861(dd)(2)(A)(iii) of the Social Security Act; and

12 (2) payments for hospice care shall be made at  
13 the rates otherwise applicable to such care under  
14 title XVIII of such Act.

15 The Secretary may require the program to comply with  
16 such additional quality assurance standards for its provi-  
17 sion of services in its facility as the Secretary deems ap-  
18 propriate.

19 (d) REPORT.—Upon completion of the project, the  
20 Secretary shall submit a report to Congress on the project  
21 and shall include in the report recommendations regarding  
22 extension of such project to hospice programs serving  
23 rural areas.

1           **Subtitle D—Other Provisions**

2   **SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOV-**  
3                   **ERY AUDIT CONTRACTORS.**

4           (a) IN GENERAL.—The Secretary of Health and  
5 Human Services shall conduct a demonstration project  
6 under this section (in this section referred to as the  
7 “project”) to demonstrate the use of recovery audit con-  
8 tractors under the Medicare Integrity Program in identi-  
9 fying underpayments and overpayments and recouping  
10 overpayments under the medicare program for services for  
11 which payment is made under part A of title XVIII of  
12 the Social Security Act. Under the project—

13                   (1) payment may be made to such a contractor  
14           on a contingent basis;

15                   (2) a percentage of the amount recovered may  
16           be retained by the Secretary and shall be available  
17           to the program management account of the Centers  
18           for Medicare & Medicaid Services; and

19                   (3) the Secretary shall examine the efficacy of  
20           such use with respect to duplicative payments, accu-  
21           racy of coding, and other payment policies in which  
22           inaccurate payments arise.

23           (b) SCOPE AND DURATION.—The project shall cover  
24 at least 2 States and at least 3 contractors and shall last  
25 for not longer than 3 years.

1 (c) WAIVER.—The Secretary of Health and Human  
2 Services shall waive such provisions of title XVIII of the  
3 Social Security Act as may be necessary to provide for  
4 payment for services under the project in accordance with  
5 subsection (a).

6 (d) QUALIFICATIONS OF CONTRACTORS.—

7 (1) IN GENERAL.—The Secretary shall enter  
8 into a recovery audit contract under this section  
9 with an entity only if the entity has staff that has  
10 knowledge of and experience with the payment rules  
11 and regulations under the medicare program or the  
12 entity has or will contract with another entity that  
13 has such knowledgeable and experienced staff.

14 (2) INELIGIBILITY OF CERTAIN CONTRAC-  
15 TORS.—The Secretary may not enter into a recovery  
16 audit contract under this section with an entity to  
17 the extent that the entity is a fiscal intermediary  
18 under section 1816 of the Social Security Act (42  
19 U.S.C. 1395h), a carrier under section 1842 of such  
20 Act (42 U.S.C. 1395u), or a Medicare Administra-  
21 tive Contractor under section 1874A of such Act.

22 (3) PREFERENCE FOR ENTITIES WITH DEM-  
23 ONSTRATED PROFICIENCY WITH PRIVATE INSUR-  
24 ERS.—In awarding contracts to recovery audit con-  
25 tractors under this section, the Secretary shall give

1 preference to those entities that the Secretary deter-  
 2 mines have demonstrated proficiency in recovery au-  
 3 dits with private insurers or under the medicaid pro-  
 4 gram under title XIX of such Act.

5 (e) REPORT.—The Secretary of Health and Human  
 6 Services shall submit to Congress a report on the project  
 7 not later than 6 months after the date of its completion.  
 8 Such reports shall include information on the impact of  
 9 the project on savings to the medicare program and rec-  
 10 ommendations on the cost-effectiveness of extending or ex-  
 11 panding the project.

12 **TITLE V—PROVISIONS**  
 13 **RELATING TO PART B**  
 14 **Subtitle A—Physicians’ Services**

15 **SEC. 501. REVISION OF UPDATES FOR PHYSICIANS’ SERV-**  
 16 **ICES.**

17 (a) UPDATE FOR 2003 THROUGH 2005.—

18 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.  
 19 1395w-4(d)) is amended by adding at the end the  
 20 following new paragraphs:

21 “(5) UPDATE FOR 2003.—The update to the  
 22 single conversion factor established in paragraph  
 23 (1)(C) for 2003 is 2 percent.

24 “(6) SPECIAL RULES FOR UPDATE FOR 2004  
 25 AND 2005.—The following rules apply in determining

1 the update adjustment factors under paragraph  
2 (4)(B) for 2004 and 2005:

3 “(A) USE OF 2002 DATA IN DETERMINING  
4 ALLOWABLE COSTS.—

5 “(i) The reference in clause (ii)(I) of  
6 such paragraph to April 1, 1996, is  
7 deemed to be a reference to January 1,  
8 2002.

9 “(ii) The allowed expenditures for  
10 2002 is deemed to be equal to the actual  
11 expenditures for physicians’ services fur-  
12 nished during 2002, as estimated by the  
13 Secretary.

14 “(B) 1 PERCENTAGE POINT INCREASE IN  
15 GDP UNDER SGR.—The annual average percent-  
16 age growth in real gross domestic product per  
17 capita under subsection (f)(2)(C) for each of  
18 2003, 2004, and 2005 is deemed to be in-  
19 creased by 1 percentage point.”.

20 (2) CONFORMING AMENDMENT.—Paragraph  
21 (4)(B) of such section is amended, in the matter be-  
22 fore clause (i), by inserting “and paragraph (6)”  
23 after “subparagraph (D)”.

24 (3) NOT TREATED AS CHANGE IN LAW AND  
25 REGULATION IN SUSTAINABLE GROWTH RATE DE-

1       TERMINATION.—The amendments made by this sub-  
2       section shall not be treated as a change in law for  
3       purposes of applying section 1848(f)(2)(D) of the  
4       Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)).

5       (b) USE OF 10-YEAR ROLLING AVERAGE IN COM-  
6       PUTING GROSS DOMESTIC PRODUCT.—

7             (1) IN GENERAL.—Section 1848(f)(2)(C) (42  
8       U.S.C. 1395w-4(f)(2)(C)) is amended—

9             (A) by striking “projected” and inserting  
10            “annual average”; and

11            (B) by striking “from the previous applica-  
12            ble period to the applicable period involved”  
13            and inserting “during the 10-year period ending  
14            with the applicable period involved”.

15            (2) EFFECTIVE DATE.—The amendment made  
16       by paragraph (1) shall apply to computations of the  
17       sustainable growth rate for years beginning with  
18       2002.

19       (c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—  
20       Section 1848(d)(4)(F) (42 U.S.C. 1395w-4(d)(4)(F)) is  
21       amended by striking “subparagraph (A)” and all that fol-  
22       lows and inserting “subparagraph (A), for each of 2001  
23       and 2002, of -0.2 percent.”.

24       (d) GAO STUDY OF MEDICARE PAYMENT FOR INHA-  
25       LATION THERAPY.—

1           (1) STUDY.—The Comptroller General of the  
2 United States shall conduct a study to examine the  
3 adequacy of current reimbursements for inhalation  
4 therapy under the medicare program.

5           (2) REPORT.—Not later than May 1, 2003, the  
6 Comptroller General shall submit to Congress a re-  
7 port on the study conducted under paragraph (1).

8 **SEC. 502. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.**

9           (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-  
10 CIANS' SERVICES.—

11           (1) STUDY.—The Comptroller General of the  
12 United States shall conduct a study on access of  
13 medicare beneficiaries to physicians' services under  
14 the medicare program. The study shall include—

15                   (A) an assessment of the use by bene-  
16 ficiaries of such services through an analysis of  
17 claims submitted by physicians for such services  
18 under part B of the medicare program;

19                   (B) an examination of changes in the use  
20 by beneficiaries of physicians' services over  
21 time;

22                   (C) an examination of the extent to which  
23 physicians are not accepting new medicare  
24 beneficiaries as patients.

1           (2) REPORT.—Not later than 18 months after  
2 the date of the enactment of this Act, the Comp-  
3 troller General shall submit to Congress a report on  
4 the study conducted under paragraph (1). The re-  
5 port shall include a determination whether—

6           (A) data from claims submitted by physi-  
7 cians under part B of the medicare program in-  
8 dicate potential access problems for medicare  
9 beneficiaries in certain geographic areas; and

10           (B) access by medicare beneficiaries to  
11 physicians' services may have improved, re-  
12 mained constant, or deteriorated over time.

13           (b) STUDY AND REPORT ON SUPPLY OF PHYSI-  
14 CIANS.—

15           (1) STUDY.—The Secretary shall request the  
16 Institute of Medicine of the National Academy of  
17 Sciences to conduct a study on the adequacy of the  
18 supply of physicians (including specialists) in the  
19 United States and the factors that affect such sup-  
20 ply.

21           (2) REPORT TO CONGRESS.—Not later than 2  
22 years after the date of enactment of this section, the  
23 Secretary shall submit to Congress a report on the  
24 results of the study described in paragraph (1), in-  
25 cluding any recommendations for legislation.

1 **SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS'**  
2 **SERVICES.**

3 Not later than 1 year after the date of the enactment  
4 of this Act, the Medicare Payment Advisory Commission  
5 shall submit to Congress a report on the effect of refine-  
6 ments to the practice expense component of payments for  
7 physicians' services, after the transition to a full resource-  
8 based payment system in 2002, under section 1848 of the  
9 Social Security Act (42 U.S.C. 1395w-4). Such report  
10 shall examine the following matters by physician specialty:

11 (1) The effect of such refinements on payment  
12 for physicians' services.

13 (2) The interaction of the practice expense com-  
14 ponent with other components of and adjustments to  
15 payment for physicians' services under such section.

16 (3) The appropriateness of the amount of com-  
17 pensation by reason of such refinements.

18 (4) The effect of such refinements on access to  
19 care by medicare beneficiaries to physicians' serv-  
20 ices.

21 (5) The effect of such refinements on physician  
22 participation under the medicare program.

1 **SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN**  
2 **PHYSICIAN PATHOLOGY SERVICES UNDER**  
3 **MEDICARE.**

4 Section 542(c) of BIPA is amended by striking “2-  
5 year period” and inserting “3-year period”.

6 **SEC. 505. PHYSICIAN FEE SCHEDULE WAGE INDEX REVI-**  
7 **SION.**

8 (a) INDEX REVISION.—

9 (1) IN GENERAL.—Subject to paragraph (2),  
10 notwithstanding any other provision of law, for pur-  
11 poses of payment under the physician fee schedule  
12 under section 1848 of the Social Security Act (42  
13 U.S.C. 1395w-4) for physicians’ services furnished  
14 during 2004, in no case may the work geographic  
15 index otherwise calculated under subsection  
16 (e)(1)(A)(iii) of such section be less than 0.985.

17 (2) SECRETARIAL DISCRETION.—Paragraph (1)  
18 shall not take effect or be in force if the Secretary  
19 determines, taking into account the report of the  
20 Comptroller General under subsection (b)(2), that  
21 there is no sound economic rationale for the imple-  
22 mentation of such paragraph.

23 (3) EXEMPTION FROM LIMITATION ON ANNUAL  
24 ADJUSTMENTS.—Any increase in expenditures at-  
25 tributable to paragraph (1) during 2004 shall not be  
26 taken into account in applying section

1 1848(e)(2)(B)(ii)(II) of the Social Security Act (42  
2 U.S.C. 1395w-4(e)(2)(B)(ii)(II)) for that year.

3 (b) GAO REPORT.—

4 (1) EVALUATION.—As part of the study on geo-  
5 graphic differences in payments for physicians' serv-  
6 ices conducted under section 309, the Comptroller  
7 General shall evaluate the following:

8 (A) Whether there is a sound economic  
9 basis for the implementation of the adjustment  
10 under subsection (a)(1) in those areas in which  
11 the adjustment applies.

12 (B) The effect of such adjustment on phy-  
13 sician location and retention in areas affected  
14 by such adjustment, taking into account—

15 (i) differences in recruitment costs  
16 and retention rates for physicians, includ-  
17 ing specialists, between large urban areas  
18 and other areas; and

19 (ii) the mobility of physicians, includ-  
20 ing specialists, over the last decade.

21 (C) The appropriateness of establishing a  
22 floor of 1.0 for the work geographic index.

23 (2) REPORT.—By not later than September 1,  
24 2003, the Comptroller General shall submit to Con-



1 “(i) at least  $\frac{1}{3}$  of such areas in 2004;

2 and

3 “(ii) at least  $\frac{2}{3}$  of such areas in  
4 2005.

5 “(C) WAIVER OF CERTAIN PROVISIONS.—

6 In carrying out the programs, the Secretary  
7 may waive such provisions of the Federal Ac-  
8 quisition Regulation as are necessary for the ef-  
9 ficient implementation of this section, other  
10 than provisions relating to confidentiality of in-  
11 formation and such other provisions as the Sec-  
12 retary determines appropriate.

13 “(2) ITEMS AND SERVICES DESCRIBED.—The  
14 items and services referred to in paragraph (1) are  
15 the following:

16 “(A) DURABLE MEDICAL EQUIPMENT AND  
17 INHALATION DRUGS USED IN CONNECTION  
18 WITH DURABLE MEDICAL EQUIPMENT.—Cov-  
19 ered items (as defined in section 1834(a)(13))  
20 for which payment is otherwise made under sec-  
21 tion 1834(a), other than items used in infusion,  
22 and inhalation drugs used in conjunction with  
23 durable medical equipment.

24 “(B) OFF-THE-SHELF ORTHOTICS.—

25 Orthotics (described in section 1861(s)(9)) for

1           which payment is otherwise made under section  
2           1834(h) which require minimal self-adjustment  
3           for appropriate use and does not require exper-  
4           tise in trimming, bending, molding, assembling,  
5           or customizing to fit to the patient.

6           “(3) EXEMPTION AUTHORITY.—In carrying out  
7           the programs under this section, the Secretary may  
8           exempt—

9                   “(A) areas that are not competitive due to  
10                   low population density; and

11                   “(B) items and services for which the ap-  
12                   plication of competitive acquisition is not likely  
13                   to result in significant savings.

14           “(b) PROGRAM REQUIREMENTS.—

15                   “(1) IN GENERAL.—The Secretary shall con-  
16                   duct a competition among entities supplying items  
17                   and services described in subsection (a)(2) for each  
18                   competitive acquisition area in which the program is  
19                   implemented under subsection (a) with respect to  
20                   such items and services.

21           “(2) CONDITIONS FOR AWARDED CONTRACT.—

22                   “(A) IN GENERAL.—The Secretary may  
23                   not award a contract to any entity under the  
24                   competition conducted in an competitive acqui-  
25                   sition area pursuant to paragraph (1) to fur-

1           nish such items or services unless the Secretary  
2           finds all of the following:

3                   “(i) The entity meets quality and fi-  
4                   nancial standards specified by the Sec-  
5                   retary or developed by accreditation enti-  
6                   ties or organizations recognized by the Sec-  
7                   retary.

8                   “(ii) The total amounts to be paid  
9                   under the contract (including costs associ-  
10                  ated with the administration of the con-  
11                  tract) are expected to be less than the total  
12                  amounts that would otherwise be paid.

13                  “(iii) Beneficiary access to a choice of  
14                  multiple suppliers in the area is main-  
15                  tained.

16                  “(iv) Beneficiary liability is limited to  
17                  the applicable percentage of contract  
18                  award price.

19                  “(B) QUALITY STANDARDS.—The quality  
20                  standards specified under subparagraph (A)(i)  
21                  shall not be less than the quality standards that  
22                  would otherwise apply if this section did not  
23                  apply and shall include consumer services  
24                  standards. The Secretary shall consult with an  
25                  expert outside advisory panel composed of an

1 appropriate selection of representatives of phy-  
2 sicians, practitioners, and suppliers to review  
3 (and advise the Secretary concerning) such  
4 quality standards.

5 “(3) CONTENTS OF CONTRACT.—

6 “(A) IN GENERAL.—A contract entered  
7 into with an entity under the competition con-  
8 ducted pursuant to paragraph (1) is subject to  
9 terms and conditions that the Secretary may  
10 specify.

11 “(B) TERM OF CONTRACTS.—The Sec-  
12 retary shall rebid contracts under this section  
13 not less often than once every 3 years.

14 “(4) LIMIT ON NUMBER OF CONTRACTORS.—

15 “(A) IN GENERAL.—The Secretary may  
16 limit the number of contractors in a competitive  
17 acquisition area to the number needed to meet  
18 projected demand for items and services covered  
19 under the contracts. In awarding contracts, the  
20 Secretary shall take into account the ability of  
21 bidding entities to furnish items or services in  
22 sufficient quantities to meet the anticipated  
23 needs of beneficiaries for such items or services  
24 in the geographic area covered under the con-  
25 tract on a timely basis.

1           “(B) MULTIPLE WINNERS.—The Secretary  
2           shall award contracts to more than one entity  
3           submitting a bid in each area for an item or  
4           service.

5           “(5) PARTICIPATING CONTRACTORS.—Payment  
6           shall not be made for items and services described  
7           in subsection (a)(2) furnished by a contractor and  
8           for which competition is conducted under this sec-  
9           tion unless—

10           “(A) the contractor has submitted a bid  
11           for such items and services under this section;  
12           and

13           “(B) the Secretary has awarded a contract  
14           to the contractor for such items and services  
15           under this section.

16           “(6) AUTHORITY TO CONTRACT FOR EDU-  
17           CATION, OUTREACH AND COMPLAINT SERVICES.—  
18           The Secretary may enter into a contract with an ap-  
19           propriate entity to address complaints from bene-  
20           ficiaries who receive items and services from an enti-  
21           ty with a contract under this section and to conduct  
22           appropriate education of and outreach to such bene-  
23           ficiaries with respect to the program.

24           “(c) ANNUAL REPORTS.—The Secretary shall submit  
25 to Congress an annual management report on the pro-

1 grams under this section. Each such report shall include  
2 information on savings, reductions in cost-sharing, access  
3 to items and services, and beneficiary satisfaction.

4 “(d) DEMONSTRATION PROJECT FOR CLINICAL LAB-  
5 ORATORY SERVICES.—

6 “(1) IN GENERAL.—The Secretary shall con-  
7 duct a demonstration project on the application of  
8 competitive acquisition under this section to clinical  
9 diagnostic laboratory tests—

10 “(A) for which payment is otherwise made  
11 under section 1833(h) or 1834(d)(1) (relating  
12 to colorectal cancer screening tests); and

13 “(B) which are furnished without a face-  
14 to-face encounter between the individual and  
15 the hospital or physician ordering the tests.

16 “(2) TERMS AND CONDITIONS.—Such project  
17 shall be under the same conditions as are applicable  
18 to items and services described in subsection (a)(2).

19 “(3) REPORT.—The Secretary shall submit to  
20 Congress—

21 “(A) an initial report on the project not  
22 later than December 31, 2004; and

23 “(B) such progress and final reports on  
24 the project after such date as the Secretary de-  
25 termines appropriate.”.

1           (b) CONTINUATION OF CERTAIN DEMONSTRATION  
2 PROJECTS.—Notwithstanding the amendment made by  
3 subsection (a), with respect to demonstration projects im-  
4 plemented by the Secretary under section 1847 of the So-  
5 cial Security Act (42 U.S.C. 1395w–3) (relating to the es-  
6 tablishment of competitive acquisition areas) that was in  
7 effect on the day before the date of the enactment of this  
8 Act, each such demonstration project may continue under  
9 the same terms and conditions applicable under that sec-  
10 tion as in effect on that date.

11           (c) REPORT ON DIFFERENCES IN PAYMENT FOR  
12 LABORATORY SERVICES.—Not later than 18 months after  
13 the date of the enactment of this Act, the Comptroller  
14 General of the United States shall submit to Congress a  
15 report that analyzes differences in reimbursement between  
16 public and private payors for clinical diagnostic laboratory  
17 services.

18 **SEC. 512. PAYMENT FOR AMBULANCE SERVICES.**

19           (a) PHASE-IN PROVIDING FLOOR USING BLEND OF  
20 FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Sec-  
21 tion 1834(l) (42 U.S.C. 1395m(l)) is amended—

22                   (1) in paragraph (2)(E), by inserting “con-  
23 sistent with paragraph (10)” after “in an efficient  
24 and fair manner”;

1           (2) by redesignating the paragraph (8) added  
2 by section 221(a) of BIPA as paragraph (9); and

3           (3) by adding at the end the following new  
4 paragraph:

5           “(10) PHASE-IN PROVIDING FLOOR USING  
6 BLEND OF FEE SCHEDULE AND REGIONAL FEE  
7 SCHEDULES.—In carrying out the phase-in under  
8 paragraph (2)(E) for each level of service furnished  
9 in a year before January 1, 2007, the portion of the  
10 payment amount that is based on the fee schedule  
11 shall not be less than the following blended rate of  
12 the fee schedule under paragraph (1) and of a re-  
13 gional fee schedule for the region involved:

14           “(A) For 2003, the blended rate shall be  
15 based 20 percent on the fee schedule under  
16 paragraph (1) and 80 percent on the regional  
17 fee schedule.

18           “(B) For 2004, the blended rate shall be  
19 based 40 percent on the fee schedule under  
20 paragraph (1) and 60 percent on the regional  
21 fee schedule.

22           “(C) For 2005, the blended rate shall be  
23 based 60 percent on the fee schedule under  
24 paragraph (1) and 40 percent on the regional  
25 fee schedule.

1           “(D) For 2006, the blended rate shall be  
2           based 80 percent on the fee schedule under  
3           paragraph (1) and 20 percent on the regional  
4           fee schedule.

5           For purposes of this paragraph, the Secretary shall  
6           establish a regional fee schedule for each of the 9  
7           Census divisions using the methodology (used in es-  
8           tablishing the fee schedule under paragraph (1)) to  
9           calculate a regional conversion factor and a regional  
10          mileage payment rate and using the same payment  
11          adjustments and the same relative value units as  
12          used in the fee schedule under such paragraph.”.

13          (b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG  
14 TRIPS.—Section 1834(l), as amended by subsection (a),  
15 is further amended by adding at the end the following new  
16 paragraph:

17           “(11) ADJUSTMENT IN PAYMENT FOR CERTAIN  
18          LONG TRIPS.—In the case of ground ambulance  
19          services furnished on or after January 1, 2003, and  
20          before January 1, 2008, regardless of where the  
21          transportation originates, the fee schedule estab-  
22          lished under this subsection shall provide that, with  
23          respect to the payment rate for mileage for a trip  
24          above 50 miles the per mile rate otherwise estab-

1 lished shall be increased by  $\frac{1}{4}$  of the payment per  
2 mile otherwise applicable to such miles.”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to ambulance services furnished  
5 on or after January 1, 2003.

6 **SEC. 513. 2-YEAR EXTENSION OF MORATORIUM ON THER-**  
7 **APY CAPS; PROVISIONS RELATING TO RE-**  
8 **PORTS.**

9 (a) 2-YEAR EXTENSION OF MORATORIUM ON THER-  
10 APY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4))  
11 is amended by striking “and 2002” and inserting “2002,  
12 2003, and 2004”.

13 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON  
14 PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY  
15 SERVICES.—Not later than December 31, 2002, the Sec-  
16 retary shall submit to Congress the reports required under  
17 section 4541(d)(2) of the Balanced Budget Act of 1997  
18 (relating to alternatives to a single annual dollar cap on  
19 outpatient therapy) and under section 221(d) of the Medi-  
20 care, Medicaid, and SCHIP Balanced Budget Refinement  
21 Act of 1999 (relating to utilization patterns for outpatient  
22 therapy).

23 (c) IDENTIFICATION OF CONDITIONS AND DISEASES  
24 JUSTIFYING WAIVER OF THERAPY CAP.—

1           (1) STUDY.—The Secretary shall request the  
2           Institute of Medicine of the National Academy of  
3           Sciences to identify conditions or diseases that  
4           should justify conducting an assessment of the need  
5           to waive the therapy caps under section 1833(g)(4)  
6           of the Social Security Act (42 U.S.C. 1395l(g)(4)).

7           (2) REPORTS TO CONGRESS.—Not later than  
8           September 1, 2003, the Secretary shall submit to  
9           Congress a preliminary report on the conditions and  
10          diseases identified under paragraph (1) and not later  
11          than December 31, 2003, a final report on the con-  
12          ditions and diseases so identified.

13          (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL  
14          THERAPIST SERVICES.—

15               (1) STUDY.—The Comptroller General of the  
16               United States shall conduct a study on access to  
17               physical therapist services in States authorizing such  
18               services without a physician referral and in States  
19               that require such a physician referral. The study  
20               shall—

21                       (A) examine the use of and referral pat-  
22                       terns for physical therapist services for patients  
23                       age 50 and older in States that authorize such  
24                       services without a physician referral and in  
25                       States that require such a physician referral;

1 (B) examine the use of and referral pat-  
2 terns for physical therapist services for patients  
3 who are medicare beneficiaries;

4 (C) examine the potential effect of prohib-  
5 iting a physician from referring patients to  
6 physical therapy services owned by the physi-  
7 cian and provided in the physician's office;

8 (D) examine the delivery of physical thera-  
9 pists' services within the facilities of Depart-  
10 ment of Defense; and

11 (E) analyze the potential impact on medi-  
12 care beneficiaries and on expenditures under  
13 the medicare program of eliminating the need  
14 for a physician referral and physician certifi-  
15 cation for physical therapist services under the  
16 medicare program.

17 (2) REPORT.—The Comptroller General shall  
18 submit to Congress a report on the study conducted  
19 under paragraph (1) by not later than 1 year after  
20 the date of the enactment of this Act.

21 **SEC. 514. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**  
22 **ICAL EXAMINATION.**

23 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
24 1395x(s)(2)) is amended—

1           (1) in subparagraph (U), by striking “and” at  
2           the end;

3           (2) in subparagraph (V), by inserting “and” at  
4           the end; and

5           (3) by adding at the end the following new sub-  
6           paragraph:

7           “(W) an initial preventive physical examination  
8           (as defined in subsection (ww));”.

9           (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
10          1395x) is amended by adding at the end the following new  
11          subsection:

12           “Initial Preventive Physical Examination  
13           “(ww) The term ‘initial preventive physical examina-  
14          tion’ means physicians’ services consisting of a physical  
15          examination with the goal of health promotion and disease  
16          detection and includes items and services (excluding clin-  
17          ical laboratory tests), as determined by the Secretary, con-  
18          sistent with the recommendations of the United States  
19          Preventive Services Task Force.”.

20          (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

21           (1) DEDUCTIBLE.—The first sentence of sec-  
22          tion 1833(b) (42 U.S.C. 1395l(b)) is amended—

23                   (A) by striking “and” before “(6)”, and

24                   (B) by inserting before the period at the  
25          end the following: “, and (7) such deductible

1 shall not apply with respect to an initial preven-  
2 tive physical examination (as defined in section  
3 1861(ww))”.

4 (2) COINSURANCE.—Section 1833(a)(1) (42  
5 U.S.C. 1395l(a)(1)) is amended—

6 (A) in clause (N), by inserting “(or 100  
7 percent in the case of an initial preventive phys-  
8 ical examination, as defined in section  
9 1861(ww))” after “80 percent”; and

10 (B) in clause (O), by inserting “(or 100  
11 percent in the case of an initial preventive phys-  
12 ical examination, as defined in section  
13 1861(ww))” after “80 percent”.

14 (d) PAYMENT AS PHYSICIANS’ SERVICES.—Section  
15 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by in-  
16 serting “(2)(W),” after “(2)(S),”.

17 (e) OTHER CONFORMING AMENDMENTS.—Section  
18 1862(a) (42 U.S.C. 1395y(a)) is amended—

19 (1) in paragraph (1)—

20 (A) by striking “and” at the end of sub-  
21 paragraph (H);

22 (B) by striking the semicolon at the end of  
23 subparagraph (I) and inserting “, and”; and

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

1           “(J) in the case of an initial preventive physical  
2           examination, which is performed not later than 6  
3           months after the date the individual’s first coverage  
4           period begins under part B;” and

5           (2) in paragraph (7), by striking “or (H)” and  
6           inserting “(H), or (J)”.

7           (f) **EFFECTIVE DATE.**—The amendments made by  
8           this section shall apply to services furnished on or after  
9           January 1, 2004, but only for individuals whose coverage  
10          period begins on or after such date.

11       **SEC. 515. RENAL DIALYSIS SERVICES.**

12          (a) **REPORT ON DIFFERENCES IN COSTS IN DIF-**  
13       **FERENT SETTINGS.**—Not later than 1 year after the date  
14       of the enactment of this Act, the Comptroller General of  
15       the United States shall submit to Congress a report  
16       containing—

17               (1) an analysis of the differences in costs of  
18               providing renal dialysis services under the medicare  
19               program in home settings and in facility settings;

20               (2) an assessment of the percentage of overhead  
21               costs in home settings and in facility settings; and

22               (3) an evaluation of whether the charges for  
23               home dialysis supplies and equipment are reasonable  
24               and necessary.

1 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR  
2 PEDIATRIC FACILITIES.—

3 (1) IN GENERAL.—Section 422(a)(2) of BIPA  
4 is amended—

5 (A) in subparagraph (A), by striking “and  
6 (C)” and inserting “, (C), and (D)”;

7 (B) in subparagraph (B), by striking “In  
8 the case” and inserting “Subject to subpara-  
9 graph (D), in the case”; and

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

12 “(D) INAPPLICABILITY TO PEDIATRIC FA-  
13 CILITIES.—Subparagraphs (A) and (B) shall  
14 not apply, as of October 1, 2002, to pediatric  
15 facilities that do not have an exception rate de-  
16 scribed in subparagraph (C) in effect on such  
17 date. For purposes of this subparagraph, the  
18 term ‘pediatric facility’ means a renal facility at  
19 least 50 percent of whose patients are individ-  
20 uals under 18 years of age.”.

21 (2) CONFORMING AMENDMENT.—The fourth  
22 sentence of section 1881(b)(7) (42 U.S.C.  
23 1395rr(b)(7)) is amended by striking “The Sec-  
24 retary” and inserting “Subject to section 422(a)(2)  
25 of the Medicare, Medicaid, and SCHIP Benefits Im-

1       provement and Protection Act of 2000, the Sec-  
2       retary”.

3       (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE  
4 FOR SERVICES FURNISHED IN 2004.—Notwithstanding  
5 any other provision of law, with respect to payment under  
6 part B of title XVIII of the Social Security Act for renal  
7 dialysis services furnished in 2004, the composite payment  
8 rate otherwise established under section 1881(b)(7) of  
9 such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by  
10 1.2 percent.

11 **SEC. 516. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**  
12 **RAPHY SERVICES.**

13       (a) EXCLUSION FROM OPD FEE SCHEDULE.—Sec-  
14 tion 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is  
15 amended by inserting before the period at the end the fol-  
16 lowing: “and does not include screening mammography (as  
17 defined in section 1861(jj)) and unilateral and bilateral  
18 diagnostic mammography”.

19       (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For  
20 diagnostic mammography performed on or after January  
21 1, 2004, for which payment is made under the physician  
22 fee schedule under section 1848 of the Social Security Act  
23 (42 U.S.C. 1395w-4), the Secretary, based on the most  
24 recent cost data available, shall provide for an appropriate

1 adjustment in the payment amount for the technical com-  
2 ponent of the diagnostic mammography.

3 (c) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to mammography performed on  
5 or after January 1, 2004.

