

107TH CONGRESS
2^D SESSION

H. R. 4954

[Report No. 107-539, Part I]

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.

IN THE HOUSE OF REPRESENTATIVES

JUNE 18, 2002

Mrs. JOHNSON of Connecticut (for herself and Mr. BILIRAKIS) introduced the following bill; which was referred, pursuant to the order of the House of June 17, 2002, jointly to the Committees on Energy and Commerce and Ways and Means

JUNE 26, 2002

Additional sponsors: Mr. THOMAS, Mr. TAUZIN, Mr. SHAW, Mr. UPTON, Ms. DUNN, Mr. GREENWOOD, Mr. PORTMAN, Mr. PICKERING, Mr. ENGLISH, Mr. BRYANT, Mr. WELLER, Mr. BASS, Mr. MCINNIS, Mr. WALDEN of Oregon, Mr. RYAN of Wisconsin, Mr. TERRY, Mr. FLETCHER, Mr. BOOZMAN, Mr. CRENSHAW, Mrs. JO ANN DAVIS of Virginia, Mr. KELLER, Mr. KENNEDY of Minnesota, Mr. GOSS, Mr. SIMMONS, Mr. SULLIVAN, Mr. LEWIS of Kentucky, Mr. VITTER, Mr. HOUGHTON, Mr. GEKAS, Mr. SHIMKUS, and Mr. MCCRERY

JUNE 26, 2002

Reported from the Committee on Ways and Means with an amendment

[Strike out all after the enacting clause and insert the part printed in *italic*]

[For text of introduced bill, see copy of bill as introduced on June 18, 2002]

A BILL

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage

under the Medicare Program, to modernize and reform payments and the regulatory structure of the Medicare Program, and for other purposes.

1 *Be it enacted by the Senate and House of 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.*—*Except*
 10 *as otherwise specifically provided, whenever in this Act an*
 11 *amendment is expressed in terms of an amendment to or*
 12 *repeal of a section or other provision, the reference shall*
 13 *be considered to be made to that section or other provision*
 14 *of the Social Security Act.*

15 (c) *BIPA; SECRETARY.*—*In this Act:*

16 (1) *BIPA.*—*The term “BIPA” means the Medi-*
 17 *care, Medicaid, and SCHIP Benefits Improvement*
 18 *and Protection Act of 2000, as enacted into law by*
 19 *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.

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

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

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

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

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

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

“Sec. 1860F. Submission of bids.

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

“Sec. 1860H. Subsidies for all medicare beneficiaries for qualified prescription drug coverage.

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

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

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

Sec. 103. Medicaid amendments.

Sec. 104. Medigap transition.

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

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

Subtitle A—Medicare+Choice Revitalization

Sec. 201. Medicare+Choice improvements.

Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.

Sec. 203. Avoiding duplicative State regulation.

Sec. 204. Specialized Medicare+Choice plans for special needs beneficiaries.

Sec. 205. Medicare MSAs.

Sec. 206. Extension of reasonable cost and SHMO contracts.

Sec. 207. Extension of municipal health service demonstration projects.^z

Subtitle B—Medicare+Choice Competition Program

Sec. 211. Medicare+Choice competition program.

Sec. 212. Demonstration program for competitive-demonstration areas.

Sec. 213. Conforming amendments.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

Sec. 301. Reference to full market basket increase for sole community hospitals.

Sec. 302. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.

Sec. 303. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.

- Sec. 304. More frequent update in weights used in hospital market basket.*
- Sec. 305. Improvements to critical access hospital program.*
- Sec. 306. Extension of temporary increase for home health services furnished in a rural area.*
- Sec. 307. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.*
- Sec. 308. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.*
- Sec. 309. GAO study of geographic differences in payments for physicians' services.*
- Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.*
- Sec. 311. Relief for certain non-teaching hospitals.*

TITLE IV—PROVISIONS RELATING TO PART A

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.*

Subtitle B—Skilled Nursing Facility Services

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

Subtitle C—Hospice

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

Subtitle D—Other Provisions

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

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

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

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

Subtitle B—Other Services

Sec. 511. Competitive acquisition of certain items and services.

Sec. 512. Payment for ambulance services.

Sec. 513. 2-year extension of moratorium on therapy caps; provisions relating to reports.

Sec. 514. Accelerated implementation of 20 percent coinsurance for hospital outpatient department (OPD) services; other OPD provisions.

Sec. 515. Coverage of an initial preventive physical examination.

Sec. 516. Renal dialysis services.

Sec. 517. Improved payment for certain mammography services.

Sec. 518. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.

Sec. 519. Coverage of cholesterol and blood lipid screening.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.

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

Sec. 603. Update in home health services.

Sec. 604. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.

Sec. 605. MedPAC study on medicare margins of home health agencies.

Subtitle B—Direct Graduate Medical Education

Sec. 611. Extension of update limitation on high cost programs.

Sec. 612. Redistribution of unused resident positions.

Subtitle C—Other Provisions

Sec. 621. Modifications to Medicare Payment Advisory Commission (MedPAC).

Sec. 622. Demonstration project for disease management for certain medicare beneficiaries with diabetes.

Sec. 623. Demonstration project for medical adult day care services.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

Sec. 701. Establishment of Medicare Benefits Administration.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

Sec. 801. Construction; definition of supplier.

Sec. 802. Issuance of regulations.

Sec. 803. Compliance with changes in regulations and policies.

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

Subtitle B—Contracting Reform

Sec. 811. Increased flexibility in medicare administration.

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

Subtitle C—Education and Outreach

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

Subtitle D—Appeals and Recovery

Sec. 831. Transfer of responsibility for medicare appeals.
Sec. 832. Process for expedited access to review.
Sec. 833. Revisions to medicare appeals process.
Sec. 834. Prepayment review.
Sec. 835. Recovery of overpayments.
Sec. 836. Provider enrollment process; right of appeal.
Sec. 837. Process for correction of minor errors and omissions on claims without pursuing appeals process.
Sec. 838. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle E—Miscellaneous Provisions

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

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

Subtitle A—Medicaid Provisions

Sec. 901. National Bipartisan Commission on the Future of Medicaid.
Sec. 902. GAO study on medicaid drug payment system.

Subtitle B—Internet Pharmacies

Sec. 911. Findings.
Sec. 912. Amendment to Federal Food, Drug, and Cosmetic Act.
Sec. 913. Public education.
Sec. 914. Study regarding coordination of regulatory activities.
Sec. 915. Effective date.

1 *B is entitled to obtain qualified prescription drug coverage*
2 *(described in section 1860B(a)) as follows:*

3 “(1) *MEDICARE+CHOICE PLAN.*—*If the indi-*
4 *vidual is eligible to enroll in a Medicare+Choice plan*
5 *that provides qualified prescription drug coverage*
6 *under section 1851(j), the individual may enroll in*
7 *the plan and obtain coverage through such plan.*

8 “(2) *PRESCRIPTION DRUG PLAN.*—*If the indi-*
9 *vidual is not enrolled in a Medicare+Choice plan*
10 *that provides qualified prescription drug coverage, the*
11 *individual may enroll under this part in a prescrip-*
12 *tion drug plan (as defined in section 1860J(a)(5)).*

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

15 “(b) *GENERAL ELECTION PROCEDURES.*—

16 “(1) *IN GENERAL.*—*An individual eligible to*
17 *make an election under subsection (a) may elect to*
18 *enroll in a prescription drug plan under this part, or*
19 *elect the option of qualified prescription drug cov-*
20 *erage under a Medicare+Choice plan under part C,*
21 *and to change such election only in such manner and*
22 *form as may be prescribed by regulations of the Ad-*
23 *ministrator of the Medicare Benefits Administration*
24 *(appointed under section 1808(b)) (in this part re-*
25 *ferred to as the ‘Medicare Benefits Administrator’)*

1 *and only during an election period prescribed in or*
2 *under this subsection.*

3 “(2) *ELECTION PERIODS.*—

4 “(A) *IN GENERAL.*—*Except as provided in*
5 *this paragraph, the election periods under this*
6 *subsection shall be the same as the coverage elec-*
7 *tion periods under the Medicare+Choice pro-*
8 *gram under section 1851(e), including—*

9 “(i) *annual coordinated election peri-*
10 *ods; and*

11 “(ii) *special election periods.*

12 *In applying the last sentence of section*
13 *1851(e)(4) (relating to discontinuance of a*
14 *Medicare+Choice election during the first year*
15 *of eligibility) under this subparagraph, in the*
16 *case of an election described in such section in*
17 *which the individual had elected or is provided*
18 *qualified prescription drug coverage at the time*
19 *of such first enrollment, the individual shall be*
20 *permitted to enroll in a prescription drug plan*
21 *under this part at the time of the election of cov-*
22 *erage under the original fee-for-service plan.*

23 “(B) *INITIAL ELECTION PERIODS.*—

24 “(i) *INDIVIDUALS CURRENTLY COV-*
25 *ERED.*—*In the case of an individual who is*

1 *entitled to benefits under part A or enrolled*
2 *under part B as of November 1, 2004, there*
3 *shall be an initial election period of 6*
4 *months beginning on that date.*

5 “(ii) *INDIVIDUAL COVERED IN FU-*
6 *TURE.—In the case of an individual who is*
7 *first entitled to benefits under part A or en-*
8 *rolled under part B after such date, there*
9 *shall be an initial election period which is*
10 *the same as the initial enrollment period*
11 *under section 1837(d).*

12 “(C) *ADDITIONAL SPECIAL ELECTION PERI-*
13 *ODS.—The Administrator shall establish special*
14 *election periods—*

15 “(i) *in cases of individuals who have*
16 *and involuntarily lose prescription drug*
17 *coverage described in subsection (c)(2)(C);*

18 “(ii) *in cases described in section*
19 *1837(h) (relating to errors in enrollment),*
20 *in the same manner as such section applies*
21 *to part B;*

22 “(iii) *in the case of an individual who*
23 *meets such exceptional conditions (including*
24 *conditions provided under section*

1 1851(e)(4)(D)) as the Administrator may
2 provide; and

3 “(iv) in cases of individuals (as deter-
4 mined by the Administrator) who become el-
5 igible for prescription drug assistance under
6 title XIX under section 1935(d).

7 “(c) *GUARANTEED ISSUE; COMMUNITY RATING; AND*
8 *NONDISCRIMINATION.*—

9 “(1) *GUARANTEED ISSUE.*—

10 “(A) *IN GENERAL.*—An eligible individual
11 who is eligible to elect qualified prescription
12 drug coverage under a prescription drug plan or
13 Medicare+Choice plan at a time during which
14 elections are accepted under this part with re-
15 spect to the plan shall not be denied enrollment
16 based on any health status-related factor (de-
17 scribed in section 2702(a)(1) of the Public
18 Health Service Act) or any other factor.

19 “(B) *MEDICARE+CHOICE LIMITATIONS PER-*
20 *MITTED.*—The provisions of paragraphs (2) and
21 (3) (other than subparagraph (C)(i), relating to
22 default enrollment) of section 1851(g) (relating
23 to priority and limitation on termination of
24 election) shall apply to PDP sponsors under this
25 subsection.

1 “(2) *COMMUNITY-RATED PREMIUM.*—

2 “(A) *IN GENERAL.*—*In the case of an indi-*
3 *vidual who maintains (as determined under sub-*
4 *paragraph (C)) continuous prescription drug*
5 *coverage since the date the individual first quali-*
6 *fies to elect prescription drug coverage under this*
7 *part, a PDP sponsor or Medicare+Choice orga-*
8 *nization offering a prescription drug plan or*
9 *Medicare+Choice plan that provides qualified*
10 *prescription drug coverage and in which the in-*
11 *dividual is enrolled may not deny, limit, or con-*
12 *dition the coverage or provision of covered pre-*
13 *scription drug benefits or increase the premium*
14 *under the plan based on any health status-re-*
15 *lated factor described in section 2702(a)(1) of the*
16 *Public Health Service Act or any other factor.*

17 “(B) *LATE ENROLLMENT PENALTY.*—*In the*
18 *case of an individual who does not maintain*
19 *such continuous prescription drug coverage (as*
20 *described in subparagraph (C)), a PDP sponsor*
21 *or Medicare+Choice organization may (notwith-*
22 *standing any provision in this title) adjust the*
23 *premium otherwise applicable or impose a pre-*
24 *existing condition exclusion with respect to*
25 *qualified prescription drug coverage in a man-*

1 *ner that reflects additional actuarial risk in-*
2 *volved. Such a risk shall be established through*
3 *an appropriate actuarial opinion of the type de-*
4 *scribed in subparagraphs (A) through (C) of sec-*
5 *tion 2103(c)(4).*

6 “(C) *CONTINUOUS PRESCRIPTION DRUG*
7 *COVERAGE.—An individual is considered for*
8 *purposes of this part to be maintaining contin-*
9 *uous prescription drug coverage on and after the*
10 *date the individual first qualifies to elect pre-*
11 *scription drug coverage under this part if the in-*
12 *dividual establishes that as of such date the indi-*
13 *vidual is covered under any of the following pre-*
14 *scription drug coverage and before the date that*
15 *is the last day of the 63-day period that begins*
16 *on the date of termination of the particular pre-*
17 *scription drug coverage involved (regardless of*
18 *whether the individual subsequently obtains any*
19 *of the following prescription drug coverage):*

20 “(i) *COVERAGE UNDER PRESCRIPTION*
21 *DRUG PLAN OR MEDICARE+CHOICE PLAN.—*
22 *Qualified prescription drug coverage under*
23 *a prescription drug plan or under a*
24 *Medicare+Choice plan.*

1 “(ii) *MEDICAID PRESCRIPTION DRUG*
2 *COVERAGE.—Prescription drug coverage*
3 *under a medicaid plan under title XIX, in-*
4 *cluding through the Program of All-inclu-*
5 *sive Care for the Elderly (PACE) under sec-*
6 *tion 1934, through a social health mainte-*
7 *nance organization (referred to in section*
8 *4104(c) of the Balanced Budget Act of*
9 *1997), or through a Medicare+Choice*
10 *project that demonstrates the application of*
11 *capitation payment rates for frail elderly*
12 *medicare beneficiaries through the use of a*
13 *interdisciplinary team and through the pro-*
14 *vision of primary care services to such bene-*
15 *ficiaries by means of such a team at the*
16 *nursing facility involved.*

17 “(iii) *PRESCRIPTION DRUG COVERAGE*
18 *UNDER GROUP HEALTH PLAN.—Any out-*
19 *patient prescription drug coverage under a*
20 *group health plan, including a health bene-*
21 *fits plan under the Federal Employees*
22 *Health Benefit Plan under chapter 89 of*
23 *title 5, United States Code, and a qualified*
24 *retiree prescription drug plan as defined in*
25 *section 1860H(f)(1), but only if (subject to*

1 *subparagraph (E)(ii)) the coverage provides*
2 *benefits at least equivalent to the benefits*
3 *under a qualified prescription drug plan.*

4 “(iv) *PRESCRIPTION DRUG COVERAGE*
5 *UNDER CERTAIN MEDIGAP POLICIES.—Cov-*
6 *erage under a medicare supplemental policy*
7 *under section 1882 that provides benefits for*
8 *prescription drugs (whether or not such cov-*
9 *erage conforms to the standards for pack-*
10 *ages of benefits under section 1882(p)(1)),*
11 *but only if the policy was in effect on Janu-*
12 *ary 1, 2005, and if (subject to subpara-*
13 *graph (E)(ii)) the coverage provides benefits*
14 *at least equivalent to the benefits under a*
15 *qualified prescription drug plan.*

16 “(v) *STATE PHARMACEUTICAL ASSIST-*
17 *ANCE PROGRAM.—Coverage of prescription*
18 *drugs under a State pharmaceutical assist-*
19 *ance program, but only if (subject to sub-*
20 *paragraph (E)(ii)) the coverage provides*
21 *benefits at least equivalent to the benefits*
22 *under a qualified prescription drug plan.*

23 “(vi) *VETERANS’ COVERAGE OF PRE-*
24 *SCRIPTION DRUGS.—Coverage of prescrip-*
25 *tion drugs for veterans under chapter 17 of*

1 *title 38, United States Code, but only if*
2 *(subject to subparagraph (E)(ii)) the cov-*
3 *erage provides benefits at least equivalent to*
4 *the benefits under a qualified prescription*
5 *drug plan.*

6 “(D) *CERTIFICATION.*—*For purposes of car-*
7 *rying out this paragraph, the certifications of the*
8 *type described in sections 2701(e) of the Public*
9 *Health Service Act and in section 9801(e) of the*
10 *Internal Revenue Code shall also include a state-*
11 *ment for the period of coverage of whether the in-*
12 *dividual involved had prescription drug coverage*
13 *described in subparagraph (C).*

14 “(E) *DISCLOSURE.*—

15 “(i) *IN GENERAL.*—*Each entity that*
16 *offers coverage of the type described in*
17 *clause (iii), (iv), (v), or (vi) of subpara-*
18 *graph (C) shall provide for disclosure, con-*
19 *sistent with standards established by the*
20 *Administrator, of whether such coverage*
21 *provides benefits at least equivalent to the*
22 *benefits under a qualified prescription drug*
23 *plan.*

24 “(ii) *WAIVER OF LIMITATIONS.*—*An*
25 *individual may apply to the Administrator*

1 to waive the requirement that coverage of
2 such type provide benefits at least equiva-
3 lent to the benefits under a qualified pre-
4 scription drug plan, if the individual estab-
5 lishes that the individual was not ade-
6 quately informed that such coverage did not
7 provide such level of benefits.

8 “(F) CONSTRUCTION.—Nothing in this sec-
9 tion shall be construed as preventing the
10 disenrollment of an individual from a prescrip-
11 tion drug plan or a Medicare+Choice plan based
12 on the termination of an election described in
13 section 1851(g)(3), including for non-payment of
14 premiums or for other reasons specified in sub-
15 section (d)(3), which takes into account a grace
16 period described in section 1851(g)(3)(B)(i).

17 “(3) NONDISCRIMINATION.—A PDP sponsor of-
18 fering a prescription drug plan shall not establish a
19 service area in a manner that would discriminate
20 based on health or economic status of potential enroll-
21 ees.

22 “(d) EFFECTIVE DATE OF ELECTIONS.—

23 “(1) IN GENERAL.—Except as provided in this
24 section, the Administrator shall provide that elections
25 under subsection (b) take effect at the same time as

1 *the Administrator provides that similar elections*
2 *under section 1851(e) take effect under section*
3 *1851(f).*

4 “(2) *NO ELECTION EFFECTIVE BEFORE 2005.—In*
5 *no case shall any election take effect before January*
6 *1, 2005.*

7 “(3) *TERMINATION.—The Administrator shall*
8 *provide for the termination of an election in the case*
9 *of—*

10 “(A) *termination of coverage under both*
11 *part A and part B; and*

12 “(B) *termination of elections described in*
13 *section 1851(g)(3) (including failure to pay re-*
14 *quired premiums).*

15 **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**
16 **TION DRUG COVERAGE.**

17 “(a) *REQUIREMENTS.—*

18 “(1) *IN GENERAL.—For purposes of this part*
19 *and part C, the term ‘qualified prescription drug cov-*
20 *erage’ means either of the following:*

21 “(A) *STANDARD COVERAGE WITH ACCESS*
22 *TO NEGOTIATED PRICES.—Standard coverage (as*
23 *defined in subsection (b)) and access to nego-*
24 *tiated prices under subsection (d).*

1 “(B) *ACTUARIALLY EQUIVALENT COVERAGE*
2 *WITH ACCESS TO NEGOTIATED PRICES.*—Cov-
3 *erage of covered outpatient drugs which meets the*
4 *alternative coverage requirements of subsection*
5 *(c) and access to negotiated prices under sub-*
6 *section (d), but only if it is approved by the Ad-*
7 *ministrator, as provided under subsection (c).*

8 “(2) *PERMITTING ADDITIONAL OUTPATIENT PRE-*
9 *SCRIPTION DRUG COVERAGE.*—

10 “(A) *IN GENERAL.*—Subject to subpara-
11 *graph (B), nothing in this part shall be con-*
12 *strued as preventing qualified prescription drug*
13 *coverage from including coverage of covered out-*
14 *patient drugs that exceeds the coverage required*
15 *under paragraph (1), but any such additional*
16 *coverage shall be limited to coverage of covered*
17 *outpatient drugs.*

18 “(B) *DISAPPROVAL AUTHORITY.*—The Ad-
19 *ministrator shall review the offering of qualified*
20 *prescription drug coverage under this part or*
21 *part C. If the Administrator finds that, in the*
22 *case of a qualified prescription drug coverage*
23 *under a prescription drug plan or a*
24 *Medicare+Choice plan, that the organization or*
25 *sponsor offering the coverage is engaged in ac-*

1 *tivities intended to discourage enrollment of*
2 *classes of eligible medicare beneficiaries obtain-*
3 *ing coverage through the plan on the basis of*
4 *their higher likelihood of utilizing prescription*
5 *drug coverage, the Administrator may terminate*
6 *the contract with the sponsor or organization*
7 *under this part or part C.*

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

12 *“(b) STANDARD COVERAGE.—For purposes of this*
13 *part, the ‘standard coverage’ is coverage of covered out-*
14 *patient drugs (as defined in subsection (f)) that meets the*
15 *following requirements:*

16 *“(1) DEDUCTIBLE.—The coverage has an annual*
17 *deductible—*

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

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

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

1 “(2) *LIMITS ON COST-SHARING.*—

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

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

11 “(I) *is equal to 20 percent; or*

12 “(II) *is actuarially equivalent*
13 *(using processes established under sub-*
14 *section (e)) to an average expected pay-*
15 *ment of 20 percent of such costs.*

16 “(ii) *SECONDARY COPAYMENT*
17 *RANGE.*—*For costs above the amount speci-*
18 *fied in subparagraph (C) and up to the ini-*
19 *tial coverage limit, the cost-sharing—*

20 “(I) *is equal to 50 percent; or*

21 “(II) *is actuarially consistent*
22 *(using processes established under sub-*
23 *section (e)) with an average expected*
24 *payment of 50 percent of such costs.*

1 “(B) *USE OF TIERED COPAYMENTS.*—*Nothing*
2 *in this part shall be construed as preventing*
3 *a PDP sponsor from applying tiered copay-*
4 *ments, so long as such tiered copayments are*
5 *consistent with subparagraph (A).*

6 “(C) *INITIAL COPAYMENT THRESHOLD.*—
7 *The amount specified in this subparagraph—*

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

9 “(ii) *for a subsequent year, is equal to*
10 *the amount specified in this subparagraph*
11 *for the previous year, increased by the an-*
12 *nuual percentage increase described in para-*
13 *graph (5) for the year involved.*

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

17 “(3) *INITIAL COVERAGE LIMIT.*—*Subject to para-*
18 *graph (4), the coverage has an initial coverage limit*
19 *on the maximum costs that may be recognized for*
20 *payment purposes—*

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

22 “(B) *for a subsequent year, that is equal to*
23 *the amount specified in this paragraph for the*
24 *previous year, increased by the annual percent-*

1 age increase described in paragraph (5) for the
2 year involved.

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

6 “(4) CATASTROPHIC PROTECTION.—

7 “(A) IN GENERAL.—Notwithstanding para-
8 graph (3), the coverage provides benefits with no
9 cost-sharing after the individual has incurred
10 costs (as described in subparagraph (C)) for cov-
11 ered outpatient drugs in a year equal to the an-
12 nual out-of-pocket threshold specified in subpara-
13 graph (B).

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

18 “(i) for 2005, is equal to \$3,800; or

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

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

4 “(C) *APPLICATION.—In applying subpara-*
5 *graph (A)—*

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

13 “(ii) *such costs shall be treated as in-*
14 *curring only if they are paid by the indi-*
15 *vidual, under section 1860G, or under title*
16 *XIX and the individual is not reimbursed*
17 *(through insurance or otherwise) by another*
18 *person for such costs.*

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

1 *mined by the Administrator for the 12-month period*
2 *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 the*
7 *Administrator determines (based on an actuarial analysis*
8 *by the Administrator) that the following requirements are*
9 *met and the plan applies for, and receives, the approval*
10 *of the Administrator for such benefit design:*

11 “(1) *ASSURING AT LEAST ACTUARIALLY EQUIVA-*
12 *LENT 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 UNSUBSIDIZED*
19 *VALUE OF COVERAGE.—The unsubsidized value*
20 *of the coverage is at least equal to the unsub-*
21 *sidized value of standard coverage. For purposes*
22 *of this subparagraph, the unsubsidized value of*
23 *coverage is the amount by which the actuarial*
24 *value of the coverage (as determined under sub-*
25 *section (e)) exceeds the actuarial value of the sub-*

1 *sidy payments under section 1860H with respect*
 2 *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 rep-*
 6 *resentative pattern of utilization (as determined*
 7 *under subsection (e)), to provide for the pay-*
 8 *ment, 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 the*
 11 *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 deduct-*
 17 *ible described in subsection (b)(1); and*

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

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

23 “(I) *the amount by which the ini-*
 24 *tial coverage limit described in sub-*
 25 *section (b)(3) exceeds the initial copay-*

1 *ment threshold described in subsection*
2 *(b)(2)(C); and*

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

6 *“(2) CATASTROPHIC PROTECTION.—The coverage*
7 *provides for beneficiaries the catastrophic protection*
8 *described in subsection (b)(4).*

9 *“(d) ACCESS TO NEGOTIATED PRICES.—*

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

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

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

20 “(e) *ACTUARIAL VALUATION; DETERMINATION OF AN-*
21 *NUAL PERCENTAGE INCREASES.*—

22 “(1) *PROCESSES.*—For purposes of this section,
23 the Administrator shall establish processes and
24 methods—

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

3 “(i) an actuarial valuation of standard
4 coverage and of the reinsurance subsidy
5 payments under section 1860H;

6 “(ii) the use of generally accepted actu-
7 arial principles and methodologies; and

8 “(iii) applying the same methodology
9 for determinations of alternative coverage
10 under subsection (c) as is used with respect
11 to determinations of standard coverage
12 under subsection (b); and

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

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

22 “(f) COVERED OUTPATIENT DRUGS DEFINED.—

23 “(1) IN GENERAL.—Except as provided in this
24 subsection, for purposes of this part, the term ‘covered
25 outpatient drug’ means—

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

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

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

13 “(2) EXCLUSIONS.—

14 “(A) IN GENERAL.—Such term does not in-
15 clude drugs or classes of drugs, or their medical
16 uses, which may be excluded from coverage or
17 otherwise restricted under section 1927(d)(2),
18 other than subparagraph (E) thereof (relating to
19 smoking cessation agents), or under section
20 1927(d)(3).

21 “(B) AVOIDANCE OF DUPLICATE COV-
22 ERAGE.—A drug prescribed for an individual
23 that would otherwise be a covered outpatient
24 drug under this part shall not be so considered
25 if payment for such drug is available under part

1 *A or B for an individual entitled to benefits*
2 *under part A and enrolled under part B.*

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

10 “(4) *APPLICATION OF GENERAL EXCLUSION PRO-*
11 *VISIONS.—A prescription drug plan or*
12 *Medicare+Choice plan may exclude from qualified*
13 *prescription drug coverage any covered outpatient*
14 *drug—*

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

17 “(B) *which are not prescribed in accordance*
18 *with the plan or this part.*

19 *Such exclusions are determinations subject to recon-*
20 *sideration and appeal pursuant to section 1860C(f).*

21 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**
22 **PRESCRIPTION DRUG COVERAGE.**

23 “(a) *GUARANTEED ISSUE, COMMUNITY-RATED PRE-*
24 *MIUMS, ACCESS TO NEGOTIATED PRICES, AND NON-*
25 *DISCRIMINATION.—For provisions requiring guaranteed*

1 *issue, community-rated premiums, access to negotiated*
2 *prices, and nondiscrimination, see sections 1860A(c)(1),*
3 *1860A(c)(2), 1860B(d), and 1860F(b), respectively.*

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

5 “(1) *GENERAL INFORMATION.*—*A PDP sponsor*
6 *shall disclose, in a clear, accurate, and standardized*
7 *form to each enrollee with a prescription drug plan*
8 *offered by the sponsor under this part at the time of*
9 *enrollment and at least annually thereafter, the infor-*
10 *mation described in section 1852(c)(1) relating to*
11 *such plan. Such information includes the following:*

12 “(A) *Access to covered outpatient drugs, in-*
13 *cluding access through pharmacy networks.*

14 “(B) *How any formulary used by the spon-*
15 *sor functions.*

16 “(C) *Co-payments and deductible require-*
17 *ments, including the identification of the tiered*
18 *or other co-payment level applicable to each drug*
19 *(or class of drugs).*

20 “(D) *Grievance and appeals procedures.*

21 “(2) *DISCLOSURE UPON REQUEST OF GENERAL*
22 *COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-*
23 *TION.*—*Upon request of an individual eligible to en-*
24 *roll under a prescription drug plan, the PDP sponsor*
25 *shall provide the information described in section*

1 1852(c)(2) (other than subparagraph (D)) to such in-
2 dividual.

3 “(3) *RESPONSE TO BENEFICIARY QUESTIONS.*—
4 *Each PDP sponsor offering a prescription drug plan*
5 *shall have a mechanism for providing specific infor-*
6 *mation to enrollees upon request. The sponsor shall*
7 *make available on a timely basis, through an Internet*
8 *website and in writing upon request, information on*
9 *specific changes in its formulary.*

10 “(4) *CLAIMS INFORMATION.*—*Each PDP sponsor*
11 *offering a prescription drug plan must furnish to en-*
12 *rolled individuals in a form easily understandable to*
13 *such individuals an explanation of benefits (in ac-*
14 *cordance with section 1806(a) or in a comparable*
15 *manner) and a notice of the benefits in relation to*
16 *initial coverage limit and annual out-of-pocket*
17 *threshold for the current year, whenever prescription*
18 *drug benefits are provided under this part (except*
19 *that such notice need not be provided more often than*
20 *monthly).*

21 “(c) *ACCESS TO COVERED BENEFITS.*—

22 “(1) *ASSURING PHARMACY ACCESS.*—

23 “(A) *IN GENERAL.*—*The PDP sponsor of the*
24 *prescription drug plan shall secure the partici-*
25 *ipation in its network of a sufficient number of*

1 *pharmacies that dispense (other than by mail*
2 *order) drugs directly to patients to ensure con-*
3 *venient access (as determined by the Adminis-*
4 *trator and including adequate emergency access)*
5 *for enrolled beneficiaries, in accordance with*
6 *standards established under section 1860D(e)*
7 *that ensure such convenient access.*

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

11 *“(i) the plan provides access to any or*
12 *all pharmacies that are not participating*
13 *pharmacies in its network; and*

14 *“(ii) the plan may charge beneficiaries*
15 *through adjustments in premiums and co-*
16 *payments any additional costs associated*
17 *with the point-of-service option.*

18 *The additional copayments so charged shall not*
19 *count toward the application of section*
20 *1860B(b).*

21 *“(2) USE OF STANDARDIZED TECHNOLOGY.—*

22 *“(A) IN GENERAL.—The PDP sponsor of a*
23 *prescription drug plan shall issue (and reissue,*
24 *as appropriate) such a card (or other technology)*
25 *that may be used by an enrolled beneficiary to*

1 *assure access to negotiated prices under section*
2 *1860B(d) for the purchase of prescription drugs*
3 *for which coverage is not otherwise provided*
4 *under the prescription drug plan.*

5 “(B) *STANDARDS.—*

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

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

19 “(3) *REQUIREMENTS ON DEVELOPMENT AND AP-*
20 *PLICATION OF FORMULARIES.—If a PDP sponsor of a*
21 *prescription drug plan uses a formulary, the fol-*
22 *lowing requirements must be met:*

23 “(A) *PHARMACY AND THERAPEUTIC (P&T)*
24 *COMMITTEE.—The sponsor must establish a*
25 *pharmacy and therapeutic committee that devel-*

1 *ops and reviews the formulary. Such committee*
2 *shall include at least one physician and at least*
3 *one pharmacist both with expertise in the care of*
4 *elderly or disabled persons and a majority of its*
5 *members shall consist of individuals who are a*
6 *physician or a pharmacist (or both).*

7 “(B) *FORMULARY DEVELOPMENT.*—*In de-*
8 *veloping and reviewing the formulary, the com-*
9 *mittee shall base clinical decisions on the*
10 *strength of scientific evidence and standards of*
11 *practice, including assessing peer-reviewed med-*
12 *ical literature, such as randomized clinical*
13 *trials, pharmacoeconomic studies, outcomes re-*
14 *search data, and such other information as the*
15 *committee determines to be appropriate.*

16 “(C) *INCLUSION OF DRUGS IN ALL THERA-*
17 *PEUTIC CATEGORIES.*—*The formulary must in-*
18 *clude drugs within each therapeutic category and*
19 *class of covered outpatient drugs (although not*
20 *necessarily for all drugs within such categories*
21 *and classes).*

22 “(D) *PROVIDER EDUCATION.*—*The com-*
23 *mittee shall establish policies and procedures to*
24 *educate and inform health care providers con-*
25 *cerning the formulary.*

1 “(E) NOTICE BEFORE REMOVING DRUGS
2 FROM FORMULARY.—Any removal of a drug from
3 a formulary shall take effect only after appro-
4 priate notice is made available to beneficiaries
5 and physicians.

6 “(F) GRIEVANCES AND APPEALS RELATING
7 TO APPLICATION OF FORMULARIES.—For provi-
8 sions relating to grievances and appeals of cov-
9 erage, see subsections (e) and (f).

10 “(d) COST AND UTILIZATION MANAGEMENT; QUALITY
11 ASSURANCE; MEDICATION THERAPY MANAGEMENT PRO-
12 GRAM.—

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

15 “(A) an effective cost and drug utilization
16 management program, including medically ap-
17 propriate incentives to use generic drugs and
18 therapeutic interchange, when appropriate;

19 “(B) quality assurance measures and sys-
20 tems to reduce medical errors and adverse drug
21 interactions, including a medication therapy
22 management program described in paragraph
23 (2) and for years beginning with 2006, an elec-
24 tronic prescription program described in para-
25 graph (3); and

1 “(C) a program to control fraud, abuse, and
2 waste.

3 *Nothing in this section shall be construed as impair-*
4 *ing a PDP sponsor from applying cost management*
5 *tools (including differential payments) under all*
6 *methods of operation.*

7 “(2) *MEDICATION THERAPY MANAGEMENT PRO-*
8 *GRAM.—*

9 “(A) *IN GENERAL.—A medication therapy*
10 *management program described in this para-*
11 *graph is a program of drug therapy management*
12 *and medication administration that is designed*
13 *to assure, with respect to beneficiaries with*
14 *chronic diseases (such as diabetes, asthma, hy-*
15 *pertension, and congestive heart failure) or mul-*
16 *tipl prescriptions, that covered outpatient drugs*
17 *under the prescription drug plan are appro-*
18 *priately used to achieve therapeutic goals and re-*
19 *duce the risk of adverse events, including adverse*
20 *drug interactions.*

21 “(B) *ELEMENTS.—Such program may*
22 *include—*

23 “(i) *enhanced beneficiary under-*
24 *standing of such appropriate use through*

1 *beneficiary education, counseling, and other*
2 *appropriate means;*

3 “(ii) *increased beneficiary adherence*
4 *with prescription medication regimens*
5 *through medication refill reminders, special*
6 *packaging, and other appropriate means;*
7 *and*

8 “(iii) *detection of patterns of overuse*
9 *and underuse of prescription drugs.*

10 “(C) *DEVELOPMENT OF PROGRAM IN CO-*
11 *OPERATION WITH LICENSED PHARMACISTS.—The*
12 *program shall be developed in cooperation with*
13 *licensed pharmacists and physicians.*

14 “(D) *CONSIDERATIONS IN PHARMACY*
15 *FEES.—The PDP sponsor of a prescription drug*
16 *program shall take into account, in establishing*
17 *fees for pharmacists and others providing serv-*
18 *ices under the medication therapy management*
19 *program, the resources and time used in imple-*
20 *menting the program.*

21 “(3) *ELECTRONIC PRESCRIPTION PROGRAM.—*

22 “(A) *IN GENERAL.—An electronic prescrip-*
23 *tion drug program described in this paragraph*
24 *is a program that includes at least the following*

1 *components, consistent with national standards*
2 *established under subparagraph (B):*

3 “(i) *ELECTRONIC TRANSMITTAL OF*
4 *PRESCRIPTIONS.—Prescriptions are only re-*
5 *ceived electronically, except in emergency*
6 *cases and other exceptional circumstances*
7 *recognized by the Administrator.*

8 “(ii) *PROVISION OF INFORMATION TO*
9 *PRESCRIBING HEALTH CARE PROFES-*
10 *SIONAL.—The program provides, upon*
11 *transmittal of a prescription by a pre-*
12 *scribing health care professional, for trans-*
13 *mittal by the pharmacist to the professional*
14 *of information that includes—*

15 “(I) *information (to the extent*
16 *available and feasible) on the drugs*
17 *being prescribed for that patient and*
18 *other information relating to the med-*
19 *ical history or condition of the patient*
20 *that may be relevant to the appro-*
21 *priate prescription for that patient;*

22 “(II) *cost-effective alternatives (if*
23 *any) for the use of the drug prescribed;*
24 *and*

1 “(III) information on the drugs
2 included in the applicable formulary.

3 To the extent feasible, such program shall
4 permit the prescribing health care profes-
5 sional to provide (and be provided) related
6 information on an interactive, real-time
7 basis.

8 “(B) STANDARDS.—

9 “(i) DEVELOPMENT.—The Adminis-
10 trator shall provide for the development of
11 national standards relating to the electronic
12 prescription drug program described in sub-
13 paragraph (A). Such standards shall be
14 compatible with standards established under
15 part C of title XI.

16 “(ii) ADVISORY TASK FORCE.—In de-
17 veloping such standards and the standards
18 described in subsection (c)(2)(B)(i) the Ad-
19 ministrators shall establish a task force that
20 includes representatives of physicians, hos-
21 pitals, pharmacists, and technology experts
22 and representatives of the Departments of
23 Veterans Affairs and Defense and other ap-
24 propriate Federal agencies to provide rec-
25 ommendations to the Administrator on such

1 standards, including recommendations re-
2 lating to the following:

3 “(I) The range of available com-
4 puterized prescribing software and
5 hardware and their costs to develop
6 and implement.

7 “(II) The extent to which such
8 systems reduce medication errors and
9 can be readily implemented by physi-
10 cians and hospitals.

11 “(III) Efforts to develop a com-
12 mon software platform for computer-
13 ized prescribing.

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

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

24 “(iii) DEADLINES.—

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

4 “(II) *Such task force shall submit*
5 *recommendations to Administrator by*
6 *not later than January 1, 2004.*

7 “(III) *The Administrator shall de-*
8 *velop and promulgate the national*
9 *standards referred to in clause (ii) by*
10 *not later than January 1, 2005.*

11 “(C) *REFERENCE TO AVAILABILITY OF*
12 *GRANT FUNDS.—Grant funds are authorized*
13 *under section 3990 of the Public Health Service*
14 *Act to provide assistance to health care providers*
15 *in implementing electronic prescription drug*
16 *programs.*

17 “(4) *TREATMENT OF ACCREDITATION.—Section*
18 *1852(e)(4) (relating to treatment of accreditation)*
19 *shall apply to prescription drug plans under this part*
20 *with respect to the following requirements, in the*
21 *same manner as they apply to Medicare+Choice*
22 *plans under part C with respect to the requirements*
23 *described in a clause of section 1852(e)(4)(B):*

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

4 “(B) Subsection (c)(1) (relating to access to
5 covered benefits).

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

8 “(5) *PUBLIC DISCLOSURE OF PHARMACEUTICAL*
9 *PRICES FOR EQUIVALENT DRUGS.—Each PDP spon-*
10 *sor shall provide that each pharmacy or other dis-*
11 *perser that arranges for the dispensing of a covered*
12 *outpatient drug shall inform the beneficiary at the*
13 *time of purchase of the drug of any differential be-*
14 *tween the price of the prescribed drug to the enrollee*
15 *and the price of the lowest cost generic drug covered*
16 *under the plan that is therapeutically equivalent and*
17 *bioequivalent.*

18 “(e) *GRIEVANCE MECHANISM, COVERAGE DETERMINA-*
19 *TIONS, AND RECONSIDERATIONS.—*

20 “(1) *IN GENERAL.—Each PDP sponsor shall*
21 *provide meaningful procedures for hearing and resolv-*
22 *ing grievances between the organization (including*
23 *any entity or individual through which the sponsor*
24 *provides covered benefits) and enrollees with prescrip-*

1 *tion drug plans of the sponsor under this part in ac-*
2 *cordance with section 1852(f).*

3 *“(2) APPLICATION OF COVERAGE DETERMINA-*
4 *TION AND RECONSIDERATION PROVISIONS.—A PDP*
5 *sponsor shall meet the requirements of paragraphs (1)*
6 *through (3) of section 1852(g) with respect to covered*
7 *benefits under the prescription drug plan it offers*
8 *under this part in the same manner as such require-*
9 *ments apply to a Medicare+Choice organization with*
10 *respect to benefits it offers under a Medicare+Choice*
11 *plan under part C.*

12 *“(3) REQUEST FOR REVIEW OF TIERED FOR-*
13 *MULARY DETERMINATIONS.—In the case of a prescrip-*
14 *tion drug plan offered by a PDP sponsor that pro-*
15 *vides for tiered cost-sharing for drugs included within*
16 *a formulary and provides lower cost-sharing for pre-*
17 *ferred drugs included within the formulary, an indi-*
18 *vidual who is enrolled in the plan may request cov-*
19 *erage of a nonpreferred drug under the terms applica-*
20 *ble for preferred drugs if the prescribing physician de-*
21 *termines that the preferred drug for treatment of the*
22 *same condition is not as effective for the individual*
23 *or has adverse effects for the individual.*

24 *“(f) APPEALS.—*

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

9 “(2) *FORMULARY DETERMINATIONS.*—An indi-
10 *vidual who is enrolled in a prescription drug plan of-*
11 *fered by a PDP sponsor may appeal to obtain cov-*
12 *erage for a covered outpatient drug that is not on a*
13 *formulary of the sponsor if the prescribing physician*
14 *determines that the formulary drug for treatment of*
15 *the same condition is not as effective for the indi-*
16 *vidual or has adverse effects for the individual.*

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

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

4 *“(a) GENERAL REQUIREMENTS.—Each PDP sponsor*
5 *of a prescription drug plan shall meet the following require-*
6 *ments:*

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

12 *“(2) ASSUMPTION OF FINANCIAL RISK.—*

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

19 *“(B) REINSURANCE PERMITTED.—The enti-*
20 *ty may obtain insurance or make other arrange-*
21 *ments for the cost of coverage provided to any*
22 *enrolled member under this part.*

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

1 “(b) *CONTRACT REQUIREMENTS.*—

2 “(1) *IN GENERAL.*—*The Administrator shall not*
3 *permit the election under section 1860A of a prescrip-*
4 *tion drug plan offered by a PDP sponsor under this*
5 *part, and the sponsor shall not be eligible for pay-*
6 *ments under section 1860G or 1860H, unless the Ad-*
7 *ministrator has entered into a contract under this*
8 *subsection with the sponsor with respect to the offer-*
9 *ing of such plan. Such a contract with a sponsor may*
10 *cover more than one prescription drug plan. Such*
11 *contract shall provide that the sponsor agrees to com-*
12 *ply with the applicable requirements and standards of*
13 *this part and the terms and conditions of payment as*
14 *provided for in this part.*

15 “(2) *NEGOTIATION REGARDING TERMS AND CON-*
16 *DITIONS.*—*The Administrator shall have the same au-*
17 *thority to negotiate the terms and conditions of pre-*
18 *scription drug plans under this part as the Director*
19 *of the Office of Personnel Management has with re-*
20 *spect to health benefits plans under chapter 89 of title*
21 *5, United States Code. In negotiating the terms and*
22 *conditions regarding premiums for which information*
23 *is submitted under section 1860F(a)(2), the Adminis-*
24 *trator shall take into account the subsidy payments*
25 *under section 1860H and the adjusted community*

1 rate (as defined in section 1854(f)(3)) for the benefits
2 covered.

3 “(3) INCORPORATION OF CERTAIN
4 MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The
5 following provisions of section 1857 shall apply, sub-
6 ject to subsection (c)(5), to contracts under this sec-
7 tion in the same manner as they apply to contracts
8 under section 1857(a):

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

11 “(B) CONTRACT PERIOD AND EFFECTIVE-
12 NESS.—Paragraphs (1) through (3) and (5) of
13 section 1857(c).

14 “(C) PROTECTIONS AGAINST FRAUD AND
15 BENEFICIARY PROTECTIONS.—Section 1857(d).

16 “(D) ADDITIONAL CONTRACT TERMS.—Sec-
17 tion 1857(e); except that in applying section
18 1857(e)(2) under this part—

19 “(i) such section shall be applied sepa-
20 rately to costs relating to this part (from
21 costs under part C);

22 “(ii) in no case shall the amount of the
23 fee established under this subparagraph for
24 a plan exceed 20 percent of the maximum
25 amount of the fee that may be established

1 under subparagraph (B) of such section;
2 and

3 “(iii) no fees shall be applied under
4 this subparagraph with respect to
5 Medicare+Choice plans.

6 “(E) INTERMEDIATE SANCTIONS.—Section
7 1857(g).

8 “(F) PROCEDURES FOR TERMINATION.—
9 Section 1857(h).

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

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

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

17 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND
18 CHOICE.—

19 “(1) IN GENERAL.—In the case of an entity that
20 seeks to offer a prescription drug plan in a State, the
21 Administrator shall waive the requirement of sub-
22 section (a)(1) that the entity be licensed in that State
23 if the Administrator determines, based on the applica-
24 tion and other evidence presented to the Adminis-

1 *trator, that any of the grounds for approval of the ap-*
2 *plication described in paragraph (2) has been met.*

3 *“(2) GROUNDS FOR APPROVAL.—The grounds for*
4 *approval under this paragraph are the grounds for*
5 *approval described in subparagraph (B), (C), and*
6 *(D) of section 1855(a)(2), and also include the appli-*
7 *cation by a State of any grounds other than those re-*
8 *quired under Federal law.*

9 *“(3) APPLICATION OF WAIVER PROCEDURES.—*
10 *With respect to an application for a waiver (or a*
11 *waiver granted) under this subsection, the provisions*
12 *of subparagraphs (E), (F), and (G) of section*
13 *1855(a)(2) shall apply.*

14 *“(4) LICENSURE DOES NOT SUBSTITUTE FOR OR*
15 *CONSTITUTE CERTIFICATION.—The fact that an entity*
16 *is licensed in accordance with subsection (a)(1) does*
17 *not deem the entity to meet other requirements im-*
18 *posed under this part for a PDP sponsor.*

19 *“(5) REFERENCES TO CERTAIN PROVISIONS.—*
20 *For purposes of this subsection, in applying provi-*
21 *sions of section 1855(a)(2) under this subsection to*
22 *prescription drug plans and PDP sponsors—*

23 *“(A) any reference to a waiver application*
24 *under section 1855 shall be treated as a reference*

1 to a waiver application under paragraph (1);
2 and

3 “(B) any reference to solvency standards
4 shall be treated as a reference to solvency stand-
5 ards established under subsection (d).

6 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
7 SPONSORS.—

8 “(1) ESTABLISHMENT.—The Administrator shall
9 establish, by not later than October 1, 2003, financial
10 solvency and capital adequacy standards that an en-
11 tity that does not meet the requirements of subsection
12 (a)(1) must meet to qualify as a PDP sponsor under
13 this part.

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

23 “(e) OTHER STANDARDS.—The Administrator shall es-
24 tablish by regulation other standards (not described in sub-
25 section (d)) for PDP sponsors and plans consistent with,

1 *and to carry out, this part. The Administrator shall publish*
2 *such regulations by October 1, 2003.*

3 “(f) *RELATION TO STATE LAWS.*—

4 “(1) *IN GENERAL.*—*The standards established*
5 *under this part shall supersede any State law or reg-*
6 *ulation (other than State licensing laws or State laws*
7 *relating to plan solvency, except as provided in sub-*
8 *section (d)) with respect to prescription drug plans*
9 *which are offered by PDP sponsors under this part.*

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

16 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**
17 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

18 “(a) *IN GENERAL.*—*The Administrator shall establish*
19 *a process for the selection of the prescription drug plan or*
20 *Medicare+Choice plan which offer qualified prescription*
21 *drug coverage through which eligible individuals elect quali-*
22 *fied prescription drug coverage under this part.*

23 “(b) *ELEMENTS.*—*Such process shall include the fol-*
24 *lowing:*

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

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

12 “(3) *Coordination of elections through filing*
13 *with a Medicare+Choice organization or a PDP*
14 *sponsor, in the manner described in (and in coordi-*
15 *nation with) section 1851(c)(2).*

16 “(c) *MEDICARE+CHOICE ENROLLEE IN PLAN OFFER-*
17 *ING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN*
18 *BENEFITS THROUGH THE PLAN.—An individual who is*
19 *enrolled under a Medicare+Choice plan that offers qualified*
20 *prescription drug coverage may only elect to receive quali-*
21 *fied prescription drug coverage under this part through*
22 *such plan.*

23 “(d) *ASSURING ACCESS TO A CHOICE OF QUALIFIED*
24 *PRESCRIPTION DRUG COVERAGE.—*

1 “(1) *CHOICE OF AT LEAST TWO PLANS IN EACH*
2 *AREA.—*

3 “(A) *IN GENERAL.—The Administrator*
4 *shall assure that each individual who is entitled*
5 *to benefits under part A or enrolled under part*
6 *B and who is residing in an area in the United*
7 *States has available, consistent with subpara-*
8 *graph (B), a choice of enrollment in at least two*
9 *qualifying plans (as defined in paragraph (5))*
10 *in the area in which the individual resides, at*
11 *least one of which is a prescription drug plan.*

12 “(B) *REQUIREMENT FOR DIFFERENT PLAN*
13 *SPONSORS.—The requirement in subparagraph*
14 *(A) is not satisfied with respect to an area if*
15 *only one PDP sponsor or Medicare+Choice orga-*
16 *nization offers all the qualifying plans in the*
17 *area.*

18 “(2) *GUARANTEEING ACCESS TO COVERAGE.—In*
19 *order to assure access under paragraph (1) and con-*
20 *sistent with paragraph (3), the Administrator may*
21 *provide financial incentives (including partial under-*
22 *writing of risk) for a PDP sponsor to expand the*
23 *service area under an existing prescription drug plan*
24 *to adjoining or additional areas or to establish such*
25 *a plan (including offering such a plan on a regional*

1 or nationwide basis), but only so long as (and to the
2 extent) necessary to assure the access guaranteed
3 under paragraph (1).

4 “(3) *LIMITATION ON AUTHORITY.*—In exercising
5 authority under this subsection, the Administrator—

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

8 “(B) shall not provide for any underwriting
9 of financial risk for a public PDP sponsor with
10 respect to the offering of a nationwide prescrip-
11 tion drug plan; and

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

15 “(4) *REPORTS.*—The Administrator shall, in
16 each annual report to Congress under section 1808(f),
17 include information on the exercise of authority under
18 this subsection. The Administrator also shall include
19 such recommendations as may be appropriate to min-
20 imize the exercise of such authority, including mini-
21 mizing the assumption of financial risk.