6 **SEC. 517. WAIVER OF PART B LATE ENROLLMENT PENALTY**  
7 **FOR CERTAIN MILITARY RETIREES; SPECIAL**  
8 **ENROLLMENT PERIOD.**

9 (a) WAIVER OF PENALTY.—

10 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.  
11 1395r(b)) is amended by adding at the end the fol-  
12 lowing new sentence: “No increase in the premium  
13 shall be effected for a month in the case of an indi-  
14 vidual who is 65 years of age or older, who enrolls  
15 under this part during 2001, 2002, or 2003, and  
16 who demonstrates to the Secretary before December  
17 31, 2003, that the individual is a covered beneficiary  
18 (as defined in section 1072(5) of title 10, United  
19 States Code). The Secretary of Health and Human  
20 Services shall consult with the Secretary of Defense  
21 in identifying individuals described in the previous  
22 sentence.”.

23 (2) EFFECTIVE DATE.—The amendment made  
24 by paragraph (1) shall apply to premiums for  
25 months beginning with January 2003. The Secretary

1 of Health and Human Services shall establish a  
2 method for providing rebates of premium penalties  
3 paid for months on or after January 2003 for which  
4 a penalty does not apply under such amendment but  
5 for which a penalty was previously collected.

6 (b) MEDICARE PART B SPECIAL ENROLLMENT PE-  
7 RIOD.—

8 (1) IN GENERAL.—In the case of any individual  
9 who, as of the date of the enactment of this Act, is  
10 65 years of age or older, is eligible to enroll but is  
11 not enrolled under part B of title XVIII of the So-  
12 cial Security Act, and is a covered beneficiary (as  
13 defined in section 1072(5) of title 10, United States  
14 Code), the Secretary of Health and Human Services  
15 shall provide for a special enrollment period during  
16 which the individual may enroll under such part.  
17 Such period shall begin as soon as possible after the  
18 date of the enactment of this Act and shall end on  
19 December 31, 2003.

20 (2) COVERAGE PERIOD.—In the case of an indi-  
21 vidual who enrolls during the special enrollment pe-  
22 riod provided under paragraph (1), the coverage pe-  
23 riod under part B of title XVIII of the Social Secu-  
24 rity Act shall begin on the first day of the month  
25 following the month in which the individual enrolls.

1 **SEC. 518. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**  
2 **SCREENING.**

3 (a) **COVERAGE.**—Section 1861(s)(2) (42 U.S.C.  
4 1395x(s)(2)), as amended by section 514(a), is amended—

5 (1) in subparagraph (V), by striking “and” at  
6 the end;

7 (2) in subparagraph (W), by inserting “and” at  
8 the end; and

9 (3) by adding at the end the following new sub-  
10 paragraph:

11 “(X) cholesterol and other blood lipid  
12 screening tests (as defined in subsection  
13 (XX));”.

14 (b) **SERVICES DESCRIBED.**—Section 1861 (42 U.S.C.  
15 1395x), as amended by section 514(b), is amended by add-  
16 ing at the end the following new subsection:

17 “Cholesterol and Other Blood Lipid Screening Test

18 “(xx)(1) The term ‘cholesterol and other blood lipid  
19 screening test’ means diagnostic testing of cholesterol and  
20 other lipid levels of the blood for the purpose of early de-  
21 tection of abnormal cholesterol and other lipid levels.

22 “(2) The Secretary shall establish standards, in con-  
23 sultation with appropriate organizations, regarding the  
24 frequency and type of cholesterol and other blood lipid  
25 screening tests, except that such frequency may not be  
26 more often than once every 2 years.”.

1 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.  
2 1395y(a)(1)), as amended by section 514(e), is  
3 amended—

4 (1) by striking “and” at the end of subpara-  
5 graph (I);

6 (2) by striking the semicolon at the end of sub-  
7 paragraph (J) and inserting “; and”; and

8 (3) by adding at the end the following new sub-  
9 paragraph:

10 “(K) in the case of a cholesterol and other  
11 blood lipid screening test (as defined in section  
12 1861(xx)(1)), which is performed more frequently  
13 than is covered under section 1861(xx)(2).”.

14 (d) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply to tests furnished on or after Janu-  
16 ary 1, 2004.

17 **TITLE VI—PROVISIONS**  
18 **RELATING TO PARTS A AND B**  
19 **Subtitle A—Home Health Services**

20 **SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN**  
21 **PAYMENT RATES UNDER THE PROSPECTIVE**  
22 **PAYMENT SYSTEM.**

23 (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.  
24 1395fff(b)(3)(A)) is amended to read as follows:

1           “(A) INITIAL BASIS.—Under such system  
2 the Secretary shall provide for computation of  
3 a standard prospective payment amount (or  
4 amounts) as follows:

5           “(i) Such amount (or amounts) shall  
6 initially be based on the most current au-  
7 dited cost report data available to the Sec-  
8 retary and shall be computed in a manner  
9 so that the total amounts payable under  
10 the system for fiscal year 2001 shall be  
11 equal to the total amount that would have  
12 been made if the system had not been in  
13 effect and if section 1861(v)(1)(L)(ix) had  
14 not been enacted.

15           “(ii) For fiscal year 2002 and for the  
16 first quarter of fiscal year 2003, such  
17 amount (or amounts) shall be equal to the  
18 amount (or amounts) determined under  
19 this paragraph for the previous fiscal year,  
20 updated under subparagraph (B).

21           “(iii) For 2003, such amount (or  
22 amounts) shall be equal to the amount (or  
23 amounts) determined under this paragraph  
24 for fiscal year 2002, updated under sub-  
25 paragraph (B) for 2003.

1                   “(iv) For 2004 and each subsequent  
2                   year, such amount (or amounts) shall be  
3                   equal to the amount (or amounts) deter-  
4                   mined under this paragraph for the pre-  
5                   vious year, updated under subparagraph  
6                   (B).

7                   Each such amount shall be standardized in a  
8                   manner that eliminates the effect of variations  
9                   in relative case mix and area wage adjustments  
10                  among different home health agencies in a  
11                  budget neutral manner consistent with the case  
12                  mix and wage level adjustments provided under  
13                  paragraph (4)(A). Under the system, the Sec-  
14                  retary may recognize regional differences or dif-  
15                  ferences based upon whether or not the services  
16                  or agency are in an urbanized area.”.

17                  (b) EFFECTIVE DATE.—The amendment made by  
18                  subsection (a) shall take effect as if included in the  
19                  amendments made by section 501 of the Medicare, Med-  
20                  icaid, and SCHIP Benefits Improvement and Protection  
21                  Act of 2000 (as enacted into law by section 1(a)(6) of  
22                  Public Law 106–554).

23                  **SEC. 602. UPDATE IN HOME HEALTH SERVICES.**

24                  (a) CHANGE TO CALENDAR YEAR UPDATE.—

1           (1) IN GENERAL.—Section 1895(b) (42 U.S.C.  
2 1395fff(b)(3)) is amended—

3           (A) in paragraph (3)(B)(i)—

4                 (i) by striking “each fiscal year (be-  
5 ginning with fiscal year 2002)” and insert-  
6 ing “fiscal year 2002 and for each subse-  
7 quent year (beginning with 2003)”; and

8                 (ii) by inserting “or year” after “the  
9 fiscal year”;

10          (B) in paragraph (3)(B)(ii)—

11                 (i) in subclause (II), by striking “fis-  
12 cal year” and inserting “year” and by re-  
13 designating such subclause as subclause  
14 (III); and

15                 (ii) in subclause (I), by striking “each  
16 of fiscal years 2002 and 2003” and insert-  
17 ing the following: “fiscal year 2002, the  
18 home health market basket percentage in-  
19 crease (as defined in clause (iii)) minus 1.1  
20 percentage points;

21                         “(II) 2003”;

22          (C) in paragraph (3)(B)(iii), by inserting  
23 “or year” after “fiscal year” each place it ap-  
24 pears;

25          (D) in paragraph (3)(B)(iv)—

1 (i) by inserting “or year” after “fiscal  
2 year” each place it appears; and

3 (ii) by inserting “or years” after “fis-  
4 cal years”; and

5 (E) in paragraph (5), by inserting “or  
6 year” after “fiscal year”.

7 (2) TRANSITION RULE.—The standard prospec-  
8 tive payment amount (or amounts) under section  
9 1895(b)(3) of the Social Security Act for the cal-  
10 endar quarter beginning on October 1, 2002, shall  
11 be such amount (or amounts) for the previous cal-  
12 endar quarter.

13 (b) CHANGES IN UPDATES FOR 2003, 2004, AND  
14 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C.  
15 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B),  
16 is amended—

17 (1) in subclause (II), by striking “the home  
18 health market basket percentage increase (as defined  
19 in clause (iii)) minus 1.1 percentage points” and in-  
20 serting “2.0 percentage points”;

21 (2) by striking “or” at the end of subclause  
22 (II);

23 (3) by redesignating subclause (III) as sub-  
24 clause (V); and

1           (4) by inserting after subclause (II) the fol-  
2           lowing new subclause:

3                           “(III) 2004, 1.1 percentage  
4                           points;

5                           “(IV) 2005, 2.7 percentage  
6                           points; or”.

7           (c) PAYMENT ADJUSTMENT.—

8                   (1) IN GENERAL.—Section 1895(b)(5) (42  
9                   U.S.C. 1395fff(b)(5)) is amended by striking “5 per-  
10                   cent” and inserting “3 percent”.

11                   (2) EFFECTIVE DATE.—The amendment made  
12                   by paragraph (1) shall apply to years beginning with  
13                   2003.

14 **SEC. 603. OASIS TASK FORCE; SUSPENSION OF CERTAIN**  
15                   **OASIS DATA COLLECTION REQUIREMENTS**  
16                   **PENDING TASK FORCE SUBMITTAL OF RE-**  
17                   **PORT.**

18           (a) ESTABLISHMENT.—The Secretary of Health and  
19           Human Services shall establish and appoint a task force  
20           (to be known as the “OASIS Task Force”) to examine  
21           the data collection and reporting requirements under  
22           OASIS. For purposes of this section, the term “OASIS”  
23           means the Outcome and Assessment Information Set re-  
24           quired by reason of section 4602(e) of Balanced Budget  
25           Act of 1997 (42 U.S.C. 1395fff note).

1 (b) COMPOSITION.—The OASIS Task Force shall be  
2 composed of the following:

3 (1) Staff of the Centers for Medicare & Med-  
4 icaid Services with expertise in post-acute care.

5 (2) Representatives of home health agencies.

6 (3) Health care professionals and research and  
7 health care quality experts outside the Federal Gov-  
8 ernment with expertise in post-acute care.

9 (4) Advocates for individuals requiring home  
10 health services.

11 (c) DUTIES.—

12 (1) REVIEW AND RECOMMENDATIONS.—The  
13 OASIS Task Force shall review and make rec-  
14 ommendations to the Secretary regarding changes in  
15 OASIS to improve and simplify data collection for  
16 purposes of—

17 (A) assessing the quality of home health  
18 services; and

19 (B) providing consistency in classification  
20 of patients into home health resource groups  
21 (HHRGs) for payment under section 1895 of  
22 the Social Security Act (42 U.S.C. 1395fff).

23 (2) SPECIFIC ITEMS.—In conducting the review  
24 under paragraph (1), the OASIS Task Force shall  
25 specifically examine—

1 (A) the 41 outcome measures currently in  
2 use;

3 (B) the timing and frequency of data col-  
4 lection; and

5 (C) the collection of information on  
6 comorbidities and clinical indicators.

7 (3) REPORT.—The OASIS Task Force shall  
8 submit a report to the Secretary containing its find-  
9 ings and recommendations for changes in OASIS by  
10 not later than 18 months after the date of the enact-  
11 ment of this Act.

12 (d) SUNSET.—The OASIS Task Force shall termi-  
13 nate 60 days after the date on which the report is sub-  
14 mitted under subsection (c)(2).

15 (e) NONAPPLICATION OF FACCA.—The provisions of  
16 the Federal Advisory Committee Act shall not apply to  
17 the OASIS Task Force.

18 (f) SUSPENSION OF OASIS REQUIREMENT FOR COL-  
19 LECTION OF DATA ON NON-MEDICARE AND NON-MED-  
20 ICAID PATIENTS PENDING TASK FORCE REPORT.—

21 (1) IN GENERAL.—During the period described  
22 in paragraph (2), the Secretary of Health and  
23 Human Services may not require, under section  
24 4602(e) of the Balanced Budget Act of 1997 or oth-  
25 erwise under OASIS, a home health agency to gath-

1 er or submit information that relates to an indi-  
2 vidual who is not eligible for benefits under either  
3 title XVIII or title XIX of the Social Security Act.

4 (2) PERIOD OF SUSPENSION.—The period de-  
5 scribed in this paragraph—

6 (A) begins on January 1, 2003, and

7 (B) ends on the last day of the 2nd month  
8 beginning after the date the report is submitted  
9 under subsection (c)(2).

10 **SEC. 604. MEDPAC STUDY ON MEDICARE MARGINS OF**  
11 **HOME HEALTH AGENCIES.**

12 (a) STUDY.—The Medicare Payment Advisory Com-  
13 mission shall conduct a study of payment margins of home  
14 health agencies under the home health prospective pay-  
15 ment system under section 1895 of the Social Security Act  
16 (42 U.S.C. 1395fff). Such study shall examine whether  
17 systematic differences in payment margins are related to  
18 differences in case mix (as measured by home health re-  
19 source groups (HHRGs)) among such agencies. The study  
20 shall use the partial or full-year cost reports filed by home  
21 health agencies.

22 (b) REPORT.—Not later than 2 years after the date  
23 of the enactment of this Act, the Commission shall submit  
24 to Congress a report on the study under subsection (a).

1 **SEC. 605. CLARIFICATION OF TREATMENT OF OCCASIONAL**  
2 **ABSENCES IN DETERMINING WHETHER AN**  
3 **INDIVIDUAL IS CONFINED TO THE HOME.**

4 (a) IN GENERAL.—The penultimate sentence of sec-  
5 tion 1814(a) (42 U.S.C. 1395f(a) and the penultimate  
6 sentence of section 1835(a) (42 U.S.C. 1395n(a)) are each  
7 amended to read as follows: “Any other absence of an indi-  
8 vidual from the home shall not so disqualify the individual  
9 if the absence is infrequent or of relatively short duration,  
10 such as an occasional trip to the barber or a walk around  
11 the block, and is not inconsistent with the assessment un-  
12 derlying the individual’s plan of care for home health serv-  
13 ices.”.

14 (b) EFFECTIVE DATE.—The amendments made by  
15 subsection (a) shall take effect on the date of the enact-  
16 ment of this Act.

17 **Subtitle B—Direct Graduate**  
18 **Medical Education**

19 **SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH**  
20 **COST PROGRAMS.**

21 Section 1886(h)(2)(D)(iv) (42 U.S.C.  
22 1395ww(h)(2)(D)(iv)) is amended—

23 (1) in subclause (I)—

24 (A) by striking “AND 2002” and inserting  
25 “THROUGH 2012”;

1 (B) by striking “during fiscal year 2001 or  
2 fiscal year 2002” and inserting “during the pe-  
3 riod beginning with fiscal year 2001 and ending  
4 with fiscal year 2012”; and

5 (C) by striking “subject to subclause  
6 (III),”;

7 (2) by striking subclause (II); and

8 (3) in subclause (III)—

9 (A) by redesignating such subclause as  
10 subclause (II); and

11 (B) by striking “or (II)”.

12 **SEC. 612. REDISTRIBUTION OF UNUSED RESIDENT POSI-**  
13 **TIONS.**

14 (a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C.  
15 1395ww(h)(4)) is amended—

16 (1) in subparagraph (F)(i), by inserting “sub-  
17 ject to subparagraph (I),” after “October 1, 1997,”;

18 (2) in subparagraph (H)(i), by inserting “sub-  
19 ject to subparagraph (I),” after “subparagraphs (F)  
20 and (G),”; and

21 (3) by adding at the end the following new sub-  
22 paragraph:

23 “(I) REDISTRIBUTION OF UNUSED RESI-  
24 DENT POSITIONS.—

1                   “(i) REDUCTION IN LIMIT BASED ON  
2                   UNUSED POSITIONS.—

3                   “(I) IN GENERAL.—If a hos-  
4                   pital’s resident level (as defined in  
5                   clause (iii)(I)) is less than the other-  
6                   wise applicable resident limit (as de-  
7                   fined in clause (iii)(II)) for each of  
8                   the reference periods (as defined in  
9                   subclause (II)), effective for cost re-  
10                  porting periods beginning on or after  
11                  January 1, 2003, the otherwise appli-  
12                  cable resident limit shall be reduced  
13                  by 75 percent of the difference be-  
14                  tween such limit and the reference  
15                  resident level specified in subclause  
16                  (III) (or subclause (IV) if applicable).

17                  “(II) REFERENCE PERIODS DE-  
18                  FINED.—In this clause, the term ‘ref-  
19                  erence periods’ means, for a hospital,  
20                  the 3 most recent consecutive cost re-  
21                  porting periods of the hospital for  
22                  which cost reports have been settled  
23                  (or, if not, submitted) on or before  
24                  September 30, 2001.

1                   “(III) REFERENCE RESIDENT  
2 LEVEL.—Subject to subclause (IV),  
3 the reference resident level specified in  
4 this subclause for a hospital is the  
5 highest resident level for the hospital  
6 during any of the reference periods.

7                   “(IV) ADJUSTMENT PROCESS.—  
8 Upon the timely request of a hospital,  
9 the Secretary may adjust the ref-  
10 erence resident level for a hospital to  
11 be the resident level for the hospital  
12 for the cost reporting period that in-  
13 cludes July 1, 2002.

14                   “(ii) REDISTRIBUTION.—

15                   “(I) IN GENERAL.—The Sec-  
16 retary is authorized to increase the  
17 otherwise applicable resident limits for  
18 hospitals by an aggregate number es-  
19 timated by the Secretary that does  
20 not exceed the aggregate reduction in  
21 such limits attributable to clause (i)  
22 (without taking into account any ad-  
23 justment under subclause (IV) of such  
24 clause).

1           “(II) EFFECTIVE DATE.—No in-  
2           crease under subclause (I) shall be  
3           permitted or taken into account for a  
4           hospital for any portion of a cost re-  
5           porting period that occurs before July  
6           1, 2003, or before the date of the hos-  
7           pital’s application for an increase  
8           under this clause. No such increase  
9           shall be permitted for a hospital un-  
10          less the hospital has applied to the  
11          Secretary for such increase by Decem-  
12          ber 31, 2004.

13           “(III) CONSIDERATIONS IN RE-  
14          DISTRIBUTION.—In determining for  
15          which hospitals the increase in the  
16          otherwise applicable resident limit is  
17          provided under subclause (I), the Sec-  
18          retary shall take into account the  
19          need for such an increase by specialty  
20          and location involved, consistent with  
21          subclause (IV).

22           “(IV) PRIORITY FOR RURAL AND  
23          SMALL URBAN AREAS.—In deter-  
24          mining for which hospitals and resi-  
25          dency training programs an increase

1 in the otherwise applicable resident  
2 limit is provided under subclause (I),  
3 the Secretary shall first distribute the  
4 increase to programs of hospitals lo-  
5 cated in rural areas or in urban areas  
6 that are not large urban areas (as de-  
7 fined for purposes of subsection (d))  
8 on a first-come-first-served basis (as  
9 determined by the Secretary) based on  
10 a demonstration that the hospital will  
11 fill the positions made available under  
12 this clause and not to exceed an in-  
13 crease of 25 full-time equivalent posi-  
14 tions with respect to any hospital.

15 “(V) APPLICATION OF LOCALITY  
16 ADJUSTED NATIONAL AVERAGE PER  
17 RESIDENT AMOUNT.—With respect to  
18 additional residency positions in a  
19 hospital attributable to the increase  
20 provided under this clause, notwith-  
21 standing any other provision of this  
22 subsection, the approved FTE resi-  
23 dent amount is deemed to be equal to  
24 the locality adjusted national average

1 per resident amount computed under  
2 subparagraph (E) for that hospital.

3 “(VI) CONSTRUCTION.—Nothing  
4 in this clause shall be construed as  
5 permitting the redistribution of reduc-  
6 tions in residency positions attrib-  
7 utable to voluntary reduction pro-  
8 grams under paragraph (6) or as af-  
9 fecting the ability of a hospital to es-  
10 tablish new medical residency training  
11 programs under subparagraph (H).

12 “(iii) RESIDENT LEVEL AND LIMIT  
13 DEFINED.—In this subparagraph:

14 “(I) RESIDENT LEVEL.—The  
15 term ‘resident level’ means, with re-  
16 spect to a hospital, the total number  
17 of full-time equivalent residents, be-  
18 fore the application of weighting fac-  
19 tors (as determined under this para-  
20 graph), in the fields of allopathic and  
21 osteopathic medicine for the hospital.

22 “(II) OTHERWISE APPLICABLE  
23 RESIDENT LIMIT.—The term ‘other-  
24 wise applicable resident limit’ means,  
25 with respect to a hospital, the limit

1 otherwise applicable under subpara-  
2 graphs (F)(i) and (H) on the resident  
3 level for the hospital determined with-  
4 out regard to this subparagraph.”.

5 (b) NO APPLICATION OF INCREASE TO IME.—Sec-  
6 tion 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is  
7 amended by adding at the end the following: “The provi-  
8 sions of clause (i) of subparagraph (I) of subsection (h)(4)  
9 shall apply with respect to the first sentence of this clause  
10 in the same manner as it applies with respect to subpara-  
11 graph (F) of such subsection, but the provisions of clause  
12 (ii) of such subparagraph shall not apply.”.

13 (c) REPORT ON EXTENSION OF APPLICATIONS  
14 UNDER REDISTRIBUTION PROGRAM.—Not later than July  
15 1, 2004, the Secretary shall submit to Congress a report  
16 containing recommendations regarding whether to extend  
17 the deadline for applications for an increase in resident  
18 limits under section 1886(h)(4)(I)(ii)(II) of the Social Se-  
19 curity Act (as added by subsection (a)).

## 20 **Subtitle C—Other Provisions**

### 21 **SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVI- 22 SORY COMMISSION (MEDPAC).**

23 (a) EXAMINATION OF BUDGET CONSEQUENCES.—  
24 Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by  
25 adding at the end the following new paragraph:

1           “(8) EXAMINATION OF BUDGET CON-  
2 SEQUENCES.—Before making any recommendations,  
3 the Commission shall examine the budget con-  
4 sequences of such recommendations, directly or  
5 through consultation with appropriate expert enti-  
6 ties.”.

7           (b) CONSIDERATION OF EFFICIENT PROVISION OF  
8 SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b-  
9 6(b)(2)(B)(i)) is amended by inserting “the efficient provi-  
10 sion of” after “expenditures for”.

11           (c) ADDITIONAL REPORTS.—

12           (1) DATA NEEDS AND SOURCES.—The Medicare  
13 Payment Advisory Commission shall conduct a  
14 study, and submit a report to Congress by not later  
15 than June 1, 2003, on the need for current data,  
16 and sources of current data available, to determine  
17 the solvency and financial circumstances of hospitals  
18 and other medicare providers of services. The Com-  
19 mission shall examine data on uncompensated care,  
20 as well as the share of uncompensated care ac-  
21 counted for by the expenses for treating illegal  
22 aliens.

23           (2) USE OF TAX-RELATED RETURNS.—Using  
24 return information provided under Form 990 of the  
25 Internal Revenue Service, the Commission shall sub-

1       mit to Congress, by not later than June 1, 2003, a  
2       report on the following:

3               (A) Investments and capital financing of  
4               hospitals participating under the medicare pro-  
5               gram and related foundations.

6               (B) Access to capital financing for private  
7               and for not-for-profit hospitals.

8 **SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MAN-**  
9               **AGEMENT FOR CERTAIN MEDICARE BENE-**  
10              **FICIARIES WITH DIABETES.**

11       (a) IN GENERAL.—The Secretary of Health and  
12 Human Services shall conduct a demonstration project  
13 under this section (in this section referred to as the  
14 “project”) to demonstrate the impact on costs and health  
15 outcomes of applying disease management to certain medi-  
16 care beneficiaries with diagnosed diabetes. In no case may  
17 the number of participants in the project exceed 30,000  
18 at any time.

19       (b) VOLUNTARY PARTICIPATION.—

20               (1) ELIGIBILITY.—Medicare beneficiaries are  
21 eligible to participate in the project only if—

22               (A) they are a member of a health dis-  
23 parity population (as defined in section  
24 485E(d) of the Public Health Service Act),  
25 such as Hispanics;

1 (B) they meet specific medical criteria  
2 demonstrating the appropriate diagnosis and  
3 the advanced nature of their disease;

4 (C) their physicians approve of participa-  
5 tion in the project; and

6 (D) they are not enrolled in a  
7 Medicare+Choice plan.

8 (2) BENEFITS.—A medicare beneficiary who is  
9 enrolled in the project shall be eligible—

10 (A) for disease management services re-  
11 lated to their diabetes; and

12 (B) for payment for all costs for prescrip-  
13 tion drugs without regard to whether or not  
14 they relate to the diabetes, except that the  
15 project may provide for modest cost-sharing  
16 with respect to prescription drug coverage.

17 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-  
18 NIZATIONS.—

19 (1) IN GENERAL.—The Secretary of Health and  
20 Human Services shall carry out the project through  
21 contracts with up to three disease management orga-  
22 nizations. The Secretary shall not enter into such a  
23 contract with an organization unless the organiza-  
24 tion demonstrates that it can produce improved

1 health outcomes and reduce aggregate medicare ex-  
2 penditures consistent with paragraph (2).

3 (2) CONTRACT PROVISIONS.—Under such  
4 contracts—

5 (A) such an organization shall be required  
6 to provide for prescription drug coverage de-  
7 scribed in subsection (b)(2)(B);

8 (B) such an organization shall be paid a  
9 fee negotiated and established by the Secretary  
10 in a manner so that (taking into account sav-  
11 ings in expenditures under parts A and B of  
12 the medicare program under title XVIII of the  
13 Social Security Act) there will be no net in-  
14 crease, and to the extent practicable, there will  
15 be a net reduction in expenditures under the  
16 medicare program as a result of the project;  
17 and

18 (C) such an organization shall guarantee,  
19 through an appropriate arrangement with a re-  
20 insurance company or otherwise, the prohibition  
21 on net increases in expenditures described in  
22 subparagraph (B).

23 (3) PAYMENTS.—Payments to such organiza-  
24 tions shall be made in appropriate proportion from

1 the Trust Funds established under title XVIII of the  
2 Social Security Act.

3 (d) APPLICATION OF MEDIGAP PROTECTIONS TO  
4 DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to  
5 paragraph (2), the provisions of section 1882(s)(3) (other  
6 than clauses (i) through (iv) of subparagraph (B)) and  
7 1882(s)(4) of the Social Security Act shall apply to enroll-  
8 ment (and termination of enrollment) in the demonstra-  
9 tion project under this section, in the same manner as they  
10 apply to enrollment (and termination of enrollment) with  
11 a Medicare+Choice organization in a Medicare+Choice  
12 plan.

13 (2) In applying paragraph (1)—

14 (A) any reference in clause (v) or (vi) of section  
15 1882(s)(3)(B) of such Act to 12 months is deemed  
16 a reference to the period of the demonstration  
17 project; and

18 (B) the notification required under section  
19 1882(s)(3)(D) of such Act shall be provided in a  
20 manner specified by the Secretary of Health and  
21 Human Services.

22 (e) DURATION.—The project shall last for not longer  
23 than 3 years.

24 (f) WAIVER.—The Secretary of Health and Human  
25 Services shall waive such provisions of title XVIII of the

1 Social Security Act as may be necessary to provide for  
2 payment for services under the project in accordance with  
3 subsection (c)(3).

4 (g) REPORT.—The Secretary of Health and Human  
5 Services shall submit to Congress an interim report on the  
6 project not later than 2 years after the date it is first im-  
7 plemented and a final report on the project not later than  
8 6 months after the date of its completion. Such reports  
9 shall include information on the impact of the project on  
10 costs and health outcomes and recommendations on the  
11 cost-effectiveness of extending or expanding the project.

12 (h) WORKING GROUP ON MEDICARE DISEASE MAN-  
13 AGEMENT PROGRAMS.—The Secretary shall establish  
14 within the Department of Health and Human Services a  
15 working group consisting of employees of the Department  
16 to carry out the following:

17 (1) To oversee the project.

18 (2) To establish policy and criteria for medicare  
19 disease management programs within the Depart-  
20 ment, including the establishment of policy and cri-  
21 teria for such programs.

22 (3) To identify targeted medical conditions and  
23 targeted individuals.

24 (4) To select areas in which such programs are  
25 carried out.

1           (5) To monitor health outcomes under such  
2 programs.

3           (6) To measure the effectiveness of such pro-  
4 grams in meeting any budget neutrality require-  
5 ments.

6           (7) Otherwise to serve as a central focal point  
7 within the Department for dissemination of informa-  
8 tion on medicare disease management programs.

9           (i) GAO STUDY ON DISEASE MANAGEMENT PRO-  
10 GRAMS.—The Comptroller General of the United States  
11 shall conduct a study that compares disease management  
12 programs under title XVIII of the Social Security Act with  
13 such programs conducted in the private sector, including  
14 the prevalence of such programs and programs for case  
15 management. The study shall identify the cost-effective-  
16 ness of such programs and any savings achieved by such  
17 programs. The Comptroller General shall submit a report  
18 on such study to Congress by not later than 18 months  
19 after the date of the enactment of this Act.

20 **SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT**  
21 **DAY CARE SERVICES.**

22           (a) ESTABLISHMENT.—Subject to the succeeding  
23 provisions of this section, the Secretary of Health and  
24 Human Services shall establish a demonstration project  
25 (in this section referred to as the “demonstration project”)

1 under which the Secretary shall, as part of a plan of an  
2 episode of care for home health services established for  
3 a medicare beneficiary, permit a home health agency, di-  
4 rectly or under arrangements with a medical adult day  
5 care facility, to provide medical adult day care services as  
6 a substitute for a portion of home health services that  
7 would otherwise be provided in the beneficiary's home.

8 (b) PAYMENT.—

9 (1) IN GENERAL.—The amount of payment for  
10 an episode of care for home health services, a por-  
11 tion of which consists of substitute medical adult  
12 day care services, under the demonstration project  
13 shall be made at a rate equal to 95 percent of the  
14 amount that would otherwise apply for such home  
15 health services under section 1895 of the Social Se-  
16 curity Act (42 u.s.c. 1395fff). In no case may a  
17 home health agency, or a medical adult day care fa-  
18 cility under arrangements with a home health agen-  
19 cy, separately charge a beneficiary for medical adult  
20 day care services furnished under the plan of care.

21 (2) BUDGET NEUTRALITY FOR DEMONSTRA-  
22 TION PROJECT.—Notwithstanding any other provi-  
23 sion of law, the Secretary shall provide for an appro-  
24 priate reduction in the aggregate amount of addi-  
25 tional payments made under section 1895 of the So-

1       cial Security Act (42 U.S.C. 1395fff) to reflect any  
2       increase in amounts expended from the Trust Funds  
3       as a result of the demonstration project conducted  
4       under this section.

5       (c) DEMONSTRATION PROJECT SITES.—The project  
6       established under this section shall be conducted in not  
7       more than 5 States selected by the Secretary that license  
8       or certify providers of services that furnish medical adult  
9       day care services.