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

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

2 “(a) *SUBMISSION OF BIDS AND RELATED INFORMA-*
3 *TION.—*

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

9 “(2) *TYPE OF INFORMATION.—The information*
10 *described in this paragraph is the following:*

11 “(A) *Information on the qualified prescrip-*
12 *tion drug coverage to be provided.*

13 “(B) *Information on the actuarial value of*
14 *the coverage.*

15 “(C) *Information on the bid for the cov-*
16 *erage, including an actuarial certification of—*

17 “(i) *the actuarial basis for such bid;*

18 “(ii) *the portion of such bid attrib-*
19 *utable to benefits in excess of standard cov-*
20 *erage; and*

21 “(iii) *the reduction in such bid result-*
22 *ing from the subsidy payments provided*
23 *under section 1860H.*

24 “(D) *Such other information as the Admin-*
25 *istrator may require to carry out this part.*

1 “(3) *REVIEW.*—*The Administrator shall review*
2 *the information filed under paragraph (2) for the*
3 *purpose of conducting negotiations under section*
4 *1860D(b)(2).*

5 “(b) *UNIFORM BID.*—

6 “(1) *IN GENERAL.*—*The bid for a prescription*
7 *drug plan under this section may not vary among in-*
8 *dividuals enrolled in the plan in the same service*
9 *area.*

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

13 “(c) *COLLECTION.*—

14 “(1) *USE AT BENEFICIARY’S OPTION OF WITH-*
15 *HOLDING FROM SOCIAL SECURITY PAYMENT AND USE*
16 *OF ELECTRONIC FUNDS TRANSFER MECHANISM.*—*In*
17 *accordance with regulations, a PDP sponsor shall*
18 *permit each enrollee, at the enrollee’s option, to make*
19 *payment of premiums through withholding from ben-*
20 *efit payments in the manner provided under section*
21 *1840 with respect to monthly premiums under section*
22 *1839. In the case in which an enrollee does not elect*
23 *such option, a PDP sponsor may, in accordance with*
24 *regulations, encourage enrollees to make payment of*
25 *the premium established by the plan under this part*

1 *through an electronic funds transfer mechanism, such*
2 *as automatic charges of an account at a financial in-*
3 *stitution or a credit or debit card account. All such*
4 *amounts shall be credited to the Medicare Prescrip-*
5 *tion Drug Trust Fund.*

6 “(2) *OFFSETTING.*—*Reductions in premiums for*
7 *coverage under parts A and B as a result of a selec-*
8 *tion of a Medicare+Choice plan may be used to re-*
9 *duce the premium otherwise imposed under para-*
10 *graph (1).*

11 “(3) *PAYMENT OF PLANS.*—*PDP plans shall re-*
12 *ceive payment based on bid amounts in the same*
13 *manner as Medicare+Choice organizations receive*
14 *payment based on bid amounts under section*
15 *1853(a)(1)(A)(ii) except that such payment shall be*
16 *made from the Medicare Prescription Drug Trust*
17 *Fund.*

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

21 “(1) *IN GENERAL.*—*If there is no standard pre-*
22 *scription drug coverage (as defined in paragraph (2))*
23 *offered in an area, in the case of an individual who*
24 *is eligible for a premium subsidy under section 1860G*
25 *and resides in the area, the PDP sponsor of any pre-*

1 *scription drug plan offered in the area (and any*
 2 *Medicare+Choice organization that offers qualified*
 3 *prescription drug coverage in the area) shall accept*
 4 *the benchmark bid amount (under section*
 5 *1860G(b)(2)) as payment in full for the premium*
 6 *charge for qualified prescription drug coverage.*

7 “(2) *STANDARD PRESCRIPTION DRUG COVERAGE*
 8 *DEFINED.—For purposes of this subsection, the term*
 9 *‘standard prescription drug coverage’ means qualified*
 10 *prescription drug coverage that is standard coverage*
 11 *or that has an actuarial value equivalent to the actu-*
 12 *arial value for standard coverage.*

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

15 “(a) *INCOME-RELATED SUBSIDIES FOR INDIVIDUALS*
 16 *WITH INCOME BELOW 175 PERCENT OF FEDERAL POVERTY*
 17 *LEVEL.—*

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

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

4 “(B) subject to subsection (c), to the substi-
5 tution for the beneficiary cost-sharing described
6 in paragraphs (1) and (2) of section 1860B(b)
7 (up to the initial coverage limit specified in
8 paragraph (3) of such section) of amounts that
9 do not exceed \$2 for a multiple source or generic
10 drug (as described in section 1927(k)(7)(A)) and
11 \$5 for a non-preferred drug.

12 “(2) *SLIDING SCALE PREMIUM SUBSIDY AND RE-*
13 *DUCTION OF COST-SHARING FOR INDIVIDUALS WITH*
14 *INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF*
15 *FEDERAL POVERTY LEVEL.—In the case of a subsidy*
16 *eligible individual who is determined to have income*
17 *that exceeds 150 percent, but does not exceed 175 per-*
18 *cent, of the Federal poverty level, the individual is en-*
19 *titled under this section to—*

20 “(A) an income-related premium subsidy
21 determined on a linear sliding scale ranging
22 from 100 percent of the amount described in sub-
23 section (b)(1) for individuals with incomes at
24 150 percent of such level to 0 percent of such

1 *amount for individuals with incomes at 175 per-*
2 *cent of such level; and*

3 “(B) *subject to subsection (c), to the substi-*
4 *tution for the beneficiary cost-sharing described*
5 *in paragraphs (1) and (2) of section 1860B(b)*
6 *(up to the initial coverage limit specified in*
7 *paragraph (3) of such section) of amounts that*
8 *do not exceed \$2 for a multiple source or generic*
9 *drug (as described in section 1927(k)(7)(A)) and*
10 *\$5 for a non-preferred drug.*

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

15 “(4) *DETERMINATION OF ELIGIBILITY.—*

16 “(A) *SUBSIDY ELIGIBLE INDIVIDUAL DE-*
17 *FINED.—For purposes of this section, subject to*
18 *subparagraph (D), the term ‘subsidy eligible in-*
19 *dividual’ means an individual who—*

20 “(i) *is eligible to elect, and has elected,*
21 *to obtain qualified prescription drug cov-*
22 *erage under this part;*

23 “(ii) *has income below 175 percent of*
24 *the Federal poverty line; and*

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

3 “(B) DETERMINATIONS.—The determina-
4 tion of whether an individual residing in a State
5 is a subsidy eligible individual and the amount
6 of such individual’s income shall be determined
7 under the State medicaid plan for the State
8 under section 1935(a) or by the Social Security
9 Administration. In the case of a State that does
10 not operate such a medicaid plan (either under
11 title XIX or under a statewide waiver granted
12 under section 1115), such determination shall be
13 made under arrangements made by the Adminis-
14 trator. There are authorized to be appropriated
15 to the Social Security Administration such sums
16 as may be necessary for the determination of eli-
17 gibility under this subparagraph.

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

20 “(i) income shall be determined in the
21 manner described in section 1905(p)(1)(B);
22 and

23 “(ii) the term ‘Federal poverty line’
24 means the official poverty line (as defined
25 by the Office of Management and Budget,

1 *and revised annually in accordance with*
2 *section 673(2) of the Omnibus Budget Rec-*
3 *onciliation Act of 1981) applicable to a*
4 *family of the size involved.*

5 “(D) *TREATMENT OF TERRITORIAL RESI-*
6 *DENTS.—In the case of an individual who is not*
7 *a resident of the 50 States or the District of Co-*
8 *lumbia, the individual is not eligible to be a sub-*
9 *sidy eligible individual but may be eligible for*
10 *financial assistance with prescription drug ex-*
11 *penditures under section 1935(e).*

12 “(E) *TREATMENT OF CONFORMING MEDIGAP*
13 *POLICIES.—For purposes of this section, the term*
14 *‘qualified prescription drug coverage’ includes a*
15 *medicare supplemental policy described in sec-*
16 *tion 1860H(b)(4).*

17 “(5) *INDEXING DOLLAR AMOUNTS.—*

18 “(A) *FOR 2006.—The dollar amounts ap-*
19 *plied under paragraphs (1)(B) and (2)(B) for*
20 *2006 shall be the dollar amounts specified in*
21 *such paragraph increased by the annual percent-*
22 *age increase described in section 1860B(b)(5) for*
23 *2006.*

24 “(B) *FOR SUBSEQUENT YEARS.—The dollar*
25 *amounts applied under paragraphs (1)(B) and*

1 (2)(B) for a year after 2006 shall be the amounts
2 (under this paragraph) applied under paragraph
3 (1)(B) or (2)(B) for the preceding year increased
4 by the annual percentage increase described in
5 section 1860B(b)(5) (relating to growth in medi-
6 care prescription drug costs per beneficiary) for
7 the year involved.

8 “(b) PREMIUM SUBSIDY AMOUNT.—

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

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

20 “(A) a prescription drug plan that—

21 “(i) provides standard coverage (or al-
22 ternative prescription drug coverage the ac-
23 tuarial value is equivalent to that of stand-
24 ard coverage), the bid amount for enroll-
25 ment under the plan under this part (deter-

1 *mined without regard to any subsidy under*
2 *this section or any late enrollment penalty*
3 *under section 1860A(c)(2)(B)); or*

4 *“(i) provides alternative prescription*
5 *drug coverage the actuarial value of which*
6 *is greater than that of standard coverage,*
7 *the bid amount described in clause (i) mul-*
8 *tiplied by the ratio of (I) the actuarial*
9 *value of standard coverage, to (II) the actu-*
10 *arial value of the alternative coverage; or*

11 *“(B) a Medicare+Choice plan, the portion*
12 *of the bid amount that is attributable to statu-*
13 *tory drug benefits (described in section*
14 *1853(a)(1)(A)(i)(II)).*

15 *“(c) RULES IN APPLYING COST-SHARING SUB-*
16 *SIDIES.—*

17 *“(1) IN GENERAL.—In applying subsections*
18 *(a)(1)(B) and (a)(2)(B), nothing in this part shall be*
19 *construed as preventing a plan or provider from*
20 *waiving or reducing the amount of cost-sharing other-*
21 *wise applicable.*

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

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

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

12 “(1) *the Administrator provides for a notifica-*
13 *tion of the PDP sponsor or Medicare+Choice organi-*
14 *zation involved that the individual is eligible for a*
15 *subsidy and the amount of the subsidy under sub-*
16 *section (a);*

17 “(2) *the sponsor or organization involved reduces*
18 *the premiums or cost-sharing otherwise imposed by*
19 *the amount of the applicable subsidy and submits to*
20 *the Administrator information on the amount of such*
21 *reduction; and*

22 “(3) *the Administrator periodically and on a*
23 *timely basis reimburses the sponsor or organization*
24 *for the amount of such reductions.*

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

6 “(e) *RELATION TO MEDICAID PROGRAM.*—

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

10 “(2) *MEDICAID PROVIDING WRAP AROUND BENE-*
11 *FITS.*—*The coverage provided under this part is pri-*
12 *mary payor to benefits for prescribed drugs provided*
13 *under the medicaid program under title XIX.*

14 “(3) *COORDINATION.*—*The Administrator shall*
15 *develop and implement a plan for the coordination of*
16 *prescription drug benefits under this part with the*
17 *benefits provided under the medicaid program under*
18 *title XIX, with particular attention to insuring co-*
19 *ordination of payments and prevention of fraud and*
20 *abuse. In developing and implementing such plan, the*
21 *Administrator shall involve the Secretary, the States,*
22 *the data processing industry, pharmacists, and phar-*
23 *maceutical manufacturers, and other experts.*

1 **“SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**
2 **FICIARIES FOR QUALIFIED PRESCRIPTION**
3 **DRUG COVERAGE.**

4 “(a) *SUBSIDY PAYMENT.*—*In order to reduce premium*
5 *levels applicable to qualified prescription drug coverage for*
6 *all medicare beneficiaries consistent with an overall subsidy*
7 *level of 65 percent, to reduce adverse selection among pre-*
8 *scription drug plans and Medicare+Choice plans that pro-*
9 *vide qualified prescription drug coverage, and to promote*
10 *the participation of PDP sponsors under this part, the Ad-*
11 *ministrators shall provide in accordance with this section*
12 *for payment to a qualifying entity (as defined in subsection*
13 *(b)) of the following subsidies:*

14 “(1) *DIRECT SUBSIDY.*—*In the case of an indi-*
15 *vidual enrolled in a prescription drug plan,*
16 *Medicare+Choice plan that provides qualified pre-*
17 *scription drug coverage, or qualified retiree prescrip-*
18 *tion drug plan, a direct subsidy equal to 35 percent*
19 *of the total payments made by a qualifying entity for*
20 *standard coverage under the respective plan.*

21 “(2) *SUBSIDY THROUGH REINSURANCE.*—*The re-*
22 *insurance payment amount (as defined in subsection*
23 *(c)), which in the aggregate is 30 percent of such total*
24 *payments, for excess costs incurred in providing*
25 *qualified prescription drug coverage—*

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

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

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

8 *This section constitutes budget authority in advance of ap-
9 propriations Acts and represents the obligation of the Ad-
10 ministrator to provide for the payment of amounts provided
11 under this section.*

12 “(b) *QUALIFYING ENTITY DEFINED.*—*For purposes of
13 this section, the term ‘qualifying entity’ means any of the
14 following that has entered into an agreement with the Ad-
15 ministrator to provide the Administrator with such infor-
16 mation as may be required to carry out this section:*

17 “(1) *A PDP sponsor offering a prescription drug
18 plan under this part.*

19 “(2) *A Medicare+Choice organization that pro-
20 vides qualified prescription drug coverage under a
21 Medicare+Choice plan under part C.*

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

24 “(c) *REINSURANCE PAYMENT AMOUNT.*—

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

7 “(A) *For the portion of the individual’s*
8 *gross covered prescription drug costs (as defined*
9 *in paragraph (3)) for the year that exceeds the*
10 *initial copayment threshold specified in section*
11 *1860B(b)(2)(C), but does not exceed the initial*
12 *coverage limit specified in section 1860B(b)(3),*
13 *an amount equal to 30 percent of the allowable*
14 *costs (as defined in paragraph (2)) attributable*
15 *to such gross covered prescription drug costs.*

16 “(B) *For the portion of the individual’s*
17 *gross covered prescription drug costs for the year*
18 *that exceeds the annual out-of-pocket threshold*
19 *specified in 1860B(b)(4)(B), an amount equal to*
20 *80 percent of the allowable costs attributable to*
21 *such gross covered prescription drug costs.*

22 “(2) *ALLOWABLE COSTS.*—*For purposes of this*
23 *section, the term ‘allowable costs’ means, with respect*
24 *to gross covered prescription drug costs under a plan*
25 *described in subsection (b) offered by a qualifying en-*

1 *tity, the part of such costs that are actually paid (net*
2 *of average percentage rebates) under the plan, but in*
3 *no case more than the part of such costs that would*
4 *have been paid under the plan if the prescription*
5 *drug coverage under the plan were standard coverage.*

6 *“(3) GROSS COVERED PRESCRIPTION DRUG*
7 *COSTS.—For purposes of this section, the term ‘gross*
8 *covered prescription drug costs’ means, with respect to*
9 *an enrollee with a qualifying entity under a plan de-*
10 *scribed in subsection (b) during a coverage year, the*
11 *costs incurred under the plan (including costs attrib-*
12 *utable to administrative costs) for covered prescrip-*
13 *tion drugs dispensed during the year, including costs*
14 *relating to the deductible, whether paid by the enrollee*
15 *or under the plan, regardless of whether the coverage*
16 *under the plan exceeds standard coverage and regard-*
17 *less of when the payment for such drugs is made.*

18 *“(4) INDEXING DOLLAR AMOUNTS.—*

19 *“(A) AMOUNTS FOR 2005.—The dollar*
20 *amounts applied under paragraph (1) for 2005*
21 *shall be the dollar amounts specified in such*
22 *paragraph.*

23 *“(B) FOR 2006.—The dollar amounts ap-*
24 *plied under paragraph (1) for 2006 shall be the*
25 *dollar amounts specified in such paragraph in-*

1 *creased by the annual percentage increase de-*
2 *scribed in section 1860B(b)(5) for 2006.*

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

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

15 “(d) *ADJUSTMENT OF PAYMENTS.—*

16 “(1) *ADJUSTMENT OF REINSURANCE PAYMENTS*
17 *TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH*
18 *REINSURANCE.—*

19 “(A) *ESTIMATION OF PAYMENTS.—The Ad-*
20 *ministrator shall estimate—*

21 “(i) *the total payments to be made*
22 *(without regard to this subsection) during a*
23 *year under subsections (a)(2) and (c); and*

24 “(ii) *the total payments to be made by*
25 *qualifying entities for standard coverage*

1 under plans described in subsection (b) dur-
2 ing the year.

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

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

19 “(e) *PAYMENT METHODS.*—

20 “(1) *IN GENERAL.*—*Payments under this section*
21 *shall be based on such a method as the Administrator*
22 *determines. The Administrator may establish a pay-*
23 *ment method by which interim payments of amounts*
24 *under this section are made during a year based on*

1 *the Administrator’s best estimate of amounts that will*
2 *be payable after obtaining all of the information.*

3 “(2) *SOURCE OF PAYMENTS.—Payments under*
4 *this section shall be made from the Medicare Prescrip-*
5 *tion Drug Trust Fund.*

6 “(f) *QUALIFIED RETIREE PRESCRIPTION DRUG PLAN*
7 *DEFINED.—*

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

15 “(A) *ASSURANCE.—The sponsor of the plan*
16 *shall annually attest, and provide such assur-*
17 *ances as the Administrator may require, that the*
18 *coverage meets or exceeds the requirements for*
19 *qualified prescription drug coverage.*

20 “(B) *AUDITS.—The sponsor (and the plan)*
21 *shall maintain, and afford the Administrator ac-*
22 *cess to, such records as the Administrator may*
23 *require for purposes of audits and other oversight*
24 *activities necessary to ensure the adequacy of*

1 *prescription drug coverage, and the accuracy of*
2 *payments made.*

3 “(C) *PROVISION OF CERTIFICATION OF PRE-*
4 *SCRIPTION DRUG COVERAGE.—The sponsor of the*
5 *plan shall provide for issuance of certifications*
6 *of the type described in section 1860A(c)(2)(D).*

7 “(2) *LIMITATION ON BENEFIT ELIGIBILITY.—No*
8 *payment shall be provided under this section with re-*
9 *spect to an individual who is enrolled under a quali-*
10 *fied retiree prescription drug plan unless the indi-*
11 *vidual is—*

12 “(A) *enrolled under this part;*

13 “(B) *is covered under the plan; and*

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

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

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

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

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

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

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

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

14 “(b) *PAYMENTS FROM TRUST FUND.*—

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

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

21 “(B) *payments under section 1860H (relat-*
22 *ing to subsidy payments); and*

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

1 “(2) *TRANSFERS TO MEDICAID ACCOUNT FOR IN-*
2 *CREASED ADMINISTRATIVE COSTS.—The Managing*
3 *Trustee shall transfer from time to time from the*
4 *Trust Fund to the Grants to States for Medicaid ac-*
5 *count amounts the Administrator certifies are attrib-*
6 *utable to increases in payment resulting from the ap-*
7 *plication 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.—Any*
25 *provision of law that relates to the solvency of the Trust*

1 *Fund under this part shall take into account the Trust*
2 *Fund and amounts receivable by, or payable from, the*
3 *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 coverage*
13 *that is not standard coverage, the comparable limit*
14 *(if any) established under the coverage.*

15 *“(3) MEDICARE PRESCRIPTION DRUG TRUST*
16 *FUND.—The term ‘Medicare Prescription Drug Trust*
17 *Fund’ means the Trust Fund created under section*
18 *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 ‘pre-*
24 *scription drug plan’ means health benefits coverage*
25 *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 ‘standard
13 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 prescrip-
17 tion drug plan and a PDP sponsor, unless otherwise pro-
18 vided in this part such provisions shall be applied as if—

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

21 “(2) any reference to a provider-sponsored orga-
22 nization included a reference to a PDP sponsor;

23 “(3) any reference to a contract under section
24 1857 included a reference to a contract under section
25 1860D(b); and

1 “(4) any reference to part C included a reference
2 to this part.”.

3 (b) *ADDITIONAL CONFORMING CHANGES.*—

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

9 (2) *CONFORMING AMENDMENT PERMITTING WAIV-*
10 *ER OF COST-SHARING.*—Section 1128B(b)(3) (42
11 U.S.C. 1320a–7b(b)(3)) is amended—

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

14 (B) by striking the period at the end of sub-
15 paragraph (F) and inserting “; and”; and

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

18 “(G) the waiver or reduction of any cost-sharing
19 imposed under part D of title XVIII.”.

20 (3) *SUBMISSION OF LEGISLATIVE PROPOSAL.*—
21 Not later than 6 months after the date of the enact-
22 ment of this Act, the Secretary of Health and Human
23 Services shall submit to the appropriate committees of
24 Congress a legislative proposal providing for such

1 *technical and conforming amendments in the law as*
 2 *are required by the provisions of this subtitle.*

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

10 **SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG**
 11 **COVERAGE UNDER THE MEDICARE+CHOICE**
 12 **PROGRAM.**

13 (a) *IN GENERAL.*—*Section 1851 (42 U.S.C. 1395w-*
 14 *21) is amended by adding at the end the following new sub-*
 15 *section:*

16 “(j) *AVAILABILITY OF PRESCRIPTION DRUG BENE-*
 17 *FITS.*—

18 “(1) *OFFER OF QUALIFIED PRESCRIPTION DRUG*
 19 *COVERAGE.*—

20 “(A) *IN GENERAL.*—*A Medicare+Choice or-*
 21 *ganization may not offer prescription drug cov-*
 22 *erage (other than that required under parts A*
 23 *and B) to an enrollee under a Medicare+Choice*
 24 *plan unless such drug coverage is at least quali-*
 25 *fied prescription drug coverage and unless the re-*

1 *quirements of this subsection with respect to such*
2 *coverage are met.*

3 *“(B) CONSTRUCTION.—Nothing in this sub-*
4 *section shall be construed as—*

5 *“(i) requiring a Medicare+Choice plan*
6 *to include coverage of qualified prescription*
7 *drug coverage; or*

8 *“(ii) permitting a Medicare+Choice*
9 *organization from providing such coverage*
10 *to an individual who has not elected such*
11 *coverage under section 1860A(b).*

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

17 *“(2) COMPLIANCE WITH ADDITIONAL BENE-*
18 *FICIARY PROTECTIONS.—With respect to the offering*
19 *of qualified prescription drug coverage by a*
20 *Medicare+Choice organization under a*
21 *Medicare+Choice plan, the organization and plan*
22 *shall meet the requirements of section 1860C, includ-*
23 *ing requirements relating to information dissemina-*
24 *tion and grievance and appeals, in the same manner*
25 *as they apply to a PDP sponsor and a prescription*

1 *drug plan under part D and shall submit to the Ad-*
2 *ministrator the information described in section*
3 *1860F(a)(2). The Administrator shall waive such re-*
4 *quirements to the extent the Administrator determines*
5 *that such requirements duplicate requirements other-*
6 *wise applicable to the organization or plan under this*
7 *part.*

8 *“(3) AVAILABILITY OF PREMIUM AND COST-SHAR-*
9 *ING SUBSIDIES FOR LOW-INCOME ENROLLEES AND DI-*
10 *RECT AND REINSURANCE SUBSIDY PAYMENTS FOR OR-*
11 *GANIZATIONS.—For provisions—*

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

16 *“(B) providing a Medicare+Choice organi-*
17 *zation with direct and insurance subsidy pay-*
18 *ments for providing qualified prescription drug*
19 *coverage under this part, see section 1860H.*

20 *“(4) TRANSITION IN INITIAL ENROLLMENT PE-*
21 *RIOD.—Notwithstanding any other provision of this*
22 *part, the annual, coordinated election period under*
23 *subsection (e)(3)(B) for 2005 shall be the 6-month pe-*
24 *riod beginning with November 2004.*

1 “(5) *QUALIFIED PRESCRIPTION DRUG COVERAGE;*
2 *STANDARD COVERAGE.*—*For purposes of this part, the*
3 *terms ‘qualified prescription drug coverage’ and*
4 *‘standard coverage’ have the meanings given such*
5 *terms in section 1860B.”.*

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

8 *(1) in subsection (a)(1)—*

9 *(A) by inserting “(other than qualified pre-*
10 *scription drug benefits)” after “benefits”;*

11 *(B) by striking the period at the end of sub-*
12 *paragraph (B) and inserting a comma; and*

13 *(C) by adding after and below subpara-*
14 *graph (B) the following:*

15 *“and may elect qualified prescription drug coverage*
16 *in accordance with section 1860A.”; and*

17 *(2) in subsection (g)(1), by inserting “and sec-*
18 *tion 1860A(c)(2)(B)” after “in this subsection”.*

19 **(c) EFFECTIVE DATE.**—*The amendments made by this*
20 *section apply to coverage provided on or after January 1,*
21 *2005.*

22 **SEC. 103. MEDICAID AMENDMENTS.**

23 **(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-**
24 **COME SUBSIDIES.**—

1 (1) *REQUIREMENT.*—Section 1902(a) (42 U.S.C.
2 1396a(a)) is amended—

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

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

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

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

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

13 (A) by redesignating section 1935 as section
14 1936; and

15 (B) by inserting after section 1934 the fol-
16 lowing new section:

17 “SPECIAL PROVISIONS RELATING TO MEDICARE
18 PRESCRIPTION DRUG BENEFIT

19 “SEC. 1935. (a) *REQUIREMENT FOR MAKING ELIGI-*
20 *BILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.*—
21 As a condition of its State plan under this title under sec-
22 tion 1902(a)(66) and receipt of any Federal financial as-
23 sistance under section 1903(a), a State shall—

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

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

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

7 “(b) *PAYMENTS FOR ADDITIONAL ADMINISTRATIVE*
8 *COSTS.—*

9 “(1) *IN GENERAL.—The amounts expended by a*
10 *State in carrying out subsection (a) are, subject to*
11 *paragraph (2), expenditures reimbursable under the*
12 *appropriate paragraph of section 1903(a); except*
13 *that, notwithstanding any other provision of such sec-*
14 *tion, the applicable Federal matching rates with re-*
15 *spect to such expenditures under such section shall be*
16 *increased as follows (but in no case shall the rate as*
17 *so increased exceed 100 percent):*

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

23 “(B)(i) *For expenditures attributable to*
24 *costs incurred during 2006 and each subsequent*
25 *year through 2013, the otherwise applicable Fed-*

1 *eral matching rate shall be increased by the ap-*
2 *plicable percent (as defined in clause (ii)) of the*
3 *percentage otherwise payable (but for this sub-*
4 *section) by the State.*

5 *“(i) For purposes of clause (i), the ‘appli-*
6 *cable percent’ for—*

7 *“(I) 2006 is 20 percent; or*

8 *“(II) a subsequent year is the applica-*
9 *ble percent under this clause for the pre-*
10 *vious year increased by 10 percentage*
11 *points.*

12 *“(C) For expenditures attributable to costs*
13 *incurred after 2013, the otherwise applicable*
14 *Federal matching rate shall be increased to 100*
15 *percent.*

16 *“(2) COORDINATION.—The State shall provide*
17 *the Administrator with such information as may be*
18 *necessary to properly allocate administrative expendi-*
19 *tures described in paragraph (1) that may otherwise*
20 *be made for similar eligibility determinations.”.*

21 *(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID*
22 *RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-*
23 *SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—*

24 *(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C.*
25 *1396b(a)(1)) is amended by inserting before the semi-*

1 *colon the following: “, reduced by the amount com-*
2 *puted under section 1935(c)(1) for the State and the*
3 *quarter”.*

4 (2) *AMOUNT DESCRIBED.*—Section 1935, as in-
5 *serted by subsection (a)(2), is amended by adding at*
6 *the end the following new subsection:*

7 “(c) *FEDERAL ASSUMPTION OF MEDICAID PRESCRIP-*
8 *TION DRUG COSTS FOR DUALY-ELIGIBLE BENE-*
9 *FICIARIES.*—

10 “(1) *IN GENERAL.*—For purposes of section
11 *1903(a)(1), for a State that is one of the 50 States*
12 *or the District of Columbia for a calendar quarter in*
13 *a year (beginning with 2005) the amount computed*
14 *under this subsection is equal to the product of the*
15 *following:*

16 “(A) *MEDICARE SUBSIDIES.*—The total
17 *amount of payments made in the quarter under*
18 *section 1860G (relating to premium and cost-*
19 *sharing prescription drug subsidies for low-in-*
20 *come medicare beneficiaries) that are attrib-*
21 *utable to individuals who are residents of the*
22 *State and are entitled to benefits with respect to*
23 *prescribed drugs under the State plan under this*
24 *title (including such a plan operating under a*
25 *waiver under section 1115).*

1 “(B) *STATE MATCHING RATE*.—A propor-
 2 tion computed by subtracting from 100 percent
 3 the Federal medical assistance percentage (as de-
 4 fined in section 1905(b)) applicable to the State
 5 and the quarter.

6 “(C) *PHASE-OUT PROPORTION*.—The phase-
 7 out proportion (as defined in paragraph (2)) for
 8 the quarter.

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

12 “(A) 2005 is 90 percent;

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

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

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

21 “(d) *ADDITIONAL PROVISIONS*.—

22 “(1) *MEDICAID AS SECONDARY PAYOR*.—In the
 23 case of an individual who is entitled to qualified pre-
 24 scription drug coverage under a prescription drug
 25 plan under part D of title XVIII (or under a

1 *Medicare+Choice plan under part C of such title)*
2 *and medical assistance for prescribed drugs under*
3 *this title, medical assistance shall continue to be pro-*
4 *vided under this title for prescribed drugs to the ex-*
5 *tent payment is not made under the prescription drug*
6 *plan or the Medicare+Choice plan selected by the in-*
7 *dividual.*

8 “(2) *CONDITION.—A State may require, as a*
9 *condition for the receipt of medical assistance under*
10 *this title with respect to prescription drug benefits for*
11 *an individual eligible to obtain qualified prescription*
12 *drug coverage described in paragraph (1), that the in-*
13 *dividual elect qualified prescription drug coverage*
14 *under section 1860A.”*

15 *(d) TREATMENT OF TERRITORIES.—*

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

18 *(A) in subsection (a) in the matter pre-*
19 *ceding paragraph (1), by inserting “subject to*
20 *subsection (e)” after “section 1903(a)”;*

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

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

25 “(e) *TREATMENT OF TERRITORIES.—*

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

3 “(A) *the previous provisions of this section*
4 *shall not apply to residents of such State; and*

5 “(B) *if the State establishes a plan de-*
6 *scribed in paragraph (2) (for providing medical*
7 *assistance with respect to the provision of pre-*
8 *scription drugs to medicare beneficiaries), the*
9 *amount otherwise determined under section*
10 *1108(f) (as increased under section 1108(g)) for*
11 *the State shall be increased by the amount speci-*
12 *fied in paragraph (3).*

13 “(2) *PLAN.*—*The plan described in this para-*
14 *graph is a plan that—*

15 “(A) *provides medical assistance with re-*
16 *spect to the provision of covered outpatient drugs*
17 *(as defined in section 1860B(f)) to low-income*
18 *medicare beneficiaries; and*

19 “(B) *assures that additional amounts re-*
20 *ceived by the State that are attributable to the*
21 *operation of this subsection are used only for*
22 *such assistance.*

23 “(3) *INCREASED AMOUNT.*—

1 “(A) *IN GENERAL.*—*The amount specified*
2 *in this paragraph for a State for a year is equal*
3 *to the product of—*

4 “(i) *the aggregate amount specified in*
5 *subparagraph (B); and*

6 “(ii) *the amount specified in section*
7 *1108(g)(1) for that State, divided by the*
8 *sum of the amounts specified in such section*
9 *for all such States.*

10 “(B) *AGGREGATE AMOUNT.*—*The aggregate*
11 *amount specified in this subparagraph for—*

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

13 “(ii) *a subsequent year, is equal to the*
14 *aggregate amount specified in this subpara-*
15 *graph for the previous year increased by*
16 *annual percentage increase specified in sec-*
17 *tion 1860B(b)(5) for the year involved.*

18 “(4) *REPORT.*—*The Administrator shall submit*
19 *to Congress a report on the application of this sub-*
20 *section and may include in the report such rec-*
21 *ommendations as the Administrator deems appro-*
22 *priate.”.*

23 (2) *CONFORMING AMENDMENT.*—*Section 1108(f)*
24 *(42 U.S.C. 1308(f)) is amended by inserting “and sec-*
25 *tion 1935(e)(1)(B)” after “Subject to subsection (g)”.*

1 **SEC. 104. MEDIGAP TRANSITION.**

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

4 “(v) *COVERAGE OF PRESCRIPTION DRUGS.*—

5 “(1) *IN GENERAL.*—Notwithstanding any other
6 provision of law, except as provided in paragraph (3)
7 no new medicare supplemental policy that provides
8 coverage of expenses for prescription drugs may be
9 issued under this section on or after January 1, 2005,
10 to an individual unless it replaces a medicare supple-
11 mental policy that was issued to that individual and
12 that provided some coverage of expenses for prescrip-
13 tion drugs.

14 “(2) *ISSUANCE OF SUBSTITUTE POLICIES IF OB-*
15 *TAIN PRESCRIPTION DRUG COVERAGE UNDER PART*
16 *D.*—

17 “(A) *IN GENERAL.*—The issuer of a medi-
18 care supplemental policy—

19 “(i) may not deny or condition the
20 issuance or effectiveness of a medicare sup-
21 plemental policy that has a benefit package
22 classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’, or ‘G’
23 (under the standards established under sub-
24 section (p)(2)) and that is offered and is
25 available for issuance to new enrollees by
26 such issuer;

1 “(ii) may not discriminate in the pric-
2 ing of such policy, because of health status,
3 claims experience, receipt of health care, or
4 medical condition; and

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

8 in the case of an individual described in sub-
9 paragraph (B) who seeks to enroll under the pol-
10 icy not later than 63 days after the date of the
11 termination of enrollment described in such
12 paragraph and who submits evidence of the date
13 of termination or disenrollment along with the
14 application for such medicare supplemental pol-
15 icy.

16 “(B) INDIVIDUAL COVERED.—An individual
17 described in this subparagraph is an individual
18 who—

19 “(i) enrolls in a prescription drug
20 plan under part D; and

21 “(ii) at the time of such enrollment
22 was enrolled and terminates enrollment in
23 a medicare supplemental policy which has a
24 benefit package classified as ‘H’, ‘I’, or ‘J’
25 under the standards referred to in subpara-

1 *graph (A)(i) or terminates enrollment in a*
2 *policy to which such standards do not apply*
3 *but which provides benefits for prescription*
4 *drugs.*

5 “(C) *ENFORCEMENT.*—*The provisions of*
6 *paragraph (4) of subsection (s) shall apply with*
7 *respect to the requirements of this paragraph in*
8 *the same manner as they apply to the require-*
9 *ments of such subsection.*

10 “(3) *NEW STANDARDS.*—*In applying subsection*
11 *(p)(1)(E) (including permitting the NAIC to revise*
12 *its model regulations in response to changes in law)*
13 *with respect to the change in benefits resulting from*
14 *title I of the Medicare Modernization and Prescrip-*
15 *tion Drug Act of 2002, with respect to policies issued*
16 *to individuals who are enrolled under part D, the*
17 *changes in standards shall only provide for sub-*
18 *stituting for the benefit packages that included cov-*
19 *erage for prescription drugs two benefit packages that*
20 *may provide for coverage of cost-sharing with respect*
21 *to qualified prescription drug coverage under such*
22 *part, except that such coverage may not cover the pre-*
23 *scription drug deductible under such part. The two*
24 *benefit packages shall be consistent with the following:*

1 “(A) *FIRST NEW POLICY.*—*The policy de-*
2 *scribed in this subparagraph has the following*
3 *benefits, notwithstanding any other provision of*
4 *this section relating to a core benefit package:*

5 “(i) *Coverage of 50 percent of the cost-*
6 *sharing otherwise applicable, except cov-*
7 *erage of 100 percent of any cost-sharing oth-*
8 *erwise applicable for preventive benefits.*

9 “(ii) *No coverage of the part B deduct-*
10 *ible.*

11 “(iii) *Coverage for all hospital coinsur-*
12 *ance for long stays (as in the current core*
13 *benefit package).*

14 “(iv) *A limitation on annual out-of-*
15 *pocket expenditures to \$4,000 in 2005 (or,*
16 *in a subsequent year, to such limitation for*
17 *the previous year increased by an appro-*
18 *priate inflation adjustment specified by the*
19 *Secretary).*

20 “(B) *SECOND NEW POLICY.*—*The policy de-*
21 *scribed in this subparagraph has the same bene-*
22 *fits as the policy described in subparagraph (A),*
23 *except as follows:*

24 “(i) *Substitute ‘75 percent’ for ‘50 per-*
25 *cent’ in clause (i) of such subparagraph.*

1 “(1) *SAVINGS TO MEDICARE BENEFICIARIES.*—
2 *The program passes on to medicare beneficiaries who*
3 *enroll in the program discounts on prescription*
4 *drugs, including discounts negotiated with manufac-*
5 *turers.*

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

9 “(3) *BENEFICIARY SERVICES.*—*The program*
10 *provides pharmaceutical support services, such as*
11 *education and counseling, and services to prevent ad-*
12 *verse drug interactions.*

13 “(4) *INFORMATION.*—*The program makes avail-*
14 *able to medicare beneficiaries through the Internet*
15 *and otherwise information, including information on*
16 *enrollment fees, prices charged to beneficiaries, and*
17 *services offered under the program, that the Secretary*
18 *identifies as being necessary to provide for informed*
19 *choice by beneficiaries among endorsed programs.*

20 “(5) *DEMONSTRATED EXPERIENCE.*—*The entity*
21 *operating the program has demonstrated experience*
22 *and expertise in operating such a program or a simi-*
23 *lar program.*

1 “(6) *QUALITY ASSURANCE.*—*The entity has in*
2 *place adequate procedures for assuring quality service*
3 *under the program.*

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

11 “(c) *PROGRAM OPERATION.*—*The Secretary shall oper-*
12 *ate the program under this section consistent with the fol-*
13 *lowing:*

14 “(1) *PROMOTION OF INFORMED CHOICE.*—*In*
15 *order to promote informed choice among endorsed*
16 *prescription drug discount card programs, the Sec-*
17 *retary shall provide for the dissemination of informa-*
18 *tion which compares the costs and benefits of such*
19 *programs in a manner coordinated with the dissemi-*
20 *nation of educational information on*
21 *Medicare+Choice plans under part C.*

22 “(2) *OVERSIGHT.*—*The Secretary shall provide*
23 *appropriate oversight to ensure compliance of en-*
24 *dorsed programs with the requirements of this section,*

1 *including verification of the discounts and services*
2 *provided.*

3 “(3) *USE OF MEDICARE TOLL-FREE NUMBER.*—
4 *The Secretary shall provide through the 1-800-medi-*
5 *care toll free telephone number for the receipt and re-*
6 *sponse to inquiries and complaints concerning the*
7 *program and programs endorsed under this section.*

8 “(4) *DISQUALIFICATION FOR ABUSIVE PRAC-*
9 *TICES.*—*The Secretary shall revoke the endorsement of*
10 *a program that the Secretary determines no longer*
11 *meets the requirements of this section or that has en-*
12 *gaged in false or misleading marketing practices.*

13 “(5) *ENROLLMENT PRACTICES.*—*A medicare ben-*
14 *eficiary may not be enrolled in more than one en-*
15 *dorsed program at any time.*

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

20 “(e) *AUTHORIZATION OF APPROPRIATIONS.*—*There are*
21 *authorized to be appropriated such sums as may be nec-*
22 *essary to carry out the program under this section.”.*

1 **TITLE II—MEDICARE+CHOICE**
2 **REVITALIZATION AND**
3 **MEDICARE+CHOICE COMPETI-**
4 **TION PROGRAM**
5 **Subtitle A—Medicare+Choice**
6 **Revitalization**

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

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

10 (1) *IN GENERAL.—Section 1853(c)(1) (42 U.S.C.*
11 *1395w-23(c)(1)) is amended by adding at the end the*
12 *following:*

13 “(D) *BASED ON 100 PERCENT OF FEE-FOR-*
14 *SERVICE COSTS.—*

15 “(i) *IN GENERAL.—For 2003 and*
16 *2004, the adjusted average per capita cost*
17 *for the year involved, determined under sec-*
18 *tion 1876(a)(4) for the Medicare+Choice*
19 *payment area for services covered under*
20 *parts A and B for individuals entitled to*
21 *benefits under part A and enrolled under*
22 *part B who are not enrolled in a*
23 *Medicare+Choice plan under this part for*
24 *the year, but adjusted to exclude costs at-*

1 *tributable to payments under section*
2 *1886(h).*

3 “(ii) *INCLUSION OF COSTS OF VA AND*
4 *DOD MILITARY FACILITY SERVICES TO MEDI-*
5 *CARE-ELIGIBLE BENEFICIARIES.—In deter-*
6 *mining the adjusted average per capita cost*
7 *under clause (i) for a year, such cost shall*
8 *be adjusted to include the Secretary’s esti-*
9 *mate, on a per capita basis, of the amount*
10 *of additional payments that would have*
11 *been made in the area involved under this*
12 *title if individuals entitled to benefits under*
13 *this title had not received services from fa-*
14 *cilities of the Department of Veterans Af-*
15 *fairs or the Department of Defense.”.*

16 (2) *CONFORMING AMENDMENT.—Such section is*
17 *further amended, in the matter before subparagraph*
18 *(A), by striking “or (C)” and inserting “(C), or (D)”.*

19 (b) *REVISION OF BLEND.—*

20 (1) *REVISION OF NATIONAL AVERAGE USED IN*
21 *CALCULATION OF BLEND.—Section*
22 *1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-*
23 *23(c)(4)(B)(i)(II)) is amended by inserting “who*
24 *(with respect to determinations for 2003 and for*

1 2004) are enrolled in a Medicare+Choice plan” after
2 “the average number of medicare beneficiaries”.

3 (2) *CHANGE IN BUDGET NEUTRALITY.*—Section
4 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

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

7 (B) in paragraph (5), by inserting “(before
8 2003)” after “for each year”.

9 (c) *REVISION IN MINIMUM PERCENTAGE INCREASE*
10 *FOR 2003 AND 2004.*—Section 1853(c)(1)(C) (42 U.S.C.
11 1395w–23(c)(1)(C)) is amended by striking clause (iv) and
12 inserting the following:

13 “(iv) For 2002, 102 percent of the an-
14 nual Medicare+Choice capitation rate
15 under this paragraph for the area for 2001.

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

20 “(vi) For 2005 and each succeeding
21 year, 102 percent of the annual
22 Medicare+Choice capitation rate under this
23 paragraph for the area for the previous
24 year.”.

1 (d) *INCLUSION OF COSTS OF DOD AND VA MILITARY*
2 *FACILITY SERVICES TO MEDICARE-ELIGIBLE BENE-*
3 *FICIARIES IN CALCULATION OF MEDICARE+CHOICE PAY-*
4 *MENT RATES.*—Section 1853(c)(3) (42 U.S.C. 1395w–
5 23(c)(3)) is amended—

6 (1) in subparagraph (A), by striking “subpara-

7 graph (B)” and inserting “subparagraphs (B) and

8 (E)”, and

9 (2) by adding at the end the following new sub-

10 paragraph:

11 “(E) *INCLUSION OF COSTS OF DOD AND VA*
12 *MILITARY FACILITY SERVICES TO MEDICARE-ELI-*
13 *GIBLE BENEFICIARIES.*—In determining the
14 *area-specific Medicare+Choice capitation rate*
15 *under subparagraph (A) for a year (beginning*
16 *with 2003), the annual per capita rate of pay-*
17 *ment for 1997 determined under section*
18 *1876(a)(1)(C) shall be adjusted to include in the*
19 *rate the Secretary’s estimate, on a per capita*
20 *basis, of the amount of additional payments that*
21 *would have been made in the area involved*
22 *under this title if individuals entitled to benefits*
23 *under this title had not received services from fa-*
24 *cilities of the Department of Defense or the De-*
25 *partment of Veterans Affairs.”.*

1 (e) *ANNOUNCEMENT OF REVISED MEDICARE+CHOICE*
2 *PAYMENT RATES.*—*Within 2 weeks after the date of the en-*
3 *actment of this Act, the Secretary shall determine, and shall*
4 *announce (in a manner intended to provide notice to inter-*
5 *ested parties) Medicare+Choice capitation rates under sec-*
6 *tion 1853 of the Social Security Act (42 U.S.C. 1395w-*
7 *23) for 2003, revised in accordance with the provisions of*
8 *this section.*

9 (f) *MEDPAC STUDY OF AAPCC.*—

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

16 (A) *the bases for variation in such costs be-*
17 *tween different areas, including differences in*
18 *input prices, utilization, and practice patterns;*

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

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

1 (2) *REPORT.*—Not later than 9 months after the
2 date of the enactment of this Act, the Commission
3 shall submit to Congress a report on the study con-
4 ducted under paragraph (1). Such report shall in-
5 clude recommendations regarding changes in the
6 methods for computing the adjusted average per cap-
7 ita cost among different areas.

8 (g) *REPORT ON IMPACT OF INCREASED FINANCIAL AS-*
9 *SISTANCE TO MEDICARE+CHOICE PLANS.*—Not later than
10 July 1, 2003, the Secretary of Health and Human Services
11 shall submit to Congress a report that describes the impact
12 of additional financing provided under this Act and other
13 Acts (including the Medicare, Medicaid, and SCHIP Bal-
14 anced Budget Refinement Act of 1999 and BIPA) on the
15 availability of Medicare+Choice plans in different areas
16 and its impact on lowering premiums and increasing bene-
17 fits under such plans.

18 **SEC. 202. MAKING PERMANENT CHANGE IN**
19 **MEDICARE+CHOICE REPORTING DEADLINES**
20 **AND ANNUAL, COORDINATED ELECTION PE-**
21 **RIOD.**

22 (a) *CHANGE IN REPORTING DEADLINE.*—Section
23 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by sec-
24 tion 532(b)(1) of the Public Health Security and Bioter-
25 rorism Preparedness and Response Act of 2002, is amended

1 *by striking “2002, 2003, and 2004 (or July 1 of each other*
2 *year)” and inserting “2002 and each subsequent year (or*
3 *July 1 of each year before 2002)”.*

4 **(b) DELAY IN ANNUAL, COORDINATED ELECTION PE-**
5 *RIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–*
6 *21(e)(3)(B)), as amended by section 532(c)(1)(A) of the*
7 *Public Health Security and Bioterrorism Preparedness and*
8 *Response Act of 2002, is amended by striking “and after*
9 *2005, the month of November before such year and with re-*
10 *spect to 2003, 2004, and 2005” and inserting “, the month*
11 *of November before such year and with respect to 2003 and*
12 *any subsequent year”.*

13 **(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—**
14 *Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amend-*
15 *ed by section 532(d)(1) of the Public Health Security and*
16 *Bioterrorism Preparedness and Response Act of 2002, is*
17 *amended by striking “and after 2005 not later than March*
18 *1 before the calendar year concerned and for 2004 and*
19 *2005” and inserting “not later than March 1 before the cal-*
20 *endar year concerned and for 2004 and each subsequent*
21 *year”.*

22 **(d) REQUIRING PROVISION OF AVAILABLE INFORMA-**
23 *TION COMPARING PLAN OPTIONS.—The first sentence of sec-*
24 *tion 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is*
25 *amended by inserting before the period the following: “to*

1 *the extent such information is available at the time of prep-*
 2 *aration of materials for the mailing”.*

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

4 (a) *IN GENERAL.*—Section 1856(b)(3) (42 U.S.C.
 5 1395w–26(b)(3)) is amended to read as follows:

6 “(3) *RELATION TO STATE LAWS.*—The standards
 7 established under this subsection shall supersede any
 8 State law or regulation (other than State licensing
 9 laws or State laws relating to plan solvency) with re-
 10 spect to Medicare+Choice plans which are offered by
 11 Medicare+Choice organizations under this part.”.

12 (b) *EFFECTIVE DATE.*—The amendment made by sub-
 13 section (a) shall take effect on the date of the enactment
 14 of this Act.

15 **SEC. 204. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPE-**
 16 **CIAL NEEDS BENEFICIARIES.**

17 (a) *TREATMENT AS COORDINATED CARE PLAN.*—Sec-
 18 tion 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is
 19 amended by adding at the end the following new sentence:
 20 “Specialized Medicare+Choice plans for special needs bene-
 21 ficiaries (as defined in section 1859(b)(4)) may be any type
 22 of coordinated care plan.”.

23 (b) *SPECIALIZED MEDICARE+CHOICE PLAN FOR SPE-*
 24 *CIAL NEEDS BENEFICIARIES DEFINED.*—Section 1859(b)

1 *(42 U.S.C. 1395w–29(b)) is amended by adding at the end*
2 *the following new paragraph:*

3 “(4) *SPECIALIZED MEDICARE+CHOICE PLANS*
4 *FOR SPECIAL NEEDS BENEFICIARIES.—*

5 “(A) *IN GENERAL.—The term ‘specialized*
6 *Medicare+Choice plan for special needs bene-*
7 *ficiaries’ means a Medicare+Choice plan that*
8 *exclusively serves special needs beneficiaries (as*
9 *defined in subparagraph (B)).*

10 “(B) *SPECIAL NEEDS BENEFICIARY.—The*
11 *term ‘special needs beneficiary’ means a*
12 *Medicare+Choice eligible individual who—*

13 “(i) *is institutionalized (as defined by*
14 *the Secretary);*

15 “(ii) *is entitled to medical assistance*
16 *under a State plan under title XIX; or*

17 “(iii) *meets such requirements as the*
18 *Secretary may determine would benefit*
19 *from enrollment in such a specialized*
20 *Medicare+Choice plan described in sub-*
21 *paragraph (A) for individuals with severe*
22 *or disabling chronic conditions.”.*

23 “(c) *RESTRICTION ON ENROLLMENT PERMITTED.—Sec-*
24 *tion 1859 (42 U.S.C. 1395w–29) is amended by adding at*
25 *the end the following new subsection:*

1 “(f) *RESTRICTION ON ENROLLMENT FOR SPECIALIZED*
2 *MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENE-*
3 *FICIARIES.—In the case of a specialized Medicare+Choice*
4 *plan (as defined in subsection (b)(4)), notwithstanding any*
5 *other provision of this part and in accordance with regula-*
6 *tions of the Secretary and for periods before January 1,*
7 *2007, the plan may restrict the enrollment of individuals*
8 *under the plan to individuals who are within one or more*
9 *classes of special needs beneficiaries.”.*

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

18 (e) *EFFECTIVE DATES.—*

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

22 (2) *DEADLINE FOR ISSUANCE OF REQUIREMENTS*
23 *FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—*
24 *No later than 6 months after the date of the enact-*
25 *ment of this Act, the Secretary of Health and Human*

1 *Services shall issue final regulations to establish re-*
 2 *quirements for special needs beneficiaries under sec-*
 3 *tion 1859(b)(4)(B)(iii) of the Social Security Act, as*
 4 *added by subsection (b).*

5 **SEC. 205. MEDICARE MSAS.**

6 (a) *EXEMPTION FROM REPORTING ENROLLEE EN-*
 7 *COUNTER DATA.—*

8 (1) *IN GENERAL.—Section 1852(e)(1) (42 U.S.C.*
 9 *1395w–22(e)(1)) is amended by inserting “(other than*
 10 *MSA plans)” after “Medicare+Choice plans”.*

11 (2) *CONFORMING AMENDMENTS.—Section 1852*
 12 *(42 U.S.C. 1395w–22) is amended—*

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

16 (B) *in subparagraphs (A) and (B) of sub-*
 17 *section (e)(2), by striking “, a non-network MSA*
 18 *plan,” and “, NON-NETWORK MSA PLANS,” each*
 19 *place it appears.*

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

23 (1) *in the heading, by striking “ON A DEM-*
 24 *ONSTRATION BASIS”;*

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

3 (3) *by striking the second sentence of subpara-*
4 *graph (C).*

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

9 (d) *ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A)*
10 *(42 U.S.C. 1395w–21(e)(5)(A)) is amended—*

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

12 (2) *by striking “, or” at the end of clause (ii)*
13 *and inserting a semicolon; and*

14 (3) *by striking clause (iii).*

15 **SEC. 206. EXTENSION OF REASONABLE COST AND SHMO**
16 **CONTRACTS.**

17 (a) *REASONABLE COST CONTRACTS.—*

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

20 (A) *by inserting “(i)” after “(C)”;*

21 (B) *by inserting before the period the fol-*
22 *lowing: “, except (subject to clause (ii)) in the*
23 *case of a contract for an area which is not cov-*
24 *ered in the service area of 1 or more coordinated*
25 *care Medicare+Choice plans under part C”; and*

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

3 “(ii) In the case in which—

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

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

12 “(III) all Medicare+Choice plans subsequently
13 terminate coverage in such area;
14 such reasonable cost reimbursement contract may be ex-
15 tended and renewed to cover such area (so long as it is not
16 included in the service area of any Medicare+Choice
17 plan).”.