10      (d) DURATION.—The Secretary shall conduct the  
11      demonstration project for a period of 3 years.

12      (e) VOLUNTARY PARTICIPATION.—Participation of  
13      medicare beneficiaries in the demonstration project shall  
14      be voluntary. The total number of such beneficiaries that  
15      may participate in the project at any given time may not  
16      exceed 15,000.

17      (f) PREFERENCE IN SELECTING AGENCIES.—In se-  
18      lecting home health agencies to participate under the dem-  
19      onstration project, the Secretary shall give preference to  
20      those agencies that are currently licensed or certified  
21      through common ownership and control to furnish medical  
22      adult day care services.

23      (g) WAIVER AUTHORITY.—The Secretary may waive  
24      such requirements of title XVIII of the Social Security Act  
25      as may be necessary for the purposes of carrying out the

1 demonstration project, other than waiving the requirement  
2 that an individual be homebound in order to be eligible  
3 for benefits for home health services.

4 (h) EVALUATION AND REPORT.—The Secretary shall  
5 conduct an evaluation of the clinical and cost effectiveness  
6 of the demonstration project. Not later 30 months after  
7 the commencement of the project, the Secretary shall sub-  
8 mit to Congress a report on the evaluation, and shall in-  
9 clude in the report the following:

10 (1) An analysis of the patient outcomes and  
11 costs of furnishing care to the medicare beneficiaries  
12 participating in the project as compared to such out-  
13 comes and costs to beneficiaries receiving only home  
14 health services for the same health conditions.

15 (2) Such recommendations regarding the exten-  
16 sion, expansion, or termination of the project as the  
17 Secretary determines appropriate.

18 (i) DEFINITIONS.—In this section:

19 (1) HOME HEALTH AGENCY.—The term “home  
20 health agency” has the meaning given such term in  
21 section 1861(o) of the Social Security Act (42  
22 U.S.C. 1395x(o)).

23 (2) MEDICAL ADULT DAY CARE FACILITY.—The  
24 term “medical adult day care facility” means a facil-  
25 ity that—

1 (A) has been licensed or certified by a  
2 State to furnish medical adult day care services  
3 in the State for a continuous 2-year period;

4 (B) is engaged in providing skilled nursing  
5 services and other therapeutic services directly  
6 or under arrangement with a home health agen-  
7 cy;

8 (C) meets such standards established by  
9 the Secretary to assure quality of care and such  
10 other requirements as the Secretary finds nec-  
11 essary in the interest of the health and safety  
12 of individuals who are furnished services in the  
13 facility; and

14 (D) provides medical adult day care serv-  
15 ices.

16 (3) MEDICAL ADULT DAY CARE SERVICES.—

17 The term “medical adult day care services” means—

18 (A) home health service items and services  
19 described in paragraphs (1) through (7) of sec-  
20 tion 1861(m) furnished in a medical adult day  
21 care facility;

22 (B) a program of supervised activities fur-  
23 nished in a group setting in the facility that—

24 (i) meet such criteria as the Secretary  
25 determines appropriate; and

1 (ii) is designed to promote physical  
2 and mental health of the individuals; and  
3 (C) such other services as the Secretary  
4 may specify.

5 (4) **MEDICARE BENEFICIARY.**—The term  
6 “medicare beneficiary” means an individual entitled  
7 to benefits under part A of this title, enrolled under  
8 part B of this title, or both.

9 **SEC. 624. PUBLICATION ON FINAL WRITTEN GUIDANCE**  
10 **CONCERNING PROHIBITIONS AGAINST DIS-**  
11 **CRIMINATION BY NATIONAL ORIGIN WITH**  
12 **RESPECT TO HEALTH CARE SERVICES.**

13 Not later than January 1, 2003, the Secretary shall  
14 issue final written guidance concerning the application of  
15 the prohibition in title VI of the Civil Rights Act of 1964  
16 against national origin discrimination as it affects persons  
17 with limited English proficiency with respect to access to  
18 health care services under the medicare program.

19 **TITLE VII—MEDICARE BENEFITS**  
20 **ADMINISTRATION**

21 **SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS AD-**  
22 **MINISTRATION.**

23 (a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et  
24 seq.), as amended by section 105, is amended by inserting  
25 after 1806 the following new section:

1 “MEDICARE BENEFITS ADMINISTRATION

2 “SEC. 1808. (a) ESTABLISHMENT.—There is estab-  
3 lished within the Department of Health and Human Serv-  
4 ices an agency to be known as the Medicare Benefits Ad-  
5 ministration.

6 “(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR;  
7 CHIEF ACTUARY.—

8 “(1) ADMINISTRATOR.—

9 “(A) IN GENERAL.—The Medicare Bene-  
10 fits Administration shall be headed by an ad-  
11 ministrator to be known as the ‘Medicare Bene-  
12 fits Administrator’ (in this section referred to  
13 as the ‘Administrator’) who shall be appointed  
14 by the President, by and with the advice and  
15 consent of the Senate. The Administrator shall  
16 be in direct line of authority to the Secretary.

17 “(B) COMPENSATION.—The Administrator  
18 shall be paid at the rate of basic pay payable  
19 for level III of the Executive Schedule under  
20 section 5314 of title 5, United States Code.

21 “(C) TERM OF OFFICE.—The Adminis-  
22 trator shall be appointed for a term of 5 years.  
23 In any case in which a successor does not take  
24 office at the end of an Administrator’s term of  
25 office, that Administrator may continue in of-

1           fice until the entry upon office of such a suc-  
2           cessor. An Administrator appointed to a term of  
3           office after the commencement of such term  
4           may serve under such appointment only for the  
5           remainder of such term.

6           “(D) GENERAL AUTHORITY.—The Admin-  
7           istrator shall be responsible for the exercise of  
8           all powers and the discharge of all duties of the  
9           Administration, and shall have authority and  
10          control over all personnel and activities thereof.

11          “(E) RULEMAKING AUTHORITY.—The Ad-  
12          ministrator may prescribe such rules and regu-  
13          lations as the Administrator determines nec-  
14          essary or appropriate to carry out the functions  
15          of the Administration. The regulations pre-  
16          scribed by the Administrator shall be subject to  
17          the rulemaking procedures established under  
18          section 553 of title 5, United States Code.

19          “(F) AUTHORITY TO ESTABLISH ORGANI-  
20          ZATIONAL UNITS.—The Administrator may es-  
21          tablish, alter, consolidate, or discontinue such  
22          organizational units or components within the  
23          Administration as the Administrator considers  
24          necessary or appropriate, except as specified in  
25          this section.

1           “(G) AUTHORITY TO DELEGATE.—The Ad-  
2           ministrator may assign duties, and delegate, or  
3           authorize successive redelegations of, authority  
4           to act and to render decisions, to such officers  
5           and employees of the Administration as the Ad-  
6           ministrator may find necessary. Within the lim-  
7           itations of such delegations, redelegations, or  
8           assignments, all official acts and decisions of  
9           such officers and employees shall have the same  
10          force and effect as though performed or ren-  
11          dered by the Administrator.

12          “(2) DEPUTY ADMINISTRATOR.—

13                 “(A) IN GENERAL.—There shall be a Dep-  
14                 uty Administrator of the Medicare Benefits Ad-  
15                 ministration who shall be appointed by the  
16                 President, by and with the advice and consent  
17                 of the Senate.

18                 “(B) COMPENSATION.—The Deputy Ad-  
19                 ministrator shall be paid at the rate of basic  
20                 pay payable for level IV of the Executive Sched-  
21                 ule under section 5315 of title 5, United States  
22                 Code.

23                 “(C) TERM OF OFFICE.—The Deputy Ad-  
24                 ministrator shall be appointed for a term of 5  
25                 years. In any case in which a successor does not

1 take office at the end of a Deputy Administra-  
2 tor's term of office, such Deputy Administrator  
3 may continue in office until the entry upon of-  
4 fice of such a successor. A Deputy Adminis-  
5 trator appointed to a term of office after the  
6 commencement of such term may serve under  
7 such appointment only for the remainder of  
8 such term.

9 “(D) DUTIES.—The Deputy Administrator  
10 shall perform such duties and exercise such  
11 powers as the Administrator shall from time to  
12 time assign or delegate. The Deputy Adminis-  
13 trator shall be Acting Administrator of the Ad-  
14 ministration during the absence or disability of  
15 the Administrator and, unless the President  
16 designates another officer of the Government as  
17 Acting Administrator, in the event of a vacancy  
18 in the office of the Administrator.

19 “(3) CHIEF ACTUARY.—

20 “(A) IN GENERAL.—There is established in  
21 the Administration the position of Chief Actu-  
22 ary. The Chief Actuary shall be appointed by,  
23 and in direct line of authority to, the Adminis-  
24 trator of such Administration. The Chief Actu-  
25 ary shall be appointed from among individuals

1           who have demonstrated, by their education and  
2           experience, superior expertise in the actuarial  
3           sciences. The Chief Actuary may be removed  
4           only for cause.

5           “(B) COMPENSATION.—The Chief Actuary  
6           shall be compensated at the highest rate of  
7           basic pay for the Senior Executive Service  
8           under section 5382(b) of title 5, United States  
9           Code.

10          “(C) DUTIES.—The Chief Actuary shall  
11          exercise such duties as are appropriate for the  
12          office of the Chief Actuary and in accordance  
13          with professional standards of actuarial inde-  
14          pendence.

15          “(4) SECRETARIAL COORDINATION OF PROGRAM  
16          ADMINISTRATION.—The Secretary shall ensure ap-  
17          propriate coordination between the Administrator  
18          and the Administrator of the Centers for Medicare  
19          & Medicaid Services in carrying out the programs  
20          under this title.

21          “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

22                  “(1) DUTIES.—

23                          “(A) GENERAL DUTIES.—The Adminis-  
24                          trator shall carry out parts C and D,  
25                          including—

1           “(i) negotiating, entering into, and en-  
2           forcing, contracts with plans for the offer-  
3           ing of Medicare+Choice plans under part  
4           C, including the offering of qualified pre-  
5           scription drug coverage under such plans;  
6           and

7           “(ii) negotiating, entering into, and  
8           enforcing, contracts with PDP sponsors for  
9           the offering of prescription drug plans  
10          under part D.

11          “(B) OTHER DUTIES.—The Administrator  
12          shall carry out any duty provided for under  
13          part C or part D, including demonstration  
14          projects carried out in part or in whole under  
15          such parts, the programs of all-inclusive care  
16          for the elderly (PACE program) under section  
17          1894, the social health maintenance organiza-  
18          tion (SHMO) demonstration projects (referred  
19          to in section 4104(c) of the Balanced Budget  
20          Act of 1997), and through a Medicare+Choice  
21          project that demonstrates the application of  
22          capitation payment rates for frail elderly medi-  
23          care beneficiaries through the use of a inter-  
24          disciplinary team and through the provision of  
25          primary care services to such beneficiaries by

1 means of such a team at the nursing facility in-  
2 volved).

3 “(C) PRESCRIPTION DRUG CARD.—The  
4 Administrator shall carry out section 1807 (re-  
5 lating to the medicare prescription drug dis-  
6 count card endorsement program).

7 “(D) NONINTERFERENCE.—In carrying  
8 out its duties with respect to the provision of  
9 qualified prescription drug coverage to bene-  
10 ficiaries under this title, the Administrator may  
11 not—

12 “(i) require a particular formulary or  
13 institute a price structure for the reim-  
14 bursement of covered outpatient drugs;

15 “(ii) interfere in any way with nego-  
16 tiations between PDP sponsors and  
17 Medicare+Choice organizations and drug  
18 manufacturers, wholesalers, or other sup-  
19 pliers of covered outpatient drugs; and

20 “(iii) otherwise interfere with the  
21 competitive nature of providing such cov-  
22 erage through such sponsors and organiza-  
23 tions.

24 “(E) ANNUAL REPORTS.—Not later March  
25 31 of each year, the Administrator shall submit

1 to Congress and the President a report on the  
2 administration of parts C and D during the  
3 previous fiscal year.

4 “(2) STAFF.—

5 “(A) IN GENERAL.—The Administrator,  
6 with the approval of the Secretary, may employ,  
7 without regard to chapter 31 of title 5, United  
8 States Code, other than sections 3110 and  
9 3112, such officers and employees as are nec-  
10 essary to administer the activities to be carried  
11 out through the Medicare Benefits Administra-  
12 tion. The Administrator shall employ staff with  
13 appropriate and necessary expertise in negoti-  
14 ating contracts in the private sector.

15 “(B) FLEXIBILITY WITH RESPECT TO COM-  
16 PENSATION.—

17 “(i) IN GENERAL.—The staff of the  
18 Medicare Benefits Administration shall,  
19 subject to clause (ii), be paid without re-  
20 gard to the provisions of chapter 51 (other  
21 than section 5101) and chapter 53 (other  
22 than section 5301) of such title (relating to  
23 classification and schedule pay rates).

24 “(ii) MAXIMUM RATE.—In no case  
25 may the rate of compensation determined

1 under clause (i) exceed the rate of basic  
2 pay payable for level IV of the Executive  
3 Schedule under section 5315 of title 5,  
4 United States Code.

5 “(C) LIMITATION ON FULL-TIME EQUIVA-  
6 LENT STAFFING FOR CURRENT CMS FUNCTIONS  
7 BEING TRANSFERRED.—The Administrator may  
8 not employ under this paragraph a number of  
9 full-time equivalent employees, to carry out  
10 functions that were previously conducted by the  
11 Centers for Medicare & Medicaid Services and  
12 that are conducted by the Administrator by rea-  
13 son of this section, that exceeds the number of  
14 such full-time equivalent employees authorized  
15 to be employed by the Centers for Medicare &  
16 Medicaid Services to conduct such functions as  
17 of the date of the enactment of this Act.

18 “(3) REDELEGATION OF CERTAIN FUNCTIONS  
19 OF THE CENTERS FOR MEDICARE & MEDICAID SERV-  
20 ICES.—

21 “(A) IN GENERAL.—The Secretary, the  
22 Administrator, and the Administrator of the  
23 Centers for Medicare & Medicaid Services shall  
24 establish an appropriate transition of responsi-  
25 bility in order to redelegate the administration

1 of part C from the Secretary and the Adminis-  
2 trator of the Centers for Medicare & Medicaid  
3 Services to the Administrator as is appropriate  
4 to carry out the purposes of this section.

5 “(B) TRANSFER OF DATA AND INFORMA-  
6 TION.—The Secretary shall ensure that the Ad-  
7 ministrator of the Centers for Medicare & Med-  
8 icaid Services transfers to the Administrator of  
9 the Medicare Benefits Administration such in-  
10 formation and data in the possession of the Ad-  
11 ministrator of the Centers for Medicare & Med-  
12 icaid Services as the Administrator of the Medi-  
13 care Benefits Administration requires to carry  
14 out the duties described in paragraph (1).

15 “(C) CONSTRUCTION.—Insofar as a re-  
16 sponsibility of the Secretary or the Adminis-  
17 trator of the Centers for Medicare & Medicaid  
18 Services is redelegated to the Administrator  
19 under this section, any reference to the Sec-  
20 retary or the Administrator of the Centers for  
21 Medicare & Medicaid Services in this title or  
22 title XI with respect to such responsibility is  
23 deemed to be a reference to the Administrator.

24 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

1           “(1) ESTABLISHMENT.—The Secretary shall es-  
2           tablish within the Medicare Benefits Administration  
3           an Office of Beneficiary Assistance to coordinate  
4           functions relating to outreach and education of  
5           medicare beneficiaries under this title, including the  
6           functions described in paragraph (2). The Office  
7           shall be separate operating division within the Ad-  
8           ministration.

9           “(2) DISSEMINATION OF INFORMATION ON  
10          BENEFITS AND APPEALS RIGHTS.—

11           “(A) DISSEMINATION OF BENEFITS INFOR-  
12          MATION.—The Office of Beneficiary Assistance  
13          shall disseminate, directly or through contract,  
14          to medicare beneficiaries, by mail, by posting on  
15          the Internet site of the Medicare Benefits Ad-  
16          ministration and through a toll-free telephone  
17          number, information with respect to the fol-  
18          lowing:

19           “(i) Benefits, and limitations on pay-  
20          ment (including cost-sharing, stop-loss pro-  
21          visions, and formulary restrictions) under  
22          parts C and D.

23           “(ii) Benefits, and limitations on pay-  
24          ment under parts A and B, including in-

1           formation on medicare supplemental poli-  
2           cies under section 1882.

3           Such information shall be presented in a man-  
4           ner so that medicare beneficiaries may compare  
5           benefits under parts A, B, D, and medicare  
6           supplemental policies with benefits under  
7           Medicare+Choice plans under part C.

8           “(B) DISSEMINATION OF APPEALS RIGHTS  
9           INFORMATION.—The Office of Beneficiary As-  
10          sistance shall disseminate to medicare bene-  
11          ficiaries in the manner provided under subpara-  
12          graph (A) a description of procedural rights (in-  
13          cluding grievance and appeals procedures) of  
14          beneficiaries under the original medicare fee-  
15          for-service program under parts A and B, the  
16          Medicare+Choice program under part C, and  
17          the Voluntary Prescription Drug Benefit Pro-  
18          gram under part D.

19          “(e) MEDICARE POLICY ADVISORY BOARD.—

20                 “(1) ESTABLISHMENT.—There is established  
21          within the Medicare Benefits Administration the  
22          Medicare Policy Advisory Board (in this section re-  
23          ferred to the ‘Board’). The Board shall advise, con-  
24          sult with, and make recommendations to the Admin-  
25          istrator of the Medicare Benefits Administration

1 with respect to the administration of parts C and D,  
2 including the review of payment policies under such  
3 parts.

4 “(2) REPORTS.—

5 “(A) IN GENERAL.—With respect to mat-  
6 ters of the administration of parts C and D, the  
7 Board shall submit to Congress and to the Ad-  
8 ministrator of the Medicare Benefits Adminis-  
9 tration such reports as the Board determines  
10 appropriate. Each such report may contain such  
11 recommendations as the Board determines ap-  
12 propriate for legislative or administrative  
13 changes to improve the administration of such  
14 parts, including the topics described in subpara-  
15 graph (B). Each such report shall be published  
16 in the Federal Register.

17 “(B) TOPICS DESCRIBED.—Reports re-  
18 quired under subparagraph (A) may include the  
19 following topics:

20 “(i) FOSTERING COMPETITION.—Rec-  
21 ommendations or proposals to increase  
22 competition under parts C and D for serv-  
23 ices furnished to medicare beneficiaries.

24 “(ii) EDUCATION AND ENROLL-  
25 MENT.—Recommendations for the im-

1           provement to efforts to provide medicare  
2           beneficiaries information and education on  
3           the program under this title, and specifi-  
4           cally parts C and D, and the program for  
5           enrollment under the title.

6           “(iii) IMPLEMENTATION OF RISK-AD-  
7           JUSTMENT.—Evaluation of the implemen-  
8           tation under section 1853(a)(3)(C) of the  
9           risk adjustment methodology to payment  
10          rates under that section to  
11          Medicare+Choice organizations offering  
12          Medicare+Choice plans that accounts for  
13          variations in per capita costs based on  
14          health status and other demographic fac-  
15          tors.

16          “(iv) DISEASE MANAGEMENT PRO-  
17          GRAMS.—Recommendations on the incor-  
18          poration of disease management programs  
19          under parts C and D.

20          “(v) RURAL ACCESS.—Recommendations  
21          to improve competition and access to  
22          plans under parts C and D in rural areas.

23          “(C) MAINTAINING INDEPENDENCE OF  
24          BOARD.—The Board shall directly submit to  
25          Congress reports required under subparagraph

1 (A). No officer or agency of the United States  
2 may require the Board to submit to any officer  
3 or agency of the United States for approval,  
4 comments, or review, prior to the submission to  
5 Congress of such reports.

6 “(3) DUTY OF ADMINISTRATOR OF MEDICARE  
7 BENEFITS ADMINISTRATION.—With respect to any  
8 report submitted by the Board under paragraph  
9 (2)(A), not later than 90 days after the report is  
10 submitted, the Administrator of the Medicare Bene-  
11 fits Administration shall submit to Congress and the  
12 President an analysis of recommendations made by  
13 the Board in such report. Each such analysis shall  
14 be published in the Federal Register.

15 “(4) MEMBERSHIP.—

16 “(A) APPOINTMENT.—Subject to the suc-  
17 ceeding provisions of this paragraph, the Board  
18 shall consist of seven members to be appointed  
19 as follows:

20 “(i) Three members shall be ap-  
21 pointed by the President.

22 “(ii) Two members shall be appointed  
23 by the Speaker of the House of Represent-  
24 atives, with the advice of the chairmen and  
25 the ranking minority members of the Com-

1           mittees on Ways and Means and on En-  
2           ergy and Commerce of the House of Rep-  
3           resentatives.

4           “(iii) Two members shall be appointed  
5           by the President pro tempore of the Senate  
6           with the advice of the chairman and the  
7           ranking minority member of the Senate  
8           Committee on Finance.

9           “(B) QUALIFICATIONS.—The members  
10          shall be chosen on the basis of their integrity,  
11          impartiality, and good judgment, and shall be  
12          individuals who are, by reason of their edu-  
13          cation and experience in health care benefits  
14          management, exceptionally qualified to perform  
15          the duties of members of the Board.

16          “(C) PROHIBITION ON INCLUSION OF FED-  
17          ERAL EMPLOYEES.—No officer or employee of  
18          the United States may serve as a member of  
19          the Board.

20          “(5) COMPENSATION.—Members of the Board  
21          shall receive, for each day (including travel time)  
22          they are engaged in the performance of the functions  
23          of the board, compensation at rates not to exceed  
24          the daily equivalent to the annual rate in effect for

1 level IV of the Executive Schedule under section  
2 5315 of title 5, United States Code.

3 “(6) TERMS OF OFFICE.—

4 “(A) IN GENERAL.—The term of office of  
5 members of the Board shall be 3 years.

6 “(B) TERMS OF INITIAL APPOINTEES.—As  
7 designated by the President at the time of ap-  
8 pointment, of the members first appointed—

9 “(i) one shall be appointed for a term  
10 of 1 year;

11 “(ii) three shall be appointed for  
12 terms of 2 years; and

13 “(iii) three shall be appointed for  
14 terms of 3 years.

15 “(C) REAPPOINTMENTS.—Any person ap-  
16 pointed as a member of the Board may not  
17 serve for more than 8 years.

18 “(D) VACANCY.—Any member appointed  
19 to fill a vacancy occurring before the expiration  
20 of the term for which the member’s predecessor  
21 was appointed shall be appointed only for the  
22 remainder of that term. A member may serve  
23 after the expiration of that member’s term until  
24 a successor has taken office. A vacancy in the

1 Board shall be filled in the manner in which the  
2 original appointment was made.

3 “(7) CHAIR.—The Chair of the Board shall be  
4 elected by the members. The term of office of the  
5 Chair shall be 3 years.

6 “(8) MEETINGS.—The Board shall meet at the  
7 call of the Chair, but in no event less than three  
8 times during each fiscal year.

9 “(9) DIRECTOR AND STAFF.—

10 “(A) APPOINTMENT OF DIRECTOR.—The  
11 Board shall have a Director who shall be ap-  
12 pointed by the Chair.

13 “(B) IN GENERAL.—With the approval of  
14 the Board, the Director may appoint, without  
15 regard to chapter 31 of title 5, United States  
16 Code, such additional personnel as the Director  
17 considers appropriate.

18 “(C) FLEXIBILITY WITH RESPECT TO COM-  
19 PENSATION.—

20 “(i) IN GENERAL.—The Director and  
21 staff of the Board shall, subject to clause  
22 (ii), be paid without regard to the provi-  
23 sions of chapter 51 and chapter 53 of such  
24 title (relating to classification and schedule  
25 pay rates).

1                   “(ii) MAXIMUM RATE.—In no case  
2                   may the rate of compensation determined  
3                   under clause (i) exceed the rate of basic  
4                   pay payable for level IV of the Executive  
5                   Schedule under section 5315 of title 5,  
6                   United States Code.

7                   “(D) ASSISTANCE FROM THE ADMINIS-  
8                   TRATOR OF THE MEDICARE BENEFITS ADMINIS-  
9                   TRATION.—The Administrator of the Medicare  
10                  Benefits Administration shall make available to  
11                  the Board such information and other assist-  
12                  ance as it may require to carry out its func-  
13                  tions.

14                  “(10) CONTRACT AUTHORITY.—The Board may  
15                  contract with and compensate government and pri-  
16                  vate agencies or persons to carry out its duties  
17                  under this subsection, without regard to section  
18                  3709 of the Revised Statutes (41 U.S.C. 5).

19                  “(f) FUNDING.—There is authorized to be appro-  
20                  priated, in appropriate part from the Federal Hospital In-  
21                  surance Trust Fund and from the Federal Supplementary  
22                  Medical Insurance Trust Fund (including the Medicare  
23                  Prescription Drug Account), such sums as are necessary  
24                  to carry out this section.”.

25                  (b) EFFECTIVE DATE.—

1           (1) IN GENERAL.—The amendment made by  
2 subsection (a) shall take effect on the date of the en-  
3 actment of this Act.

4           (2) TIMING OF INITIAL APPOINTMENTS.—The  
5 Administrator and Deputy Administrator of the  
6 Medicare Benefits Administration may not be ap-  
7 pointed before March 1, 2003.

8           (3) DUTIES WITH RESPECT TO ELIGIBILITY DE-  
9 TERMINATIONS AND ENROLLMENT.—The Adminis-  
10 trator of the Medicare Benefits Administration shall  
11 carry out enrollment under title XVIII of the Social  
12 Security Act, make eligibility determinations under  
13 such title, and carry out part C of such title for  
14 years beginning or after January 1, 2005.

15           (4) TRANSITION.—Before the date the Adminis-  
16 trator of the Medicare Benefits Administration is  
17 appointed and assumes responsibilities under this  
18 section and section 1807 of the Social Security Act,  
19 the Secretary of Health and Human Services shall  
20 provide for the conduct of any responsibilities of  
21 such Administrator that are otherwise provided  
22 under law.

23           (c) MISCELLANEOUS ADMINISTRATIVE PROVI-  
24 SIONS.—

1           (1) ADMINISTRATOR AS MEMBER OF THE  
2 BOARD OF TRUSTEES OF THE MEDICARE TRUST  
3 FUNDS.—Section 1817(b) and section 1841(b) (42  
4 U.S.C. 1395i(b), 1395t(b)) are each amended by  
5 striking “and the Secretary of Health and Human  
6 Services, all ex officio,” and inserting “the Secretary  
7 of Health and Human Services, and the Adminis-  
8 trator of the Medicare Benefits Administration, all  
9 ex officio,”.

10           (2) INCREASE IN GRADE TO EXECUTIVE LEVEL  
11 III FOR THE ADMINISTRATOR OF THE CENTERS FOR  
12 MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDI-  
13 CARE BENEFITS ADMINISTRATOR.—

14           (A) IN GENERAL.—Section 5314 of title 5,  
15 United States Code, by adding at the end the  
16 following:

17           “Administrator of the Centers for Medicare &  
18 Medicaid Services.

19           “Administrator of the Medicare Benefits Ad-  
20 ministration.”.

21           (B) CONFORMING AMENDMENT.—Section  
22 5315 of such title is amended by striking “Ad-  
23 ministrator of the Health Care Financing Ad-  
24 ministration.”.

1 (C) EFFECTIVE DATE.—The amendments  
2 made by this paragraph take effect on January  
3 1, 2003.

4 **TITLE VIII—REGULATORY RE-**  
5 **DUCTION AND CONTRACTING**  
6 **REFORM**

7 **Subtitle A—Regulatory Reform**

8 **SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.**

9 (a) CONSTRUCTION.—Nothing in this title shall be  
10 construed—

11 (1) to compromise or affect existing legal reme-  
12 dies for addressing fraud or abuse, whether it be  
13 criminal prosecution, civil enforcement, or adminis-  
14 trative remedies, including under sections 3729  
15 through 3733 of title 31, United States Code  
16 (known as the False Claims Act); or

17 (2) to prevent or impede the Department of  
18 Health and Human Services in any way from its on-  
19 going efforts to eliminate waste, fraud, and abuse in  
20 the medicare program.

21 Furthermore, the consolidation of medicare administrative  
22 contracting set forth in this Act does not constitute con-  
23 solidation of the Federal Hospital Insurance Trust Fund  
24 and the Federal Supplementary Medical Insurance Trust  
25 Fund or reflect any position on that issue.

1 (b) DEFINITION OF SUPPLIER.—Section 1861 (42  
2 U.S.C. 1395x) is amended by inserting after subsection  
3 (c) the following new subsection:

4 “Supplier

5 “(d) The term ‘supplier’ means, unless the context  
6 otherwise requires, a physician or other practitioner, a fa-  
7 cility, or other entity (other than a provider of services)  
8 that furnishes items or services under this title.”.

9 **SEC. 802. ISSUANCE OF REGULATIONS.**

10 (a) CONSOLIDATION OF PROMULGATION TO ONCE A  
11 MONTH.—

12 (1) IN GENERAL.—Section 1871 (42 U.S.C.  
13 1395hh) is amended by adding at the end the fol-  
14 lowing new subsection:

15 “(d)(1) Subject to paragraph (2), the Secretary shall  
16 issue proposed or final (including interim final) regula-  
17 tions to carry out this title only on one business day of  
18 every month.

19 “(2) The Secretary may issue a proposed or final reg-  
20 ulation described in paragraph (1) on any other day than  
21 the day described in paragraph (1) if the Secretary—

22 “(A) finds that issuance of such regulation on  
23 another day is necessary to comply with require-  
24 ments under law; or

1           “(B) finds that with respect to that regulation  
2           the limitation of issuance on the date described in  
3           paragraph (1) is contrary to the public interest.

4 If the Secretary makes a finding under this paragraph,  
5 the Secretary shall include such finding, and brief state-  
6 ment of the reasons for such finding, in the issuance of  
7 such regulation.

8           “(3) The Secretary shall coordinate issuance of new  
9 regulations described in paragraph (1) relating to a cat-  
10 egory of provider of services or suppliers based on an anal-  
11 ysis of the collective impact of regulatory changes on that  
12 category of providers or suppliers.”.

13           (2) GAO REPORT ON PUBLICATION OF REGULA-  
14 TIONS ON A QUARTERLY BASIS.—Not later than 3  
15 years after the date of the enactment of this Act, the  
16 Comptroller General of the United States shall sub-  
17 mit to Congress a report on the feasibility of requir-  
18 ing that regulations described in section 1871(d) of  
19 the Social Security Act be promulgated on a quar-  
20 terly basis rather than on a monthly basis.

21           (3) EFFECTIVE DATE.—The amendment made  
22 by paragraph (1) shall apply to regulations promul-  
23 gated on or after the date that is 30 days after the  
24 date of the enactment of this Act.

1 (b) REGULAR TIMELINE FOR PUBLICATION OF  
2 FINAL RULES.—

3 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
4 1395hh(a)) is amended by adding at the end the fol-  
5 lowing new paragraph:

6 “(3)(A) The Secretary, in consultation with the Di-  
7 rector of the Office of Management and Budget, shall es-  
8 tablish and publish a regular timeline for the publication  
9 of final regulations based on the previous publication of  
10 a proposed regulation or an interim final regulation.