18 (2) *STUDY.*—*The Medicare Benefits Adminis-*
19 *trator shall conduct a study of an appropriate transi-*
20 *tion for plans offered under reasonable cost contracts*
21 *under section 1876 of the Social Security Act on and*
22 *after January 1, 2005. Such a transition may take*
23 *into account whether there are one or more coordi-*
24 *nated care Medicare+Choice plans being offered in*
25 *the areas involved. Not later than February 1, 2004,*

1 *the Administrator shall submit to Congress a report*
 2 *on such study and shall include recommendations re-*
 3 *garding any changes in the amendment made by*
 4 *paragraph (1) as the Administrator determines to be*
 5 *appropriate.*

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

8 *(1) IN GENERAL.—Section 4018(b)(1) of the Om-*
 9 *nibus Budget Reconciliation Act of 1987 is amended*
 10 *by striking “the date that is 30 months after the date*
 11 *that the Secretary submits to Congress the report de-*
 12 *scribed in section 4014(c) of the Balanced Budget Act*
 13 *of 1997” and inserting “December 31, 2004”.*

14 *(2) SHMOS OFFERING MEDICARE+CHOICE*
 15 *PLANS.—Nothing in such section 4018 shall be con-*
 16 *strued as preventing a social health maintenance or-*
 17 *ganization from offering a Medicare+Choice plan*
 18 *under part C of title XVIII of the Social Security Act.*

19 **SEC. 207. EXTENSION OF MUNICIPAL HEALTH SERVICE**
 20 **DEMONSTRATION PROJECTS.**

21 *The last sentence of section 9215(a) of the Consolidated*
 22 *Omnibus Budget Reconciliation Act of 1985 (42 U.S.C.*
 23 *1395b–1 note), as previously amended, is amended by strik-*
 24 *ing “December 31, 2004, but only with respect to” and all*
 25 *that follows and inserting “December 31, 2009, but only*

1 *with respect to individuals who reside in the city in which*
 2 *the project is operated and so long as the total number of*
 3 *individuals participating in the project does not exceed the*
 4 *number of such individuals participating as of January 1,*
 5 *1996.”.*

6 ***Subtitle B—Medicare+Choice***
 7 ***Competition Program***

8 ***SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.***

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

11 *(1) in the heading by inserting “AND BID*
 12 *AMOUNTS” after “PREMIUMS”;*

13 *(2) in subsection (a)(1)(A)—*

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

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

20 *(3) by adding at the end of subsection (a) the fol-*
 21 *lowing:*

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

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

4 “(i) *The monthly aggregate bid*
5 *amount for provision of all items and serv-*
6 *ices under this part and the actuarial basis*
7 *for determining such amount.*

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

10 “(I) *the provision of statutory*
11 *non-drug benefits (such portion re-*
12 *ferred to in this part as the*
13 *‘unadjusted non-drug monthly bid*
14 *amount’);*

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

17 “(III) *the provision of non-statu-*
18 *tory benefits;*

19 *and the actuarial basis for determining*
20 *such proportions.*

21 “(iii) *Such additional information as*
22 *the Administrator may require to verify the*
23 *actuarial bases described in clauses (i) and*
24 *(ii).*

1 “(B) *STATUTORY BENEFITS DEFINED.*—For
2 purposes of this part:

3 “(i) The term ‘statutory non-drug ben-
4 efits’ means benefits under parts A and B.

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

7 “(iii) The term ‘statutory benefits’
8 means statutory prescription drug benefits
9 and statutory non-drug benefits.

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

20 (b) *PROVIDING FOR BENEFICIARY SAVINGS FOR CER-*
21 *TAIN PLANS.*—

22 (1) *IN GENERAL.*—Section 1854(b) (42 U.S.C.
23 1395w-24(b)) is amended—

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

1 “(C) *BENEFICIARY REBATE RULE.*—

2 “(i) *REQUIREMENT.*—*The*
3 *Medicare+Choice plan shall provide to the*
4 *enrollee a monthly rebate equal to 75 per-*
5 *cent of the average per capita savings (if*
6 *any) described in paragraph (3) applicable*
7 *to the plan and year involved.*

8 “(iii) *FORM OF REBATE.*—*A rebate re-*
9 *quired under this subparagraph shall be*
10 *provided—*

11 “(I) *through the crediting of the*
12 *amount of the rebate towards the*
13 *Medicare+Choice monthly supple-*
14 *mentary beneficiary premium or the*
15 *premium imposed for prescription*
16 *drug coverage under part D;*

17 “(II) *through a direct monthly*
18 *payment (through electronic funds*
19 *transfer or otherwise); or*

20 “(III) *through other means ap-*
21 *proved by the Medicare Benefits Ad-*
22 *ministrator,*

23 *or any combination thereof.”; and*

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

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

6 “(A) *DETERMINATION OF STATE-WIDE AV-*
7 *ERAGE RISK ADJUSTMENT.—*

8 “(i) *IN GENERAL.—The Medicare Ben-*
9 *efits Administrator shall determine, at the*
10 *same time rates are promulgated under sec-*
11 *tion 1853(b)(1) (beginning with 2005), for*
12 *each State the average of the risk adjust-*
13 *ment factors to be applied to enrollees under*
14 *section 1853(a)(1)(A) in that State. In the*
15 *case of a State in which a Medicare+Choice*
16 *plan was offered in the previous year, the*
17 *Administrator may compute such average*
18 *based upon risk adjustment factors applied*
19 *in that State in a previous year.*

20 “(ii) *TREATMENT OF NEW STATES.—In*
21 *the case of a State in which no*
22 *Medicare+Choice plan was offered in the*
23 *previous year, the Administrator shall esti-*
24 *mate such average. In making such esti-*
25 *mate, the Administrator may use average*

1 *risk adjustment factors applied to com-*
2 *parable States or applied on a national*
3 *basis.*

4 “(B) *DETERMINATION OF RISK ADJUSTED*
5 *BENCHMARK AND RISK-ADJUSTED BID.—For*
6 *each Medicare+Choice plan offered in a State,*
7 *the Administrator shall—*

8 “(i) *adjust the fee-for-service area-spe-*
9 *cific non-drug benchmark amount by the*
10 *applicable average risk adjustment factor*
11 *computed under subparagraph (A); and*

12 “(ii) *adjust the unadjusted non-drug*
13 *monthly bid amount by such applicable av-*
14 *erage risk adjustment factor.*

15 “(C) *DETERMINATION OF AVERAGE PER*
16 *CAPITA MONTHLY SAVINGS.—The average per*
17 *capita monthly savings described in this sub-*
18 *paragraph is equal to the amount (if any) by*
19 *which—*

20 “(i) *the risk-adjusted benchmark*
21 *amount computed under subparagraph*
22 *(B)(i), exceeds*

23 “(ii) *the risk-adjusted bid computed*
24 *under subparagraph (B)(i).*

1 “(D) *AUTHORITY TO DETERMINE RISK AD-*
2 *JUSTMENT FOR AREAS OTHER THAN STATES.—*
3 *The Administrator may provide for the deter-*
4 *mination and application of risk adjustment fac-*
5 *tors under this paragraph on the basis of areas*
6 *other than States.”.*

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

11 “(j) *COMPUTATION OF FEE-FOR-SERVICE AREA-SPE-*
12 *CIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes of*
13 *this part, the term ‘fee-for-service area-specific non-drug*
14 *benchmark amount’ means, with respect to a*
15 *Medicare+Choice payment area for a month in a year, an*
16 *amount equal to the greater of the following (but in no case*
17 *less than $\frac{1}{12}$ of the rate computed under subsection (c)(1),*
18 *without regard to subparagraph (A), for the year):*

19 “(1) *BASED ON 100 PERCENT OF FEE-FOR-SERV-*
20 *ICE COSTS IN THE AREA.—An amount equal to $\frac{1}{12}$*
21 *of 100 percent (for 2005 through 2007, or 95 percent*
22 *for 2008 and years thereafter) of the adjusted average*
23 *per capita cost for the year involved, determined*
24 *under section 1876(a)(4) for the Medicare+Choice*
25 *payment area, for the area and the year involved, for*

1 *services covered under parts A and B for individuals*
2 *entitled to benefits under part A and enrolled under*
3 *part B who are not enrolled in a Medicare+Choice*
4 *plan under this part for the year, and adjusted to ex-*
5 *clude from such cost the amount the Medicare Benefits*
6 *Administrator estimates is payable for costs described*
7 *in subclauses (I) and (II) of subsection (c)(3)(C)(i)*
8 *for the year involved and also adjusted in the manner*
9 *described in subsection (c)(1)(D)(ii) (relating to in-*
10 *clusion of costs of VA and DOD military facility serv-*
11 *ices to medicare-eligible beneficiaries).*

12 *“(2) MINIMUM MONTHLY AMOUNT.—The min-*
13 *imum amount specified in this paragraph is the*
14 *amount specified in subsection (c)(1)(B)(iv) for the*
15 *year involved.”.*

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

17 *(1) IN GENERAL.—Section 1853(a)(1)(A) (42*
18 *U.S.C. 1395w–23) is amended by striking “in an*
19 *amount” and all that follows and inserting the fol-*
20 *lowing: “in an amount determined as follows:*

21 *“(i) PAYMENT BEFORE 2005.—For*
22 *years before 2005, the payment amount*
23 *shall be equal to $\frac{1}{12}$ of the annual*
24 *Medicare+Choice capitation rate (as cal-*
25 *culated under subsection (c)) with respect to*

1 that individual for that area, reduced by the
2 amount of any reduction elected under sec-
3 tion 1854(f)(1)(E) and adjusted under
4 clause (iii).

5 “(ii) *PAYMENT FOR STATUTORY NON-*
6 *DRUG BENEFITS BEGINNING WITH 2005.—*
7 *For years beginning with 2005—*

8 “(I) *PLANS WITH BIDS BELOW*
9 *BENCHMARK.—In the case of a plan*
10 *for which there are average per capita*
11 *monthly savings described in section*
12 *1854(b)(3)(C), the payment under this*
13 *subsection is equal to the unadjusted*
14 *non-drug monthly bid amount, ad-*
15 *justed under clause (iii), plus the*
16 *amount of the monthly rebate com-*
17 *puted under section 1854(b)(1)(C)(i)*
18 *for that plan and year.*

19 “(II) *PLANS WITH BIDS AT OR*
20 *ABOVE BENCHMARK.—In the case of a*
21 *plan for which there are no average*
22 *per capita monthly savings described*
23 *in section 1854(b)(3)(C), the payment*
24 *amount under this subsection is equal*
25 *to the fee-for-service area-specific non-*

1 *drug benchmark amount, adjusted*
2 *under clause (iii).*

3 “(iii) *DEMOGRAPHIC ADJUSTMENT, IN-*
4 *CLUDING ADJUSTMENT FOR HEALTH STA-*
5 *TUS.—The Administrator shall adjust the*
6 *payment amount under clause (i), the*
7 *unadjusted non-drug monthly bid amount*
8 *under clause (ii)(I), and the fee-for-service*
9 *area-specific non-drug benchmark amount*
10 *under clause (ii)(II) for such risk factors as*
11 *age, disability status, gender, institutional*
12 *status, and such other factors as the Admin-*
13 *istrator determines to be appropriate, in-*
14 *cluding adjustment for health status under*
15 *paragraph (3), so as to ensure actuarial*
16 *equivalence. The Administrator may add to,*
17 *modify, or substitute for such adjustment*
18 *factors if such changes will improve the de-*
19 *termination of actuarial equivalence.*

20 “(iv) *REFERENCE TO SUBSIDY PAY-*
21 *MENT FOR STATUTORY DRUG BENEFITS.—*
22 *In the case in which an enrollee is enrolled*
23 *under part D, the Medicare+Choice organi-*
24 *zation also is entitled to a subsidy payment*
25 *amount under section 1860H.”.*

1 (d) *CONFORMING AMENDMENTS.*—

2 (1) *PROTECTION AGAINST BENEFICIARY SELEC-*
 3 *TION.*—Section 1852(b)(1)(A) (42 U.S.C. 1395w–
 4 22(b)(1)(A)) is amended by adding at the end the fol-
 5 lowing: “The Administrator shall not approve a plan
 6 of an organization if the Administrator determines
 7 that the benefits are designed to substantially discour-
 8 age enrollment by certain Medicare+Choice eligible
 9 individuals with the organization.”.

10 (2) *CONFORMING AMENDMENT TO PREMIUM TER-*
 11 *MINOLOGY.*—Subparagraphs (A) and (B) of section
 12 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) are amended
 13 to read as follows:

14 “(A) *MEDICARE+CHOICE MONTHLY BASIC*
 15 *BENEFICIARY PREMIUM.*—The term
 16 ‘Medicare+Choice monthly basic beneficiary pre-
 17 mium’ means, with respect to a
 18 Medicare+Choice plan—

19 “(i) described in section
 20 1853(a)(1)(A)(ii)(I) (relating to plans pro-
 21 viding rebates), zero; or

22 “(ii) described in section
 23 1853(a)(1)(A)(ii)(II), the amount (if any)
 24 by which the unadjusted non-drug monthly

1 *bid amount exceeds the fee-for-service area-*
 2 *specific non-drug benchmark amount.*

3 “(B) *MEDICARE+CHOICE MONTHLY SUP-*
 4 *PLEMENTAL BENEFICIARY PREMIUM.—The term*
 5 *‘Medicare+Choice monthly supplemental bene-*
 6 *ficiary premium’ means, with respect to a*
 7 *Medicare+Choice plan, the portion of the aggre-*
 8 *gate monthly bid amount submitted under clause*
 9 *(i) of subsection (a)(6)(A) for the year that is at-*
 10 *tributable under such section to the provision of*
 11 *nonstatutory benefits.”.*

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

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

19 (4) *PERMITTING BENEFICIARY REBATES.—*

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

24 (B) *Section 1854(d) (42 U.S.C. 1395w–*
 25 *24(d)) is amended by inserting “, except as pro-*

1 *vided under subsection (b)(1)(C),” after “and*
 2 *may not provide”.*

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

6 **SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-**
 7 **DEMONSTRATION AREAS.**

8 *(a) IDENTIFICATION OF COMPETITIVE-DEMONSTRA-*
 9 *TION AREAS FOR DEMONSTRATION PROGRAM; COMPUTA-*
 10 *TION OF CHOICE NON-DRUG BENCHMARKS.—Section 1853,*
 11 *as amended by section 211(b)(2), is amended by adding at*
 12 *the end the following new subsection:*

13 *“(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRA-*
 14 *TION PROGRAM.—*

15 *“(1) DESIGNATION OF COMPETITIVE-DEMONSTRA-*
 16 *TION AREAS AS PART OF PROGRAM.—*

17 *“(A) IN GENERAL.—For purposes of this*
 18 *part, the Administrator shall establish a dem-*
 19 *onstration program under which the Adminis-*
 20 *trator designates Medicare+Choice areas as com-*
 21 *petitive-demonstration areas consistent with the*
 22 *following limitations:*

23 *“(i) LIMITATION ON NUMBER OF AREAS*
 24 *THAT MAY BE DESIGNATED.—The Adminis-*

1 *trator may not designate more than 4 areas*
2 *as competitive-demonstration areas.*

3 *“(ii) LIMITATION ON PERIOD OF DES-*
4 *IGNATION OF ANY AREA.—The Adminis-*
5 *trator may not designate any area as a*
6 *competitive-demonstration area for a period*
7 *of more than 2 years.*

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

12 *“(B) QUALIFICATIONS FOR DESIGNATION.—*
13 *For purposes of this title, a Medicare+Choice*
14 *area (which is a metropolitan statistical area or*
15 *other area with a substantial number of*
16 *Medicare+Choice enrollees) may not be des-*
17 *ignated as a ‘competitive-demonstration area’ for*
18 *a 2-year period beginning with a year unless the*
19 *Administrator determines, by such date before*
20 *the beginning of the year as the Administrator*
21 *determines appropriate, that—*

22 *“(i) there will be offered during the*
23 *open enrollment period under this part be-*
24 *fore the beginning of the year at least 2*
25 *Medicare+Choice plans (in addition to the*

1 *fee-for-service program under parts A and*
2 *B), each offered by a different*
3 *Medicare+Choice organization; and*

4 “(i) *during March of the previous*
5 *year at least 50 percent of the number of*
6 *Medicare+Choice eligible individuals who*
7 *reside in the area were enrolled in a*
8 *Medicare+Choice plan.*

9 “(2) *CHOICE NON-DRUG BENCHMARK AMOUNT.—*

10 *For purposes of this part, the term ‘choice non-drug*
11 *benchmark amount’ means, with respect to a*
12 *Medicare+Choice payment area for a month in a*
13 *year, the sum of the 2 components described in para-*
14 *graph (3) for the area and year. The Administrator*
15 *shall compute such benchmark amount for each com-*
16 *petitive-demonstration area before the beginning of*
17 *each annual, coordinated election period under sec-*
18 *tion 1851(e)(3)(B) for each year (beginning with*
19 *2005) in which it is designated as such an area.*

20 “(3) *2 COMPONENTS.—For purposes of para-*
21 *graph (2), the 2 components described in this para-*
22 *graph for an area and a year are the following:*

23 “(A) *FEE-FOR-SERVICE COMPONENT*
24 *WEIGHTED BY NATIONAL FEE-FOR-SERVICE MAR-*
25 *KET SHARE.—The product of the following:*

1 “(i) *NATIONAL FEE-FOR-SERVICE MAR-*
 2 *KET SHARE.*—*The national fee-for-service*
 3 *market share percentage (determined under*
 4 *paragraph (5)) for the year.*

5 “(ii) *FEE-FOR-SERVICE AREA-SPECIFIC*
 6 *NON-DRUG BID.*—*The fee-for-service area-*
 7 *specific non-drug bid (as defined in para-*
 8 *graph (6)) for the area and year.*

9 “(B) *M+C COMPONENT WEIGHTED BY NA-*
 10 *TIONAL MEDICARE+CHOICE MARKET SHARE.*—
 11 *The product of the following:*

12 “(i) *NATIONAL MEDICARE+CHOICE*
 13 *MARKET SHARE.*—*1 minus the national fee-*
 14 *for-service market share percentage for the*
 15 *year.*

16 “(ii) *WEIGHTED AVERAGE OF PLAN*
 17 *BIDS IN AREA.*—*The weighted average of the*
 18 *plan bids for the area and year (as deter-*
 19 *mined under paragraph (4)(A)).*

20 “(4) *DETERMINATION OF WEIGHTED AVERAGE*
 21 *BIDS FOR AN AREA.*—

22 “(A) *IN GENERAL.*—*For purposes of para-*
 23 *graph (3)(B)(ii), the weighted average of plan*
 24 *bids for an area and a year is the sum of the*
 25 *following products for Medicare+Choice plans*

1 described in subparagraph (C) in the area and
2 year:

3 “(i) *PROPORTION OF EACH PLAN’S EN-*
4 *ROLLEES IN THE AREA.*—The number of in-
5 *dividuals described in subparagraph (B),*
6 *divided by the total number of such individ-*
7 *uals for all Medicare+Choice plans de-*
8 *scribed in subparagraph (C) for that area*
9 *and year.*

10 “(ii) *MONTHLY NON-DRUG BID*
11 *AMOUNT.*—The unadjusted non-drug month-
12 *ly bid amount.*

13 “(B) *COUNTING OF INDIVIDUALS.*—The Ad-
14 *ministrator shall count, for each*
15 *Medicare+Choice plan described in subpara-*
16 *graph (C) for an area and year, the number of*
17 *individuals who reside in the area and who were*
18 *enrolled under such plan under this part during*
19 *March of the previous year.*

20 “(C) *EXCLUSION OF PLANS NOT OFFERED*
21 *IN PREVIOUS YEAR.*—For an area and year, the
22 *Medicare+Choice plans described in this sub-*
23 *paragraph are plans that are offered in the area*
24 *and year and were offered in the area in March*
25 *of the previous year.*

1 “(5) *COMPUTATION OF NATIONAL FEE-FOR-SERV-*
 2 *ICE MARKET SHARE PERCENTAGE.*—*The Adminis-*
 3 *trator shall determine, for a year, the proportion (in*
 4 *this subsection referred to as the ‘national fee-for-serv-*
 5 *ice market share percentage’)* of Medicare+Choice eli-
 6 *gible individuals who during March of the previous*
 7 *year were not enrolled in a Medicare+Choice plan.*

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

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

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

18 **(A)** *in subsection (b)(1)(C)(i), as added by*
 19 *section 211(b)(1)(A), by striking “(i) REQUIRE-*
 20 *MENT.—The” and inserting “(i) REQUIREMENT*
 21 **FOR** **NON-COMPETITIVE-DEMONSTRATION**
 22 **AREAS.**—*In the case of a Medicare+Choice pay-*
 23 *ment area that is not a competitive-demonstra-*
 24 *tion area designated under section 1853(k)(1),*
 25 *the”;*

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

4 “(i) *REQUIREMENT FOR COMPETITIVE-*
5 *DEMONSTRATION AREAS.*—In the case of a
6 *Medicare+Choice* payment area that is des-
7 ignated as a competitive-demonstration
8 area under section 1853(k)(1), if there are
9 average per capita monthly savings de-
10 scribed in paragraph (4) for a
11 *Medicare+Choice* plan and year, the
12 *Medicare+Choice* plan shall provide to the
13 enrollee a monthly rebate equal to 75 per-
14 cent of such savings.”;

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

18 “(4) *COMPUTATION OF AVERAGE PER CAPITA*
19 *MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRA-*
20 *TION AREAS.*—For purposes of paragraph (1)(C)(ii),
21 the average per capita monthly savings referred to in
22 such paragraph for a *Medicare+Choice* plan and
23 year shall be computed in the same manner as the av-
24 erage per capita monthly savings is computed under
25 paragraph (3) except that the reference to the fee-for-

1 *service area-specific non-drug benchmark amount in*
 2 *paragraph (3)(B)(i) (or to the benchmark amount as*
 3 *adjusted under paragraph (3)(C)(i)) is deemed to be*
 4 *a reference to the choice non-drug benchmark amount*
 5 *(or such amount as adjusted in the manner described*
 6 *in paragraph (3)(B)(i)).”;* and

7 *(D) in subsection (d), as amended by sec-*
 8 *tion 211(d)(4), by inserting “and subsection*
 9 *(b)(1)(D)” after “subsection (b)(1)(C)”.*

10 *(2) CONFORMING AMENDMENTS.—*

11 *(A) PAYMENT OF PLANS.—Section*
 12 *1853(a)(1)(A)(ii), as amended by section*
 13 *211(c)(1), is amended—*

14 *(i) in subclause (I), by inserting “(or,*
 15 *in the case of a competitive-demonstration*
 16 *area, the choice non-drug benchmark*
 17 *amount)” after “unadjusted non-drug*
 18 *monthly bid amount”;* and

19 *(ii) in subclauses (I) and (II), by in-*
 20 *serting “(or, in the case of a competitive-*
 21 *demonstration area, described in section*
 22 *1854(b)(4))” after “section 1854(b)(3)(C)”.*

23 *(B) DEFINITION OF MONTHLY BASIC PRE-*
 24 *MIUM.—Section 1854(b)(2)(A)(ii), as amended*
 25 *by section 211(d)(2), is amended by inserting*

1 “(or, in the case of a competitive-demonstration
2 area, the choice non-drug benchmark amount)”
3 after “benchmark amount”.

4 (c) *PREMIUM ADJUSTMENT.*—Section 1839 (42 U.S.C.
5 1395r) is amended by adding at the end the following new
6 subsection:

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

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

23 “(B) exceeds such choice non-drug benchmark,
24 the amount of the premium for the individual for the
25 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 for
3 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, so-
20 cial security account number, and the amount of the
21 adjustment (if any) under this subsection for each in-
22 dividual enrolled under this part for each month dur-
23 ing the year; and

1 “(B) periodically throughout the year, informa-
2 tion to update the information previously transmitted
3 under this paragraph for the year.”.

4 (d) *CONFORMING AMENDMENT*.—Section 1844(c) (42
5 U.S.C. 1395w(c)) is amended by inserting “and without re-
6 gard to any premium adjustment effected under section
7 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 designation
10 of the 4th competitive-demonstration area under section
11 1851(k)(1) of the Social Security Act ends, the Medicare
12 Payment Advisory Commission shall submit to Congress a
13 report on the impact of the demonstration program under
14 the amendments made by this section, including such im-
15 pact on premiums of medicare beneficiaries, savings to the
16 medicare program, and on adverse selection.

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

20 **SEC. 213. CONFORMING AMENDMENTS.**

21 (a) *CONFORMING AMENDMENTS RELATING TO BIDS*.—

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

1 (A) in the heading of subsection (a), by in-
2 serting “AND BID AMOUNTS” after “PREMIUMS”;
3 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 risk
23 and other factors to be used in adjusting
24 such rates under subsection (a)(1)(A) for
25 payments for months in that year.

1 “(B) *COMPETITION INFORMATION.*—*For*
2 *years beginning with 2005, the following:*

3 “(i) *BENCHMARKS.*—*The fee-for-service*
4 *area-specific non-drug benchmark under*
5 *section 1853(j) and, if applicable, the choice*
6 *non-drug benchmark under section*
7 *1853(k)(2), for the year involved and, if ap-*
8 *plicable, the national fee-for-service market*
9 *share percentage.*

10 “(ii) *ADJUSTMENT FACTORS.*—*The ad-*
11 *justment factors applied under section*
12 *1853(a)(1)(A)(iii) (relating to demographic*
13 *adjustment), section 1853(a)(1)(B) (relating*
14 *to adjustment for end-stage renal disease),*
15 *and section 1853(a)(3) (relating to health*
16 *status adjustment).*

17 “(iii) *PROJECTED FEE-FOR-SERVICE*
18 *BID.*—*In the case of a competitive area, the*
19 *projected fee-for-service area-specific non-*
20 *drug bid (as determined under subsection*
21 *(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 follows*
12 *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 to*
16 *read as follows:*

17 “*(5) PROSPECTIVE IMPLEMENTATION OF NA-*
18 *TIONAL COVERAGE DETERMINATIONS.—The Secretary*
19 *shall only implement a national coverage determina-*
20 *tion that will result in a significant change in the*
21 *costs to a Medicare+Choice organization in a pro-*
22 *spective manner that applies to announcements made*
23 *under section 1853(b) after the date of the implemen-*
24 *tation 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 amended—*

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

8 *“(i) to a single statewide*
9 *Medicare+Choice payment area,”; and*

10 *(B) by amending subparagraph (B) to read*
11 *as follows:*

12 *“(B) BUDGET NEUTRALITY ADJUSTMENT.—*
13 *In the case of a State requesting an adjustment*
14 *under this paragraph, the Medicare Benefits Ad-*
15 *ministrators shall initially (and annually there-*
16 *after) adjust the payment rates otherwise estab-*
17 *lished under this section for Medicare+Choice*
18 *payment areas in the State in a manner so that*
19 *the aggregate of the payments under this section*
20 *in the State shall not exceed the aggregate pay-*
21 *ments that would have been made under this sec-*
22 *tion for Medicare+Choice payment areas in the*
23 *State in the absence of the adjustment under this*
24 *paragraph.”.*

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

4 ***TITLE III—RURAL HEALTH CARE***
 5 ***IMPROVEMENTS***

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

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

11 ***SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOS-***
 12 ***PITAL (DSH) TREATMENT FOR RURAL HOS-***
 13 ***PITALS AND URBAN HOSPITALS WITH FEWER***
 14 ***THAN 100 BEDS.***

15 (a) *BLENDING OF PAYMENT AMOUNTS.*—

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

19 *“(xiv)(I) In the case of discharges in a fiscal year be-*
 20 *ginning on or after October 1, 2002, subject to subclause*
 21 *(II), there shall be substituted for the disproportionate share*
 22 *adjustment percentage otherwise determined under clause*
 23 *(iv) (other than subclause (I)) or under clause (viii), (x),*
 24 *(xi), (xii), or (xiii), the old blend proportion (specified*
 25 *under subclause (III)) of the disproportionate share adjust-*

1 *ment percentage otherwise determined under the respective*
 2 *clause and 100 percent minus such old blend proportion*
 3 *of the disproportionate share adjustment percentage deter-*
 4 *mined under clause (vii) (relating to large, urban hos-*
 5 *pitals).*

6 “(II) Under subclause (I), the disproportionate share
 7 adjustment percentage shall not exceed 10 percent for a hos-
 8 pital that is not classified as a rural referral center under
 9 subparagraph (C).