11 “(B) Such timeline may vary among different regula-  
12 tions based on differences in the complexity of the regula-  
13 tion, the number and scope of comments received, and  
14 other relevant factors, but shall not be longer than 3 years  
15 except under exceptional circumstances. If the Secretary  
16 intends to vary such timeline with respect to the publica-  
17 tion of a final regulation, the Secretary shall cause to have  
18 published in the Federal Register notice of the different  
19 timeline by not later than the timeline previously estab-  
20 lished with respect to such regulation. Such notice shall  
21 include a brief explanation of the justification for such  
22 variation.

23 “(C) In the case of interim final regulations, upon  
24 the expiration of the regular timeline established under  
25 this paragraph for the publication of a final regulation

1 after opportunity for public comment, the interim final  
2 regulation shall not continue in effect unless the Secretary  
3 publishes (at the end of the regular timeline and, if appli-  
4 cable, at the end of each succeeding 1-year period) a notice  
5 of continuation of the regulation that includes an expla-  
6 nation of why the regular timeline (and any subsequent  
7 1-year extension) was not complied with. If such a notice  
8 is published, the regular timeline (or such timeline as pre-  
9 viously extended under this paragraph) for publication of  
10 the final regulation shall be treated as having been ex-  
11 tended for 1 additional year.

12 “(D) The Secretary shall annually submit to Con-  
13 gress a report that describes the instances in which the  
14 Secretary failed to publish a final regulation within the  
15 applicable regular timeline under this paragraph and that  
16 provides an explanation for such failures.”.

17 (2) EFFECTIVE DATE.—The amendment made  
18 by paragraph (1) shall take effect on the date of the  
19 enactment of this Act. The Secretary shall provide  
20 for an appropriate transition to take into account  
21 the backlog of previously published interim final reg-  
22 ulations.

23 (c) LIMITATIONS ON NEW MATTER IN FINAL REGU-  
24 LATIONS.—

1           (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
2           1395hh(a)), as amended by subsection (b), is further  
3           amended by adding at the end the following new  
4           paragraph:

5           “(4) If the Secretary publishes notice of proposed  
6           rulemaking relating to a regulation (including an interim  
7           final regulation), insofar as such final regulation includes  
8           a provision that is not a logical outgrowth of such notice  
9           of proposed rulemaking, that provision shall be treated as  
10          a proposed regulation and shall not take effect until there  
11          is the further opportunity for public comment and a publi-  
12          cation of the provision again as a final regulation.”.

13           (2) EFFECTIVE DATE.—The amendment made  
14          by paragraph (1) shall apply to final regulations  
15          published on or after the date of the enactment of  
16          this Act.

17 **SEC. 803. COMPLIANCE WITH CHANGES IN REGULATIONS**  
18 **AND POLICIES.**

19           (a) NO RETROACTIVE APPLICATION OF SUB-  
20          STANTIVE CHANGES.—

21           (1) IN GENERAL.—Section 1871 (42 U.S.C.  
22          1395hh), as amended by section 802(a), is amended  
23          by adding at the end the following new subsection:  
24          “(e)(1)(A) A substantive change in regulations, man-  
25          ual instructions, interpretative rules, statements of policy,

1 or guidelines of general applicability under this title shall  
2 not be applied (by extrapolation or otherwise) retroactively  
3 to items and services furnished before the effective date  
4 of the change, unless the Secretary determines that—

5 “(i) such retroactive application is necessary to  
6 comply with statutory requirements; or

7 “(ii) failure to apply the change retroactively  
8 would be contrary to the public interest.”.

9 (2) EFFECTIVE DATE.—The amendment made  
10 by paragraph (1) shall apply to substantive changes  
11 issued on or after the date of the enactment of this  
12 Act.

13 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE  
14 CHANGES AFTER NOTICE.—

15 (1) IN GENERAL.—Section 1871(e)(1), as  
16 added by subsection (a), is amended by adding at  
17 the end the following:

18 “(B)(i) Except as provided in clause (ii), a sub-  
19 stantive change referred to in subparagraph (A) shall not  
20 become effective before the end of the 30-day period that  
21 begins on the date that the Secretary has issued or pub-  
22 lished, as the case may be, the substantive change.

23 “(ii) The Secretary may provide for such a sub-  
24 stantive change to take effect on a date that precedes the  
25 end of the 30-day period under clause (i) if the Secretary

1 finds that waiver of such 30-day period is necessary to  
2 comply with statutory requirements or that the application  
3 of such 30-day period is contrary to the public interest.  
4 If the Secretary provides for an earlier effective date pur-  
5 suant to this clause, the Secretary shall include in the  
6 issuance or publication of the substantive change a finding  
7 described in the first sentence, and a brief statement of  
8 the reasons for such finding.

9 “(C) No action shall be taken against a provider of  
10 services or supplier with respect to noncompliance with  
11 such a substantive change for items and services furnished  
12 before the effective date of such a change.”.

13 (2) EFFECTIVE DATE.—The amendment made  
14 by paragraph (1) shall apply to compliance actions  
15 undertaken on or after the date of the enactment of  
16 this Act.

17 (c) RELIANCE ON GUIDANCE.—

18 (1) IN GENERAL.—Section 1871(e), as added  
19 by subsection (a), is further amended by adding at  
20 the end the following new paragraph:

21 “(2)(A) If—

22 “(i) a provider of services or supplier follows  
23 the written guidance (which may be transmitted  
24 electronically) provided by the Secretary or by a  
25 medicare contractor (as defined in section 1889(g))

1 acting within the scope of the contractor's contract  
2 authority, with respect to the furnishing of items or  
3 services and submission of a claim for benefits for  
4 such items or services with respect to such provider  
5 or supplier;

6 “(ii) the Secretary determines that the provider  
7 of services or supplier has accurately presented the  
8 circumstances relating to such items, services, and  
9 claim to the contractor in writing; and

10 “(iii) the guidance was in error;

11 the provider of services or supplier shall not be subject  
12 to any sanction (including any penalty or requirement for  
13 repayment of any amount) if the provider of services or  
14 supplier reasonably relied on such guidance.

15 “(B) Subparagraph (A) shall not be construed as pre-  
16 venting the recoupment or repayment (without any addi-  
17 tional penalty) relating to an overpayment insofar as the  
18 overpayment was solely the result of a clerical or technical  
19 operational error.”.

20 (2) EFFECTIVE DATE.—The amendment made  
21 by paragraph (1) shall take effect on the date of the  
22 enactment of this Act but shall not apply to any  
23 sanction for which notice was provided on or before  
24 the date of the enactment of this Act.

1 **SEC. 804. REPORTS AND STUDIES RELATING TO REGU-**  
2 **LATORY REFORM.**

3 (a) GAO STUDY ON ADVISORY OPINION AUTHOR-  
4 ITY.—

5 (1) STUDY.—The Comptroller General of the  
6 United States shall conduct a study to determine the  
7 feasibility and appropriateness of establishing in the  
8 Secretary authority to provide legally binding advi-  
9 sory opinions on appropriate interpretation and ap-  
10 plication of regulations to carry out the medicare  
11 program under title XVIII of the Social Security  
12 Act. Such study shall examine the appropriate time-  
13 frame for issuing such advisory opinions, as well as  
14 the need for additional staff and funding to provide  
15 such opinions.

16 (2) REPORT.—The Comptroller General shall  
17 submit to Congress a report on the study conducted  
18 under paragraph (1) by not later than January 1,  
19 2004.

20 (b) REPORT ON LEGAL AND REGULATORY INCON-  
21 SISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as  
22 amended by section 803(a), is amended by adding at the  
23 end the following new subsection:

24 “(f)(1) Not later than 2 years after the date of the  
25 enactment of this subsection, and every 2 years thereafter,  
26 the Secretary shall submit to Congress a report with re-

1 spect to the administration of this title and areas of incon-  
2 sistency or conflict among the various provisions under  
3 law and regulation.

4 “(2) In preparing a report under paragraph (1), the  
5 Secretary shall collect—

6 “(A) information from individuals entitled to  
7 benefits under part A or enrolled under part B, or  
8 both, providers of services, and suppliers and from  
9 the Medicare Beneficiary Ombudsman and the Medi-  
10 care Provider Ombudsman with respect to such  
11 areas of inconsistency and conflict; and

12 “(B) information from medicare contractors  
13 that tracks the nature of written and telephone in-  
14 quiries.

15 “(3) A report under paragraph (1) shall include a de-  
16 scription of efforts by the Secretary to reduce such incon-  
17 sistency or conflicts, and recommendations for legislation  
18 or administrative action that the Secretary determines ap-  
19 propriate to further reduce such inconsistency or con-  
20 flicts.”.

## 21 **Subtitle B—Contracting Reform**

### 22 **SEC. 811. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-** 23 **TRATION.**

24 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE  
25 ADMINISTRATION.—



1           “(D) the entity meets such other require-  
2           ments as the Secretary may impose.

3           “(3) MEDICARE ADMINISTRATIVE CONTRACTOR  
4           DEFINED.—For purposes of this title and title XI—

5           “(A) IN GENERAL.—The term ‘medicare  
6           administrative contractor’ means an agency, or-  
7           ganization, or other person with a contract  
8           under this section.

9           “(B) APPROPRIATE MEDICARE ADMINIS-  
10           TRATIVE CONTRACTOR.—With respect to the  
11           performance of a particular function in relation  
12           to an individual entitled to benefits under part  
13           A or enrolled under part B, or both, a specific  
14           provider of services or supplier (or class of such  
15           providers of services or suppliers), the ‘appro-  
16           priate’ medicare administrative contractor is the  
17           medicare administrative contractor that has a  
18           contract under this section with respect to the  
19           performance of that function in relation to that  
20           individual, provider of services or supplier or  
21           class of provider of services or supplier.

22           “(4) FUNCTIONS DESCRIBED.—The functions  
23           referred to in paragraphs (1) and (2) are payment  
24           functions, provider services functions, and functions  
25           relating to services furnished to individuals entitled

1 to benefits under part A or enrolled under part B,  
2 or both, as follows:

3 “(A) DETERMINATION OF PAYMENT  
4 AMOUNTS.—Determining (subject to the provi-  
5 sions of section 1878 and to such review by the  
6 Secretary as may be provided for by the con-  
7 tracts) the amount of the payments required  
8 pursuant to this title to be made to providers  
9 of services, suppliers and individuals.

10 “(B) MAKING PAYMENTS.—Making pay-  
11 ments described in subparagraph (A) (including  
12 receipt, disbursement, and accounting for funds  
13 in making such payments).

14 “(C) BENEFICIARY EDUCATION AND AS-  
15 SISTANCE.—Providing education and outreach  
16 to individuals entitled to benefits under part A  
17 or enrolled under part B, or both, and pro-  
18 viding assistance to those individuals with spe-  
19 cific issues, concerns or problems.

20 “(D) PROVIDER CONSULTATIVE SERV-  
21 ICES.—Providing consultative services to insti-  
22 tutions, agencies, and other persons to enable  
23 them to establish and maintain fiscal records  
24 necessary for purposes of this title and other-

1 wise to qualify as providers of services or sup-  
2 pliers.

3 “(E) COMMUNICATION WITH PRO-  
4 VIDERS.—Communicating to providers of serv-  
5 ices and suppliers any information or instruc-  
6 tions furnished to the medicare administrative  
7 contractor by the Secretary, and facilitating  
8 communication between such providers and sup-  
9 pliers and the Secretary.

10 “(F) PROVIDER EDUCATION AND TECH-  
11 NICAL ASSISTANCE.—Performing the functions  
12 relating to provider education, training, and  
13 technical assistance.

14 “(G) ADDITIONAL FUNCTIONS.—Per-  
15 forming such other functions as are necessary  
16 to carry out the purposes of this title.

17 “(5) RELATIONSHIP TO MIP CONTRACTS.—

18 “(A) NONDUPLICATION OF DUTIES.—In  
19 entering into contracts under this section, the  
20 Secretary shall assure that functions of medi-  
21 care administrative contractors in carrying out  
22 activities under parts A and B do not duplicate  
23 activities carried out under the Medicare Integ-  
24 rity Program under section 1893. The previous  
25 sentence shall not apply with respect to the ac-

1           tivity described in section 1893(b)(5) (relating  
2           to prior authorization of certain items of dura-  
3           ble medical equipment under section  
4           1834(a)(15)).

5           “(B) CONSTRUCTION.—An entity shall not  
6           be treated as a medicare administrative con-  
7           tractor merely by reason of having entered into  
8           a contract with the Secretary under section  
9           1893.

10          “(6) APPLICATION OF FEDERAL ACQUISITION  
11          REGULATION.—Except to the extent inconsistent  
12          with a specific requirement of this title, the Federal  
13          Acquisition Regulation applies to contracts under  
14          this title.

15          “(b) CONTRACTING REQUIREMENTS.—

16                 “(1) USE OF COMPETITIVE PROCEDURES.—

17                         “(A) IN GENERAL.—Except as provided in  
18                         laws with general applicability to Federal acqui-  
19                         sition and procurement or in subparagraph (B),  
20                         the Secretary shall use competitive procedures  
21                         when entering into contracts with medicare ad-  
22                         ministrative contractors under this section, tak-  
23                         ing into account performance quality as well as  
24                         price and other factors.

1           “(B) RENEWAL OF CONTRACTS.—The Sec-  
2           retary may renew a contract with a medicare  
3           administrative contractor under this section  
4           from term to term without regard to section 5  
5           of title 41, United States Code, or any other  
6           provision of law requiring competition, if the  
7           medicare administrative contractor has met or  
8           exceeded the performance requirements applica-  
9           ble with respect to the contract and contractor,  
10          except that the Secretary shall provide for the  
11          application of competitive procedures under  
12          such a contract not less frequently than once  
13          every five years.

14          “(C) TRANSFER OF FUNCTIONS.—The  
15          Secretary may transfer functions among medi-  
16          care administrative contractors consistent with  
17          the provisions of this paragraph. The Secretary  
18          shall ensure that performance quality is consid-  
19          ered in such transfers. The Secretary shall pro-  
20          vide public notice (whether in the Federal Reg-  
21          ister or otherwise) of any such transfer (includ-  
22          ing a description of the functions so trans-  
23          ferred, a description of the providers of services  
24          and suppliers affected by such transfer, and

1 contact information for the contractors in-  
2 volved).

3 “(D) INCENTIVES FOR QUALITY.—The  
4 Secretary shall provide incentives for medicare  
5 administrative contractors to provide quality  
6 service and to promote efficiency.

7 “(2) COMPLIANCE WITH REQUIREMENTS.—No  
8 contract under this section shall be entered into with  
9 any medicare administrative contractor unless the  
10 Secretary finds that such medicare administrative  
11 contractor will perform its obligations under the con-  
12 tract efficiently and effectively and will meet such  
13 requirements as to financial responsibility, legal au-  
14 thority, quality of services provided, and other mat-  
15 ters as the Secretary finds pertinent.

16 “(3) PERFORMANCE REQUIREMENTS.—

17 “(A) DEVELOPMENT OF SPECIFIC PER-  
18 FORMANCE REQUIREMENTS.—In developing  
19 contract performance requirements, the Sec-  
20 retary shall develop performance requirements  
21 applicable to functions described in subsection  
22 (a)(4).

23 “(B) CONSULTATION.— In developing such  
24 requirements, the Secretary may consult with  
25 providers of services and suppliers, organiza-

1           tions representing individuals entitled to bene-  
2           fits under part A or enrolled under part B, or  
3           both, and organizations and agencies per-  
4           forming functions necessary to carry out the  
5           purposes of this section with respect to such  
6           performance requirements.

7           “(C) INCLUSION IN CONTRACTS.—All con-  
8           tractor performance requirements shall be set  
9           forth in the contract between the Secretary and  
10          the appropriate medicare administrative con-  
11          tractor. Such performance requirements—

12                 “(i) shall reflect the performance re-  
13                 quirements developed under subparagraph  
14                 (A), but may include additional perform-  
15                 ance requirements;

16                 “(ii) shall be used for evaluating con-  
17                 tractor performance under the contract;  
18                 and

19                 “(iii) shall be consistent with the writ-  
20                 ten statement of work provided under the  
21                 contract.

22          “(4) INFORMATION REQUIREMENTS.—The Sec-  
23          retary shall not enter into a contract with a medi-  
24          care administrative contractor under this section un-  
25          less the contractor agrees—

1           “(A) to furnish to the Secretary such time-  
2           ly information and reports as the Secretary may  
3           find necessary in performing his functions  
4           under this title; and

5           “(B) to maintain such records and afford  
6           such access thereto as the Secretary finds nec-  
7           essary to assure the correctness and verification  
8           of the information and reports under subpara-  
9           graph (A) and otherwise to carry out the pur-  
10          poses of this title.

11          “(5) SURETY BOND.—A contract with a medi-  
12          care administrative contractor under this section  
13          may require the medicare administrative contractor,  
14          and any of its officers or employees certifying pay-  
15          ments or disbursing funds pursuant to the contract,  
16          or otherwise participating in carrying out the con-  
17          tract, to give surety bond to the United States in  
18          such amount as the Secretary may deem appro-  
19          priate.

20          “(c) TERMS AND CONDITIONS.—

21                 “(1) IN GENERAL.—A contract with any medi-  
22          care administrative contractor under this section  
23          may contain such terms and conditions as the Sec-  
24          retary finds necessary or appropriate and may pro-  
25          vide for advances of funds to the medicare adminis-

1 trative contractor for the making of payments by it  
2 under subsection (a)(4)(B).

3 “(2) PROHIBITION ON MANDATES FOR CERTAIN  
4 DATA COLLECTION.—The Secretary may not require,  
5 as a condition of entering into, or renewing, a con-  
6 tract under this section, that the medicare adminis-  
7 trative contractor match data obtained other than in  
8 its activities under this title with data used in the  
9 administration of this title for purposes of identi-  
10 fying situations in which the provisions of section  
11 1862(b) may apply.

12 “(d) LIMITATION ON LIABILITY OF MEDICARE AD-  
13 MINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

14 “(1) CERTIFYING OFFICER.—No individual des-  
15 ignated pursuant to a contract under this section as  
16 a certifying officer shall, in the absence of gross neg-  
17 ligence or intent to defraud the United States, be  
18 liable with respect to any payments certified by the  
19 individual under this section.

20 “(2) DISBURSING OFFICER.—No disbursing of-  
21 ficer shall, in the absence of gross negligence or in-  
22 tent to defraud the United States, be liable with re-  
23 spect to any payment by such officer under this sec-  
24 tion if it was based upon an authorization (which  
25 meets the applicable requirements for such internal

1 controls established by the Comptroller General) of  
2 a certifying officer designated as provided in para-  
3 graph (1) of this subsection.

4 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE  
5 CONTRACTOR.—No medicare administrative con-  
6 tractor shall be liable to the United States for a pay-  
7 ment by a certifying or disbursing officer unless in  
8 connection with such payment or in the supervision  
9 of or selection of such officer the medicare adminis-  
10 trative contractor acted with gross negligence.

11 “(4) INDEMNIFICATION BY SECRETARY.—

12 “(A) IN GENERAL.—Subject to subpara-  
13 graphs (B) and (D), in the case of a medicare  
14 administrative contractor (or a person who is a  
15 director, officer, or employee of such a con-  
16 tractor or who is engaged by the contractor to  
17 participate directly in the claims administration  
18 process) who is made a party to any judicial or  
19 administrative proceeding arising from or relat-  
20 ing directly to the claims administration process  
21 under this title, the Secretary may, to the ex-  
22 tent the Secretary determines to be appropriate  
23 and as specified in the contract with the con-  
24 tractor, indemnify the contractor and such per-  
25 sons.

1           “(B) CONDITIONS.—The Secretary may  
2 not provide indemnification under subparagraph  
3 (A) insofar as the liability for such costs arises  
4 directly from conduct that is determined by the  
5 judicial proceeding or by the Secretary to be  
6 criminal in nature, fraudulent, or grossly neg-  
7 ligent. If indemnification is provided by the Sec-  
8 retary with respect to a contractor before a de-  
9 termination that such costs arose directly from  
10 such conduct, the contractor shall reimburse the  
11 Secretary for costs of indemnification.

12           “(C) SCOPE OF INDEMNIFICATION.—In-  
13 demnification by the Secretary under subpara-  
14 graph (A) may include payment of judgments,  
15 settlements (subject to subparagraph (D)),  
16 awards, and costs (including reasonable legal  
17 expenses).

18           “(D) WRITTEN APPROVAL FOR SETTLE-  
19 MENTS.—A contractor or other person de-  
20 scribed in subparagraph (A) may not propose to  
21 negotiate a settlement or compromise of a pro-  
22 ceeding described in such subparagraph without  
23 the prior written approval of the Secretary to  
24 negotiate such settlement or compromise. Any  
25 indemnification under subparagraph (A) with

1           respect to amounts paid under a settlement or  
2           compromise of a proceeding described in such  
3           subparagraph are conditioned upon prior writ-  
4           ten approval by the Secretary of the final settle-  
5           ment or compromise.

6           “(E) CONSTRUCTION.—Nothing in this  
7           paragraph shall be construed—

8                   “(i) to change any common law immu-  
9                   nity that may be available to a medicare  
10                  administrative contractor or person de-  
11                  scribed in subparagraph (A); or

12                  “(ii) to permit the payment of costs  
13                  not otherwise allowable, reasonable, or allo-  
14                  cable under the Federal Acquisition Regu-  
15                  lations.”.

16           (2) CONSIDERATION OF INCORPORATION OF  
17           CURRENT LAW STANDARDS.—In developing contract  
18           performance requirements under section 1874A(b)  
19           of the Social Security Act, as inserted by paragraph  
20           (1), the Secretary shall consider inclusion of the per-  
21           formance standards described in sections 1816(f)(2)  
22           of such Act (relating to timely processing of recon-  
23           siderations and applications for exemptions) and sec-  
24           tion 1842(b)(2)(B) of such Act (relating to timely  
25           review of determinations and fair hearing requests),

1 as such sections were in effect before the date of the  
2 enactment of this Act.

3 (b) CONFORMING AMENDMENTS TO SECTION 1816  
4 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816  
5 (42 U.S.C. 1395h) is amended as follows:

6 (1) The heading is amended to read as follows:

7 “PROVISIONS RELATING TO THE ADMINISTRATION OF  
8 PART A”.

9 (2) Subsection (a) is amended to read as fol-  
10 lows:

11 “(a) The administration of this part shall be con-  
12 ducted through contracts with medicare administrative  
13 contractors under section 1874A.”.

14 (3) Subsection (b) is repealed.

15 (4) Subsection (c) is amended—

16 (A) by striking paragraph (1); and

17 (B) in each of paragraphs (2)(A) and  
18 (3)(A), by striking “agreement under this sec-  
19 tion” and inserting “contract under section  
20 1874A that provides for making payments  
21 under this part”.

22 (5) Subsections (d) through (i) are repealed.

23 (6) Subsections (j) and (k) are each amended—

24 (A) by striking “An agreement with an  
25 agency or organization under this section” and  
26 inserting “A contract with a medicare adminis-



1 (iii) by striking subparagraphs (D)  
2 and (E);

3 (C) in paragraph (3)—

4 (i) in the matter before subparagraph  
5 (A), by striking “Each such contract shall  
6 provide that the carrier” and inserting  
7 “The Secretary”;

8 (ii) by striking “will” the first place it  
9 appears in each of subparagraphs (A), (B),  
10 (F), (G), (H), and (L) and inserting  
11 “shall”;

12 (iii) in subparagraph (B), in the mat-  
13 ter before clause (i), by striking “to the  
14 policyholders and subscribers of the car-  
15 rier” and inserting “to the policyholders  
16 and subscribers of the medicare adminis-  
17 trative contractor”;

18 (iv) by striking subparagraphs (C),  
19 (D), and (E);

20 (v) in subparagraph (H)—

21 (I) by striking “if it makes deter-  
22 minations or payments with respect to  
23 physicians’ services,” in the matter  
24 preceding clause (i); and

- 1 (II) by striking “carrier” and in-  
2 serting “medicare administrative con-  
3 tractor” in clause (i);  
4 (vi) by striking subparagraph (I);  
5 (vii) in subparagraph (L), by striking  
6 the semicolon and inserting a period;  
7 (viii) in the first sentence, after sub-  
8 paragraph (L), by striking “and shall con-  
9 tain” and all that follows through the pe-  
10 riod; and  
11 (ix) in the seventh sentence, by insert-  
12 ing “medicare administrative contractor,”  
13 after “carrier,”; and  
14 (D) by striking paragraph (5);  
15 (E) in paragraph (6)(D)(iv), by striking  
16 “carrier” and inserting “medicare administra-  
17 tive contractor”; and  
18 (F) in paragraph (7), by striking “the car-  
19 rier” and inserting “the Secretary” each place  
20 it appears.
- 21 (4) Subsection (c) is amended—
- 22 (A) by striking paragraph (1);  
23 (B) in paragraph (2)(A), by striking “con-  
24 tract under this section which provides for the  
25 disbursement of funds, as described in sub-

1 section (a)(1)(B),” and inserting “contract  
2 under section 1874A that provides for making  
3 payments under this part”;

4 (C) in paragraph (3)(A), by striking “sub-  
5 section (a)(1)(B)” and inserting “section  
6 1874A(a)(3)(B)”;

7 (D) in paragraph (4), in the matter pre-  
8 ceding subparagraph (A), by striking “carrier”  
9 and inserting “medicare administrative con-  
10 tractor”; and

11 (E) by striking paragraphs (5) and (6).

12 (5) Subsections (d), (e), and (f) are repealed.

13 (6) Subsection (g) is amended by striking “car-  
14 rier or carriers” and inserting “medicare administra-  
15 tive contractor or contractors”.

16 (7) Subsection (h) is amended—

17 (A) in paragraph (2)—

18 (i) by striking “Each carrier having  
19 an agreement with the Secretary under  
20 subsection (a)” and inserting “The Sec-  
21 retary”; and

22 (ii) by striking “Each such carrier”  
23 and inserting “The Secretary”;

24 (B) in paragraph (3)(A)—

1 (i) by striking “a carrier having an  
2 agreement with the Secretary under sub-  
3 section (a)” and inserting “medicare ad-  
4 ministrative contractor having a contract  
5 under section 1874A that provides for  
6 making payments under this part”; and

7 (ii) by striking “such carrier” and in-  
8 serting “such contractor”;

9 (C) in paragraph (3)(B)—

10 (i) by striking “a carrier” and insert-  
11 ing “a medicare administrative contractor”  
12 each place it appears; and

13 (ii) by striking “the carrier” and in-  
14 serting “the contractor” each place it ap-  
15 pears; and

16 (D) in paragraphs (5)(A) and (5)(B)(iii),  
17 by striking “carriers” and inserting “medicare  
18 administrative contractors” each place it ap-  
19 pears.

20 (8) Subsection (l) is amended—

21 (A) in paragraph (1)(A)(iii), by striking  
22 “carrier” and inserting “medicare administra-  
23 tive contractor”; and

1 (B) in paragraph (2), by striking “carrier”  
2 and inserting “medicare administrative con-  
3 tractor”.

4 (9) Subsection (p)(3)(A) is amended by striking  
5 “carrier” and inserting “medicare administrative  
6 contractor”.

7 (10) Subsection (q)(1)(A) is amended by strik-  
8 ing “carrier”.

9 (d) EFFECTIVE DATE; TRANSITION RULE.—

10 (1) EFFECTIVE DATE.—

11 (A) IN GENERAL.—Except as otherwise  
12 provided in this subsection, the amendments  
13 made by this section shall take effect on Octo-  
14 ber 1, 2004, and the Secretary is authorized to  
15 take such steps before such date as may be nec-  
16 essary to implement such amendments on a  
17 timely basis.

18 (B) CONSTRUCTION FOR CURRENT CON-  
19 TRACTS.—Such amendments shall not apply to  
20 contracts in effect before the date specified  
21 under subparagraph (A) that continue to retain  
22 the terms and conditions in effect on such date  
23 (except as otherwise provided under this Act,  
24 other than under this section) until such date

1 as the contract is let out for competitive bid-  
2 ding under such amendments.

3 (C) DEADLINE FOR COMPETITIVE BID-  
4 DING.—The Secretary shall provide for the let-  
5 ting by competitive bidding of all contracts for  
6 functions of medicare administrative contrac-  
7 tors for annual contract periods that begin on  
8 or after October 1, 2009.

9 (D) WAIVER OF PROVIDER NOMINATION  
10 PROVISIONS DURING TRANSITION.—During the  
11 period beginning on the date of the enactment  
12 of this Act and before the date specified under  
13 subparagraph (A), the Secretary may enter into  
14 new agreements under section 1816 of the So-  
15 cial Security Act (42 U.S.C. 1395h) without re-  
16 gard to any of the provider nomination provi-  
17 sions of such section.

18 (2) GENERAL TRANSITION RULES.—The Sec-  
19 retary shall take such steps, consistent with para-  
20 graph (1)(B) and (1)(C), as are necessary to provide  
21 for an appropriate transition from contracts under  
22 section 1816 and section 1842 of the Social Security  
23 Act (42 U.S.C. 1395h, 1395u) to contracts under  
24 section 1874A, as added by subsection (a)(1).

1           (3) AUTHORIZING CONTINUATION OF MIP  
2           FUNCTIONS UNDER CURRENT CONTRACTS AND  
3           AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—

4           The provisions contained in the exception in section  
5           1893(d)(2) of the Social Security Act (42 U.S.C.  
6           1395ddd(d)(2)) shall continue to apply notwith-  
7           standing the amendments made by this section, and  
8           any reference in such provisions to an agreement or  
9           contract shall be deemed to include a contract under  
10          section 1874A of such Act, as inserted by subsection  
11          (a)(1), that continues the activities referred to in  
12          such provisions.

13          (e) REFERENCES.—On and after the effective date  
14          provided under subsection (d)(1), any reference to a fiscal  
15          intermediary or carrier under title XI or XVIII of the So-  
16          cial Security Act (or any regulation, manual instruction,  
17          interpretative rule, statement of policy, or guideline issued  
18          to carry out such titles) shall be deemed a reference to  
19          an appropriate medicare administrative contractor (as  
20          provided under section 1874A of the Social Security Act).

21          (f) REPORTS ON IMPLEMENTATION.—

22                  (1) PLAN FOR IMPLEMENTATION.—By not later  
23                  than October 1, 2003, the Secretary shall submit a  
24                  report to Congress and the Comptroller General of  
25                  the United States that describes the plan for imple-

1       mentation of the amendments made by this section.  
2       The Comptroller General shall conduct an evaluation  
3       of such plan and shall submit to Congress, not later  
4       than 6 months after the date the report is received,  
5       a report on such evaluation and shall include in such  
6       report such recommendations as the Comptroller  
7       General deems appropriate.

8               (2) STATUS OF IMPLEMENTATION.—The Sec-  
9       retary shall submit a report to Congress not later  
10      than October 1, 2007, that describes the status of  
11      implementation of such amendments and that in-  
12      cludes a description of the following:

13              (A) The number of contracts that have  
14      been competitively bid as of such date.

15              (B) The distribution of functions among  
16      contracts and contractors.

17              (C) A timeline for complete transition to  
18      full competition.