10 “(III) For purposes of subclause (I), the old blend pro-
 11 portion for fiscal year 2003 is 80 percent, for each subse-
 12 quent year (through 2006) is the old blend proportion under
 13 this subclause for the previous year minus 20 percentage
 14 points, and for each year beginning with 2007 is 0 per-
 15 cent.”.

16 (2) CONFORMING AMENDMENTS.—Section
 17 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is
 18 amended—

19 (A) in each of subclauses (II), (III), (IV),
 20 (V), and (VI) of clause (iv), by inserting “subject
 21 to clause (xiv) and” before “for discharges occur-
 22 ring”;

23 (B) in clause (viii), by striking “The for-
 24 mula” and inserting “Subject to clause (xiv), the
 25 formula”; and

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

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

7 **SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARD-**
 8 **IZED AMOUNT IN RURAL AND SMALL URBAN**
 9 **AREAS TO ACHIEVE A SINGLE, UNIFORM**
 10 **STANDARDIZED AMOUNT.**

11 Section 1886(d)(3)(A)(iv) (42 U.S.C.
 12 1395ww(d)(3)(A)(iv)) is amended—

13 (1) by striking “(iv) For discharges” and insert-
 14 ing “(iv)(I) Subject to the succeeding provisions of
 15 this clause, for discharges”; and

16 (2) by adding at the end the following new sub-
 17 clauses:

18 “(II) For discharges occurring during fiscal year
 19 2003, the average standardized amount for hospitals
 20 located other than in a large urban area shall be in-
 21 creased by $\frac{1}{2}$ of the difference between the average
 22 standardized amount determined under subclause (I)
 23 for hospitals located in large urban areas for such fis-
 24 cal year and such amount determined (without regard

1 to this subclause) for other hospitals for such fiscal
2 year.

3 “(III) For discharges occurring in a fiscal year
4 beginning with fiscal year 2004, the Secretary shall
5 compute an average standardized amount for hos-
6 pitals located in any area within the United States
7 and within each region equal to the average standard-
8 ized amount computed for the previous fiscal year
9 under this subparagraph for hospitals located in a
10 large urban area (or, beginning with fiscal year 2005,
11 for hospitals located in any area) increased by the
12 applicable percentage increase under subsection
13 (b)(3)(B)(i).”.

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

16 (a) *MORE FREQUENT UPDATES IN WEIGHTS.*—After
17 revising the weights used in the hospital market basket
18 under section 1886(b)(3)(B)(iii) of the Social Security Act
19 (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current
20 data available, the Secretary shall establish a frequency for
21 revising such weights in such market basket to reflect the
22 most current data available more frequently than once every
23 5 years.

24 (b) *REPORT.*—Not later than October 1, 2003, the Sec-
25 retary shall submit a report to Congress on the frequency

1 *established under subsection (a), including an explanation*
2 *of the reasons for, and options considered, in determining*
3 *such frequency.*

4 **SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**
5 **PROGRAM.**

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

9 *(1) by striking “and” at the end of subpara-*
10 *graph (C);*

11 *(2) by adding “and” at the end of subparagraph*
12 *(D); and*

13 *(3) by inserting after subparagraph (D) the fol-*
14 *lowing new subparagraph:*

15 *“(E) inpatient critical access hospital services;”.*

16 *(b) CONDITION FOR APPLICATION OF SPECIAL PHYSI-*
17 *CIAN PAYMENT ADJUSTMENT.—Section 1834(g)(2) (42*
18 *U.S.C. 1395m(g)(2)) is amended by adding after and below*
19 *subparagraph (B) the following:*

20 *“The Secretary may not require, as a condition for*
21 *applying subparagraph (B) with respect to a critical*
22 *access hospital, that each physician providing profes-*
23 *sional services in the hospital must assign billing*
24 *rights with respect to such services, except that such*

1 *subparagraph shall not apply to those physicians who*
2 *have not assigned such billing rights.”.*

3 *(c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS*
4 *WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—Sec-*
5 *tion 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 fol-*
9 *lowing new paragraph:*

10 *“(3) INCREASE IN MAXIMUM NUMBER OF BEDS*
11 *FOR HOSPITALS WITH STRONG SEASONAL CENSUS*
12 *FLUCTUATIONS.—*

13 *“(A) IN GENERAL.—In the case of a hos-*
14 *pital that demonstrates that it meets the stand-*
15 *ards established under subparagraph (B), the bed*
16 *limitations otherwise applicable under para-*
17 *graph (2)(B)(iii) and subsection (f) shall be in-*
18 *creased by 5 beds.*

19 *“(B) STANDARDS.—The Secretary shall*
20 *specify standards for determining whether a crit-*
21 *ical access hospital has sufficiently strong sea-*
22 *sonal variations in patient admissions to justify*
23 *the increase in bed limitation provided under*
24 *subparagraph (A).”;* and

1 (3) *in subsection (f), by adding at the end the*
2 *following new sentence: “The limitations in numbers*
3 *of beds under the first sentence are subject to adjust-*
4 *ment under subsection (c)(3).”.*

5 (d) *5-YEAR EXTENSION OF THE AUTHORIZATION FOR*
6 *APPROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j)*
7 *(42 U.S.C. 1395i–4(j)) is amended by striking “through*
8 *2002” and inserting “through 2007”.*

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

18 (f) *EFFECTIVE DATES.—*

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

22 (2) *PHYSICIAN PAYMENT ADJUSTMENT CONDI-*
23 *TION.—The amendment made by subsection (b) shall*
24 *be effective as if included in the enactment of section*
25 *403(d) of the Medicare, Medicaid, and SCHIP Bal-*

1 *anced Budget Refinement Act of 1999 (113 Stat.*
2 *1501A–371).*

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

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

11 (a) *IN GENERAL.*—*Section 508(a) BIPA (114 Stat.*
12 *2763A–533) is amended—*

13 (1) *by striking “24-MONTH INCREASE BEGIN-*
14 *NING APRIL 1, 2001” and inserting “IN GENERAL”;*
15 *and*

16 (2) *by striking “April 1, 2003” and inserting*
17 *“January 1, 2005”.*

18 (b) *CONFORMING AMENDMENT.*—*Section 547(c)(2) of*
19 *BIPA (114 Stat. 2763A–553) is amended by striking “the*
20 *period beginning on April 1, 2001, and ending on Sep-*
21 *tember 30, 2002,” and inserting “a period under such sec-*
22 *tion”.*

1 **SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAY-**
2 **MENT FOR HOSPICE CARE FURNISHED IN A**
3 **FRONTIER AREA AND RURAL HOSPICE DEM-**
4 **ONSTRATION PROJECT.**

5 *For—*

6 *(1) provision of 10 percent increase in payment*
7 *for hospice care furnished in a frontier area, see sec-*
8 *tion 422; and*

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

11 **SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LO-**
12 **CATED IN RURAL OR SMALL URBAN AREAS IN**
13 **REDISTRIBUTION OF UNUSED GRADUATE**
14 **MEDICAL EDUCATION RESIDENCIES.**

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

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

20 *(a) STUDY.—The Comptroller General of the United*
21 *States shall conduct a study of differences in payment*
22 *amounts under the physician fee schedule under section*
23 *1848 of the Social Security Act (42 U.S.C. 1395w-4) for*
24 *physicians' services in different geographic areas. Such*
25 *study shall include—*

1 (1) *an assessment of the validity of the geo-*
2 *graphic adjustment factors used for each component of*
3 *the fee schedule;*

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

6 (3) *an evaluation of the methods used to deter-*
7 *mine professional liability insurance costs used in*
8 *computing the malpractice component, including a*
9 *review of increases in professional liability insurance*
10 *premiums and variation in such increases by State*
11 *and physician specialty and methods used to update*
12 *the geographic cost of practice index and relative*
13 *weights for the malpractice component.*

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

1 **SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COL-**
2 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**
3 **CALLY UNDERSERVED POPULATIONS.**

4 (a) *IN GENERAL.*—Section 1128B(b)(3) (42 U.S.C.
5 1320a–7(b)(3)), as amended by section 101(b)(2), is
6 amended—

7 (1) in subparagraph (F), by striking “and” after
8 the semicolon at the end;

9 (2) in subparagraph (G), by striking the period
10 at the end and inserting “; and”; and

11 (3) by adding at the end the following new sub-
12 paragraph:

13 “(H) any remuneration between a public or
14 nonprofit private health center entity described
15 under clause (i) or (ii) of section 1905(l)(2)(B)
16 and any individual or entity providing goods,
17 items, services, donations or loans, or a combina-
18 tion thereof, to such health center entity pursu-
19 ant to a contract, lease, grant, loan, or other
20 agreement, if such agreement contributes to the
21 ability of the health center entity to maintain or
22 increase the availability, or enhance the quality,
23 of services provided to a medically underserved
24 population served by the health center entity.”.

25 (b) *RULEMAKING FOR EXCEPTION FOR HEALTH CEN-*
26 *TER ENTITY ARRANGEMENTS.*—

1 (1) *ESTABLISHMENT.*—

2 (A) *IN GENERAL.*—*The Secretary of Health*
3 *and Human Services (in this subsection referred*
4 *to as the “Secretary”)* shall establish, on an ex-
5 *pedited basis, standards relating to the exception*
6 *described in section 1128B(b)(3)(H) of the Social*
7 *Security Act, as added by subsection (a), for*
8 *health center entity arrangements to the*
9 *antikickback penalties.*

10 (B) *FACTORS TO CONSIDER.*—*The Secretary*
11 *shall consider the following factors, among oth-*
12 *ers, in establishing standards relating to the ex-*
13 *ception for health center entity arrangements*
14 *under subparagraph (A):*

15 (i) *Whether the arrangement between*
16 *the health center entity and the other party*
17 *results in savings of Federal grant funds or*
18 *increased revenues to the health center enti-*
19 *ty.*

20 (ii) *Whether the arrangement between*
21 *the health center entity and the other party*
22 *restricts or limits a patient’s freedom of*
23 *choice.*

24 (iii) *Whether the arrangement between*
25 *the health center entity and the other party*

1 *protects a health care professional's inde-*
2 *pendent medical judgment regarding medi-*
3 *cally appropriate treatment.*

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

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

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

18 (a) *IN GENERAL.*—*In the case of a non-teaching hos-*
19 *pital that meets the condition of subsection (b), for its cost*
20 *reporting period beginning in each of fiscal years 2003,*
21 *2004, and 2005 the amount of payment made to the hos-*
22 *pital under section 1886(d) of the Social Security Act for*
23 *discharges occurring during such fiscal year only shall be*
24 *increased as though the applicable percentage increase (oth-*
25 *erwise applicable to discharges occurring during such fiscal*

1 *year under section 1886(b)(3)(B)(i) of the Social Security*
2 *Act (42 U.S.C. 1395ww(b)(3)(B)(i)) had been increased by*
3 *5 percentage points. The previous sentence shall be applied*
4 *for each such fiscal year separately without regard to its*
5 *application in a previous fiscal year and shall not affect*
6 *payment for discharges for any hospital occurring during*
7 *a fiscal year after fiscal year 2005.*

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

10 (1) *it is located in a rural area and the amount*
11 *of the aggregate payments under subsection (d) of*
12 *such section for hospitals located in rural areas in the*
13 *State for their cost reporting periods beginning dur-*
14 *ing fiscal year 1999 is less than the aggregate allow-*
15 *able operating costs of inpatient hospital services (as*
16 *defined in section 1886(a)(4) of such Act) for all sub-*
17 *section (d) hospitals in such areas in such State with*
18 *respect to such cost reporting periods; or*

19 (2) *it is located in an urban area and the*
20 *amount of the aggregate payments under subsection*
21 *(d) of such section for hospitals located in urban*
22 *areas in the State for their cost reporting periods be-*
23 *ginning during fiscal year 1999 is less than 103 per-*
24 *cent of the aggregate allowable operating costs of in-*
25 *patient hospital services (as defined in section*

1 1886(a)(4) of such Act) for all subsection (d) hospitals
2 in such areas in such State with respect to such cost
3 reporting periods.

4 The amounts under paragraphs (1) and (2) shall be deter-
5 mined by the Secretary of Health and Human Services
6 based on data of the Medicare Payment Advisory Commis-
7 sion.

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

9 (1) *NON-TEACHING HOSPITAL.*—The term “non-
10 teaching hospital” means, for a cost reporting period,
11 a subsection (d) hospital (as defined in section
12 1886(d)(1)(B) of the Social Security Act, 42 U.S.C.
13 1395ww(d)(1)(B))) that is not receiving any addi-
14 tional payment under section 1886(d)(5)(B) of such
15 Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment
16 under section 1886(h) of such Act (42 U.S.C.
17 1395ww(h)) for discharges occurring during the pe-
18 riod.

19 (2) *RURAL; URBAN.*—The terms “rural” and
20 “urban” have the meanings given such terms for pur-
21 poses of section 1886(d) of the Social Security Act (42
22 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 follows:*

9 *“(XVIII) for fiscal year 2003, the market basket*
10 *percentage increase for sole community hospitals and*
11 *such increase minus 0.25 percentage points for other*
12 *hospitals, and”.*

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

16 *Section 1886(d)(5)(B)(ii) (42 U.S.C.*
17 *1395ww(d)(5)(B)(ii)) is amended—*

18 *(1) in subclause (VI) by striking “and” at the*
19 *end;*

20 *(2) by redesignating subclause (VII) as subclause*
21 *(IX);*

22 *(3) in subclause (IX) as so redesignated, by*
23 *striking “2002” and inserting “2004”; and*

24 *(4) by inserting after subclause (VI) the fol-*
25 *lowing new subclause:*

1 “(VII) during fiscal year 2003, ‘c’ is equal
2 to 1.47;

3 “(VIII) during fiscal year 2004, ‘c’ is equal
4 to 1.45; and”.

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

7 (a) *IMPROVING TIMELINESS OF DATA COLLECTION.*—
8 Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is
9 amended by adding at the end the following new clause:
10 “(vii) Under the mechanism under this subparagraph,
11 the Secretary shall provide for the addition of new diagnosis
12 and procedure codes in April 1 of each year, but the addi-
13 tion of such codes shall not require the Secretary to adjust
14 the payment (or diagnosis-related group classification)
15 under this subsection until the fiscal year that begins after
16 such date.”.

17 (b) *ELIGIBILITY STANDARD.*—

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

21 (A) by inserting “(I)” after “(vi)”; and

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

24 “(II) Under such criteria, a service or technology shall
25 not be denied treatment as a new service or technology on

1 *the basis of the period of time in which the service or tech-*
2 *nology has been in use if such period ends before the end*
3 *of the 2-to-3-year period that begins on the effective date*
4 *of implementation of a code under ICD–9–CM (or a suc-*
5 *cessor coding methodology) that enables the identification*
6 *of a significant sample of specific discharges in which the*
7 *service or technology has been used.”.*

8 (2) *ADJUSTMENT OF THRESHOLD.*—Section
9 1886(d)(5)(K)(ii)(I) (42 U.S.C.
10 1395ww(d)(5)(K)(ii)(I)) *is amended by inserting*
11 “*(applying a threshold specified by the Secretary that*
12 *is the lesser of 50 percent of the national average*
13 *standardized amount for operating costs of inpatient*
14 *hospital services for all hospitals and all diagnosis-re-*
15 *lated groups or one standard deviation for the diag-*
16 *nosis-related group involved)” after “is inadequate”.*

17 (3) *CRITERION FOR SUBSTANTIAL IMPROVE-*
18 *MENT.*—Section 1886(d)(5)(K)(vi) (42 U.S.C.
19 1395ww(d)(5)(K)(vi)), *as amended by paragraph (1),*
20 *is further amended by adding at the end the following*
21 *subclause:*

22 “*(III) The Secretary shall by regulation provide for*
23 *further clarification of the criteria applied to determine*
24 *whether a new service or technology represents an advance*
25 *in medical technology that substantially improves the diag-*

1 *nosis or treatment of beneficiaries. Under such criteria, in*
2 *determining whether a new service or technology represents*
3 *an advance in medical technology that substantially im-*
4 *proves the diagnosis or treatment of beneficiaries, the Sec-*
5 *retary shall deem a service or technology as meeting such*
6 *requirement if the service or technology is a drug or biologi-*
7 *cal that is designated under section 506 or 526 of the Fed-*
8 *eral Food, Drug, and Cosmetic Act, approved under section*
9 *314.510 or 601.41 of title 21, Code of Federal Regulations,*
10 *or designated for priority review when the marketing appli-*
11 *cation for such drug or biological was filed or is a medical*
12 *device for which an exemption has been granted under sec-*
13 *tion 520(m) of such Act, or for which priority review has*
14 *been provided under section 515(d)(5) of such Act.”.*

15 (4) *PROCESS FOR PUBLIC INPUT.—Section*
16 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), *as*
17 *amended by paragraph (1), is amended—*

18 (A) *in clause (i), by adding at the end the*
19 *following: “Such mechanism shall be modified to*
20 *meet the requirements of clause (viii).”;* *and*

21 (B) *by adding at the end the following new*
22 *clause:*

23 “(viii) *The mechanism established pursuant to clause*
24 *(i) shall be adjusted to provide, before publication of a pro-*
25 *posed rule, for public input regarding whether a new service*

1 *or technology not described in the second sentence of clause*
2 *(vi)(III) represents an advance in medical technology that*
3 *substantially improves the diagnosis or treatment of bene-*
4 *ficiaries as follows:*

5 *“(I) The Secretary shall make public and peri-*
6 *odically update a list of all the services and tech-*
7 *nologies for which an application for additional pay-*
8 *ment under this subparagraph is pending.*

9 *“(II) The Secretary shall accept comments, rec-*
10 *ommendations, and data from the public regarding*
11 *whether the service or technology represents a substan-*
12 *tial improvement.*

13 *“(III) The Secretary shall provide for a meeting*
14 *at which organizations representing hospitals, physi-*
15 *cians, medicare beneficiaries, manufacturers, and any*
16 *other interested party may present comments, rec-*
17 *ommendations, and data to the clinical staff of the*
18 *Centers for Medicare & Medicaid Services before pub-*
19 *lication of a notice of proposed rulemaking regarding*
20 *whether service or technology represents a substantial*
21 *improvement.”.*

22 *(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—*
23 *Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is fur-*
24 *ther amended by adding at the end the following new clause:*

1 “(ix) Before establishing any add-on payment under
2 this subparagraph with respect to a new technology, the
3 Secretary shall seek to identify one or more diagnosis-re-
4 lated groups associated with such technology, based on simi-
5 lar clinical or anatomical characteristics and the cost of
6 the technology. Within such groups the Secretary shall as-
7 sign an eligible new technology into a diagnosis-related
8 group where the average costs of care most closely approxi-
9 mate the costs of care of using the new technology. In such
10 case, no add-on payment under this subparagraph shall be
11 made with respect to such new technology and this clause
12 shall not affect the application of paragraph (4)(C)(iii).”.

13 (d) *IMPROVEMENT IN PAYMENT FOR NEW TECH-*
14 *NOLOGY.*—Section 1886(d)(5)(K)(i)(III) (42 U.S.C.
15 1395ww(d)(5)(K)(i)(III)) is amended by inserting after
16 “the estimated average cost of such service or technology”
17 the following: “(based on the marginal rate applied to costs
18 under subparagraph (A))”.

19 (e) *EFFECTIVE DATE.*—

20 (1) *IN GENERAL.*—The Secretary shall imple-
21 ment the amendments made by this section so that
22 they apply to classification for fiscal years beginning
23 with fiscal year 2004.

24 (2) *RECONSIDERATIONS OF APPLICATIONS FOR*
25 *FISCAL YEAR 2003 THAT ARE DENIED.*—In the case of

1 *an application for a classification of a medical serv-*
2 *ice or technology as a new medical service or tech-*
3 *nology under section 1886(d)(5)(K) of the Social Se-*
4 *curity Act (42 U.S.C. 1395ww(d)(5)(K)) that was*
5 *filed for fiscal year 2003 and that is denied—*

6 *(A) the Secretary shall automatically recon-*
7 *sider the application as an application for fiscal*
8 *year 2004 under the amendments made by this*
9 *section; and*

10 *(B) the maximum time period otherwise*
11 *permitted for such classification of the service or*
12 *technology shall be extended by 12 months.*

13 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN**
14 **PUERTO RICO.**

15 *Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is*
16 *amended—*

17 *(1) in subparagraph (A)—*

18 *(A) in clause (i), by striking “for discharges*
19 *beginning on or after October 1, 1997, 50 percent*
20 *(and for discharges between October 1, 1987, and*
21 *September 30, 1997, 75 percent)” and inserting*
22 *“the applicable Puerto Rico percentage (specified*
23 *in subparagraph (E))”; and*

24 *(B) in clause (ii), by striking “for dis-*
25 *charges beginning in a fiscal year beginning on*

1 *or after October 1, 1997, 50 percent (and for dis-*
2 *charges between October 1, 1987, and September*
3 *30, 1997, 25 percent)” and inserting “the appli-*
4 *cable Federal percentage (specified in subpara-*
5 *graph (E))”;* and

6 *(2) by adding at the end the following new sub-*
7 *paragraph:*

8 *“(E) For purposes of subparagraph (A), for discharges*
9 *occurring—*

10 *“(i) between October 1, 1987, and September 30,*
11 *1997, the applicable Puerto Rico percentage is 75 per-*
12 *cent and the applicable Federal percentage is 25 per-*
13 *cent;*

14 *“(ii) on or after October 1, 1997, and before Oc-*
15 *tober 1, 2003, the applicable Puerto Rico percentage*
16 *is 50 percent and the applicable Federal percentage is*
17 *50 percent;*

18 *“(iii) during fiscal year 2004, the applicable*
19 *Puerto Rico percentage is 45 percent and the applica-*
20 *ble Federal percentage is 55 percent;*

21 *“(iv) during fiscal year 2005, the applicable*
22 *Puerto Rico percentage is 40 percent and the applica-*
23 *ble Federal percentage is 60 percent;*

1 “(v) during fiscal year 2006, the applicable
2 Puerto Rico percentage is 35 percent and the applica-
3 ble Federal percentage is 65 percent;

4 “(vi) during fiscal year 2007, the applicable
5 Puerto Rico percentage is 30 percent and the applica-
6 ble Federal percentage is 70 percent; and

7 “(vii) on or after October 1, 2007, the applicable
8 Puerto Rico percentage is 25 percent and the applica-
9 ble Federal percentage is 75 percent.”.

10 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**
11 **HANCED DISPROPORTIONATE SHARE HOS-**
12 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**
13 **PITALS AND URBAN HOSPITALS WITH FEWER**
14 **THAN 100 BEDS.**

15 *For provision enhancing disproportionate share hos-*
16 *pital (DSH) treatment for rural hospitals and urban hos-*
17 *pitals with fewer than 100 beds, see section 302.*

18 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR**
19 **PHASED-IN INCREASE IN THE STANDARDIZED**
20 **AMOUNT IN RURAL AND SMALL URBAN AREAS**
21 **TO ACHIEVE A SINGLE, UNIFORM STANDARD-**
22 **IZED AMOUNT.**

23 *For provision phasing in over a 2-year period an in-*
24 *crease in the standardized amount for rural and small*

1 *urban areas to achieve a single, uniform, standardized*
 2 *amount, see section 303.*

3 **SEC. 407. REFERENCE TO PROVISION FOR MORE FREQUENT**
 4 **UPDATES IN THE WEIGHTS USED IN HOS-**
 5 **PITAL MARKET BASKET.**

6 *For provision providing for more frequent updates in*
 7 *the weights used in hospital market basket, see section 304.*

8 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**
 9 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**
 10 **GRAM.**

11 *For provision providing making improvements to crit-*
 12 *ical access hospital program, see section 305.*

13 ***Subtitle B—Skilled Nursing***
 14 ***Facility Services***

15 **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FA-**
 16 **CILITY SERVICES.**

17 *(a) TEMPORARY INCREASE IN NURSING COMPONENT*
 18 *OF PPS FEDERAL RATE.—Section 312(a) of BIPA is*
 19 *amended by adding at the end the following new sentence:*
 20 *“The Secretary of Health and Human Services shall in-*
 21 *crease by 12, 10, and 8 percent the nursing component of*
 22 *the case-mix adjusted Federal prospective payment rate*
 23 *specified in Tables 3 and 4 of the final rule published in*
 24 *the Federal Register by the Health Care Financing Admin-*
 25 *istration on July 31, 2000 (65 Fed. Reg. 46770) and as*

1 *subsequently updated under section 1888(e)(4)(E)(ii) of the*
2 *Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effec-*
3 *tive for services furnished during fiscal years 2003, 2004,*
4 *and 2005, respectively.”*

5 *(b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—*

6 *(1) IN GENERAL.—Paragraph (12) of section*
7 *1888(e) (42 U.S.C. 1395yy(e)) is amended to read as*
8 *follows:*

9 *“(12) ADJUSTMENT FOR RESIDENTS WITH*
10 *AIDS.—*

11 *“(A) IN GENERAL.—Subject to subpara-*
12 *graph (B), in the case of a resident of a skilled*
13 *nursing facility who is afflicted with acquired*
14 *immune deficiency syndrome (AIDS), the per*
15 *diem amount of payment otherwise applicable*
16 *shall be increased by 128 percent to reflect in-*
17 *creased costs associated with such residents.*

18 *“(B) SUNSET.—Subparagraph (A) shall not*
19 *apply on and after such date as the Secretary*
20 *certifies that there is an appropriate adjustment*
21 *in the case mix under paragraph (4)(G)(i) to*
22 *compensate for the increased costs associated*
23 *with residents described in such subparagraph.”*

1 (2) *EFFECTIVE DATE.*—*The amendment made by*
2 *paragraph (1) shall apply to services furnished on or*
3 *after October 1, 2003.*

4 ***Subtitle C—Hospice***

5 ***SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERV-*** 6 ***ICES.***

7 (a) *COVERAGE OF HOSPICE CONSULTATION SERV-*
8 *ICES.*—*Section 1812(a) (42 U.S.C. 1395d(a)) is amended—*

9 (1) *by striking “and” at the end of paragraph*
10 (3);

11 (2) *by striking the period at the end of para-*
12 *graph (4) and inserting “; and”; and*

13 (3) *by inserting after paragraph (4) the fol-*
14 *lowing new paragraph:*

15 “*(5) for individuals who are terminally ill, have*
16 *not made an election under subsection (d)(1), and*
17 *have not previously received services under this para-*
18 *graph, services that are furnished by a physician who*
19 *is either the medical director or an employee of a hos-*
20 *pice program and that consist of—*

21 “*(A) an evaluation of the individual’s need*
22 *for pain and symptom management;*

23 “*(B) counseling the individual with respect*
24 *to end-of-life issues and care options; and*

1 “(C) advising the individual regarding ad-
2 vanced care planning.”.