19              (D) A detailed description of how the Sec-  
20      retary has modified oversight and management  
21      of medicare contractors to adapt to full com-  
22      petition.

1 **SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY**  
2 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**  
3 **TORS.**

4 (a) IN GENERAL.—Section 1874A, as added by sec-  
5 tion 811(a)(1), is amended by adding at the end the fol-  
6 lowing new subsection:

7 “(e) REQUIREMENTS FOR INFORMATION SECUR-  
8 RITY.—

9 “(1) DEVELOPMENT OF INFORMATION SECUR-  
10 RITY PROGRAM.—A medicare administrative con-  
11 tractor that performs the functions referred to in  
12 subparagraphs (A) and (B) of subsection (a)(4) (re-  
13 lating to determining and making payments) shall  
14 implement a contractor-wide information security  
15 program to provide information security for the op-  
16 eration and assets of the contractor with respect to  
17 such functions under this title. An information secu-  
18 rity program under this paragraph shall meet the re-  
19 quirements for information security programs im-  
20 posed on Federal agencies under section 3534(b)(2)  
21 of title 44, United States Code (other than require-  
22 ments under subparagraphs (B)(ii), (F)(iii), and  
23 (F)(iv) of such section).

24 “(2) INDEPENDENT AUDITS.—

25 “(A) PERFORMANCE OF ANNUAL EVALUA-  
26 TIONS.—Each year a medicare administrative

1 contractor that performs the functions referred  
2 to in subparagraphs (A) and (B) of subsection  
3 (a)(4) (relating to determining and making pay-  
4 ments) shall undergo an evaluation of the infor-  
5 mation security of the contractor with respect  
6 to such functions under this title. The evalua-  
7 tion shall—

8 “(i) be performed by an entity that  
9 meets such requirements for independence  
10 as the Inspector General of the Depart-  
11 ment of Health and Human Services may  
12 establish; and

13 “(ii) test the effectiveness of informa-  
14 tion security control techniques for an ap-  
15 propriate subset of the contractor’s infor-  
16 mation systems (as defined in section  
17 3502(8) of title 44, United States Code)  
18 relating to such functions under this title  
19 and an assessment of compliance with the  
20 requirements of this subsection and related  
21 information security policies, procedures,  
22 standards and guidelines.

23 “(B) DEADLINE FOR INITIAL EVALUA-  
24 TION.—

1           “(i) NEW CONTRACTORS.—In the case  
2 of a medicare administrative contractor  
3 covered by this subsection that has not  
4 previously performed the functions referred  
5 to in subparagraphs (A) and (B) of sub-  
6 section (a)(4) (relating to determining and  
7 making payments) as a fiscal intermediary  
8 or carrier under section 1816 or 1842, the  
9 first independent evaluation conducted  
10 pursuant subparagraph (A) shall be com-  
11 pleted prior to commencing such functions.

12           “(ii) OTHER CONTRACTORS.—In the  
13 case of a medicare administrative con-  
14 tractor covered by this subsection that is  
15 not described in clause (i), the first inde-  
16 pendent evaluation conducted pursuant  
17 subparagraph (A) shall be completed with-  
18 in 1 year after the date the contractor  
19 commences functions referred to in clause  
20 (i) under this section.

21           “(C) REPORTS ON EVALUATIONS.—

22           “(i) TO THE INSPECTOR GENERAL.—  
23 The results of independent evaluations  
24 under subparagraph (A) shall be submitted  
25 promptly to the Inspector General of the

1 Department of Health and Human Serv-  
2 ices.

3 “(ii) TO CONGRESS.—The Inspector  
4 General of Department of Health and  
5 Human Services shall submit to Congress  
6 annual reports on the results of such eval-  
7 uations.”.

8 (b) APPLICATION OF REQUIREMENTS TO FISCAL  
9 INTERMEDIARIES AND CARRIERS.—

10 (1) IN GENERAL.—The provisions of section  
11 1874A(e)(2) of the Social Security Act (other than  
12 subparagraph (B)), as added by subsection (a), shall  
13 apply to each fiscal intermediary under section 1816  
14 of the Social Security Act (42 U.S.C. 1395h) and  
15 each carrier under section 1842 of such Act (42  
16 U.S.C. 1395u) in the same manner as they apply to  
17 medicare administrative contractors under such pro-  
18 visions.

19 (2) DEADLINE FOR INITIAL EVALUATION.—In  
20 the case of such a fiscal intermediary or carrier with  
21 an agreement or contract under such respective sec-  
22 tion in effect as of the date of the enactment of this  
23 Act, the first evaluation under section  
24 1874A(e)(2)(A) of the Social Security Act (as added  
25 by subsection (a)), pursuant to paragraph (1), shall

1 be completed (and a report on the evaluation sub-  
2 mitted to the Secretary) by not later than 1 year  
3 after such date.

## 4 **Subtitle C—Education and** 5 **Outreach**

### 6 **SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSIST-** 7 **ANCE.**

8 (a) COORDINATION OF EDUCATION FUNDING.—

9 (1) IN GENERAL.—The Social Security Act is  
10 amended by inserting after section 1888 the fol-  
11 lowing new section:

12 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE  
13 “SEC. 1889. (a) COORDINATION OF EDUCATION  
14 FUNDING.—The Secretary shall coordinate the edu-  
15 cational activities provided through medicare contractors  
16 (as defined in subsection (g), including under section  
17 1893) in order to maximize the effectiveness of Federal  
18 education efforts for providers of services and suppliers.”.

19 (2) EFFECTIVE DATE.—The amendment made  
20 by paragraph (1) shall take effect on the date of the  
21 enactment of this Act.

22 (3) REPORT.—Not later than October 1, 2003,  
23 the Secretary shall submit to Congress a report that  
24 includes a description and evaluation of the steps  
25 taken to coordinate the funding of provider edu-

1 cation under section 1889(a) of the Social Security  
2 Act, as added by paragraph (1).

3 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-  
4 FORMANCE.—

5 (1) IN GENERAL.—Section 1874A, as added by  
6 section 811(a)(1) and as amended by section 812(a),  
7 is amended by adding at the end the following new  
8 subsection:

9 “(f) INCENTIVES TO IMPROVE CONTRACTOR PER-  
10 FORMANCE IN PROVIDER EDUCATION AND OUTREACH.—  
11 In order to give medicare administrative contractors an  
12 incentive to implement effective education and outreach  
13 programs for providers of services and suppliers, the Sec-  
14 retary shall develop and implement a methodology to  
15 measure the specific claims payment error rates of such  
16 contractors in the processing or reviewing of medicare  
17 claims.”.

18 (2) APPLICATION TO FISCAL INTERMEDIARIES  
19 AND CARRIERS.—The provisions of section 1874A(f)  
20 of the Social Security Act, as added by paragraph  
21 (1), shall apply to each fiscal intermediary under  
22 section 1816 of the Social Security Act (42 U.S.C.  
23 1395h) and each carrier under section 1842 of such  
24 Act (42 U.S.C. 1395u) in the same manner as they

1 apply to medicare administrative contractors under  
2 such provisions.

3 (3) GAO REPORT ON ADEQUACY OF METHOD-  
4 OLOGY.—Not later than October 1, 2003, the Comp-  
5 troller General of the United States shall submit to  
6 Congress and to the Secretary a report on the ade-  
7 quacy of the methodology under section 1874A(f) of  
8 the Social Security Act, as added by paragraph (1),  
9 and shall include in the report such recommenda-  
10 tions as the Comptroller General determines appro-  
11 priate with respect to the methodology.

12 (4) REPORT ON USE OF METHODOLOGY IN AS-  
13 SESSING CONTRACTOR PERFORMANCE.—Not later  
14 than October 1, 2003, the Secretary shall submit to  
15 Congress a report that describes how the Secretary  
16 intends to use such methodology in assessing medi-  
17 care contractor performance in implementing effec-  
18 tive education and outreach programs, including  
19 whether to use such methodology as a basis for per-  
20 formance bonuses. The report shall include an anal-  
21 ysis of the sources of identified errors and potential  
22 changes in systems of contractors and rules of the  
23 Secretary that could reduce claims error rates.

1 (c) PROVISION OF ACCESS TO AND PROMPT RE-  
2 SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-  
3 TORS.—

4 (1) IN GENERAL.—Section 1874A, as added by  
5 section 811(a)(1) and as amended by section 812(a)  
6 and subsection (b), is further amended by adding at  
7 the end the following new subsection:

8 “(g) COMMUNICATIONS WITH BENEFICIARIES, PRO-  
9 VIDERS OF SERVICES AND SUPPLIERS.—

10 “(1) COMMUNICATION STRATEGY.—The Sec-  
11 retary shall develop a strategy for communications  
12 with individuals entitled to benefits under part A or  
13 enrolled under part B, or both, and with providers  
14 of services and suppliers under this title.

15 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each  
16 medicare administrative contractor shall, for those  
17 providers of services and suppliers which submit  
18 claims to the contractor for claims processing and  
19 for those individuals entitled to benefits under part  
20 A or enrolled under part B, or both, with respect to  
21 whom claims are submitted for claims processing,  
22 provide general written responses (which may be  
23 through electronic transmission) in a clear, concise,  
24 and accurate manner to inquiries of providers of  
25 services, suppliers and individuals entitled to bene-

1 fits under part A or enrolled under part B, or both,  
2 concerning the programs under this title within 45  
3 business days of the date of receipt of such inquiries.

4 “(3) RESPONSE TO TOLL-FREE LINES.—The  
5 Secretary shall ensure that each medicare adminis-  
6 trative contractor shall provide, for those providers  
7 of services and suppliers which submit claims to the  
8 contractor for claims processing and for those indi-  
9 viduals entitled to benefits under part A or enrolled  
10 under part B, or both, with respect to whom claims  
11 are submitted for claims processing, a toll-free tele-  
12 phone number at which such individuals, providers  
13 of services and suppliers may obtain information re-  
14 garding billing, coding, claims, coverage, and other  
15 appropriate information under this title.

16 “(4) MONITORING OF CONTRACTOR RE-  
17 SPONSES.—

18 “(A) IN GENERAL.—Each medicare admin-  
19 istrative contractor shall, consistent with stand-  
20 ards developed by the Secretary under subpara-  
21 graph (B)—

22 “(i) maintain a system for identifying  
23 who provides the information referred to in  
24 paragraphs (2) and (3); and

1           “(ii) monitor the accuracy, consist-  
2           ency, and timeliness of the information so  
3           provided.

4           “(B) DEVELOPMENT OF STANDARDS.—

5           “(i) IN GENERAL.—The Secretary  
6           shall establish and make public standards  
7           to monitor the accuracy, consistency, and  
8           timeliness of the information provided in  
9           response to written and telephone inquiries  
10          under this subsection. Such standards shall  
11          be consistent with the performance require-  
12          ments established under subsection (b)(3).

13          “(ii) EVALUATION.—In conducting  
14          evaluations of individual medicare adminis-  
15          trative contractors, the Secretary shall  
16          take into account the results of the moni-  
17          toring conducted under subparagraph (A)  
18          taking into account as performance re-  
19          quirements the standards established  
20          under clause (i). The Secretary shall, in  
21          consultation with organizations rep-  
22          resenting providers of services, suppliers,  
23          and individuals entitled to benefits under  
24          part A or enrolled under part B, or both,  
25          establish standards relating to the accu-

1           racy, consistency, and timeliness of the in-  
2           formation so provided.

3           “(C) DIRECT MONITORING.—Nothing in  
4           this paragraph shall be construed as preventing  
5           the Secretary from directly monitoring the ac-  
6           curacy, consistency, and timeliness of the infor-  
7           mation so provided.”.

8           (2) EFFECTIVE DATE.—The amendment made  
9           by paragraph (1) shall take effect October 1, 2003.

10          (3) APPLICATION TO FISCAL INTERMEDIARIES  
11          AND CARRIERS.—The provisions of section 1874A(g)  
12          of the Social Security Act, as added by paragraph  
13          (1), shall apply to each fiscal intermediary under  
14          section 1816 of the Social Security Act (42 U.S.C.  
15          1395h) and each carrier under section 1842 of such  
16          Act (42 U.S.C. 1395u) in the same manner as they  
17          apply to medicare administrative contractors under  
18          such provisions.

19          (d) IMPROVED PROVIDER EDUCATION AND TRAIN-  
20          ING.—

21                 (1) IN GENERAL.—Section 1889, as added by  
22                 subsection (a), is amended by adding at the end the  
23                 following new subsections:

24                 “(b) ENHANCED EDUCATION AND TRAINING.—

1           “(1) ADDITIONAL RESOURCES.—There are au-  
2           thorized to be appropriated to the Secretary (in ap-  
3           propriate part from the Federal Hospital Insurance  
4           Trust Fund and the Federal Supplementary Medical  
5           Insurance Trust Fund) \$25,000,000 for each of fis-  
6           cal years 2004 and 2005 and such sums as may be  
7           necessary for succeeding fiscal years.

8           “(2) USE.—The funds made available under  
9           paragraph (1) shall be used to increase the conduct  
10          by medicare contractors of education and training of  
11          providers of services and suppliers regarding billing,  
12          coding, and other appropriate items and may also be  
13          used to improve the accuracy, consistency, and time-  
14          liness of contractor responses.

15          “(c) TAILORING EDUCATION AND TRAINING ACTIVI-  
16          TIES FOR SMALL PROVIDERS OR SUPPLIERS.—

17                 “(1) IN GENERAL.—Insofar as a medicare con-  
18                 tractor conducts education and training activities, it  
19                 shall tailor such activities to meet the special needs  
20                 of small providers of services or suppliers (as defined  
21                 in paragraph (2)).

22                 “(2) SMALL PROVIDER OF SERVICES OR SUP-  
23                 PLIER.—In this subsection, the term ‘small provider  
24                 of services or supplier’ means—

1           “(A) a provider of services with fewer than  
2           25 full-time-equivalent employees; or

3           “(B) a supplier with fewer than 10 full-  
4           time-equivalent employees.”.

5           (2) EFFECTIVE DATE.—The amendment made  
6           by paragraph (1) shall take effect on October 1,  
7           2003.

8           (e) REQUIREMENT TO MAINTAIN INTERNET  
9           SITES.—

10           (1) IN GENERAL.—Section 1889, as added by  
11           subsection (a) and as amended by subsection (d), is  
12           further amended by adding at the end the following  
13           new subsection:

14           “(d) INTERNET SITES; FAQs.—The Secretary, and  
15           each medicare contractor insofar as it provides services  
16           (including claims processing) for providers of services or  
17           suppliers, shall maintain an Internet site which—

18           “(1) provides answers in an easily accessible  
19           format to frequently asked questions, and

20           “(2) includes other published materials of the  
21           contractor,

22           that relate to providers of services and suppliers under the  
23           programs under this title (and title XI insofar as it relates  
24           to such programs).”.

1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) shall take effect on October 1,  
3           2003.

4           (f) ADDITIONAL PROVIDER EDUCATION PROVI-  
5           SIONS.—

6           (1) IN GENERAL.—Section 1889, as added by  
7           subsection (a) and as amended by subsections (d)  
8           and (e), is further amended by adding at the end the  
9           following new subsections:

10          “(e) ENCOURAGEMENT OF PARTICIPATION IN EDU-  
11          CATION PROGRAM ACTIVITIES.—A medicare contractor  
12          may not use a record of attendance at (or failure to at-  
13          tend) educational activities or other information gathered  
14          during an educational program conducted under this sec-  
15          tion or otherwise by the Secretary to select or track pro-  
16          viders of services or suppliers for the purpose of con-  
17          ducting any type of audit or prepayment review.

18          “(f) CONSTRUCTION.—Nothing in this section or sec-  
19          tion 1893(g) shall be construed as providing for disclosure  
20          by a medicare contractor of information that would com-  
21          promise pending law enforcement activities or reveal find-  
22          ings of law enforcement-related audits.

23          “(g) DEFINITIONS.—For purposes of this section, the  
24          term ‘medicare contractor’ includes the following:

1           “(1) A medicare administrative contractor with  
2           a contract under section 1874A, including a fiscal  
3           intermediary with a contract under section 1816 and  
4           a carrier with a contract under section 1842.

5           “(2) An eligible entity with a contract under  
6           section 1893.

7           Such term does not include, with respect to activities of  
8           a specific provider of services or supplier an entity that  
9           has no authority under this title or title IX with respect  
10          to such activities and such provider of services or sup-  
11          plier.”.

12           (2) EFFECTIVE DATE.—The amendment made  
13          by paragraph (1) shall take effect on the date of the  
14          enactment of this Act.

15   **SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**  
16                                   **ONSTRATION PROGRAM.**

17          (a) ESTABLISHMENT.—

18           (1) IN GENERAL.—The Secretary shall establish  
19          a demonstration program (in this section referred to  
20          as the “demonstration program”) under which tech-  
21          nical assistance described in paragraph (2) is made  
22          available, upon request and on a voluntary basis, to  
23          small providers of services or suppliers in order to  
24          improve compliance with the applicable requirements  
25          of the programs under medicare program under title

1 XVIII of the Social Security Act (including provi-  
2 sions of title XI of such Act insofar as they relate  
3 to such title and are not administered by the Office  
4 of the Inspector General of the Department of  
5 Health and Human Services).

6 (2) FORMS OF TECHNICAL ASSISTANCE.—The  
7 technical assistance described in this paragraph is—

8 (A) evaluation and recommendations re-  
9 garding billing and related systems; and

10 (B) information and assistance regarding  
11 policies and procedures under the medicare pro-  
12 gram, including coding and reimbursement.

13 (3) SMALL PROVIDERS OF SERVICES OR SUP-  
14 PLIERS.—In this section, the term “small providers  
15 of services or suppliers” means—

16 (A) a provider of services with fewer than  
17 25 full-time-equivalent employees; or

18 (B) a supplier with fewer than 10 full-  
19 time-equivalent employees.

20 (b) QUALIFICATION OF CONTRACTORS.—In con-  
21 ducting the demonstration program, the Secretary shall  
22 enter into contracts with qualified organizations (such as  
23 peer review organizations or entities described in section  
24 1889(g)(2) of the Social Security Act, as inserted by sec-  
25 tion 5(f)(1)) with appropriate expertise with billing sys-

1 tems of the full range of providers of services and sup-  
2 pliers to provide the technical assistance. In awarding such  
3 contracts, the Secretary shall consider any prior investiga-  
4 tions of the entity's work by the Inspector General of De-  
5 partment of Health and Human Services or the Comp-  
6 troller General of the United States.

7 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The  
8 technical assistance provided under the demonstration  
9 program shall include a direct and in-person examination  
10 of billing systems and internal controls of small providers  
11 of services or suppliers to determine program compliance  
12 and to suggest more efficient or effective means of achiev-  
13 ing such compliance.

14 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROB-  
15 LEMS IDENTIFIED AS CORRECTED.—The Secretary shall  
16 provide that, absent evidence of fraud and notwith-  
17 standing any other provision of law, any errors found in  
18 a compliance review for a small provider of services or sup-  
19 plier that participates in the demonstration program shall  
20 not be subject to recovery action if the technical assistance  
21 personnel under the program determine that—

22 (1) the problem that is the subject of the com-  
23 pliance review has been corrected to their satisfac-  
24 tion within 30 days of the date of the visit by such

1 personnel to the small provider of services or sup-  
2 plier; and

3 (2) such problem remains corrected for such pe-  
4 riod as is appropriate.

5 The previous sentence applies only to claims filed as part  
6 of the demonstration program and lasts only for the dura-  
7 tion of such program and only as long as the small pro-  
8 vider of services or supplier is a participant in such pro-  
9 gram.

10 (e) GAO EVALUATION.—Not later than 2 years after  
11 the date of the date the demonstration program is first  
12 implemented, the Comptroller General, in consultation  
13 with the Inspector General of the Department of Health  
14 and Human Services, shall conduct an evaluation of the  
15 demonstration program. The evaluation shall include a de-  
16 termination of whether claims error rates are reduced for  
17 small providers of services or suppliers who participated  
18 in the program and the extent of improper payments made  
19 as a result of the demonstration program. The Comp-  
20 troller General shall submit a report to the Secretary and  
21 the Congress on such evaluation and shall include in such  
22 report recommendations regarding the continuation or ex-  
23 tension of the demonstration program.

24 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The  
25 provision of technical assistance to a small provider of

1 services or supplier under the demonstration program is  
2 conditioned upon the small provider of services or supplier  
3 paying an amount estimated (and disclosed in advance of  
4 a provider's or supplier's participation in the program) to  
5 be equal to 25 percent of the cost of the technical assist-  
6 ance.

7 (g) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated to the Secretary (in ap-  
9 propriate part from the Federal Hospital Insurance Trust  
10 Fund and the Federal Supplementary Medical Insurance  
11 Trust Fund) to carry out the demonstration program—

12 (1) for fiscal year 2004, \$1,000,000, and

13 (2) for fiscal year 2005, \$6,000,000.

14 **SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**  
15 **BENEFICIARY OMBUDSMAN.**

16 (a) MEDICARE PROVIDER OMBUDSMAN.—Section  
17 1868 (42 U.S.C. 1395ee) is amended—

18 (1) by adding at the end of the heading the fol-  
19 lowing: “; MEDICARE PROVIDER OMBUDSMAN”;

20 (2) by inserting “PRACTICING PHYSICIANS AD-  
21 VISORY COUNCIL.—(1)” after “(a)”;

22 (3) in paragraph (1), as so redesignated under  
23 paragraph (2), by striking “in this section” and in-  
24 serting “in this subsection”;

1           (4) by redesignating subsections (b) and (c) as  
2 paragraphs (2) and (3), respectively; and

3           (5) by adding at the end the following new sub-  
4 section:

5           “(b) MEDICARE PROVIDER OMBUDSMAN.—The Sec-  
6 retary shall appoint within the Department of Health and  
7 Human Services a Medicare Provider Ombudsman. The  
8 Ombudsman shall—

9           “(1) provide assistance, on a confidential basis,  
10 to providers of services and suppliers with respect to  
11 complaints, grievances, and requests for information  
12 concerning the programs under this title (including  
13 provisions of title XI insofar as they relate to this  
14 title and are not administered by the Office of the  
15 Inspector General of the Department of Health and  
16 Human Services) and in the resolution of unclear or  
17 conflicting guidance given by the Secretary and  
18 medicare contractors to such providers of services  
19 and suppliers regarding such programs and provi-  
20 sions and requirements under this title and such  
21 provisions; and

22           “(2) submit recommendations to the Secretary  
23 for improvement in the administration of this title  
24 and such provisions, including—

1           “(A) recommendations to respond to recur-  
2           ring patterns of confusion in this title and such  
3           provisions (including recommendations regard-  
4           ing suspending imposition of sanctions where  
5           there is widespread confusion in program ad-  
6           ministration), and

7           “(B) recommendations to provide for an  
8           appropriate and consistent response (including  
9           not providing for audits) in cases of self-identi-  
10          fied overpayments by providers of services and  
11          suppliers.

12 The Ombudsman shall not serve as an advocate for any  
13 increases in payments or new coverage of services, but  
14 may identify issues and problems in payment or coverage  
15 policies.”.

16          (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title  
17 XVIII, as amended by sections 105 and 701, is amended  
18 by inserting after section 1808 the following new section:

19           “MEDICARE BENEFICIARY OMBUDSMAN

20          “SEC. 1809. (a) IN GENERAL.—The Secretary shall  
21          appoint within the Department of Health and Human  
22          Services a Medicare Beneficiary Ombudsman who shall  
23          have expertise and experience in the fields of health care  
24          and education of (and assistance to) individuals entitled  
25          to benefits under this title.

1       “(b) DUTIES.—The Medicare Beneficiary Ombuds-  
2 man shall—

3           “(1) receive complaints, grievances, and re-  
4 quests for information submitted by individuals enti-  
5 tled to benefits under part A or enrolled under part  
6 B, or both, with respect to any aspect of the medi-  
7 care program;

8           “(2) provide assistance with respect to com-  
9 plaints, grievances, and requests referred to in para-  
10 graph (1), including—

11           “(A) assistance in collecting relevant infor-  
12 mation for such individuals, to seek an appeal  
13 of a decision or determination made by a fiscal  
14 intermediary, carrier, Medicare+Choice organi-  
15 zation, or the Secretary; and

16           “(B) assistance to such individuals with  
17 any problems arising from disenrollment from a  
18 Medicare+Choice plan under part C; and

19           “(3) submit annual reports to Congress and the  
20 Secretary that describe the activities of the Office  
21 and that include such recommendations for improve-  
22 ment in the administration of this title as the Om-  
23 budsman determines appropriate.

24 The Ombudsman shall not serve as an advocate for any  
25 increases in payments or new coverage of services, but

1 may identify issues and problems in payment or coverage  
2 policies.

3       “(c) WORKING WITH HEALTH INSURANCE COUN-  
4 SELING PROGRAMS.—To the extent possible, the Ombuds-  
5 man shall work with health insurance counseling programs  
6 (receiving funding under section 4360 of Omnibus Budget  
7 Reconciliation Act of 1990) to facilitate the provision of  
8 information to individuals entitled to benefits under part  
9 A or enrolled under part B, or both regarding  
10 Medicare+Choice plans and changes to those plans. Noth-  
11 ing in this subsection shall preclude further collaboration  
12 between the Ombudsman and such programs.”.

13       (c) DEADLINE FOR APPOINTMENT.—The Secretary  
14 shall appoint the Medicare Provider Ombudsman and the  
15 Medicare Beneficiary Ombudsman, under the amendments  
16 made by subsections (a) and (b), respectively, by not later  
17 than 1 year after the date of the enactment of this Act.

18       (d) FUNDING.—There are authorized to be appro-  
19 priated to the Secretary (in appropriate part from the  
20 Federal Hospital Insurance Trust Fund and the Federal  
21 Supplementary Medical Insurance Trust Fund) to carry  
22 out the provisions of subsection (b) of section 1868 of the  
23 Social Security Act (relating to the Medicare Provider  
24 Ombudsman), as added by subsection (a)(5) and section  
25 1809 of such Act (relating to the Medicare Beneficiary

1 Ombudsman), as added by subsection (b), such sums as  
2 are necessary for fiscal year 2003 and each succeeding fis-  
3 cal year.

4 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-  
5 MEDICARE).—

6 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDI-  
7 CARE HANDBOOK INSTEAD OF OTHER TOLL-FREE  
8 NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-  
9 2(b)) is amended by adding at the end the following:  
10 “The Secretary shall provide, through the toll-free  
11 number 1-800-MEDICARE, for a means by which  
12 individuals seeking information about, or assistance  
13 with, such programs who phone such toll-free num-  
14 ber are transferred (without charge) to appropriate  
15 entities for the provision of such information or as-  
16 sistance. Such toll-free number shall be the toll-free  
17 number listed for general information and assistance  
18 in the annual notice under subsection (a) instead of  
19 the listing of numbers of individual contractors.”.

20 (2) MONITORING ACCURACY.—

21 (A) STUDY.—The Comptroller General of  
22 the United States shall conduct a study to mon-  
23 itor the accuracy and consistency of information  
24 provided to individuals entitled to benefits  
25 under part A or enrolled under part B, or both,

1 through the toll-free number 1-800-MEDI-  
2 CARE, including an assessment of whether the  
3 information provided is sufficient to answer  
4 questions of such individuals. In conducting the  
5 study, the Comptroller General shall examine  
6 the education and training of the individuals  
7 providing information through such number.

8 (B) REPORT.—Not later than 1 year after  
9 the date of the enactment of this Act, the  
10 Comptroller General shall submit to Congress a  
11 report on the study conducted under subpara-  
12 graph (A).

13 **SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION PRO-**  
14 **GRAM.**

15 (a) IN GENERAL.—The Secretary shall establish a  
16 demonstration program (in this section referred to as the  
17 “demonstration program”) under which medicare special-  
18 ists employed by the Department of Health and Human  
19 Services provide advice and assistance to individuals enti-  
20 tled to benefits under part A of title XVIII of the Social  
21 Security Act, or enrolled under part B of such title, or  
22 both, regarding the medicare program at the location of  
23 existing local offices of the Social Security Administration.

24 (b) LOCATIONS.—

1           (1) IN GENERAL.—The demonstration program  
2 shall be conducted in at least 6 offices or areas.  
3 Subject to paragraph (2), in selecting such offices  
4 and areas, the Secretary shall provide preference for  
5 offices with a high volume of visits by individuals re-  
6 ferred to in subsection (a).

7           (2) ASSISTANCE FOR RURAL BENEFICIARIES.—  
8 The Secretary shall provide for the selection of at  
9 least 2 rural areas to participate in the demonstra-  
10 tion program. In conducting the demonstration pro-  
11 gram in such rural areas, the Secretary shall provide  
12 for medicare specialists to travel among local offices  
13 in a rural area on a scheduled basis.

14          (c) DURATION.—The demonstration program shall be  
15 conducted over a 3-year period.

16          (d) EVALUATION AND REPORT.—

17           (1) EVALUATION.—The Secretary shall provide  
18 for an evaluation of the demonstration program.  
19 Such evaluation shall include an analysis of—

20                   (A) utilization of, and satisfaction of those  
21 individuals referred to in subsection (a) with,  
22 the assistance provided under the program; and

23                   (B) the cost-effectiveness of providing ben-  
24 efiary assistance through out-stationing medi-

1 care specialists at local offices of the Social Se-  
2 curity Administration.

3 (2) REPORT.—The Secretary shall submit to  
4 Congress a report on such evaluation and shall in-  
5 clude in such report recommendations regarding the  
6 feasibility of permanently out-stationing medicare  
7 specialists at local offices of the Social Security Ad-  
8 ministration.

## 9 **Subtitle D—Appeals and Recovery**

### 10 **SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDICARE**

#### 11 **APPEALS.**

12 (a) TRANSITION PLAN.—

13 (1) IN GENERAL.—Not later than October 1,  
14 2003, the Commissioner of Social Security and the  
15 Secretary shall develop and transmit to Congress  
16 and the Comptroller General of the United States a  
17 plan under which the functions of administrative law  
18 judges responsible for hearing cases under title  
19 XVIII of the Social Security Act (and related provi-  
20 sions in title XI of such Act) are transferred from  
21 the responsibility of the Commissioner and the So-  
22 cial Security Administration to the Secretary and  
23 the Department of Health and Human Services.

24 (2) GAO EVALUATION.—The Comptroller Gen-  
25 eral of the United States shall evaluate the plan

1 and, not later than the date that is 6 months after  
2 the date on which the plan is received by the Comp-  
3 troller General, shall submit to Congress a report on  
4 such evaluation.

5 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

6 (1) IN GENERAL.—Not earlier than July 1,  
7 2004, and not later than October 1, 2004, the Com-  
8 missioner of Social Security and the Secretary shall  
9 implement the transition plan under subsection (a)  
10 and transfer the administrative law judge functions  
11 described in such subsection from the Social Secu-  
12 rity Administration to the Secretary.

13 (2) ASSURING INDEPENDENCE OF JUDGES.—

14 The Secretary shall assure the independence of ad-  
15 ministrative law judges performing the administra-  
16 tive law judge functions transferred under para-  
17 graph (1) from the Centers for Medicare & Medicaid  
18 Services and its contractors.

19 (3) GEOGRAPHIC DISTRIBUTION.—The Sec-

20 retary shall provide for an appropriate geographic  
21 distribution of administrative law judges performing  
22 the administrative law judge functions transferred  
23 under paragraph (1) throughout the United States  
24 to ensure timely access to such judges.