3 (b) *PAYMENT.*—Section 1814(i) (42 U.S.C. 1395f(i)) is
4 amended by adding at the end the following new paragraph:

5 “(4) The amount paid to a hospice program with re-
6 spect to the services under section 1812(a)(5) for which pay-
7 ment may be made under this part shall be equal to an
8 amount equivalent to the amount established for an office
9 or other outpatient visit for evaluation and management
10 associated with presenting problems of moderate severity
11 under the fee schedule established under section 1848(b),
12 other than the portion of such amount attributable to the
13 practice expense component.”.

14 (c) *CONFORMING AMENDMENT.*—Section
15 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is
16 amended by inserting before the comma at the end the fol-
17 lowing: “and services described in section 1812(a)(5)”.

18 (d) *EFFECTIVE DATE.*—The amendments made by this
19 section shall apply to services provided by a hospice pro-
20 gram on or after January 1, 2004.

21 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE**
22 **CARE FURNISHED IN A FRONTIER AREA.**

23 (a) *IN GENERAL.*—Section 1814(i)(1) (42 U.S.C.
24 1395f(i)(1)) is amended by adding at the end the following
25 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 hos-*
11 *pice care in frontier areas. Such report shall include rec-*
12 *ommendations regarding the appropriateness of extending,*
13 *and modifying, the payment increase provided under the*
14 *amendment made by subsection (a).*

15 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

16 (a) *IN GENERAL.—The Secretary shall conduct a dem-*
17 *onstration project for the delivery of hospice care to medi-*
18 *care beneficiaries in rural areas. Under the project medi-*
19 *care beneficiaries who are unable to receive hospice care in*
20 *the home for lack of an appropriate caregiver are provided*
21 *such care in a facility of 20 or fewer beds which offers, with-*
22 *in its walls, the full range of services provided by hospice*
23 *programs under section 1861(dd) of the Social Security Act*
24 *(42 U.S.C. 1395x(dd)).*

1 (b) *SCOPE OF PROJECT.*—*The Secretary shall conduct*
2 *the project under this section with respect to no more than*
3 *3 hospice programs over a period of not longer than 5 years*
4 *each.*

5 (c) *COMPLIANCE WITH CONDITIONS.*—*Under the dem-*
6 *onstratation project—*

7 (1) *the hospice program shall comply with other-*
8 *wise applicable requirements, except that it shall not*
9 *be required to offer services outside of the home or to*
10 *meet the requirements of section 1861(dd)(2)(A)(iii)*
11 *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 title*
14 *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 appro-*
18 *priate.*

19 (d) *REPORT.*—*Upon completion of the project, the Sec-*
20 *retary shall submit a report to Congress on the project and*
21 *shall include in the report recommendations regarding ex-*
22 *tension of such project to hospice programs serving rural*
23 *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 contrac-*
8 *tors under the Medicare Integrity Program in identifying*
9 *and recouping overpayments under the medicare program*
10 *for services for which payment is made under part A of*
11 *title XVIII of the Social Security Act. Under the project—*

12 (1) *payment may be made to such a contractor*
13 *on a contingent basis;*

14 (2) *a percentage of the amount recovered may be*
15 *retained by the Secretary and shall be available to the*
16 *program management account of the Centers for*
17 *Medicare & Medicaid Services; and*

18 (3) *the Secretary shall examine the efficacy of*
19 *such use with respect to duplicative payments, accu-*
20 *racy of coding, and other payment policies in which*
21 *inaccurate payments arise.*

22 (b) *SCOPE AND DURATION.*—*The project shall cover at*
23 *least 2 States and at least 3 contractors and shall last for*
24 *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 pay-*
4 *ment for services under the project in accordance with sub-*
5 *section (a).*

6 (d) *QUALIFICATIONS OF CONTRACTORS.*—

7 (1) *IN GENERAL.*—*The Secretary shall enter into*
8 *a recovery audit contract under this section with an*
9 *entity only if the entity has staff that has knowledge*
10 *of and experience with the payment rules and regula-*
11 *tions under the medicare program or the entity has*
12 *or will contract with another entity that has such*
13 *knowledgeable and experienced staff.*

14 (2) *INELIGIBILITY OF CERTAIN CONTRACTORS.*—
15 *The Secretary may not enter into a recovery audit*
16 *contract under this section with an entity to the ex-*
17 *tent that the entity is a fiscal intermediary under sec-*
18 *tion 1816 of the Social Security Act (42 U.S.C.*
19 *1395h), a carrier under section 1842 of such Act (42*
20 *U.S.C. 1395u), or a Medicare Administrative Con-*
21 *tractor under section 1874A of such Act.*

22 (3) *PREFERENCE FOR ENTITIES WITH DEM-*
23 *ONSTRATED PROFICIENCY WITH PRIVATE INSURERS.*—
24 *In awarding contracts to recovery audit contractors*
25 *under this section, the Secretary shall give preference*

1 to those entities that the Secretary determines have
2 demonstrated proficiency in recovery audits with pri-
3 vate insurers or under the medicaid program under
4 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 the
9 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 RELATING**
13 **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 fol-
20 lowing new paragraphs:

21 “(5) *UPDATE FOR 2003.*—The update to the sin-
22 gle conversion factor established in paragraph (1)(C)
23 for 2003 is 2 percent.

24 “(6) *SPECIAL RULES FOR UPDATE FOR 2004 AND*
25 2005.—The following rules apply in determining the

1 *update adjustment factors under paragraph (4)(B) for*
2 *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 deemed*
7 *to be a reference to January 1, 2002.*

8 *“(ii) The allowed expenditures for 2002*
9 *is deemed to be equal to the actual expendi-*
10 *tures for physicians’ services furnished dur-*
11 *ing 2002, as estimated by the Secretary.*

12 *“(B) 1 PERCENTAGE POINT INCREASE IN*
13 *GDP UNDER SGR.—The annual average percent-*
14 *age growth in real gross domestic product per*
15 *capita under subsection (f)(2)(C) for each of*
16 *2003, 2004, and 2005 is deemed to be increased*
17 *by 1 percentage point.”.*

18 *(2) CONFORMING AMENDMENT.—Paragraph*
19 *(4)(B) of such section is amended, in the matter be-*
20 *fore clause (i), by inserting “and paragraph (6)”*
21 *after “subparagraph (D)”.*

22 *(3) NOT TREATED AS CHANGE IN LAW AND REG-*
23 *ULATION IN SUSTAINABLE GROWTH RATE DETERMINA-*
24 *TION.—The amendments made by this subsection shall*
25 *not be treated as a change in law for purposes of ap-*

1 *plying section 1848(f)(2)(D) of the Social Security*
2 *Act (42 U.S.C. 1395w-4(f)(2)(D)).*

3 *(b) USE OF 10-YEAR ROLLING AVERAGE IN COM-*
4 *PUTING GROSS DOMESTIC PRODUCT.—*

5 *(1) IN GENERAL.—Section 1848(f)(2)(C) (42*
6 *U.S.C. 1395w-4(f)(2)(C)) is amended—*

7 *(A) by striking “projected” and inserting*
8 *“annual average”; and*

9 *(B) by striking “from the previous applica-*
10 *ble period to the applicable period involved” and*
11 *inserting “during the 10-year period ending with*
12 *the applicable period involved”.*

13 *(2) EFFECTIVE DATE.—The amendment made by*
14 *paragraph (1) shall apply to computations of the sus-*
15 *tainable growth rate for years beginning with 2002.*

16 *(c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—*
17 *Section 1848(d)(4)(F) (42 U.S.C. 1395w-4(d)(4)(F)) is*
18 *amended by striking “subparagraph (A)” and all that fol-*
19 *lows and inserting “subparagraph (A), for each of 2001 and*
20 *2002, of -0.2 percent.”*

21 **SEC. 502. STUDIES ON ACCESS TO PHYSICIANS’ SERVICES.**

22 *(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-*
23 *CIANS’ SERVICES.—*

24 *(1) STUDY.—The Comptroller General of the*
25 *United States shall conduct a study on access of*

1 *medicare beneficiaries to physicians' services under*
2 *the medicare program. The study shall include—*

3 *(A) an assessment of the use by beneficiaries*
4 *of such services through an analysis of claims*
5 *submitted by physicians for such services under*
6 *part B of the medicare program;*

7 *(B) an examination of changes in the use*
8 *by beneficiaries of physicians' services over time;*

9 *(C) an examination of the extent to which*
10 *physicians are not accepting new medicare bene-*
11 *ficiaries as patients.*

12 *(2) REPORT.—Not later than 18 months after the*
13 *date of the enactment of this Act, the Comptroller*
14 *General shall submit to Congress a report on the*
15 *study conducted under paragraph (1). The report*
16 *shall include a determination whether—*

17 *(A) data from claims submitted by physi-*
18 *cians under part B of the medicare program in-*
19 *dicating potential access problems for medicare*
20 *beneficiaries in certain geographic areas; and*

21 *(B) access by medicare beneficiaries to phy-*
22 *sicians' services may have improved, remained*
23 *constant, or deteriorated over time.*

24 *(b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—*

1 *competitive acquisition areas are established*
2 *throughout the United States for contract award*
3 *purposes for the furnishing under this part of*
4 *competitively priced items and services (de-*
5 *scribed in paragraph (2)) for which payment is*
6 *made under this part. Such areas may differ for*
7 *different items and services.*

8 “(B) *PHASED-IN IMPLEMENTATION.*—*The*
9 *programs shall be phased-in among competitive*
10 *acquisition areas over a period of not longer*
11 *than 3 years in a manner so that the competi-*
12 *tion under the programs occurs in—*

13 “(i) *at least $\frac{1}{3}$ of such areas in 2004;*

14 *and*

15 “(ii) *at least $\frac{2}{3}$ of such areas in 2005.*

16 “(C) *WAIVER OF CERTAIN PROVISIONS.*—*In*
17 *carrying out the programs, the Secretary may*
18 *waive such provisions of the Federal Acquisition*
19 *Regulation as are necessary for the efficient im-*
20 *plementation of this section, other than provi-*
21 *sions relating to confidentiality of information*
22 *and such other provisions as the Secretary deter-*
23 *mines appropriate.*

1 “(2) *ITEMS AND SERVICES DESCRIBED.*—*The*
2 *items and services referred to in paragraph (1) are*
3 *the following:*

4 “(A) *DURABLE MEDICAL EQUIPMENT AND*
5 *INHALATION DRUGS USED IN CONNECTION WITH*
6 *DURABLE MEDICAL EQUIPMENT.*—*Covered items*
7 *(as defined in section 1834(a)(13)) for which*
8 *payment is otherwise made under section*
9 *1834(a), other than items used in infusion, and*
10 *inhalation drugs used in conjunction with dura-*
11 *ble medical equipment.*

12 “(B) *OFF-THE-SHELF ORTHOTICS.*—
13 *Orthotics (described in section 1861(s)(9)) for*
14 *which payment is otherwise made under section*
15 *1834(h) which require minimal self-adjustment*
16 *for appropriate use and does not require exper-*
17 *tise in trimming, bending, molding, assembling,*
18 *or customizing to fit to the patient.*

19 “(3) *EXEMPTION AUTHORITY.*—*In carrying out*
20 *the programs under this section, the Secretary may*
21 *exempt—*

22 “(A) *areas that are not competitive due to*
23 *low population density; and*

1 “(B) items and services for which the appli-
2 cation of competitive acquisition is not likely to
3 result in significant savings.

4 “(b) PROGRAM REQUIREMENTS.—

5 “(1) IN GENERAL.—The Secretary shall conduct
6 a competition among entities supplying items and
7 services described in subsection (a)(2) for each com-
8 petitive acquisition area in which the program is im-
9 plemented under subsection (a) with respect to such
10 items and services.

11 “(2) CONDITIONS FOR AWARDING CONTRACT.—

12 “(A) IN GENERAL.—The Secretary may not
13 award a contract to any entity under the com-
14 petition conducted in an competitive acquisition
15 area pursuant to paragraph (1) to furnish such
16 items or services unless the Secretary finds all of
17 the following:

18 “(i) The entity meets quality and fi-
19 nancial standards specified by the Secretary
20 or developed by accreditation entities or or-
21 ganizations recognized by the Secretary.

22 “(ii) The total amounts to be paid
23 under the contract (including costs associ-
24 ated with the administration of the con-

1 *tract) are expected to be less than the total*
2 *amounts that would otherwise be paid.*

3 “(iii) *Beneficiary access to a choice of*
4 *multiple suppliers in the area is main-*
5 *tained.*

6 “(iv) *Beneficiary liability is limited to*
7 *the applicable percentage of contract award*
8 *price.*

9 “(B) *QUALITY STANDARDS.—The quality*
10 *standards specified under subparagraph (A)(i)*
11 *shall not be less than the quality standards that*
12 *would otherwise apply if this section did not*
13 *apply and shall include consumer services stand-*
14 *ards. The Secretary shall consult with an expert*
15 *outside advisory panel composed of an appro-*
16 *priate selection of representatives of physicians,*
17 *practitioners, and suppliers to review (and ad-*
18 *vice the Secretary concerning) such quality*
19 *standards.*

20 “(3) *CONTENTS OF CONTRACT.—*

21 “(A) *IN GENERAL.—A contract entered into*
22 *with an entity under the competition conducted*
23 *pursuant to paragraph (1) is subject to terms*
24 *and conditions that the Secretary may specify.*

1 “(B) *TERM OF CONTRACTS.*—*The Secretary*
2 *shall rebid contracts under this section not less*
3 *often than once every 3 years.*

4 “(4) *LIMIT ON NUMBER OF CONTRACTORS.*—

5 “(A) *IN GENERAL.*—*The Secretary may*
6 *limit the number of contractors in a competitive*
7 *acquisition area to the number needed to meet*
8 *projected demand for items and services covered*
9 *under the contracts. In awarding contracts, the*
10 *Secretary shall take into account the ability of*
11 *bidding entities to furnish items or services in*
12 *sufficient quantities to meet the anticipated*
13 *needs of beneficiaries for such items or services*
14 *in the geographic area covered under the contract*
15 *on a timely basis.*

16 “(B) *MULTIPLE WINNERS.*—*The Secretary*
17 *shall award contracts to more than one entity*
18 *submitting a bid in each area for an item or*
19 *service.*

20 “(5) *PARTICIPATING CONTRACTORS.*—*Payment*
21 *shall not be made for items and services described in*
22 *subsection (a)(2) furnished by a contractor and for*
23 *which competition is conducted under this section*
24 *unless—*

1 “(A) *the contractor has submitted a bid for*
2 *such items and services under this section; and*

3 “(B) *the Secretary has awarded a contract*
4 *to the contractor for such items and services*
5 *under this section.*

6 “(6) *AUTHORITY TO CONTRACT FOR EDUCATION,*
7 *OUTREACH AND COMPLAINT SERVICES.—The Sec-*
8 *retary may enter into a contract with an appropriate*
9 *entity to address complaints from beneficiaries who*
10 *receive items and services from an entity with a con-*
11 *tract under this section and to conduct appropriate*
12 *education of and outreach to such beneficiaries with*
13 *respect to the program.*

14 “(c) *ANNUAL REPORTS.—The Secretary shall submit*
15 *to Congress an annual management report on the programs*
16 *under this section. Each such report shall include informa-*
17 *tion on savings, reductions in cost-sharing, access to items*
18 *and services, and beneficiary satisfaction.*

19 “(d) *DEMONSTRATION PROJECT FOR CLINICAL LAB-*
20 *ORATORY SERVICES.—*

21 “(1) *IN GENERAL.—The Secretary shall conduct*
22 *a demonstration project on the application of com-*
23 *petitive acquisition under this section to clinical di-*
24 *agnostic laboratory tests—*

1 “(A) for which payment is otherwise made
2 under section 1833(h) or 1834(d)(1) (relating to
3 colorectal cancer screening tests); and

4 “(B) which are furnished without a face-to-
5 face encounter between the individual and the
6 hospital or physician ordering the tests.

7 “(2) *TERMS AND CONDITIONS.*—Such project
8 shall be under the same conditions as are applicable
9 to items and services described in subsection (a)(2).

10 “(3) *REPORT.*—The Secretary shall submit to
11 Congress—

12 “(A) an initial report on the project not
13 later than December 31, 2004; and

14 “(B) such progress and final reports on the
15 project after such date as the Secretary deter-
16 mines appropriate.”.

17 (b) *CONTINUATION OF CERTAIN DEMONSTRATION*
18 *PROJECTS.*—Notwithstanding the amendment made by sub-
19 section (a), with respect to demonstration projects imple-
20 mented by the Secretary under section 1847 of the Social
21 Security Act (42 U.S.C. 1395w–3) (relating to the establish-
22 ment of competitive acquisition areas) that was in effect
23 on the day before the date of the enactment of this Act, each
24 such demonstration project may continue under the same

1 *terms and conditions applicable under that section as in*
2 *effect on that date.*

3 (c) *REPORT ON DIFFERENCES IN PAYMENT FOR LAB-*
4 *ORATORY SERVICES.*—*Not later than 18 months after the*
5 *date of the enactment of this Act, the Comptroller General*
6 *of the United States shall submit to Congress a report that*
7 *analyzes differences in reimbursement between public and*
8 *private payors for clinical diagnostic laboratory services.*

9 **SEC. 512. PAYMENT FOR AMBULANCE SERVICES.**

10 (a) *PHASE-IN PROVIDING FLOOR USING BLEND OF*
11 *FEE SCHEDULE AND REGIONAL FEE SCHEDULES.*—*Sec-*
12 *tion 1834(l) (42 U.S.C. 1395m(l)) is amended—*

13 (1) *in paragraph (2)(E), by inserting “consistent*
14 *with paragraph (10)” after “in an efficient and fair*
15 *manner”;*

16 (2) *by redesignating the paragraph (8) added by*
17 *section 221(a) of BIPA as paragraph (9); and*

18 (3) *by adding at the end the following new para-*
19 *graph:*

20 “(10) *PHASE-IN PROVIDING FLOOR USING BLEND*
21 *OF FEE SCHEDULE AND REGIONAL FEE SCHED-*
22 *ULES.*—*In carrying out the phase-in under para-*
23 *graph (2)(E) for each level of service furnished in a*
24 *year before January 1, 2007, the portion of the pay-*
25 *ment amount that is based on the fee schedule shall*

1 *not be less than the following blended rate of the fee*
2 *schedule under paragraph (1) and of a regional fee*
3 *schedule for the region involved:*

4 “(A) *For 2003, the blended rate shall be*
5 *based 20 percent on the fee schedule under para-*
6 *graph (1) and 80 percent on the regional fee*
7 *schedule.*

8 “(B) *For 2004, the blended rate shall be*
9 *based 40 percent on the fee schedule under para-*
10 *graph (1) and 60 percent on the regional fee*
11 *schedule.*

12 “(C) *For 2005, the blended rate shall be*
13 *based 60 percent on the fee schedule under para-*
14 *graph (1) and 40 percent on the regional fee*
15 *schedule.*

16 “(D) *For 2006, the blended rate shall be*
17 *based 80 percent on the fee schedule under para-*
18 *graph (1) and 20 percent on the regional fee*
19 *schedule.*

20 *For purposes of this paragraph, the Secretary shall*
21 *establish a regional fee schedule for each of the 9 Cen-*
22 *sus divisions using the methodology (used in estab-*
23 *lishing the fee schedule under paragraph (1)) to cal-*
24 *culate a regional conversion factor and a regional*
25 *mileage payment rate and using the same payment*

1 *adjustments and the same relative value units as used*
2 *in the fee schedule under such paragraph.”.*

3 *(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG*
4 *TRIPS.—Section 1834(l), as amended by subsection (a), is*
5 *further amended by adding at the end the following new*
6 *paragraph:*

7 *“(11) ADJUSTMENT IN PAYMENT FOR CERTAIN*
8 *LONG TRIPS.—In the case of ground ambulance serv-*
9 *ices furnished on or after January 1, 2003, and before*
10 *January 1, 2008, regardless of where the transpor-*
11 *tation originates, the fee schedule established under*
12 *this subsection shall provide that, with respect to the*
13 *payment rate for mileage for a trip above 50 miles*
14 *the per mile rate otherwise established shall be in-*
15 *creased by $\frac{1}{4}$ of the payment per mile otherwise ap-*
16 *plicable to such miles.”.*

17 *(c) EFFECTIVE DATE.—The amendments made by this*
18 *section shall apply to ambulance services furnished on or*
19 *after January 1, 2003.*

20 **SEC. 513. 2-YEAR EXTENSION OF MORATORIUM ON THER-**
21 **APY CAPS; PROVISIONS RELATING TO RE-**
22 **PORTS.**

23 *(a) 2-YEAR EXTENSION OF MORATORIUM ON THERAPY*
24 *CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is*

1 *amended by striking “and 2002” and inserting “2002,*
2 *2003, and 2004”.*

3 **(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON**
4 *PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY*
5 *SERVICES.*—*Not later than December 31, 2002, the Sec-*
6 *retary shall submit to Congress the reports required under*
7 *section 4541(d)(2) of the Balanced Budget Act of 1997 (re-*
8 *lating to alternatives to a single annual dollar cap on out-*
9 *patient therapy) and under section 221(d) of the Medicare,*
10 *Medicaid, and SCHIP Balanced Budget Refinement Act of*
11 *1999 (relating to utilization patterns for outpatient ther-*
12 *apy).*

13 **(c) IDENTIFICATION OF CONDITIONS AND DISEASES**
14 *JUSTIFYING WAIVER OF THERAPY CAP.*—

15 **(1) STUDY.**—*The Secretary shall request the In-*
16 *stitute of Medicine of the National Academy of*
17 *Sciences to identify conditions or diseases that should*
18 *justify conducting an assessment of the need to waive*
19 *the therapy caps under section 1833(g)(4) of the So-*
20 *cial Security Act (42 U.S.C. 1395l(g)(4)).*

21 **(2) REPORTS TO CONGRESS.**—*Not later than*
22 *July 1, 2003, the Secretary shall submit to Congress*
23 *a preliminary report on the conditions and diseases*
24 *identified under paragraph (1) and not later than*

1 *September 1, 2003, a final report on the conditions*
2 *and diseases so identified.*

3 *(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL*
4 *THERAPIST SERVICES.—*

5 *(1) STUDY.—The Comptroller General of the*
6 *United States shall conduct a study on access to phys-*
7 *ical therapist services in States authorizing such serv-*
8 *ices without a physician referral and in States that*
9 *require such a physician referral. The study shall—*

10 *(A) examine the use of and referral patterns*
11 *for physical therapist services for patients age 50*
12 *and older in States that authorize such services*
13 *without a physician referral and in States that*
14 *require such a physician referral;*

15 *(B) examine the use of and referral patterns*
16 *for physical therapist services for patients who*
17 *are medicare beneficiaries;*

18 *(C) examine the potential effect of prohib-*
19 *iting a physician from referring patients to*
20 *physical therapy services owned by the physician*
21 *and provided in the physician's office;*

22 *(D) examine the delivery of physical thera-*
23 *pists' services within the facilities of Department*
24 *of Defense; and*

1 (E) analyze the potential impact on medi-
 2 care beneficiaries and on expenditures under the
 3 medicare program of eliminating the need for a
 4 physician referral and physician certification for
 5 physical therapist services under the medicare
 6 program.

7 (2) *REPORT.*—The Comptroller General shall
 8 submit to Congress a report on the study conducted
 9 under paragraph (1) by not later than 1 year after
 10 the date of the enactment of this Act.

11 **SEC. 514. ACCELERATED IMPLEMENTATION OF 20 PERCENT**
 12 **COINSURANCE FOR HOSPITAL OUTPATIENT**
 13 **DEPARTMENT (OPD) SERVICES; OTHER OPD**
 14 **PROVISIONS.**

15 (a) *ACCELERATED IMPLEMENTATION OF COINSURANCE*
 16 *REDUCTIONS.*—Section 1833(t)(8)(C)(ii) (42 U.S.C.
 17 1395l(t)(8)(C)(ii)) is amended by striking subclauses (III)
 18 through (V) and inserting the following:

19 “(III) For procedures performed
 20 in 2004, 45 percent.

21 “(IV) For procedures performed
 22 in 2005, 40 percent.

23 “(V) For procedures performed in
 24 2006, 2007, 2008 and 2009, 35 per-
 25 cent.

1 “(VI) For procedures performed
2 in 2010, 30 percent.

3 “(VII) For procedures performed
4 in 2011, 25 percent.

5 “(VIII) For procedures performed
6 in 2012 and thereafter, 20 percent.”.

7 (b) *TREATMENT OF TEMPERATURE MONITORED*
8 *CRYOABLATION.*—

9 (1) *IN GENERAL.*—Section 1833(t)(6)(A)(ii) (42
10 U.S.C. 1395l(t)(6)(A)(ii)) is amended by striking “or
11 temperature monitored cryoablation”.

12 (2) *EFFECTIVE DATE.*—The amendment made by
13 paragraph (1) applies to payment for services fur-
14 nished on or after January 1, 2003.

15 **SEC. 515. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL**
16 **EXAMINATION.**

17 (a) *COVERAGE.*—Section 1861(s)(2) (42 U.S.C.
18 1395x(s)(2)), is amended—

19 (1) in subparagraph (U), by striking “and” at
20 the end;

21 (2) in subparagraph (V), by inserting “and” at
22 the end; and

23 (3) by adding at the end the following new sub-
24 paragraph:

1 “(W) an initial preventive physical exam-
2 ination (as defined in subsection (ww));”.