1           (4) HIRING AUTHORITY.—Subject to the  
2 amounts provided in advance in appropriations Act,  
3 the Secretary shall have authority to hire adminis-  
4 trative law judges to hear such cases, giving priority  
5 to those judges with prior experience in handling  
6 medicare appeals and in a manner consistent with  
7 paragraph (3), and to hire support staff for such  
8 judges.

9           (5) FINANCING.—Amounts payable under law  
10 to the Commissioner for administrative law judges  
11 performing the administrative law judge functions  
12 transferred under paragraph (1) from the Federal  
13 Hospital Insurance Trust Fund and the Federal  
14 Supplementary Medical Insurance Trust Fund shall  
15 become payable to the Secretary for the functions so  
16 transferred.

17           (6) SHARED RESOURCES.—The Secretary shall  
18 enter into such arrangements with the Commissioner  
19 as may be appropriate with respect to transferred  
20 functions of administrative law judges to share office  
21 space, support staff, and other resources, with ap-  
22 propriate reimbursement from the Trust Funds de-  
23 scribed in paragraph (5).

24           (c) INCREASED FINANCIAL SUPPORT.—In addition to  
25 any amounts otherwise appropriated, to ensure timely ac-

1 tion on appeals before administrative law judges and the  
2 Departmental Appeals Board consistent with section 1869  
3 of the Social Security Act (as amended by section 521 of  
4 BIPA, 114 Stat. 2763A–534), there are authorized to be  
5 appropriated (in appropriate part from the Federal Hos-  
6 pital Insurance Trust Fund and the Federal Supple-  
7 mentary Medical Insurance Trust Fund) to the Secretary  
8 such sums as are necessary for fiscal year 2004 and each  
9 subsequent fiscal year to—

10 (1) increase the number of administrative law  
11 judges (and their staffs) under subsection (b)(4);

12 (2) improve education and training opportuni-  
13 ties for administrative law judges (and their staffs);  
14 and

15 (3) increase the staff of the Departmental Ap-  
16 peals Board.

17 (d) CONFORMING AMENDMENT.—Section  
18 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added  
19 by section 522(a) of BIPA (114 Stat. 2763A–543), is  
20 amended by striking “of the Social Security Administra-  
21 tion”.

22 **SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

23 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Sec-  
24 tion 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA,  
25 is amended—

1           (1) in paragraph (1)(A), by inserting “, subject  
2           to paragraph (2),” before “to judicial review of the  
3           Secretary’s final decision”;

4           (2) in paragraph (1)(F)—

5                 (A) by striking clause (ii);

6                 (B) by striking “PROCEEDING” and all  
7           that follows through “DETERMINATION” and in-  
8           serting “DETERMINATIONS AND RECONSIDER-  
9           ATIONS”; and

10                (C) by redesignating subclauses (I) and  
11           (II) as clauses (i) and (ii) and by moving the  
12           indentation of such subclauses (and the matter  
13           that follows) 2 ems to the left; and

14           (3) by adding at the end the following new  
15           paragraph:

16                “(2) EXPEDITED ACCESS TO JUDICIAL RE-  
17           VIEW.—

18                “(A) IN GENERAL.—The Secretary shall  
19           establish a process under which a provider of  
20           services or supplier that furnishes an item or  
21           service or an individual entitled to benefits  
22           under part A or enrolled under part B, or both,  
23           who has filed an appeal under paragraph (1)  
24           may obtain access to judicial review when a re-  
25           view panel (described in subparagraph (D)), on

1 its own motion or at the request of the appel-  
2 lant, determines that no entity in the adminis-  
3 trative appeals process has the authority to de-  
4 cide the question of law or regulation relevant  
5 to the matters in controversy and that there is  
6 no material issue of fact in dispute. The appel-  
7 lant may make such request only once with re-  
8 spect to a question of law or regulation in a  
9 case of an appeal.

10 “(B) PROMPT DETERMINATIONS.—If, after  
11 or coincident with appropriately filing a request  
12 for an administrative hearing, the appellant re-  
13 quests a determination by the appropriate re-  
14 view panel that no review panel has the author-  
15 ity to decide the question of law or regulations  
16 relevant to the matters in controversy and that  
17 there is no material issue of fact in dispute and  
18 if such request is accompanied by the docu-  
19 ments and materials as the appropriate review  
20 panel shall require for purposes of making such  
21 determination, such review panel shall make a  
22 determination on the request in writing within  
23 60 days after the date such review panel re-  
24 ceives the request and such accompanying docu-  
25 ments and materials. Such a determination by

1 such review panel shall be considered a final de-  
2 cision and not subject to review by the Sec-  
3 retary.

4 “(C) ACCESS TO JUDICIAL REVIEW.—

5 “(i) IN GENERAL.—If the appropriate  
6 review panel—

7 “(I) determines that there are no  
8 material issues of fact in dispute and  
9 that the only issue is one of law or  
10 regulation that no review panel has  
11 the authority to decide; or

12 “(II) fails to make such deter-  
13 mination within the period provided  
14 under subparagraph (B);

15 then the appellant may bring a civil action  
16 as described in this subparagraph.

17 “(ii) DEADLINE FOR FILING.—Such  
18 action shall be filed, in the case described  
19 in—

20 “(I) clause (i)(I), within 60 days  
21 of date of the determination described  
22 in such subparagraph; or

23 “(II) clause (i)(II), within 60  
24 days of the end of the period provided

1 under subparagraph (B) for the deter-  
2 mination.

3 “(iii) VENUE.—Such action shall be  
4 brought in the district court of the United  
5 States for the judicial district in which the  
6 appellant is located (or, in the case of an  
7 action brought jointly by more than one  
8 applicant, the judicial district in which the  
9 greatest number of applicants are located)  
10 or in the district court for the District of  
11 Columbia.

12 “(iv) INTEREST ON AMOUNTS IN CON-  
13 TROVERSY.—Where a provider of services  
14 or supplier seeks judicial review pursuant  
15 to this paragraph, the amount in con-  
16 troversy shall be subject to annual interest  
17 beginning on the first day of the first  
18 month beginning after the 60-day period  
19 as determined pursuant to clause (ii) and  
20 equal to the rate of interest on obligations  
21 issued for purchase by the Federal Hos-  
22 pital Insurance Trust Fund and by the  
23 Federal Supplementary Medical Insurance  
24 Trust Fund for the month in which the  
25 civil action authorized under this para-

1 graph is commenced, to be awarded by the  
2 reviewing court in favor of the prevailing  
3 party. No interest awarded pursuant to the  
4 preceding sentence shall be deemed income  
5 or cost for the purposes of determining re-  
6 imbursement due providers of services or  
7 suppliers under this Act.

8 “(D) REVIEW PANELS.—For purposes of  
9 this subsection, a ‘review panel’ is a panel con-  
10 sisting of 3 members (who shall be administra-  
11 tive law judges, members of the Departmental  
12 Appeals Board, or qualified individuals associ-  
13 ated with a qualified independent contractor (as  
14 defined in subsection (c)(2)) or with another  
15 independent entity) designated by the Secretary  
16 for purposes of making determinations under  
17 this paragraph.”.

18 (b) APPLICATION TO PROVIDER AGREEMENT DETER-  
19 MINATIONS.—Section 1866(h)(1) (42 U.S.C.  
20 1395cc(h)(1)) is amended—

21 (1) by inserting “(A)” after “(h)(1)”; and

22 (2) by adding at the end the following new sub-  
23 paragraph:

24 “(B) An institution or agency described in subpara-  
25 graph (A) that has filed for a hearing under subparagraph

1 (A) shall have expedited access to judicial review under  
2 this subparagraph in the same manner as providers of  
3 services, suppliers, and individuals entitled to benefits  
4 under part A or enrolled under part B, or both, may ob-  
5 tain expedited access to judicial review under the process  
6 established under section 1869(b)(2). Nothing in this sub-  
7 paragraph shall be construed to affect the application of  
8 any remedy imposed under section 1819 during the pend-  
9 ency of an appeal under this subparagraph.”.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 this section shall apply to appeals filed on or after October  
12 1, 2003.

13 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER  
14 AGREEMENT DETERMINATIONS.—

15 (1) TERMINATION AND CERTAIN OTHER IMME-  
16 DIATE REMEDIES.—The Secretary shall develop and  
17 implement a process to expedite proceedings under  
18 sections 1866(h) of the Social Security Act (42  
19 U.S.C. 1395cc(h)) in which the remedy of termi-  
20 nation of participation, or a remedy described in  
21 clause (i) or (iii) of section 1819(h)(2)(B) of such  
22 Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied  
23 on an immediate basis, has been imposed. Under  
24 such process priority shall be provided in cases of  
25 termination.

1           (2) INCREASED FINANCIAL SUPPORT.—In addi-  
2           tion to any amounts otherwise appropriated, to re-  
3           duce by 50 percent the average time for administra-  
4           tive determinations on appeals under section  
5           1866(h) of the Social Security Act (42 U.S.C.  
6           1395cc(h)), there are authorized to be appropriated  
7           (in appropriate part from the Federal Hospital In-  
8           surance Trust Fund and the Federal Supplementary  
9           Medical Insurance Trust Fund) to the Secretary  
10          such additional sums for fiscal year 2004 and each  
11          subsequent fiscal year as may be necessary. The  
12          purposes for which such amounts are available in-  
13          clude increasing the number of administrative law  
14          judges (and their staffs) and the appellate level staff  
15          at the Departmental Appeals Board of the Depart-  
16          ment of Health and Human Services and educating  
17          such judges and staffs on long-term care issues.

18 **SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.**

19          (a) REQUIRING FULL AND EARLY PRESENTATION OF  
20 EVIDENCE.—

21           (1) IN GENERAL.—Section 1869(b) (42 U.S.C.  
22           1395ff(b)), as amended by BIPA and as amended by  
23           section 832(a), is further amended by adding at the  
24           end the following new paragraph:

1           “(3) REQUIRING FULL AND EARLY PRESEN-  
2           TATION OF EVIDENCE BY PROVIDERS.—A provider  
3           of services or supplier may not introduce evidence in  
4           any appeal under this section that was not presented  
5           at the reconsideration conducted by the qualified  
6           independent contractor under subsection (c), unless  
7           there is good cause which precluded the introduction  
8           of such evidence at or before that reconsideration.”.

9           (2) EFFECTIVE DATE.—The amendment made  
10          by paragraph (1) shall take effect on October 1,  
11          2003.

12          (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section  
13          1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as  
14          amended by BIPA, is amended by inserting “(including  
15          the medical records of the individual involved)” after  
16          “clinical experience”.

17          (c) NOTICE REQUIREMENTS FOR MEDICARE AP-  
18          PEALS.—

19                 (1) INITIAL DETERMINATIONS AND REDETER-  
20                 MINATIONS.—Section 1869(a) (42 U.S.C.  
21                 1395ff(a)), as amended by BIPA, is amended by  
22                 adding at the end the following new paragraph:

23                 “(4) REQUIREMENTS OF NOTICE OF DETER-  
24                 MINATIONS AND REDETERMINATIONS.—A written  
25                 notice of a determination on an initial determination

1 or on a redetermination, insofar as such determina-  
2 tion or redetermination results in a denial of a claim  
3 for benefits, shall include—

4 “(A) the specific reasons for the deter-  
5 mination, including—

6 “(i) upon request, the provision of the  
7 policy, manual, or regulation used in mak-  
8 ing the determination; and

9 “(ii) as appropriate in the case of a  
10 redetermination, a summary of the clinical  
11 or scientific evidence used in making the  
12 determination;

13 “(B) the procedures for obtaining addi-  
14 tional information concerning the determination  
15 or redetermination; and

16 “(C) notification of the right to seek a re-  
17 determination or otherwise appeal the deter-  
18 mination and instructions on how to initiate  
19 such a redetermination or appeal under this  
20 section.

21 The written notice on a redetermination shall be  
22 provided in printed form and written in a manner  
23 calculated to be understood by the individual entitled  
24 to benefits under part A or enrolled under part B,  
25 or both.”.

1           (2)                           RECONSIDERATIONS.—Section  
2   1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as  
3   amended by BIPA, is amended—

4                   (A) by inserting “be written in a manner  
5                   calculated to be understood by the individual  
6                   entitled to benefits under part A or enrolled  
7                   under part B, or both, and shall include (to the  
8                   extent appropriate)” after “in writing, ”; and

9                   (B) by inserting “and a notification of the  
10                  right to appeal such determination and instruc-  
11                  tions on how to initiate such appeal under this  
12                  section” after “such decision,”.

13           (3) APPEALS.—Section 1869(d) (42 U.S.C.  
14   1395ff(d)), as amended by BIPA, is amended—

15                  (A) in the heading, by inserting “; NO-  
16                  TICE” after “SECRETARY”; and

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

19                  “(4) NOTICE.—Notice of the decision of an ad-  
20                  ministrative law judge shall be in writing in a man-  
21                  ner calculated to be understood by the individual en-  
22                  titled to benefits under part A or enrolled under part  
23                  B, or both, and shall include—

24                         “(A) the specific reasons for the deter-  
25                         mination (including, to the extent appropriate,

1 a summary of the clinical or scientific evidence  
2 used in making the determination);

3 “(B) the procedures for obtaining addi-  
4 tional information concerning the decision; and

5 “(C) notification of the right to appeal the  
6 decision and instructions on how to initiate  
7 such an appeal under this section.”.

8 (4) SUBMISSION OF RECORD FOR APPEAL.—

9 Section 1869(c)(3)(J)(i) (42 U.S.C.  
10 1395ff(c)(3)(J)(i)) by striking “prepare” and insert-  
11 ing “submit” and by striking “with respect to” and  
12 all that follows through “and relevant policies”.

13 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

14 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED  
15 INDEPENDENT CONTRACTORS.—Section 1869(c)(3)  
16 (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is  
17 amended—

18 (A) in subparagraph (A), by striking “suf-  
19 ficient training and expertise in medical science  
20 and legal matters” and inserting “sufficient  
21 medical, legal, and other expertise (including  
22 knowledge of the program under this title) and  
23 sufficient staffing”; and

24 (B) by adding at the end the following new  
25 subparagraph:

1 “(K) INDEPENDENCE REQUIREMENTS.—

2 “(i) IN GENERAL.—Subject to clause  
3 (ii), a qualified independent contractor  
4 shall not conduct any activities in a case  
5 unless the entity—

6 “(I) is not a related party (as de-  
7 fined in subsection (g)(5));

8 “(II) does not have a material fa-  
9 milial, financial, or professional rela-  
10 tionship with such a party in relation  
11 to such case; and

12 “(III) does not otherwise have a  
13 conflict of interest with such a party.

14 “(ii) EXCEPTION FOR REASONABLE  
15 COMPENSATION.—Nothing in clause (i)  
16 shall be construed to prohibit receipt by a  
17 qualified independent contractor of com-  
18 pensation from the Secretary for the con-  
19 duct of activities under this section if the  
20 compensation is provided consistent with  
21 clause (iii).

22 “(iii) LIMITATIONS ON ENTITY COM-  
23 PENSATION.—Compensation provided by  
24 the Secretary to a qualified independent  
25 contractor in connection with reviews

1           under this section shall not be contingent  
2           on any decision rendered by the contractor  
3           or by any reviewing professional.”.

4           (2) ELIGIBILITY REQUIREMENTS FOR REVIEW-  
5           ERS.—Section 1869 (42 U.S.C. 1395ff), as amended  
6           by BIPA, is amended—

7           (A) by amending subsection (c)(3)(D) to  
8           read as follows:

9           “(D) QUALIFICATIONS FOR REVIEWERS.—  
10          The requirements of subsection (g) shall be met  
11          (relating to qualifications of reviewing profes-  
12          sionals).”; and

13          (B) by adding at the end the following new  
14          subsection:

15          “(g) QUALIFICATIONS OF REVIEWERS.—

16          “(1) IN GENERAL.—In reviewing determina-  
17          tions under this section, a qualified independent con-  
18          tractor shall assure that—

19                 “(A) each individual conducting a review  
20                 shall meet the qualifications of paragraph (2);

21                 “(B) compensation provided by the con-  
22                 tractor to each such reviewer is consistent with  
23                 paragraph (3); and

24                 “(C) in the case of a review by a panel de-  
25                 scribed in subsection (c)(3)(B) composed of

1 physicians or other health care professionals  
2 (each in this subsection referred to as a ‘review-  
3 ing professional’), each reviewing professional  
4 meets the qualifications described in paragraph  
5 (4) and, where a claim is regarding the fur-  
6 nishing of treatment by a physician (allopathic  
7 or osteopathic) or the provision of items or  
8 services by a physician (allopathic or osteo-  
9 pathic), each reviewing professional shall be a  
10 physician (allopathic or osteopathic).

11 “(2) INDEPENDENCE.—

12 “(A) IN GENERAL.—Subject to subpara-  
13 graph (B), each individual conducting a review  
14 in a case shall—

15 “(i) not be a related party (as defined  
16 in paragraph (5));

17 “(ii) not have a material familial, fi-  
18 nancial, or professional relationship with  
19 such a party in the case under review; and

20 “(iii) not otherwise have a conflict of  
21 interest with such a party.

22 “(B) EXCEPTION.—Nothing in subpara-  
23 graph (A) shall be construed to—

24 “(i) prohibit an individual, solely on  
25 the basis of a participation agreement with

1 a fiscal intermediary, carrier, or other con-  
2 tractor, from serving as a reviewing profes-  
3 sional if—

4 “(I) the individual is not involved  
5 in the provision of items or services in  
6 the case under review;

7 “(II) the fact of such an agree-  
8 ment is disclosed to the Secretary and  
9 the individual entitled to benefits  
10 under part A or enrolled under part  
11 B, or both, (or authorized representa-  
12 tive) and neither party objects; and

13 “(III) the individual is not an  
14 employee of the intermediary, carrier,  
15 or contractor and does not provide  
16 services exclusively or primarily to or  
17 on behalf of such intermediary, car-  
18 rier, or contractor;

19 “(ii) prohibit an individual who has  
20 staff privileges at the institution where the  
21 treatment involved takes place from serv-  
22 ing as a reviewer merely on the basis of  
23 having such staff privileges if the existence  
24 of such privileges is disclosed to the Sec-  
25 retary and such individual (or authorized

1 representative), and neither party objects;  
2 or

3 “(iii) prohibit receipt of compensation  
4 by a reviewing professional from a con-  
5 tractor if the compensation is provided  
6 consistent with paragraph (3).

7 For purposes of this paragraph, the term ‘par-  
8 ticipation agreement’ means an agreement re-  
9 lating to the provision of health care services by  
10 the individual and does not include the provi-  
11 sion of services as a reviewer under this sub-  
12 section.

13 “(3) LIMITATIONS ON REVIEWER COMPENSA-  
14 TION.—Compensation provided by a qualified inde-  
15 pendent contractor to a reviewer in connection with  
16 a review under this section shall not be contingent  
17 on the decision rendered by the reviewer.

18 “(4) LICENSURE AND EXPERTISE.—Each re-  
19 viewing professional shall be—

20 “(A) a physician (allopathic or osteopathic)  
21 who is appropriately credentialed or licensed in  
22 one or more States to deliver health care serv-  
23 ices and has medical expertise in the field of  
24 practice that is appropriate for the items or  
25 services at issue; or

1           “(B) a health care professional who is le-  
2 gally authorized in one or more States (in ac-  
3 cordance with State law or the State regulatory  
4 mechanism provided by State law) to furnish  
5 the health care items or services at issue and  
6 has medical expertise in the field of practice  
7 that is appropriate for such items or services.

8           “(5) RELATED PARTY DEFINED.—For purposes  
9 of this section, the term ‘related party’ means, with  
10 respect to a case under this title involving a specific  
11 individual entitled to benefits under part A or en-  
12 rolled under part B, or both, any of the following:

13           “(A) The Secretary, the medicare adminis-  
14 trative contractor involved, or any fiduciary, of-  
15 ficer, director, or employee of the Department  
16 of Health and Human Services, or of such con-  
17 tractor.

18           “(B) The individual (or authorized rep-  
19 resentative).

20           “(C) The health care professional that pro-  
21 vides the items or services involved in the case.

22           “(D) The institution at which the items or  
23 services (or treatment) involved in the case are  
24 provided.

1           “(E) The manufacturer of any drug or  
2           other item that is included in the items or serv-  
3           ices involved in the case.

4           “(F) Any other party determined under  
5           any regulations to have a substantial interest in  
6           the case involved.”.

7           (3) EFFECTIVE DATE.—The amendments made  
8           by paragraphs (1) and (2) shall be effective as if in-  
9           cluded in the enactment of the respective provisions  
10          of subtitle C of title V of BIPA, (114 Stat. 2763A–  
11          534).

12          (4) TRANSITION.—In applying section 1869(g)  
13          of the Social Security Act (as added by paragraph  
14          (2)), any reference to a medicare administrative con-  
15          tractor shall be deemed to include a reference to a  
16          fiscal intermediary under section 1816 of the Social  
17          Security Act (42 U.S.C. 1395h) and a carrier under  
18          section 1842 of such Act (42 U.S.C. 1395u).

19   **SEC. 834. PREPAYMENT REVIEW.**

20          (a) IN GENERAL.—Section 1874A, as added by sec-  
21          tion 811(a)(1) and as amended by sections 812(b),  
22          821(b)(1), and 821(c)(1), is further amended by adding  
23          at the end the following new subsection:

24          “(h) CONDUCT OF PREPAYMENT REVIEW.—

1           “(1) CONDUCT OF RANDOM PREPAYMENT RE-  
2           VIEW.—

3                   “(A) IN GENERAL.—A medicare adminis-  
4                   trative contractor may conduct random prepay-  
5                   ment review only to develop a contractor-wide  
6                   or program-wide claims payment error rates or  
7                   under such additional circumstances as may be  
8                   provided under regulations, developed in con-  
9                   sultation with providers of services and sup-  
10                  pliers.

11                   “(B) USE OF STANDARD PROTOCOLS  
12                   WHEN CONDUCTING PREPAYMENT REVIEWS.—  
13                   When a medicare administrative contractor con-  
14                   ducts a random prepayment review, the con-  
15                   tractor may conduct such review only in accord-  
16                   ance with a standard protocol for random pre-  
17                   payment audits developed by the Secretary.

18                   “(C) CONSTRUCTION.—Nothing in this  
19                   paragraph shall be construed as preventing the  
20                   denial of payments for claims actually reviewed  
21                   under a random prepayment review.

22                   “(D) RANDOM PREPAYMENT REVIEW.—  
23                   For purposes of this subsection, the term ‘ran-  
24                   dom prepayment review’ means a demand for

1 the production of records or documentation ab-  
2 sent cause with respect to a claim.

3 “(2) LIMITATIONS ON NON-RANDOM PREPAY-  
4 MENT REVIEW.—

5 “(A) LIMITATIONS ON INITIATION OF NON-  
6 RANDOM PREPAYMENT REVIEW.—A medicare  
7 administrative contractor may not initiate non-  
8 random prepayment review of a provider of  
9 services or supplier based on the initial identi-  
10 fication by that provider of services or supplier  
11 of an improper billing practice unless there is a  
12 likelihood of sustained or high level of payment  
13 error (as defined in subsection (i)(3)(A)).

14 “(B) TERMINATION OF NON-RANDOM PRE-  
15 PAYMENT REVIEW.—The Secretary shall issue  
16 regulations relating to the termination, includ-  
17 ing termination dates, of non-random prepay-  
18 ment review. Such regulations may vary such a  
19 termination date based upon the differences in  
20 the circumstances triggering prepayment re-  
21 view.”.

22 (b) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as provided in this  
24 subsection, the amendment made by subsection (a)

1 shall take effect 1 year after the date of the enact-  
2 ment of this Act.

3 (2) DEADLINE FOR PROMULGATION OF CER-  
4 TAIN REGULATIONS.—The Secretary shall first issue  
5 regulations under section 1874A(h) of the Social Se-  
6 curity Act, as added by subsection (a), by not later  
7 than 1 year after the date of the enactment of this  
8 Act.

9 (3) APPLICATION OF STANDARD PROTOCOLS  
10 FOR RANDOM PREPAYMENT REVIEW.—Section  
11 1874A(h)(1)(B) of the Social Security Act, as added  
12 by subsection (a), shall apply to random prepayment  
13 reviews conducted on or after such date (not later  
14 than 1 year after the date of the enactment of this  
15 Act) as the Secretary shall specify.

16 (c) APPLICATION TO FISCAL INTERMEDIARIES AND  
17 CARRIERS.—The provisions of section 1874A(h) of the So-  
18 cial Security Act, as added by subsection (a), shall apply  
19 to each fiscal intermediary under section 1816 of the So-  
20 cial Security Act (42 U.S.C. 1395h) and each carrier  
21 under section 1842 of such Act (42 U.S.C. 1395u) in the  
22 same manner as they apply to medicare administrative  
23 contractors under such provisions.

1 **SEC. 835. RECOVERY OF OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1893 (42 U.S.C.  
3 1395ddd) is amended by adding at the end the following  
4 new subsection:

5 “(f) RECOVERY OF OVERPAYMENTS.—

6 “(1) USE OF REPAYMENT PLANS.—

7 “(A) IN GENERAL.—If the repayment,  
8 within 30 days by a provider of services or sup-  
9 plier, of an overpayment under this title would  
10 constitute a hardship (as defined in subpara-  
11 graph (B)), subject to subparagraph (C), upon  
12 request of the provider of services or supplier  
13 the Secretary shall enter into a plan with the  
14 provider of services or supplier for the repay-  
15 ment (through offset or otherwise) of such over-  
16 payment over a period of at least 6 months but  
17 not longer than 3 years (or not longer than 5  
18 years in the case of extreme hardship, as deter-  
19 mined by the Secretary). Interest shall accrue  
20 on the balance through the period of repay-  
21 ment. Such plan shall meet terms and condi-  
22 tions determined to be appropriate by the Sec-  
23 retary.

24 “(B) HARDSHIP.—

25 “(i) IN GENERAL.—For purposes of  
26 subparagraph (A), the repayment of an

1 overpayment (or overpayments) within 30  
2 days is deemed to constitute a hardship  
3 if—

4 “(I) in the case of a provider of  
5 services that files cost reports, the ag-  
6 gregate amount of the overpayments  
7 exceeds 10 percent of the amount paid  
8 under this title to the provider of  
9 services for the cost reporting period  
10 covered by the most recently sub-  
11 mitted cost report; or

12 “(II) in the case of another pro-  
13 vider of services or supplier, the ag-  
14 gregate amount of the overpayments  
15 exceeds 10 percent of the amount paid  
16 under this title to the provider of  
17 services or supplier for the previous  
18 calendar year.

19 “(ii) RULE OF APPLICATION.—The  
20 Secretary shall establish rules for the ap-  
21 plication of this subparagraph in the case  
22 of a provider of services or supplier that  
23 was not paid under this title during the  
24 previous year or was paid under this title  
25 only during a portion of that year.

1                   “(iii) TREATMENT OF PREVIOUS  
2                   OVERPAYMENTS.—If a provider of services  
3                   or supplier has entered into a repayment  
4                   plan under subparagraph (A) with respect  
5                   to a specific overpayment amount, such  
6                   payment amount under the repayment plan  
7                   shall not be taken into account under  
8                   clause (i) with respect to subsequent over-  
9                   payment amounts.

10                   “(C) EXCEPTIONS.—Subparagraph (A)  
11                   shall not apply if—

12                   “(i) the Secretary has reason to sus-  
13                   pect that the provider of services or sup-  
14                   plier may file for bankruptcy or otherwise  
15                   cease to do business or discontinue partici-  
16                   pation in the program under this title; or

17                   “(ii) there is an indication of fraud or  
18                   abuse committed against the program.

19                   “(D) IMMEDIATE COLLECTION IF VIOLA-  
20                   TION OF REPAYMENT PLAN.—If a provider of  
21                   services or supplier fails to make a payment in  
22                   accordance with a repayment plan under this  
23                   paragraph, the Secretary may immediately seek  
24                   to offset or otherwise recover the total balance

1 outstanding (including applicable interest)  
2 under the repayment plan.

3 “(E) RELATION TO NO FAULT PROVI-  
4 SION.—Nothing in this paragraph shall be con-  
5 strued as affecting the application of section  
6 1870(c) (relating to no adjustment in the cases  
7 of certain overpayments).

8 “(2) LIMITATION ON RECOUPMENT.—

9 “(A) IN GENERAL.—In the case of a pro-  
10 vider of services or supplier that is determined  
11 to have received an overpayment under this title  
12 and that seeks a reconsideration by a qualified  
13 independent contractor on such determination  
14 under section 1869(b)(1), the Secretary may  
15 not take any action (or authorize any other per-  
16 son, including any medicare contractor, as de-  
17 fined in subparagraph (C)) to recoup the over-  
18 payment until the date the decision on the re-  
19 consideration has been rendered. If the provi-  
20 sions of section 1869(b)(1) (providing for such  
21 a reconsideration by a qualified independent  
22 contractor) are not in effect, in applying the  
23 previous sentence any reference to such a recon-  
24 sideration shall be treated as a reference to a

1 redetermination by the fiscal intermediary or  
2 carrier involved.

3 “(B) COLLECTION WITH INTEREST.—Inso-  
4 far as the determination on such appeal is  
5 against the provider of services or supplier, in-  
6 terest on the overpayment shall accrue on and  
7 after the date of the original notice of overpay-  
8 ment. Insofar as such determination against the  
9 provider of services or supplier is later reversed,  
10 the Secretary shall provide for repayment of the  
11 amount recouped plus interest at the same rate  
12 as would apply under the previous sentence for  
13 the period in which the amount was recouped.

14 “(C) MEDICARE CONTRACTOR DEFINED.—  
15 For purposes of this subsection, the term ‘medi-  
16 care contractor’ has the meaning given such  
17 term in section 1889(g).

18 “(3) LIMITATION ON USE OF EXTRAPO-  
19 LATION.—A medicare contractor may not use ex-  
20 trapolation to determine overpayment amounts to be  
21 recovered by recoupment, offset, or otherwise  
22 unless—

23 “(A) there is a sustained or high level of  
24 payment error (as defined by the Secretary by  
25 regulation); or

1           “(B) documented educational intervention  
2           has failed to correct the payment error (as de-  
3           termined by the Secretary).

4           “(4) PROVISION OF SUPPORTING DOCUMENTA-  
5           TION.—In the case of a provider of services or sup-  
6           plier with respect to which amounts were previously  
7           overpaid, a medicare contractor may request the  
8           periodic production of records or supporting docu-  
9           mentation for a limited sample of submitted claims  
10          to ensure that the previous practice is not con-  
11          tinuing.

12          “(5) CONSENT SETTLEMENT REFORMS.—

13                 “(A) IN GENERAL.—The Secretary may  
14                 use a consent settlement (as defined in sub-  
15                 paragraph (D)) to settle a projected overpay-  
16                 ment.

17                 “(B) OPPORTUNITY TO SUBMIT ADDI-  
18                 TIONAL INFORMATION BEFORE CONSENT SET-  
19                 TLEMENT OFFER.—Before offering a provider  
20                 of services or supplier a consent settlement, the  
21                 Secretary shall—

22                         “(i) communicate to the provider of  
23                         services or supplier—

24                                 “(I) that, based on a review of  
25                                 the medical records requested by the

1 Secretary, a preliminary evaluation of  
2 those records indicates that there  
3 would be an overpayment;

4 “(II) the nature of the problems  
5 identified in such evaluation; and

6 “(III) the steps that the provider  
7 of services or supplier should take to  
8 address the problems; and

9 “(ii) provide for a 45-day period dur-  
10 ing which the provider of services or sup-  
11 plier may furnish additional information  
12 concerning the medical records for the  
13 claims that had been reviewed.

14 “(C) CONSENT SETTLEMENT OFFER.—The  
15 Secretary shall review any additional informa-  
16 tion furnished by the provider of services or  
17 supplier under subparagraph (B)(ii). Taking  
18 into consideration such information, the Sec-  
19 retary shall determine if there still appears to  
20 be an overpayment. If so, the Secretary—

21 “(i) shall provide notice of such deter-  
22 mination to the provider of services or sup-  
23 plier, including an explanation of the rea-  
24 son for such determination; and

1                   “(ii) in order to resolve the overpay-  
2                   ment, may offer the provider of services or  
3                   supplier—

4                                 “(I) the opportunity for a statis-  
5                                 tically valid random sample; or

6                                 “(II) a consent settlement.

7                   The opportunity provided under clause (ii)(I)  
8                   does not waive any appeal rights with respect to  
9                   the alleged overpayment involved.

10                               “(D) CONSENT SETTLEMENT DEFINED.—

11                   For purposes of this paragraph, the term ‘con-  
12                   sent settlement’ means an agreement between  
13                   the Secretary and a provider of services or sup-  
14                   plier whereby both parties agree to settle a pro-  
15                   jected overpayment based on less than a statis-  
16                   tically valid sample of claims and the provider  
17                   of services or supplier agrees not to appeal the  
18                   claims involved.

19                               “(6) NOTICE OF OVER-UTILIZATION OF  
20                   CODES.—The Secretary shall establish, in consulta-  
21                   tion with organizations representing the classes of  
22                   providers of services and suppliers, a process under  
23                   which the Secretary provides for notice to classes of  
24                   providers of services and suppliers served by the con-  
25                   tractor in cases in which the contractor has identi-

1       fied that particular billing codes may be overutilized  
2       by that class of providers of services or suppliers  
3       under the programs under this title (or provisions of  
4       title XI insofar as they relate to such programs).

5               “(7) PAYMENT AUDITS.—

6                       “(A) WRITTEN NOTICE FOR POST-PAY-  
7                       MENT AUDITS.—Subject to subparagraph (C), if  
8                       a medicare contractor decides to conduct a  
9                       post-payment audit of a provider of services or  
10                      supplier under this title, the contractor shall  
11                      provide the provider of services or supplier with  
12                      written notice (which may be in electronic form)  
13                      of the intent to conduct such an audit.

14                     “(B) EXPLANATION OF FINDINGS FOR ALL  
15                     AUDITS.—Subject to subparagraph (C), if a  
16                     medicare contractor audits a provider of serv-  
17                     ices or supplier under this title, the contractor  
18                     shall—

19                               “(i) give the provider of services or  
20                               supplier a full review and explanation of  
21                               the findings of the audit in a manner that  
22                               is understandable to the provider of serv-  
23                               ices or supplier and permits the develop-  
24                               ment of an appropriate corrective action  
25                               plan;

1           “(ii) inform the provider of services or  
2           supplier of the appeal rights under this  
3           title as well as consent settlement options  
4           (which are at the discretion of the Sec-  
5           retary);

6           “(iii) give the provider of services or  
7           supplier an opportunity to provide addi-  
8           tional information to the contractor; and

9           “(iv) take into account information  
10          provided, on a timely basis, by the provider  
11          of services or supplier under clause (iii).

12          “(C) EXCEPTION.—Subparagraphs (A)  
13          and (B) shall not apply if the provision of no-  
14          tice or findings would compromise pending law  
15          enforcement activities, whether civil or criminal,  
16          or reveal findings of law enforcement-related  
17          audits.

18          “(8) STANDARD METHODOLOGY FOR PROBE  
19          SAMPLING.—The Secretary shall establish a stand-  
20          ard methodology for medicare contractors to use in  
21          selecting a sample of claims for review in the case  
22          of an abnormal billing pattern.”.

23          (b) EFFECTIVE DATES AND DEADLINES.—

24                  (1) USE OF REPAYMENT PLANS.—Section  
25          1893(f)(1) of the Social Security Act, as added by

1 subsection (a), shall apply to requests for repayment  
2 plans made after the date of the enactment of this  
3 Act.

4 (2) LIMITATION ON RECOUPMENT.—Section  
5 1893(f)(2) of the Social Security Act, as added by  
6 subsection (a), shall apply to actions taken after the  
7 date of the enactment of this Act.

8 (3) USE OF EXTRAPOLATION.—Section  
9 1893(f)(3) of the Social Security Act, as added by  
10 subsection (a), shall apply to statistically valid ran-  
11 dom samples initiated after the date that is 1 year  
12 after the date of the enactment of this Act.

13 (4) PROVISION OF SUPPORTING DOCUMENTA-  
14 TION.—Section 1893(f)(4) of the Social Security  
15 Act, as added by subsection (a), shall take effect on  
16 the date of the enactment of this Act.

17 (5) CONSENT SETTLEMENT.—Section  
18 1893(f)(5) of the Social Security Act, as added by  
19 subsection (a), shall apply to consent settlements en-  
20 tered into after the date of the enactment of this  
21 Act.

22 (6) NOTICE OF OVERUTILIZATION.—Not later  
23 than 1 year after the date of the enactment of this  
24 Act, the Secretary shall first establish the process  
25 for notice of overutilization of billing codes under

1 section 1893A(f)(6) of the Social Security Act, as  
2 added by subsection (a).

3 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of  
4 the Social Security Act, as added by subsection (a),  
5 shall apply to audits initiated after the date of the  
6 enactment of this Act.

7 (8) STANDARD FOR ABNORMAL BILLING PAT-  
8 TERNS.—Not later than 1 year after the date of the  
9 enactment of this Act, the Secretary shall first es-  
10 tablish a standard methodology for selection of sam-  
11 ple claims for abnormal billing patterns under sec-  
12 tion 1893(f)(8) of the Social Security Act, as added  
13 by subsection (a).

14 **SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF AP-**  
15 **PEAL.**

16 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)  
17 is amended—

18 (1) by adding at the end of the heading the fol-  
19 lowing: “; ENROLLMENT PROCESSES”; and

20 (2) by adding at the end the following new sub-  
21 section:

22 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF  
23 SERVICES AND SUPPLIERS.—

24 “(1) ENROLLMENT PROCESS.—

1           “(A) IN GENERAL.—The Secretary shall  
2           establish by regulation a process for the enroll-  
3           ment of providers of services and suppliers  
4           under this title.

5           “(B) DEADLINES.—The Secretary shall es-  
6           tablish by regulation procedures under which  
7           there are deadlines for actions on applications  
8           for enrollment (and, if applicable, renewal of  
9           enrollment). The Secretary shall monitor the  
10          performance of medicare administrative con-  
11          tractors in meeting the deadlines established  
12          under this subparagraph.

13          “(C) CONSULTATION BEFORE CHANGING  
14          PROVIDER ENROLLMENT FORMS.—The Sec-  
15          retary shall consult with providers of services  
16          and suppliers before making changes in the pro-  
17          vider enrollment forms required of such pro-  
18          viders and suppliers to be eligible to submit  
19          claims for which payment may be made under  
20          this title.

21          “(2) HEARING RIGHTS IN CASES OF DENIAL OR  
22          NON-RENEWAL.—A provider of services or supplier  
23          whose application to enroll (or, if applicable, to  
24          renew enrollment) under this title is denied may  
25          have a hearing and judicial review of such denial

1 under the procedures that apply under subsection  
2 (h)(1)(A) to a provider of services that is dissatisfied  
3 with a determination by the Secretary.”.

4 (b) EFFECTIVE DATES.—

5 (1) ENROLLMENT PROCESS.—The Secretary  
6 shall provide for the establishment of the enrollment  
7 process under section 1866(j)(1) of the Social Secu-  
8 rity Act, as added by subsection (a)(2), within 6  
9 months after the date of the enactment of this Act.

10 (2) CONSULTATION.—Section 1866(j)(1)(C) of  
11 the Social Security Act, as added by subsection  
12 (a)(2), shall apply with respect to changes in pro-  
13 vider enrollment forms made on or after January 1,  
14 2003.

15 (3) HEARING RIGHTS.—Section 1866(j)(2) of  
16 the Social Security Act, as added by subsection  
17 (a)(2), shall apply to denials occurring on or after  
18 such date (not later than 1 year after the date of  
19 the enactment of this Act) as the Secretary specifies.

20 **SEC. 837. PROCESS FOR CORRECTION OF MINOR ERRORS**  
21 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**  
22 **SUING APPEALS PROCESS.**

23 The Secretary shall develop, in consultation with ap-  
24 propriate medicare contractors (as defined in section  
25 1889(g) of the Social Security Act, as inserted by section

1 821(a)(1)) and representatives of providers of services and  
2 suppliers, a process whereby, in the case of minor errors  
3 or omissions (as defined by the Secretary) that are de-  
4 tected in the submission of claims under the programs  
5 under title XVIII of such Act, a provider of services or  
6 supplier is given an opportunity to correct such an error  
7 or omission without the need to initiate an appeal. Such  
8 process shall include the ability to resubmit corrected  
9 claims.

10 **SEC. 838. PRIOR DETERMINATION PROCESS FOR CERTAIN**  
11 **ITEMS AND SERVICES; ADVANCE BENE-**  
12 **FICIARY NOTICES.**

13 (a) IN GENERAL.—Section 1869 (42 U.S.C.  
14 1395ff(b)), as amended by sections 521 and 522 of BIPA  
15 and section 833(d)(2)(B), is further amended by adding  
16 at the end the following new subsection:

17 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN  
18 ITEMS AND SERVICES.—

19 “(1) ESTABLISHMENT OF PROCESS.—

20 “(A) IN GENERAL.—With respect to a  
21 medicare administrative contractor that has a  
22 contract under section 1874A that provides for  
23 making payments under this title with respect  
24 to eligible items and services described in sub-  
25 paragraph (C), the Secretary shall establish a

1 prior determination process that meets the re-  
2 quirements of this subsection and that shall be  
3 applied by such contractor in the case of eligible  
4 requesters.

5 “(B) ELIGIBLE REQUESTER.—For pur-  
6 poses of this subsection, each of the following  
7 shall be an eligible requester:

8 “(i) A physician, but only with respect  
9 to eligible items and services for which the  
10 physician may be paid directly.

11 “(ii) An individual entitled to benefits  
12 under this title, but only with respect to an  
13 item or service for which the individual re-  
14 ceives, from the physician who may be paid  
15 directly for the item or service, an advance  
16 beneficiary notice under section 1879(a)  
17 that payment may not be made (or may no  
18 longer be made) for the item or service  
19 under this title.

20 “(C) ELIGIBLE ITEMS AND SERVICES.—  
21 For purposes of this subsection and subject to  
22 paragraph (2), eligible items and services are  
23 items and services which are physicians’ serv-  
24 ices (as defined in paragraph (4)(A) of section

1           1848(f) for purposes of calculating the sustain-  
2           able growth rate under such section).

3           “(2) SECRETARIAL FLEXIBILITY.—The Sec-  
4           retary shall establish by regulation reasonable limits  
5           on the categories of eligible items and services for  
6           which a prior determination of coverage may be re-  
7           quested under this subsection. In establishing such  
8           limits, the Secretary may consider the dollar amount  
9           involved with respect to the item or service, adminis-  
10          trative costs and burdens, and other relevant factors.

11          “(3) REQUEST FOR PRIOR DETERMINATION.—

12                 “(A) IN GENERAL.—Subject to paragraph  
13                 (2), under the process established under this  
14                 subsection an eligible requester may submit to  
15                 the contractor a request for a determination,  
16                 before the furnishing of an eligible item or serv-  
17                 ice involved as to whether the item or service is  
18                 covered under this title consistent with the ap-  
19                 plicable requirements of section 1862(a)(1)(A)  
20                 (relating to medical necessity).

21                 “(B) ACCOMPANYING DOCUMENTATION.—  
22                 The Secretary may require that the request be  
23                 accompanied by a description of the item or  
24                 service, supporting documentation relating to  
25                 the medical necessity for the item or service,

1 and any other appropriate documentation. In  
2 the case of a request submitted by an eligible  
3 requester who is described in paragraph  
4 (1)(B)(ii), the Secretary may require that the  
5 request also be accompanied by a copy of the  
6 advance beneficiary notice involved.

7 “(4) RESPONSE TO REQUEST.—

8 “(A) IN GENERAL.—Under such process,  
9 the contractor shall provide the eligible re-  
10 quester with written notice of a determination  
11 as to whether—

12 “(i) the item or service is so covered;

13 “(ii) the item or service is not so cov-  
14 ered; or

15 “(iii) the contractor lacks sufficient  
16 information to make a coverage determina-  
17 tion.

18 If the contractor makes the determination de-  
19 scribed in clause (iii), the contractor shall in-  
20 clude in the notice a description of the addi-  
21 tional information required to make the cov-  
22 erage determination.

23 “(B) DEADLINE TO RESPOND.—Such no-  
24 tice shall be provided within the same time pe-  
25 riod as the time period applicable to the con-

1 tractor providing notice of initial determinations  
2 on a claim for benefits under subsection  
3 (a)(2)(A).

4 “(C) INFORMING BENEFICIARY IN CASE OF  
5 PHYSICIAN REQUEST.—In the case of a request  
6 in which an eligible requester is not the indi-  
7 vidual described in paragraph (1)(B)(ii), the  
8 process shall provide that the individual to  
9 whom the item or service is proposed to be fur-  
10 nished shall be informed of any determination  
11 described in clause (ii) (relating to a determina-  
12 tion of non-coverage) and the right (referred to  
13 in paragraph (6)(B)) to obtain the item or serv-  
14 ice and have a claim submitted for the item or  
15 service.

16 “(5) EFFECT OF DETERMINATIONS.—

17 “(A) BINDING NATURE OF POSITIVE DE-  
18 TERMINATION.—If the contractor makes the de-  
19 termination described in paragraph (4)(A)(i),  
20 such determination shall be binding on the con-  
21 tractor in the absence of fraud or evidence of  
22 misrepresentation of facts presented to the con-  
23 tractor.

24 “(B) NOTICE AND RIGHT TO REDETER-  
25 MINATION IN CASE OF A DENIAL.—

1           “(i) IN GENERAL.—If the contractor  
2 makes the determination described in para-  
3 graph (4)(A)(ii)—

4           “(I) the eligible requester has the  
5 right to a redetermination by the con-  
6 tractor on the determination that the  
7 item or service is not so covered; and

8           “(II) the contractor shall include  
9 in notice under paragraph (4)(A) a  
10 brief explanation of the basis for the  
11 determination, including on what na-  
12 tional or local coverage or noncov-  
13 erage determination (if any) the de-  
14 termination is based, and the right to  
15 such a redetermination.

16           “(ii) DEADLINE FOR REDETERMINA-  
17 TIONS.—The contractor shall complete and  
18 provide notice of such redetermination  
19 within the same time period as the time  
20 period applicable to the contractor pro-  
21 viding notice of redeterminations relating  
22 to a claim for benefits under subsection  
23 (a)(3)(C)(ii).

24           “(6) LIMITATION ON FURTHER REVIEW.—

1           “(A) IN GENERAL.—Contractor determina-  
2           tions described in paragraph (4)(A)(ii) or  
3           (4)(A)(iii) (and redeterminations made under  
4           paragraph (5)(B)), relating to pre-service  
5           claims are not subject to further administrative  
6           appeal or judicial review under this section or  
7           otherwise.

8           “(B) DECISION NOT TO SEEK PRIOR DE-  
9           TERMINATION OR NEGATIVE DETERMINATION  
10          DOES NOT IMPACT RIGHT TO OBTAIN SERVICES,  
11          SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—  
12          Nothing in this subsection shall be construed as  
13          affecting the right of an individual who—

14               “(i) decides not to seek a prior deter-  
15               mination under this subsection with re-  
16               spect to items or services; or

17               “(ii) seeks such a determination and  
18               has received a determination described in  
19               paragraph (4)(A)(ii),  
20               from receiving (and submitting a claim for)  
21               such items services and from obtaining adminis-  
22               trative or judicial review respecting such claim  
23               under the other applicable provisions of this  
24               section. Failure to seek a prior determination  
25               under this subsection with respect to items and

1 services shall not be taken into account in such  
2 administrative or judicial review.

3 “(C) NO PRIOR DETERMINATION AFTER  
4 RECEIPT OF SERVICES.—Once an individual is  
5 provided items and services, there shall be no  
6 prior determination under this subsection with  
7 respect to such items or services.”.

8 (b) EFFECTIVE DATE; TRANSITION.—

9 (1) EFFECTIVE DATE.—The Secretary shall es-  
10 tablish the prior determination process under the  
11 amendment made by subsection (a) in such a man-  
12 ner as to provide for the acceptance of requests for  
13 determinations under such process filed not later  
14 than 18 months after the date of the enactment of  
15 this Act.

16 (2) TRANSITION.—During the period in which  
17 the amendment made by subsection (a) has become  
18 effective but contracts are not provided under sec-  
19 tion 1874A of the Social Security Act with medicare  
20 administrative contractors, any reference in section  
21 1869(g) of such Act (as added by such amendment)  
22 to such a contractor is deemed a reference to a fiscal  
23 intermediary or carrier with an agreement under  
24 section 1816, or contract under section 1842, re-  
25 spectively, of such Act.

1           (3) LIMITATION ON APPLICATION TO SGR.—For  
2 purposes of applying section 1848(f)(2)(D) of the  
3 Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)),  
4 the amendment made by subsection (a) shall not be  
5 considered to be a change in law or regulation.

6           (c) PROVISIONS RELATING TO ADVANCE BENE-  
7 FICIARY NOTICES; REPORT ON PRIOR DETERMINATION  
8 PROCESS.—

9           (1) DATA COLLECTION.—The Secretary shall  
10 establish a process for the collection of information  
11 on the instances in which an advance beneficiary no-  
12 tice (as defined in paragraph (4)) has been provided  
13 and on instances in which a beneficiary indicates on  
14 such a notice that the beneficiary does not intend to  
15 seek to have the item or service that is the subject  
16 of the notice furnished.

17           (2) OUTREACH AND EDUCATION.—The Sec-  
18 retary shall establish a program of outreach and  
19 education for beneficiaries and providers of services  
20 and other persons on the appropriate use of advance  
21 beneficiary notices and coverage policies under the  
22 medicare program.

23           (3) GAO REPORT REPORT ON USE OF ADVANCE  
24 BENEFCIARY NOTICES.—Not later than 18 months  
25 after the date on which section 1869(g) of the Social

1 Security Act (as added by subsection (a)) takes ef-  
2 fect, the Comptroller General of the United States  
3 shall submit to Congress a report on the use of ad-  
4 vance beneficiary notices under title XVIII of such  
5 Act. Such report shall include information con-  
6 cerning the providers of services and other persons  
7 that have provided such notices and the response of  
8 beneficiaries to such notices.

9 (4) GAO REPORT ON USE OF PRIOR DETER-  
10 MINATION PROCESS.—Not later than 18 months  
11 after the date on which section 1869(g) of the Social  
12 Security Act (as added by subsection (a)) takes ef-  
13 fect, the Comptroller General of the United States  
14 shall submit to Congress a report on the use of the  
15 prior determination process under such section. Such  
16 report shall include—

17 (A) information concerning the types of  
18 procedures for which a prior determination has  
19 been sought, determinations made under the  
20 process, and changes in receipt of services re-  
21 sulting from the application of such process;  
22 and

23 (B) an evaluation of whether the process  
24 was useful for physicians (and other suppliers)  
25 and beneficiaries, whether it was timely, and

1           whether the amount of information required  
2           was burdensome to physicians and beneficiaries.

3           (5) ADVANCE BENEFICIARY NOTICE DE-  
4           FINED.—In this subsection, the term “advance bene-  
5           ficiary notice” means a written notice provided  
6           under section 1879(a) of the Social Security Act (42  
7           U.S.C. 1395pp(a)) to an individual entitled to bene-  
8           fits under part A or B of title XVIII of such Act  
9           before items or services are furnished under such  
10          part in cases where a provider of services or other  
11          person that would furnish the item or service be-  
12          lieves that payment will not be made for some or all  
13          of such items or services under such title.

14                           **Subtitle E—Miscellaneous**  
15                           **Provisions**

16   **SEC. 841. POLICY DEVELOPMENT REGARDING EVALUATION**  
17                           **AND MANAGEMENT (E & M) DOCUMENTATION**  
18                           **GUIDELINES.**

19          (a) IN GENERAL.—The Secretary may not implement  
20          any new documentation guidelines for evaluation and man-  
21          agement physician services under the title XVIII of the  
22          Social Security Act on or after the date of the enactment  
23          of this Act unless the Secretary—

24                  (1) has developed the guidelines in collaboration  
25          with practicing physicians (including both generalists

1 and specialists) and provided for an assessment of  
2 the proposed guidelines by the physician community;

3 (2) has established a plan that contains specific  
4 goals, including a schedule, for improving the use of  
5 such guidelines;

6 (3) has conducted appropriate and representa-  
7 tive pilot projects under subsection (b) to test modi-  
8 fications to the evaluation and management docu-  
9 mentation guidelines;

10 (4) finds that the objectives described in sub-  
11 section (c) will be met in the implementation of such  
12 guidelines; and

13 (5) has established, and is implementing, a pro-  
14 gram to educate physicians on the use of such guide-  
15 lines and that includes appropriate outreach.

16 The Secretary shall make changes to the manner in which  
17 existing evaluation and management documentation guide-  
18 lines are implemented to reduce paperwork burdens on  
19 physicians.

20 (b) PILOT PROJECTS TO TEST EVALUATION AND  
21 MANAGEMENT DOCUMENTATION GUIDELINES.—

22 (1) IN GENERAL.—The Secretary shall conduct  
23 under this subsection appropriate and representative  
24 pilot projects to test new evaluation and manage-

1       ment documentation guidelines referred to in sub-  
2       section (a).

3           (2) LENGTH AND CONSULTATION.—Each pilot  
4       project under this subsection shall—

5           (A) be voluntary;

6           (B) be of sufficient length as determined  
7       by the Secretary to allow for preparatory physi-  
8       cian and medicare contractor education, anal-  
9       ysis, and use and assessment of potential eval-  
10      uation and management guidelines; and

11          (C) be conducted, in development and  
12      throughout the planning and operational stages  
13      of the project, in consultation with practicing  
14      physicians (including both generalists and spe-  
15      cialists).

16          (3) RANGE OF PILOT PROJECTS.—Of the pilot  
17      projects conducted under this subsection—

18          (A) at least one shall focus on a peer re-  
19      view method by physicians (not employed by a  
20      medicare contractor) which evaluates medical  
21      record information for claims submitted by phy-  
22      sicians identified as statistical outliers relative  
23      to definitions published in the Current Proce-  
24      dures Terminology (CPT) code book of the  
25      American Medical Association;

1 (B) at least one shall focus on an alter-  
2 native method to detailed guidelines based on  
3 physician documentation of face to face encoun-  
4 ter time with a patient;

5 (C) at least one shall be conducted for  
6 services furnished in a rural area and at least  
7 one for services furnished outside such an area;  
8 and

9 (D) at least one shall be conducted in a  
10 setting where physicians bill under physicians'  
11 services in teaching settings and at least one  
12 shall be conducted in a setting other than a  
13 teaching setting.

14 (4) BANNING OF TARGETING OF PILOT  
15 PROJECT PARTICIPANTS.—Data collected under this  
16 subsection shall not be used as the basis for overpay-  
17 ment demands or post-payment audits. Such limita-  
18 tion applies only to claims filed as part of the pilot  
19 project and lasts only for the duration of the pilot  
20 project and only as long as the provider is a partici-  
21 pant in the pilot project.

22 (5) STUDY OF IMPACT.—Each pilot project  
23 shall examine the effect of the new evaluation and  
24 management documentation guidelines on—

1 (A) different types of physician practices,  
2 including those with fewer than 10 full-time-  
3 equivalent employees (including physicians);  
4 and

5 (B) the costs of physician compliance, in-  
6 cluding education, implementation, auditing,  
7 and monitoring.

8 (6) PERIODIC REPORTS.—The Secretary shall  
9 submit to Congress periodic reports on the pilot  
10 projects under this subsection.

11 (c) OBJECTIVES FOR EVALUATION AND MANAGE-  
12 MENT GUIDELINES.—The objectives for modified evalua-  
13 tion and management documentation guidelines developed  
14 by the Secretary shall be to—

15 (1) identify clinically relevant documentation  
16 needed to code accurately and assess coding levels  
17 accurately;

18 (2) decrease the level of non-clinically pertinent  
19 and burdensome documentation time and content in  
20 the physician's medical record;

21 (3) increase accuracy by reviewers; and

22 (4) educate both physicians and reviewers.

23 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF  
24 DOCUMENTATION FOR PHYSICIAN CLAIMS.—

1           (1) STUDY.—The Secretary shall carry out a  
2 study of the matters described in paragraph (2).

3           (2) MATTERS DESCRIBED.—The matters re-  
4 ferred to in paragraph (1) are—

5                 (A) the development of a simpler, alter-  
6 native system of requirements for documenta-  
7 tion accompanying claims for evaluation and  
8 management physician services for which pay-  
9 ment is made under title XVIII of the Social  
10 Security Act; and

11                 (B) consideration of systems other than  
12 current coding and documentation requirements  
13 for payment for such physician services.

14           (3) CONSULTATION WITH PRACTICING PHYSI-  
15 CIANS.—In designing and carrying out the study  
16 under paragraph (1), the Secretary shall consult  
17 with practicing physicians, including physicians who  
18 are part of group practices and including both gen-  
19 eralists and specialists.

20           (4) APPLICATION OF HIPAA UNIFORM CODING  
21 REQUIREMENTS.—In developing an alternative sys-  
22 tem under paragraph (2), the Secretary shall con-  
23 sider requirements of administrative simplification  
24 under part C of title XI of the Social Security Act.

1           (5) REPORT TO CONGRESS.—(A) Not later than  
2           October 1, 2004, the Secretary shall submit to Con-  
3           gress a report on the results of the study conducted  
4           under paragraph (1).

5           (B) The Medicare Payment Advisory Commis-  
6           sion shall conduct an analysis of the results of the  
7           study included in the report under subparagraph (A)  
8           and shall submit a report on such analysis to Con-  
9           gress.

10          (e) STUDY ON APPROPRIATE CODING OF CERTAIN  
11          EXTENDED OFFICE VISITS.—The Secretary shall conduct  
12          a study of the appropriateness of coding in cases of ex-  
13          tended office visits in which there is no diagnosis made.  
14          Not later than October 1, 2004, the Secretary shall submit  
15          a report to Congress on such study and shall include rec-  
16          ommendations on how to code appropriately for such visits  
17          in a manner that takes into account the amount of time  
18          the physician spent with the patient.

19          (f) DEFINITIONS.—In this section—

20                 (1) the term “rural area” has the meaning  
21                 given that term in section 1886(d)(2)(D) of the So-  
22                 cial Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

23                 (2) the term “teaching settings” are those set-  
24                 tings described in section 415.150 of title 42, Code  
25                 of Federal Regulations.

1 **SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**  
2 **AND COVERAGE.**

3 (a) IMPROVED COORDINATION BETWEEN FDA AND  
4 CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DE-  
5 VICES.—

6 (1) IN GENERAL.—Upon request by an appli-  
7 cant and to the extent feasible (as determined by the  
8 Secretary), the Secretary shall, in the case of a class  
9 III medical device that is subject to premarket ap-  
10 proval under section 515 of the Federal Food, Drug,  
11 and Cosmetic Act, ensure the sharing of appropriate  
12 information from the review for application for pre-  
13 market approval conducted by the Food and Drug  
14 Administration for coverage decisions under title  
15 XVIII of the Social Security Act.

16 (2) PUBLICATION OF PLAN.—Not later than 6  
17 months after the date of the enactment of this Act,  
18 the Secretary shall submit to appropriate Commit-  
19 tees of Congress a report that contains the plan for  
20 improving such coordination and for shortening the  
21 time lag between the premarket approval by the  
22 Food and Drug Administration and coding and cov-  
23 erage decisions by the Centers for Medicare & Med-  
24 icaid Services.

25 (3) CONSTRUCTION.—Nothing in this sub-  
26 section shall be construed as changing the criteria

1 for coverage of a medical device under title XVIII of  
2 the Social Security Act nor premarket approval by  
3 the Food and Drug Administration and nothing in  
4 this subsection shall be construed to increase pre-  
5 market approval application requirements under the  
6 Federal Food, Drug, and Cosmetic Act.

7 (b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—  
8 Section 1868 (42 U.S.C. 1395ee), as amended by section  
9 823(a), is amended by adding at the end the following new  
10 subsection:

11 “(c) COUNCIL FOR TECHNOLOGY AND INNOVA-  
12 TION.—

13 “(1) ESTABLISHMENT.—The Secretary shall es-  
14 tablish a Council for Technology and Innovation  
15 within the Centers for Medicare & Medicaid Services  
16 (in this section referred to as ‘CMS’).

17 “(2) COMPOSITION.—The Council shall be com-  
18 posed of senior CMS staff and clinicians and shall  
19 be chaired by the Executive Coordinator for Tech-  
20 nology and Innovation (appointed or designated  
21 under paragraph (4)).

22 “(3) DUTIES.—The Council shall coordinate the  
23 activities of coverage, coding, and payment processes  
24 under this title with respect to new technologies and  
25 procedures, including new drug therapies, and shall

1 coordinate the exchange of information on new tech-  
2 nologies between CMS and other entities that make  
3 similar decisions.

4 “(4) EXECUTIVE COORDINATOR FOR TECH-  
5 NOLOGY AND INNOVATION.—The Secretary shall ap-  
6 point (or designate) a noncareer appointee (as de-  
7 fined in section 3132(a)(7) of title 5, United States  
8 Code) who shall serve as the Executive Coordinator  
9 for Technology and Innovation. Such executive coor-  
10 dinator shall report to the Administrator of CMS,  
11 shall chair the Council, shall oversee the execution of  
12 its duties, and shall serve as a single point of con-  
13 tact for outside groups and entities regarding the  
14 coverage, coding, and payment processes under this  
15 title.”.

16 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL  
17 DATA COLLECTION FOR USE IN THE MEDICARE INPA-  
18 TIENT PAYMENT SYSTEM.—

19 (1) STUDY.—The Comptroller General of the  
20 United States shall conduct a study that analyzes  
21 which external data can be collected in a shorter  
22 time frame by the Centers for Medicare & Medicaid  
23 Services for use in computing payments for inpatient  
24 hospital services. The study may include an evalua-  
25 tion of the feasibility and appropriateness of using

1 of quarterly samples or special surveys or any other  
2 methods. The study shall include an analysis of  
3 whether other executive agencies, such as the Bu-  
4 reau of Labor Statistics in the Department of Com-  
5 merce, are best suited to collect this information.

6 (2) REPORT.—By not later than October 1,  
7 2003, the Comptroller General shall submit a report  
8 to Congress on the study under paragraph (1).

9 (d) IOM STUDY ON LOCAL COVERAGE DETERMINA-  
10 TIONS.—

11 (1) STUDY.—The Secretary shall enter into an  
12 arrangement with the Institute of Medicine of the  
13 National Academy of Sciences under which the Insti-  
14 tute shall conduct a study on local coverage deter-  
15 minations (including the application of local medical  
16 review policies) under the medicare program under  
17 title XVIII of the Social Security Act. Such study  
18 shall examine—

19 (A) the consistency of the definitions used  
20 in such determinations;

21 (B) the types of evidence on which such  
22 determinations are based, including medical and  
23 scientific evidence;

24 (C) the advantages and disadvantages of  
25 local coverage decisionmaking, including the

1 flexibility it offers for ensuring timely patient  
2 access to new medical technology for which data  
3 are still be collected;

4 (D) the manner in which the local coverage  
5 determination process is used to develop data  
6 needed for a national coverage determination,  
7 including the need for collection of such data  
8 within a protocol and informed consent by indi-  
9 viduals entitled to benefits under part A of title  
10 XVIII of the Social Security Act, or enrolled  
11 under part B of such title, or both; and

12 (E) the advantages and disadvantages of  
13 maintaining local medicare contractor advisory  
14 committees that can advise on local coverage  
15 decisions based on an open, collaborative public  
16 process.

17 (2) REPORT.—Such arrangement shall provide  
18 that the Institute shall submit to the Secretary a re-  
19 port on such study by not later than 3 years after  
20 the date of the enactment of this Act. The Secretary  
21 shall promptly transmit a copy of such report to  
22 Congress.

23 (e) METHODS FOR DETERMINING PAYMENT BASIS  
24 FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C.  
25 1395l(h)) is amended by adding at the end the following:

1       “(8)(A) The Secretary shall establish by regulation  
2 procedures for determining the basis for, and amount of,  
3 payment under this subsection for any clinical diagnostic  
4 laboratory test with respect to which a new or substan-  
5 tially revised HCPCS code is assigned on or after January  
6 1, 2004 (in this paragraph referred to as ‘new tests’).

7       “(B) Determinations under subparagraph (A) shall  
8 be made only after the Secretary—

9           “(i) makes available to the public (through an  
10 Internet site and other appropriate mechanisms) a  
11 list that includes any such test for which establish-  
12 ment of a payment amount under this subsection is  
13 being considered for a year;

14           “(ii) on the same day such list is made avail-  
15 able, causes to have published in the Federal Reg-  
16 ister notice of a meeting to receive comments and  
17 recommendations (and data on which recommenda-  
18 tions are based) from the public on the appropriate  
19 basis under this subsection for establishing payment  
20 amounts for the tests on such list;

21           “(iii) not less than 30 days after publication of  
22 such notice convenes a meeting, that includes rep-  
23 resentatives of officials of the Centers for Medicare  
24 & Medicaid Services involved in determining pay-  
25 ment amounts, to receive such comments and rec-

1       ommendations (and data on which the recommenda-  
2       tions are based);

3           “(iv) taking into account the comments and rec-  
4       ommendations (and accompanying data) received at  
5       such meeting, develops and makes available to the  
6       public (through an Internet site and other appro-  
7       priate mechanisms) a list of proposed determinations  
8       with respect to the appropriate basis for establishing  
9       a payment amount under this subsection for each  
10      such code, together with an explanation of the rea-  
11      sons for each such determination, the data on which  
12      the determinations are based, and a request for pub-  
13      lic written comments on the proposed determination;  
14      and

15           “(v) taking into account the comments received  
16      during the public comment period, develops and  
17      makes available to the public (through an Internet  
18      site and other appropriate mechanisms) a list of  
19      final determinations of the payment amounts for  
20      such tests under this subsection, together with the  
21      rationale for each such determination, the data on  
22      which the determinations are based, and responses  
23      to comments and suggestions received from the pub-  
24      lic.

1 “(C) Under the procedures established pursuant to  
2 subparagraph (A), the Secretary shall—

3 “(i) set forth the criteria for making determina-  
4 tions under subparagraph (A); and

5 “(ii) make available to the public the data  
6 (other than proprietary data) considered in making  
7 such determinations.

8 “(D) The Secretary may convene such further public  
9 meetings to receive public comments on payment amounts  
10 for new tests under this subsection as the Secretary deems  
11 appropriate.

12 “(E) For purposes of this paragraph:

13 “(i) The term ‘HCPCS’ refers to the Health  
14 Care Procedure Coding System.

15 “(ii) A code shall be considered to be ‘substan-  
16 tially revised’ if there is a substantive change to the  
17 definition of the test or procedure to which the code  
18 applies (such as a new analyte or a new methodology  
19 for measuring an existing analyte-specific test).”.

20 **SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**  
21 **ICES UNDER MEDICARE SECONDARY PAYOR**  
22 **(MSP) PROVISIONS.**

23 (a) **IN GENERAL.**—The Secretary shall not require  
24 a hospital (including a critical access hospital) to ask ques-  
25 tions (or obtain information) relating to the application

1 of section 1862(b) of the Social Security Act (relating to  
2 medicare secondary payor provisions) in the case of ref-  
3 erence laboratory services described in subsection (b), if  
4 the Secretary does not impose such requirement in the  
5 case of such services furnished by an independent labora-  
6 tory.

7 (b) REFERENCE LABORATORY SERVICES DE-  
8 SCRIBED.—Reference laboratory services described in this  
9 subsection are clinical laboratory diagnostic tests (or the  
10 interpretation of such tests, or both) furnished without a  
11 face-to-face encounter between the individual entitled to  
12 benefits under part A or enrolled under part B, or both,  
13 and the hospital involved and in which the hospital sub-  
14 mits a claim only for such test or interpretation.

15 **SEC. 844. EMTALA IMPROVEMENTS.**

16 (a) PAYMENT FOR EMTALA-MANDATED SCREEN-  
17 ING AND STABILIZATION SERVICES.—

18 (1) IN GENERAL.—Section 1862 (42 U.S.C.  
19 1395y) is amended by inserting after subsection (c)  
20 the following new subsection:

21 “(d) For purposes of subsection (a)(1)(A), in the case  
22 of any item or service that is required to be provided pur-  
23 suant to section 1867 to an individual who is entitled to  
24 benefits under this title, determinations as to whether the  
25 item or service is reasonable and necessary shall be made

1 on the basis of the information available to the treating  
2 physician or practitioner (including the patient's pre-  
3 senting symptoms or complaint) at the time the item or  
4 service was ordered or furnished by the physician or prac-  
5 titioner (and not on the patient's principal diagnosis).  
6 When making such determinations with respect to such  
7 an item or service, the Secretary shall not consider the  
8 frequency with which the item or service was provided to  
9 the patient before or after the time of the admission or  
10 visit.”.

11           (2) EFFECTIVE DATE.—The amendment made  
12       by paragraph (1) shall apply to items and services  
13       furnished on or after January 1, 2003.

14       (b) NOTIFICATION OF PROVIDERS WHEN EMTALA  
15 INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42  
16 U.S.C. 1395dd(d)) is amended by adding at the end the  
17 following new paragraph:

18           “(4) NOTICE UPON CLOSING AN INVESTIGA-  
19       TION.—The Secretary shall establish a procedure to  
20       notify hospitals and physicians when an investigation  
21       under this section is closed.”.

22       (c) PRIOR REVIEW BY PEER REVIEW ORGANIZA-  
23 TIONS IN EMTALA CASES INVOLVING TERMINATION OF  
24 PARTICIPATION.—

1           (1) IN GENERAL.—Section 1867(d)(3) (42  
2 U.S.C. 1395dd(d)(3)) is amended—

3           (A) in the first sentence, by inserting “or  
4 in terminating a hospital’s participation under  
5 this title” after “in imposing sanctions under  
6 paragraph (1)”; and

7           (B) by adding at the end the following new  
8 sentences: “Except in the case in which a delay  
9 would jeopardize the health or safety of individ-  
10 uals, the Secretary shall also request such a re-  
11 view before making a compliance determination  
12 as part of the process of terminating a hos-  
13 pital’s participation under this title for viola-  
14 tions related to the appropriateness of a med-  
15 ical screening examination, stabilizing treat-  
16 ment, or an appropriate transfer as required by  
17 this section, and shall provide a period of 5  
18 days for such review. The Secretary shall pro-  
19 vide a copy of the organization’s report to the  
20 hospital or physician consistent with confiden-  
21 tiality requirements imposed on the organiza-  
22 tion under such part B.”.

23           (2) EFFECTIVE DATE.—The amendments made  
24 by paragraph (1) shall apply to terminations of par-

1 participation initiated on or after the date of the enact-  
2 ment of this Act.

3 **SEC. 845. EMERGENCY MEDICAL TREATMENT AND LABOR**  
4 **ACT (EMTALA) TECHNICAL ADVISORY GROUP.**

5 (a) ESTABLISHMENT.—The Secretary shall establish  
6 a Technical Advisory Group (in this section referred to  
7 as the “Advisory Group”) to review issues related to the  
8 Emergency Medical Treatment and Labor Act  
9 (EMTALA) and its implementation. In this section, the  
10 term “EMTALA” refers to the provisions of section 1867  
11 of the Social Security Act (42 U.S.C. 1395dd).

12 (b) MEMBERSHIP.—The Advisory Group shall be  
13 composed of 19 members, including the Administrator of  
14 the Centers for Medicare & Medicaid Services and the In-  
15 spector General of the Department of Health and Human  
16 Services and of which—

17 (1) 4 shall be representatives of hospitals, in-  
18 cluding at least one public hospital, that have experi-  
19 ence with the application of EMTALA and at least  
20 2 of which have not been cited for EMTALA viola-  
21 tions;

22 (2) 7 shall be practicing physicians drawn from  
23 the fields of emergency medicine, cardiology or  
24 cardiothoracic surgery, orthopedic surgery, neuro-  
25 surgery, obstetrics-gynecology, and psychiatry, with

1 not more than one physician from any particular  
2 field;

3 (3) 2 shall represent patients;

4 (4) 2 shall be staff involved in EMTALA inves-  
5 tigations from different regional offices of the Cen-  
6 ters for Medicare & Medicaid Services; and

7 (5) 1 shall be from a State survey office in-  
8 volved in EMTALA investigations and 1 shall be  
9 from a peer review organization, both of whom shall  
10 be from areas other than the regions represented  
11 under paragraph (4).

12 In selecting members described in paragraphs (1) through  
13 (3), the Secretary shall consider qualified individuals nom-  
14 inated by organizations representing providers and pa-  
15 tients.

16 (c) GENERAL RESPONSIBILITIES.—The Advisory  
17 Group—

18 (1) shall review EMTALA regulations;

19 (2) may provide advice and recommendations to  
20 the Secretary with respect to those regulations and  
21 their application to hospitals and physicians;

22 (3) shall solicit comments and recommendations  
23 from hospitals, physicians, and the public regarding  
24 the implementation of such regulations; and

1           (4) may disseminate information on the applica-  
2           tion of such regulations to hospitals, physicians, and  
3           the public.

4           (d) ADMINISTRATIVE MATTERS.—

5           (1) CHAIRPERSON.—The members of the Advi-  
6           sory Group shall elect a member to serve as chair-  
7           person of the Advisory Group for the life of the Ad-  
8           visory Group.

9           (2) MEETINGS.—The Advisory Group shall first  
10          meet at the direction of the Secretary. The Advisory  
11          Group shall then meet twice per year and at such  
12          other times as the Advisory Group may provide.

13          (e) TERMINATION.—The Advisory Group shall termi-  
14          nate 30 months after the date of its first meeting.

15          (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The  
16          Secretary shall establish the Advisory Group notwith-  
17          standing any limitation that may apply to the number of  
18          advisory committees that may be established (within the  
19          Department of Health and Human Services or otherwise).

1 **SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH**  
2 **OTHER HOSPICE PROGRAMS TO PROVIDE**  
3 **CORE HOSPICE SERVICES IN CERTAIN CIR-**  
4 **CUMSTANCES.**

5 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.  
6 1395x(dd)(5)) is amended by adding at the end the fol-  
7 lowing new subparagraph:

8 “(D) In extraordinary, exigent, or other non-routine  
9 circumstances, such as unanticipated periods of high pa-  
10 tient loads, staffing shortages due to illness or other  
11 events, or temporary travel of a patient outside a hospice  
12 program’s service area, a hospice program may enter into  
13 arrangements with another hospice program for the provi-  
14 sion by that other program of services described in para-  
15 graph (2)(A)(ii)(I). The provisions of paragraph  
16 (2)(A)(ii)(II) shall apply with respect to the services pro-  
17 vided under such arrangements.”.

18 (b) CONFORMING PAYMENT PROVISION.—Section  
19 1814(i) (42 U.S.C. 1395f(i)), as amended by section  
20 421(b), is amended by adding at the end the following new  
21 paragraph:

22 “(5) In the case of hospice care provided by a hospice  
23 program under arrangements under section  
24 1861(dd)(5)(D) made by another hospice program, the  
25 hospice program that made the arrangements shall bill  
26 and be paid for the hospice care.”.

1           (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to hospice care provided on or after  
3 the date of the enactment of this Act.

4 **SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHO-**  
5 **GENS STANDARD TO CERTAIN HOSPITALS.**

6           (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc)  
7 is amended—

8                   (1) in subsection (a)(1)—

9                           (A) in subparagraph (R), by striking  
10 “and” at the end;

11                           (B) in subparagraph (S), by striking the  
12 period at the end and inserting “, and”; and

13                           (C) by inserting after subparagraph (S)  
14 the following new subparagraph:

15                           “(T) in the case of hospitals that are not other-  
16 wise subject to the Occupational Safety and Health  
17 Act of 1970, to comply with the Bloodborne Patho-  
18 gens standard under section 1910.1030 of title 29 of  
19 the Code of Federal Regulations (or as subsequently  
20 redesignated).”; and

21                   (2) by adding at the end of subsection (b) the  
22 following new paragraph:

23                   “(4)(A) A hospital that fails to comply with the re-  
24 quirement of subsection (a)(1)(T) (relating to the  
25 Bloodborne Pathogens standard) is subject to a civil

1 money penalty in an amount described in subparagraph  
2 (B), but is not subject to termination of an agreement  
3 under this section.

4 “(B) The amount referred to in subparagraph (A) is  
5 an amount that is similar to the amount of civil penalties  
6 that may be imposed under section 17 of the Occupational  
7 Safety and Health Act of 1970 for a violation of the  
8 Bloodborne Pathogens standard referred to in subsection  
9 (a)(1)(T) by a hospital that is subject to the provisions  
10 of such Act.

11 “(C) A civil money penalty under this paragraph shall  
12 be imposed and collected in the same manner as civil  
13 money penalties under subsection (a) of section 1128A are  
14 imposed and collected under that section.”.

15 (b) EFFECTIVE DATE.—The amendments made by  
16 this subsection (a) shall apply to hospitals as of July 1,  
17 2003.

18 **SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND**  
19 **CORRECTIONS.**

20 (a) TECHNICAL AMENDMENTS RELATING TO ADVI-  
21 SORY COMMITTEE UNDER BIPA SECTION 522.—(1) Sub-  
22 section (i) of section 1114 (42 U.S.C. 1314)—

23 (A) is transferred to section 1862 and added at  
24 the end of such section; and

25 (B) is redesignated as subsection (j).

1 (2) Section 1862 (42 U.S.C. 1395y) is amended—

2 (A) in the last sentence of subsection (a), by  
3 striking “established under section 1114(f)”; and

4 (B) in subsection (j), as so transferred and  
5 redesignated—

6 (i) by striking “under subsection (f)”; and

7 (ii) by striking “section 1862(a)(1)” and  
8 inserting “subsection (a)(1)”.

9 (b) TERMINOLOGY CORRECTIONS.—(1) Section  
10 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as  
11 amended by section 521 of BIPA, is amended—

12 (A) in subclause (III), by striking “policy” and  
13 inserting “determination”; and

14 (B) in subclause (IV), by striking “medical re-  
15 view policies” and inserting “coverage determina-  
16 tions”.

17 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-  
18 22(a)(2)(C)) is amended by striking “policy” and “POL-  
19 ICY” and inserting “determination” each place it appears  
20 and “DETERMINATION”, respectively.

21 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4)  
22 (42 U.S.C. 1395ff(f)(4)), as added by section 522 of  
23 BIPA, is amended—



1 shall be not less than five years, except that, upon the  
2 request of the administrator of a Federal health care pro-  
3 gram (as defined in section 1128B(f)) who determines  
4 that the exclusion would impose a hardship on individuals  
5 entitled to benefits under part A of title XVIII or enrolled  
6 under part B of such title, or both, the Secretary may  
7 waive the exclusion under subsection (a)(1), (a)(3), or  
8 (a)(4) with respect to that program in the case of an indi-  
9 vidual or entity that is the sole community physician or  
10 sole source of essential specialized services in a commu-  
11 nity.”.

12 **SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.**

13 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y)  
14 is amended by adding after subsection (g) the following  
15 new subsection:

16 “(h)(1) Subject to paragraph (2), a group health plan  
17 (as defined in subsection (a)(1)(A)(v)) providing supple-  
18 mental or secondary coverage to individuals also entitled  
19 to services under this title shall not require a medicare  
20 claims determination under this title for dental benefits  
21 specifically excluded under subsection (a)(12) as a condi-  
22 tion of making a claims determination for such benefits  
23 under the group health plan.

24 “(2) A group health plan may require a claims deter-  
25 mination under this title in cases involving or appearing

1 to involve inpatient dental hospital services or dental serv-  
2 ices expressly covered under this title pursuant to actions  
3 taken by the Secretary.”.

4 (b) EFFECTIVE DATE.—The amendment made by  
5 subsection (a) shall take effect on the date that is 60 days  
6 after the date of the enactment of this Act.

7 **SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL**  
8 **COVERAGE DETERMINATIONS.**

9 The Secretary shall provide, in an appropriate annual  
10 publication available to the public, a list of national cov-  
11 erage determinations made under title XVIII of the Social  
12 Security Act in the previous year and information on how  
13 to get more information with respect to such determina-  
14 tions.

15 **TITLE IX—MEDICAID**  
16 **PROVISIONS**

17 **SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE FU-**  
18 **TURE OF MEDICAID.**

19 (a) ESTABLISHMENT.—There is established a com-  
20 mission to be known as the National Bipartisan Commis-  
21 sion on the Future of Medicaid (in this section referred  
22 to as the “Commission”).

23 (b) DUTIES OF THE COMMISSION.—The Commission  
24 shall—

1           (1) review and analyze the long-term financial  
2           condition of the medicaid program under title XIX  
3           of the Social Security Act (42 U.S.C. 1396 et seq.);

4           (2) identify the factors that are causing, and  
5           the consequences of, increases in costs under the  
6           medicaid program, including—

7                   (A) the impact of these cost increases upon  
8                   State budgets, funding for other State pro-  
9                   grams, and levels of State taxes necessary to  
10                  fund growing expenditures under the medicaid  
11                  program;

12                  (B) the financial obligations of the Federal  
13                  government arising from the Federal matching  
14                  requirement for expenditures under the med-  
15                  icaid program; and

16                  (C) the size and scope of the current pro-  
17                  gram and how the program has evolved over  
18                  time;

19           (3) analyze potential policies that will ensure  
20           both the financial integrity of the medicaid program  
21           and the provision of appropriate benefits under such  
22           program;

23           (4) make recommendations for establishing in-  
24           centives and structures to promote enhanced effi-

1       ciencies and ways of encouraging innovative State  
2       policies under the medicaid program;

3           (5) make recommendations for establishing the  
4       appropriate balance between benefits covered, pay-  
5       ments to providers, State and Federal contributions  
6       and, where appropriate, recipient cost-sharing obli-  
7       gations;

8           (6) make recommendations on the impact of  
9       promoting increased utilization of competitive, pri-  
10      vate enterprise models to contain program cost  
11      growth, through enhanced utilization of private  
12      plans, pharmacy benefit managers, and other meth-  
13      ods currently being used to contain private sector  
14      health-care costs;

15          (7) make recommendations on the financing of  
16      prescription drug benefits currently covered under  
17      medicaid programs, including analysis of the current  
18      Federal manufacturer rebate program, its impact  
19      upon both private market prices as well as those  
20      paid by other government purchasers, recent State  
21      efforts to negotiate additional supplemental manu-  
22      facturer rebates and the ability of pharmacy benefit  
23      managers to lower drug costs;

1           (8) review and analyze such other matters relat-  
2           ing to the medicaid program as the Commission  
3           deems appropriate; and

4           (9) analyze the impact of impending demo-  
5           graphic changes upon medicaid benefits, including  
6           long term care services, and make recommendations  
7           for how best to appropriately divide State and Fed-  
8           eral responsibilities for funding these benefits.

9           (c) MEMBERSHIP.—

10           (1) NUMBER AND APPOINTMENT.—The Com-  
11           mission shall be composed of 17 members, of  
12           whom—

13                   (A) four shall be appointed by the Presi-  
14                   dent;

15                   (B) six shall be appointed by the Majority  
16                   Leader of the Senate, in consultation with the  
17                   Minority Leader of the Senate, of whom not  
18                   more than 4 shall be of the same political party;

19                   (C) six shall be appointed by the Speaker  
20                   of the House of Representatives, in consultation  
21                   with the Minority Leader of the House of Rep-  
22                   resentatives, of whom not more than 4 shall be  
23                   of the same political party; and

24                   (D) one, who shall serve as Chairman of  
25                   the Commission, appointed jointly by the Presi-

1           dent, Majority Leader of the Senate, and the  
2           Speaker of the House of Representatives.

3           (2) DEADLINE FOR APPOINTMENT.—Members  
4           of the Commission shall be appointed by not later  
5           than December 1, 2002.

6           (3) TERMS OF APPOINTMENT.—The term of  
7           any appointment under paragraph (1) to the Com-  
8           mission shall be for the life of the Commission.

9           (4) MEETINGS.—The Commission shall meet at  
10          the call of its Chairman or a majority of its mem-  
11          bers.

12          (5) QUORUM.—A quorum shall consist of 8  
13          members of the Commission, except that 4 members  
14          may conduct a hearing under subsection (e).

15          (6) VACANCIES.—A vacancy on the Commission  
16          shall be filled in the same manner in which the origi-  
17          nal appointment was made not later than 30 days  
18          after the Commission is given notice of the vacancy  
19          and shall not affect the power of the remaining  
20          members to execute the duties of the Commission.

21          (7) COMPENSATION.—Members of the Commis-  
22          sion shall receive no additional pay, allowances, or  
23          benefits by reason of their service on the Commis-  
24          sion.

1           (8) EXPENSES.—Each member of the Commis-  
2           sion shall receive travel expenses and per diem in  
3           lieu of subsistence in accordance with sections 5702  
4           and 5703 of title 5, United States Code.

5           (d) STAFF AND SUPPORT SERVICES.—

6           (1) EXECUTIVE DIRECTOR.—

7           (A) APPOINTMENT.—The Chairman shall  
8           appoint an executive director of the Commis-  
9           sion.

10          (B) COMPENSATION.—The executive direc-  
11          tor shall be paid the rate of basic pay for level  
12          V of the Executive Schedule.

13          (2) STAFF.—With the approval of the Commis-  
14          sion, the executive director may appoint such per-  
15          sonnel as the executive director considers appro-  
16          priate.

17          (3) APPLICABILITY OF CIVIL SERVICE LAWS.—  
18          The staff of the Commission shall be appointed with-  
19          out regard to the provisions of title 5, United States  
20          Code, governing appointments in the competitive  
21          service, and shall be paid without regard to the pro-  
22          visions of chapter 51 and subchapter III of chapter  
23          53 of such title (relating to classification and Gen-  
24          eral Schedule pay rates).

1           (4) EXPERTS AND CONSULTANTS.—With the  
2 approval of the Commission, the executive director  
3 may procure temporary and intermittent services  
4 under section 3109(b) of title 5, United States Code.

5           (5) PHYSICAL FACILITIES.—The Administrator  
6 of the General Services Administration shall locate  
7 suitable office space for the operation of the Com-  
8 mission. The facilities shall serve as the head-  
9 quarters of the Commission and shall include all  
10 necessary equipment and incidentals required for the  
11 proper functioning of the Commission.

12           (e) POWERS OF COMMISSION.—

13           (1) HEARINGS AND OTHER ACTIVITIES.—For  
14 the purpose of carrying out its duties, the Commis-  
15 sion may hold such hearings and undertake such  
16 other activities as the Commission determines to be  
17 necessary to carry out its duties.

18           (2) STUDIES BY GAO.—Upon the request of the  
19 Commission, the Comptroller General shall conduct  
20 such studies or investigations as the Commission de-  
21 termines to be necessary to carry out its duties.

22           (3) COST ESTIMATES BY CONGRESSIONAL  
23 BUDGET OFFICE AND OFFICE OF THE CHIEF ACTU-  
24 ARY OF CMS.—

1           (A) The Director of the Congressional  
2           Budget Office or the Chief Actuary of the Cen-  
3           ters for Medicare & Medicaid Services, or both,  
4           shall provide to the Commission, upon the re-  
5           quest of the Commission, such cost estimates as  
6           the Commission determines to be necessary to  
7           carry out its duties.

8           (B) The Commission shall reimburse the  
9           Director of the Congressional Budget Office for  
10          expenses relating to the employment in the of-  
11          fice of the Director of such additional staff as  
12          may be necessary for the Director to comply  
13          with requests by the Commission under sub-  
14          paragraph (A).

15          (4) DETAIL OF FEDERAL EMPLOYEES.—Upon  
16          the request of the Commission, the head of any Fed-  
17          eral agency is authorized to detail, without reim-  
18          bursement, any of the personnel of such agency to  
19          the Commission to assist the Commission in car-  
20          rying out its duties. Any such detail shall not inter-  
21          rupt or otherwise affect the civil service status or  
22          privileges of the Federal employee.

23          (5) TECHNICAL ASSISTANCE.—Upon the re-  
24          quest of the Commission, the head of a Federal  
25          agency shall provide such technical assistance to the

1 Commission as the Commission determines to be  
2 necessary to carry out its duties.

3 (6) USE OF MAILS.—The Commission may use  
4 the United States mails in the same manner and  
5 under the same conditions as Federal agencies and  
6 shall, for purposes of the frank, be considered a  
7 commission of Congress as described in section 3215  
8 of title 39, United States Code.

9 (7) OBTAINING INFORMATION.—The Commis-  
10 sion may secure directly from any Federal agency  
11 information necessary to enable it to carry out its  
12 duties, if the information may be disclosed under  
13 section 552 of title 5, United States Code. Upon re-  
14 quest of the Chairman of the Commission, the head  
15 of such agency shall furnish such information to the  
16 Commission.

17 (8) ADMINISTRATIVE SUPPORT SERVICES.—  
18 Upon the request of the Commission, the Adminis-  
19 trator of General Services shall provide to the Com-  
20 mission on a reimbursable basis such administrative  
21 support services as the Commission may request.

22 (9) PRINTING.—For purposes of costs relating  
23 to printing and binding, including the cost of per-  
24 sonnel detailed from the Government Printing Of-



1           creased, subject to subparagraph (B) and  
2           paragraph (5), by the percentage change in  
3           the consumer price index for all urban con-  
4           sumers (all items; U.S. city average), for  
5           fiscal year 2001; and

6           “(ii) for each succeeding fiscal year is  
7           equal to the DSH allotment for the State  
8           for the previous fiscal year under this sub-  
9           paragraph increased, subject to subpara-  
10          graph (B) and paragraph (5), by 1.7 per-  
11          cent or, in the case of fiscal years begin-  
12          ning with the fiscal year specified in sub-  
13          paragraph (C) for that State, the percent-  
14          age change in the consumer price index for  
15          all urban consumers (all items; U.S. city  
16          average), for the previous fiscal year.”; and

17          (2) by adding at the end the following new sub-  
18          paragraph:

19                 “(C) FISCAL YEAR SPECIFIED.—For pur-  
20                 poses of subparagraph (A)(ii), the fiscal year  
21                 specified in this subparagraph for a State is the  
22                 first fiscal year for which the Secretary esti-  
23                 mates that the DSH allotment for that State  
24                 will equal (or no longer exceed) the DSH allot-  
25                 ment for that State under the law as in effect

1 before the date of the enactment of this sub-  
2 paragraph.”.

3 **SEC. 903. MEDICAID PHARMACY ASSISTANCE PROGRAM.**

4 Title XIX is amended—

5 (1) by redesignating section 1935 as section  
6 1936; and

7 (2) by inserting after section 1934 the following  
8 new section:

9 “PHARMACY ASSISTANCE PROGRAM

10 “SEC. 1936. (a) IN GENERAL.—A State plan under  
11 this title may provide assistance, consistent with this sec-  
12 tion, to pharmacies in implementing the new prescription  
13 drug benefit under part D of title XVIII.

14 “(b) USE OF FUNDS.—Such grants may be provided  
15 to assist pharmacies—

16 “(1) in complying with requirements relating to  
17 electronic prescribing;

18 “(2) in prospective drug utilization review; and

19 “(3) in developing innovative medication ther-  
20 apy management programs using information tech-  
21 nology.

22 “(c) CONDITION FOR RECEIPT.—A pharmacy is not  
23 eligible for a grant under this section unless the pharmacy  
24 demonstrates how it will operate a program that will work  
25 effectively with patients to reduce adverse drug reactions

1 and medical errors. No grant shall be awarded under this  
2 section before January 1, 2004.

3 (d) PRIORITIES.—In awarding grants under this sec-  
4 tion, a State shall take into account and give priority to  
5 the needs of small or rural pharmacies and to pharmacies  
6 which service underserved areas.

7 “(e) FUNDING.—

8 “(1) TREATMENT AS MEDICAL ASSISTANCE.—  
9 Subject to paragraph (2), amounts provided under  
10 grants by a State under this section (and the rea-  
11 sonable administrative expenses of a State in car-  
12 rying out this section, not to exceed 10 percent of  
13 the total amount awarded as grants by a State) shall  
14 be treated as the provision of medical assistance for  
15 purposes of section 1903. In applying section  
16 1903(a)(1) with respect to such assistance, the Fed-  
17 eral medical assistance percentage is deemed to be  
18 100 percent.

19 “(2) LIMITATION AND ALLOTMENT.—

20 “(A) LIMITATION.—The total amount for  
21 which Federal financial participation is avail-  
22 able under section 1903(a) for grants and ad-  
23 ministrative expenses under this section in cal-  
24 endar quarters in any fiscal year is limited to

1           \$150,000,000 in each of fiscal years 2004  
2           through 2007.

3           “(B) ALLOCATION.—The Secretary shall  
4           provide a method for the allocation of the  
5           amount of funds described in subparagraph (A)  
6           in each fiscal year among the States. Such  
7           method shall take into account the distribution  
8           among States of priority pharmacies specified  
9           in subsection (d).

10          “(3) REQUIREMENT FOR APPLICATION.—The  
11          preceding provisions of this section shall only apply  
12          to a State if the State has filed with the Secretary  
13          an amendment to its State plan that provides for the  
14          awarding of grants under this section that is con-  
15          sistent with the requirements of this section.”.

        Passed the House of Representatives June 28 (legis-  
lative day, June 27), 2002.

Attest:

*Clerk.*