3 (b) *SERVICES DESCRIBED.*—Section 1861 (42 U.S.C.
4 1395x) is amended by adding at the end the following new
5 subsection:

6 “*Initial Preventive Physical Examination*

7 “(ww) The term ‘initial preventive physical examina-
8 tion’ means physicians’ services consisting of a physical ex-
9 amination with the goal of health promotion and disease
10 detection and includes items and services specified by the
11 Secretary in regulations.”.

12 (c) *WAIVER OF DEDUCTIBLE AND COINSURANCE.*—

13 (1) *DEDUCTIBLE.*—The first sentence of section
14 1833(b) (42 U.S.C. 1395l(b)) is amended—

15 (A) by striking “and” before “(6)”, and

16 (B) by inserting before the period at the end
17 the following: “, and (7) such deductible shall not
18 apply with respect to an initial preventive phys-
19 ical examination (as defined in section
20 1861(ww))”.

21 (2) *COINSURANCE.*—Section 1833(a)(1) (42
22 U.S.C. 1395l(a)(1)) is amended—

23 (A) in clause (N), by inserting “(or 100
24 percent in the case of an initial preventive phys-

1 *ical examination, as defined in section*
2 *1861(ww))” after “80 percent”; and*

3 *(B) in clause (O), by inserting “(or 100*
4 *percent in the case of an initial preventive phys-*
5 *ical examination, as defined in section*
6 *1861(ww))” after “80 percent”.*

7 *(d) PAYMENT AS PHYSICIANS’ SERVICES.—Section*
8 *1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by insert-*
9 *ing “(2)(W),” after “(2)(S),”.*

10 *(e) OTHER CONFORMING AMENDMENTS.—Section*
11 *1862(a) (42 U.S.C. 1395y(a)) is amended—*

12 *(1) in paragraph (1)—*

13 *(A) by striking “and” at the end of sub-*
14 *paragraph (H);*

15 *(B) by striking the semicolon at the end of*
16 *subparagraph (I) and inserting “, and”; and*

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

19 *“(J) in the case of an initial preventive physical*
20 *examination, which is performed not later than 6*
21 *months after the date the individual’s first coverage*
22 *period begins under part B;”;* and

23 *(2) in paragraph (7), by striking “or (H)” and*
24 *inserting “(H), or (J)”.*

1 (f) *EFFECTIVE DATE.*—*The amendments made by this*
 2 *section shall apply to services furnished on or after January*
 3 *1, 2004, but only for individuals whose coverage period be-*
 4 *gins on or after such date.*

5 **SEC. 516. RENAL DIALYSIS SERVICES.**

6 (a) *REPORT ON DIFFERENCES IN COSTS IN DIF-*
 7 *FERENT SETTINGS.*—*Not later than 1 year after the date*
 8 *of the enactment of this Act, the Comptroller General of the*
 9 *United States shall submit to Congress a report*
 10 *containing—*

11 (1) *an analysis of the differences in costs of pro-*
 12 *viding renal dialysis services under the medicare pro-*
 13 *gram in home settings and in facility settings;*

14 (2) *an assessment of the percentage of overhead*
 15 *costs in home settings and in facility settings; and*

16 (3) *an evaluation of whether the charges for*
 17 *home dialysis supplies and equipment are reasonable*
 18 *and necessary.*

19 (b) *RESTORING COMPOSITE RATE EXCEPTIONS FOR*
 20 *PEDIATRIC FACILITIES.*—

21 (1) *IN GENERAL.*—*Section 422(a)(2) of BIPA is*
 22 *amended—*

23 (A) *in subparagraph (A), by striking “and*
 24 *(C)” and inserting “, (C), and (D)”;*

1 (B) in subparagraph (B), by striking “In
2 the case” and inserting “Subject to subpara-
3 graph (D), in the case”; and

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

6 “(D) *INAPPLICABILITY TO PEDIATRIC FA-*
7 *CILITIES.—Subparagraphs (A) and (B) shall not*
8 *apply, as of October 1, 2002, to pediatric facili-*
9 *ties that do not have an exception rate described*
10 *in subparagraph (C) in effect on such date. For*
11 *purposes of this subparagraph, the term ‘pedi-*
12 *atric facility’ means a renal facility at least 50*
13 *percent of whose patients are individuals under*
14 *18 years of age.”.*

15 (2) *CONFORMING AMENDMENT.—The fourth sen-*
16 *tence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is*
17 *amended by striking “The Secretary” and inserting*
18 *“Subject to section 422(a)(2) of the Medicare, Med-*
19 *icaid, and SCHIP Benefits Improvement and Protec-*
20 *tion Act of 2000, the Secretary”.*

21 (c) *INCREASE IN RENAL DIALYSIS COMPOSITE RATE*
22 *FOR SERVICES FURNISHED IN 2004.—Notwithstanding any*
23 *other provision of law, with respect to payment under part*
24 *B of title XVIII of the Social Security Act for renal dialysis*
25 *services furnished in 2004, the composite payment rate oth-*

1 *erwise established under section 1881(b)(7) of such Act (42*
 2 *U.S.C. 1395rr(b)(7)) shall be increased by 1.2 percent.*

3 **SEC. 517. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**
 4 **RAPHY SERVICES.**

5 *(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section*
 6 *1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amend-*
 7 *ed by inserting before the period at the end the following:*
 8 *“and does not include screening mammography (as defined*
 9 *in section 1861(jj)) and unilateral and bilateral diagnostic*
 10 *mammography”.*

11 *(b) ADJUSTMENT TO TECHNICAL COMPONENT.—For*
 12 *diagnostic mammography performed on or after January*
 13 *1, 2004, for which payment is made under the physician*
 14 *fee schedule under section 1848 of the Social Security Act*
 15 *(42 U.S.C. 1395w–4), the Secretary, based on the most re-*
 16 *cent cost data available, shall provide for an appropriate*
 17 *adjustment in the payment amount for the technical compo-*
 18 *nent of the diagnostic mammography.*

19 *(c) EFFECTIVE DATE.—The amendment made by sub-*
 20 *section (a) shall apply to mammography performed on or*
 21 *after January 1, 2004.*

22 **SEC. 518. WAIVER OF PART B LATE ENROLLMENT PENALTY**
 23 **FOR CERTAIN MILITARY RETIREES; SPECIAL**
 24 **ENROLLMENT PERIOD.**

25 *(a) WAIVER OF PENALTY.—*

1 (1) *IN GENERAL.*—Section 1839(b) (42 U.S.C.
2 1395r(b)) is amended by adding at the end the fol-
3 lowing new sentence: “No increase in the premium
4 shall be effected for a month in the case of an indi-
5 vidual who is 65 years of age or older, who enrolls
6 under this part during 2001, 2002, or 2003, and who
7 demonstrates to the Secretary before December 31,
8 2003, that the individual is a covered beneficiary (as
9 defined in section 1072(5) of title 10, United States
10 Code). The Secretary of Health and Human Services
11 shall consult with the Secretary of Defense in identi-
12 fying individuals described in the previous sentence.”.

13 (2) *EFFECTIVE DATE.*—The amendment made by
14 paragraph (1) shall apply to premiums for months
15 beginning with January 2003. The Secretary of
16 Health and Human Services shall establish a method
17 for providing rebates of premium penalties paid for
18 months on or after January 2003 for which a penalty
19 does not apply under such amendment but for which
20 a penalty was previously collected.

21 (b) *MEDICARE PART B SPECIAL ENROLLMENT PE-*
22 *RIOD.*—

23 (1) *IN GENERAL.*—In the case of any individual
24 who, as of the date of the enactment of this Act, is
25 65 years of age or older, is eligible to enroll but is not

1 enrolled under part B of title XVIII of the Social Se-
2 curity Act, and is a covered beneficiary (as defined
3 in section 1072(5) of title 10, United States Code), the
4 Secretary of Health and Human Services shall pro-
5 vide for a special enrollment period during which the
6 individual may enroll under such part. Such period
7 shall begin as soon as possible after the date of the en-
8 actment of this Act and shall end on December 31,
9 2003.

10 (2) *COVERAGE PERIOD.*—In the case of an indi-
11 vidual who enrolls during the special enrollment pe-
12 riod provided under paragraph (1), the coverage pe-
13 riod under part B of title XVIII of the Social Secu-
14 rity Act shall begin on the first day of the month fol-
15 lowing the month in which the individual enrolls.

16 **SEC. 519. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**
17 **SCREENING.**

18 (a) *COVERAGE.*—Section 1861(s)(2) (42 U.S.C.
19 1395x(s)(2)), as amended by section 515(a), is amended—

20 (1) in subparagraph (V), by striking “and” at
21 the end;

22 (2) in subparagraph (W), by inserting “and” at
23 the end; and

24 (3) by adding at the end the following new sub-
25 paragraph:

1 “(X) cholesterol and other blood lipid
2 screening tests (as defined in subsection (XX));”.

3 (b) *SERVICES DESCRIBED.*—Section 1861 (42 U.S.C.
4 1395x), as amended by section 515(b), is amended by add-
5 ing at the end the following new subsection:

6 “Cholesterol and Other Blood Lipid Screening Test

7 “(xx)(1) The term ‘cholesterol and other blood lipid
8 screening test’ means diagnostic testing of cholesterol and
9 other lipid levels of the blood for the purpose of early detec-
10 tion of abnormal cholesterol and other lipid levels.

11 “(2) The Secretary shall establish standards, in con-
12 sultation with appropriate organizations, regarding the fre-
13 quency and type of cholesterol and other blood lipid screen-
14 ing tests, except that such frequency may not be more often
15 than once every 2 years.”.

16 (c) *FREQUENCY.*—Section 1862(a)(1) (42 U.S.C.
17 1395y(a)(1)), as amended by section 515(e), is amended

18 (1) by striking “and” at the end of subpara-
19 graph (I);

20 (2) by striking the semicolon at the end of sub-
21 paragraph (J) and inserting “; and”; and

22 (3) by adding at the end the following new sub-
23 paragraph:

24 “(K) in the case of a cholesterol and other blood
25 lipid screening test (as defined in section

1 1861(xx)(1)), which is performed more frequently
 2 than is covered under section 1861(xx)(2).”.

3 (d) *EFFECTIVE DATE.*—The amendments made by this
 4 section shall apply to tests furnished on or after January
 5 1, 2004.

6 **TITLE VI—PROVISIONS**
 7 **RELATING TO PARTS A AND B**
 8 **Subtitle A—Home Health Services**

9 **SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN PAY-**
 10 **MENT RATES UNDER THE PROSPECTIVE PAY-**
 11 **MENT SYSTEM.**

12 (a) *IN GENERAL.*—Section 1895(b)(3)(A) (42 U.S.C.
 13 1395fff(b)(3)(A)) is amended to read as follows:

14 “(A) *INITIAL BASIS.*—Under such system
 15 the Secretary shall provide for computation of a
 16 standard prospective payment amount (or
 17 amounts) as follows:

18 “(i) Such amount (or amounts) shall
 19 initially be based on the most current au-
 20 dited cost report data available to the Sec-
 21 retary and shall be computed in a manner
 22 so that the total amounts payable under the
 23 system for fiscal year 2001 shall be equal to
 24 the total amount that would have been made
 25 if the system had not been in effect and if

1 *section 1861(v)(1)(L)(ix) had not been en-*
2 *acted.*

3 *“(ii) For fiscal year 2002 and for the*
4 *first quarter of fiscal year 2003, such*
5 *amount (or amounts) shall be equal to the*
6 *amount (or amounts) determined under this*
7 *paragraph for the previous fiscal year, up-*
8 *dated under subparagraph (B).*

9 *“(iii) For 2003, such amount (or*
10 *amounts) shall be equal to the amount (or*
11 *amounts) determined under this paragraph*
12 *for fiscal year 2002, updated under sub-*
13 *paragraph (B) for 2003.*

14 *“(iv) For 2004 and each subsequent*
15 *year, such amount (or amounts) shall be*
16 *equal to the amount (or amounts) deter-*
17 *mined under this paragraph for the pre-*
18 *vious year, updated under subparagraph*
19 *(B).*

20 *Each such amount shall be standardized in a*
21 *manner that eliminates the effect of variations in*
22 *relative case mix and area wage adjustments*
23 *among different home health agencies in a budget*
24 *neutral manner consistent with the case mix and*
25 *wage level adjustments provided under para-*

1 *graph (4)(A). Under the system, the Secretary*
2 *may recognize regional differences or differences*
3 *based upon whether or not the services or agency*
4 *are in an urbanized area.”.*

5 ***(b) EFFECTIVE DATE.***—*The amendment made by sub-*
6 *section (a) shall take effect as if included in the amendments*
7 *made by section 501 of the Medicare, Medicaid, and SCHIP*
8 *Benefits Improvement and Protection Act of 2000 (as en-*
9 *acted into law by section 1(a)(6) of Public Law 106–554).*

10 **SEC. 602. ESTABLISHMENT OF REDUCED COPAYMENT FOR A**
11 **HOME HEALTH SERVICE EPISODE OF CARE**
12 **FOR CERTAIN BENEFICIARIES.**

13 ***(a) PART A.***—

14 ***(1) IN GENERAL.***—*Section 1813(a) (42 U.S.C.*
15 *1395e(a)) is amended by adding at the end the fol-*
16 *lowing new paragraph:*

17 ***“(5)(A)(i) Subject to clause (ii), the amount payable***
18 *for home health services furnished to the individual under*
19 *this title for each episode of care beginning in a year (begin-*
20 *ning with 2003) shall be reduced by a copayment equal to*
21 *the copayment amount specified in subparagraph (B)(ii)*
22 *such year.*

23 ***“(ii) The copayment under clause (i) shall not apply—***

24 ***“(I) in the case of an individual who has been***
25 ***determined to be a qualified medicare beneficiary (as***

1 *defined in section 1905(p)(1)) or otherwise to be enti-*
2 *tled to medical assistance under section*
3 *1902(a)(10)(A) or 1902(a)(10)(C); and*

4 *“(II) in the case of an episode of care which con-*
5 *sists of 4 or fewer visits.*

6 *“(B)(i) The Secretary shall estimate, before the begin-*
7 *ning of each year (beginning with 2003), the national aver-*
8 *age payment under this title per episode for home health*
9 *services projected for the year involved.*

10 *“(ii) For each year the copayment amount under this*
11 *clause is equal to 1.5 percent of the national average pay-*
12 *ment estimated for the year involved under clause (i). Any*
13 *amount determined under the preceding sentence which is*
14 *not a multiple of \$5 shall be rounded to the nearest multiple*
15 *of \$5.*

16 *“(iii) There shall be no administrative or judicial re-*
17 *view under section 1869, 1878, or otherwise of the esti-*
18 *mation of average payment under clause (i).”.*

19 (2) *TIMELY IMPLEMENTATION.*—*Unless the Sec-*
20 *retary of Health and Human Services otherwise pro-*
21 *vides on a timely basis, the copayment amount speci-*
22 *fied under section 1813(a)(5)(B)(ii) of the Social Se-*
23 *curity Act (as added by paragraph (1)) for 2003 shall*
24 *be deemed to be \$40.*

25 (b) *CONFORMING PROVISIONS.*—

1 (1) Section 1833(a)(2)(A) (42 U.S.C.
2 1395l(a)(2)(A)) is amended by inserting “less the co-
3 payment amount applicable under section
4 1813(a)(5)” after “1895”.

5 (2) Section 1866(a)(2)(A)(i) (42 U.S.C.
6 1395cc(a)(2)(A)(i)) is amended—

7 (A) by striking “or coinsurance” and in-
8 serting “, coinsurance, or copayment”; and

9 (B) by striking “or (a)(4)” and inserting
10 “(a)(4), or (a)(5)”.

11 **SEC. 603. UPDATE IN HOME HEALTH SERVICES.**

12 (a) CHANGE TO CALENDAR YEAR UPDATE.—

13 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.
14 1395fff(b)(3)) is amended—

15 (A) in paragraph (3)(B)(i)—

16 (i) by striking “each fiscal year (begin-
17 ning with fiscal year 2002)” and inserting
18 “fiscal year 2002 and for each subsequent
19 year (beginning with 2003)”; and

20 (ii) by inserting “or year” after “the
21 fiscal year”;

22 (B) in paragraph (3)(B)(ii)—

23 (i) in subclause (II), by striking “fiscal
24 year” and inserting “year” and by redesignig-

1 nating such subclause as subclause (III);
2 and

3 (ii) in subclause (I), by striking “each
4 of fiscal years 2002 and 2003” and insert-
5 ing the following: “fiscal year 2002, the
6 home health market basket percentage in-
7 crease (as defined in clause (iii)) minus 1.1
8 percentage points;

9 “(II) 2003”;

10 (C) in paragraph (3)(B)(iii), by inserting
11 “or year” after “fiscal year” each place it ap-
12 pears;

13 (D) in paragraph (3)(B)(iv)—

14 (i) by inserting “or year” after “fiscal
15 year” each place it appears; and

16 (ii) by inserting “or years” after “fis-
17 cal years”; and

18 (E) in paragraph (5), by inserting “or
19 year” after “fiscal year”.

20 (2) *TRANSITION RULE.*—The standard prospec-
21 tive payment amount (or amounts) under section
22 1895(b)(3) of the Social Security Act for the calendar
23 quarter beginning on October 1, 2002, shall be such
24 amount (or amounts) for the previous calendar quar-
25 ter.

1 **SEC. 604. OASIS TASK FORCE; SUSPENSION OF CERTAIN**
2 **OASIS DATA COLLECTION REQUIREMENTS**
3 **PENDING TASK FORCE SUBMITTAL OF RE-**
4 **PORT.**

5 (a) *ESTABLISHMENT.*—*The Secretary of Health and*
6 *Human Services shall establish and appoint a task force*
7 *(to be known as the “OASIS Task Force”) to examine the*
8 *data collection and reporting requirements under OASIS.*
9 *For purposes of this section, the term “OASIS” means the*
10 *Outcome and Assessment Information Set required by rea-*
11 *son of section 4602(e) of Balanced Budget Act of 1997 (42*
12 *U.S.C. 1395fff note).*

13 (b) *COMPOSITION.*—*The OASIS Task Force shall be*
14 *composed of the following:*

15 (1) *Staff of the Centers for Medicare & Medicaid*
16 *Services with expertise in post-acute care.*

17 (2) *Representatives of home health agencies.*

18 (3) *Health care professionals and research and*
19 *health care quality experts outside the Federal Gov-*
20 *ernment with expertise in post-acute care.*

21 (4) *Advocates for individuals requiring home*
22 *health services.*

23 (c) *DUTIES.*—

24 (1) *REVIEW AND RECOMMENDATIONS.*—*The*
25 *OASIS Task Force shall review and make rec-*
26 *ommendations to the Secretary regarding changes in*

1 *OASIS to improve and simplify data collection for*
2 *purposes of—*

3 *(A) assessing the quality of home health*
4 *services; and*

5 *(B) providing consistency in classification*
6 *of patients into home health resource groups*
7 *(HHRGs) for payment under section 1895 of the*
8 *Social Security Act (42 U.S.C. 1395fff).*

9 *(2) SPECIFIC ITEMS.—In conducting the review*
10 *under paragraph (1), the OASIS Task Force shall*
11 *specifically examine—*

12 *(A) the 41 outcome measures currently in*
13 *use;*

14 *(B) the timing and frequency of data collec-*
15 *tion; and*

16 *(C) the collection of information on*
17 *comorbidities and clinical indicators.*

18 *(3) REPORT.—The OASIS Task Force shall sub-*
19 *mit a report to the Secretary containing its findings*
20 *and recommendations for changes in OASIS by not*
21 *later than 18 months after the date of the enactment*
22 *of this Act.*

23 *(d) SUNSET.—The OASIS Task Force shall terminate*
24 *60 days after the date on which the report is submitted*
25 *under subsection (c)(2).*

1 (e) *NONAPPLICATION OF FACA.*—*The provisions of the*
2 *Federal Advisory Committee Act shall not apply to the*
3 *OASIS Task Force.*

4 (f) *SUSPENSION OF OASIS REQUIREMENT FOR COL-*
5 *LECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID*
6 *PATIENTS PENDING TASK FORCE REPORT.*—

7 (1) *IN GENERAL.*—*During the period described*
8 *in paragraph (2), the Secretary of Health and*
9 *Human Services may not require, under section*
10 *4602(e) of the Balanced Budget Act of 1997 or other-*
11 *wise under OASIS, a home health agency to gather*
12 *or submit information that relates to an individual*
13 *who is not eligible for benefits under either title XVIII*
14 *or title XIX of the Social Security Act.*

15 (2) *PERIOD OF SUSPENSION.*—*The period de-*
16 *scribed in this paragraph—*

17 (A) *begins on January 1, 2003, and*

18 (B) *ends on the last day of the 2nd month*
19 *beginning after the date the report is submitted*
20 *under subsection (c)(2).*

21 **SEC. 605. MEDPAC STUDY ON MEDICARE MARGINS OF HOME**
22 **HEALTH AGENCIES.**

23 (a) *STUDY.*—*The Medicare Payment Advisory Com-*
24 *mission shall conduct a study of payment margins of home*
25 *health agencies under the home health prospective payment*

1 *system under section 1895 of the Social Security Act (42*
 2 *U.S.C. 1395fff). Such study shall examine whether system-*
 3 *atic differences in payment margins are related to dif-*
 4 *ferences in case mix (as measured by home health resource*
 5 *groups (HHRGs)) among such agencies. The study shall use*
 6 *the partial or full-year cost reports filed by home health*
 7 *agencies.*

8 (b) *REPORT.*—*Not later than 2 years after the date*
 9 *of the enactment of this Act, the Commission shall submit*
 10 *to Congress a report on the study under subsection (a).*

11 ***Subtitle B—Direct Graduate***
 12 ***Medical Education***

13 ***SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH***
 14 ***COST PROGRAMS.***

15 *Section 1886(h)(2)(D)(iv) (42 U.S.C.*
 16 *1395ww(h)(2)(D)(iv)) is amended—*

17 (1) *in subclause (I)—*

18 (A) *by striking “AND 2002” and inserting*
 19 *“THROUGH 2012”;*

20 (B) *by striking “during fiscal year 2001 or*
 21 *fiscal year 2002” and inserting “during the pe-*
 22 *riod beginning with fiscal year 2001 and ending*
 23 *with fiscal year 2012”; and*

24 (C) *by striking “subject to subclause (III),”;*

25 (2) *by striking subclause (II); and*

1 (3) *in subclause (III)*—

2 (A) *by redesignating such subclause as sub-*
3 *clause (II); and*

4 (B) *by striking “or (II)”*.

5 **SEC. 612. REDISTRIBUTION OF UNUSED RESIDENT POSI-**
6 **TIONS.**

7 (a) *IN GENERAL.*—Section 1886(h)(4) (42 U.S.C.
8 1395ww(h)(4)) *is amended*—

9 (1) *in subparagraph (F)(i), by inserting “subject*
10 *to subparagraph (I),” after “October 1, 1997,”;*

11 (2) *in subparagraph (H)(i), by inserting “subject*
12 *to subparagraph (I),” after “subparagraphs (F) and*
13 *(G),”;* *and*

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

16 “(I) *REDISTRIBUTION OF UNUSED RESI-*
17 *DENT POSITIONS.*—

18 “(i) *REDUCTION IN LIMIT BASED ON*
19 *UNUSED POSITIONS.*—

20 “(I) *IN GENERAL.*—*If a hospital’s*
21 *resident level (as defined in clause*
22 *(iii)(I)) is less than the otherwise ap-*
23 *plicable resident limit (as defined in*
24 *clause (iii)(II)) for each of the ref-*
25 *erence periods (as defined in subclause*

1 (ii)), effective for cost reporting peri-
2 ods beginning on or after January 1,
3 2003, the otherwise applicable resident
4 limit shall be reduced by 75 percent of
5 the difference between such limit and
6 the reference resident level specified in
7 subclause (iii) (or subclause (iv) if
8 applicable).

9 “(ii) REFERENCE PERIODS DE-
10 FINED.—In this clause, the term ‘ref-
11 erence periods’ means, for a hospital,
12 the 3 most recent consecutive cost re-
13 porting periods of the hospital for
14 which cost reports have been settled (or,
15 if not, submitted) on or before Sep-
16 tember 30, 2001.

17 “(iii) REFERENCE RESIDENT
18 LEVEL.—Subject to subclause (iv), the
19 reference resident level specified in this
20 subclause for a hospital is the highest
21 resident level for the hospital during
22 any of the reference periods.

23 “(iv) ADJUSTMENT PROCESS.—
24 Upon the timely request of a hospital,
25 the Secretary may adjust the reference

1 *resident level for a hospital to be the*
2 *resident level for the hospital for the*
3 *cost reporting period that includes*
4 *July 1, 2002.*

5 “(ii) *REDISTRIBUTION.*—

6 “(I) *IN GENERAL.*—*The Secretary*
7 *is authorized to increase the otherwise*
8 *applicable resident limits for hospitals*
9 *by an aggregate number estimated by*
10 *the Secretary that does not exceed the*
11 *aggregate reduction in such limits at-*
12 *tributable to clause (i) (without taking*
13 *into account any adjustment under*
14 *subclause (IV) of such clause).*

15 “(II) *EFFECTIVE DATE.*—*No in-*
16 *crease under subclause (I) shall be per-*
17 *mitted or taken into account for a hos-*
18 *pital for any portion of a cost report-*
19 *ing period that occurs before July 1,*
20 *2003, or before the date of the hos-*
21 *pital’s application for an increase*
22 *under this clause. No such increase*
23 *shall be permitted for a hospital unless*
24 *the hospital has applied to the Sec-*

1 *retary for such increase by December*
2 *31, 2004.*

3 “(III) *CONSIDERATIONS IN REDIS-*
4 *TRIBUTION.—In determining for which*
5 *hospitals the increase in the otherwise*
6 *applicable resident limit is provided*
7 *under subclause (I), the Secretary shall*
8 *take into account the need for such an*
9 *increase by specialty and location in-*
10 *olved, consistent with subclause (IV).*

11 “(IV) *PRIORITY FOR RURAL AND*
12 *SMALL URBAN AREAS.—In determining*
13 *for which hospitals and residency*
14 *training programs an increase in the*
15 *otherwise applicable resident limit is*
16 *provided under subclause (I), the Sec-*
17 *retary shall first distribute the increase*
18 *to programs of hospitals located in*
19 *rural areas or in urban areas that are*
20 *not large urban areas (as defined for*
21 *purposes of subsection (d)) on a first-*
22 *come-first-served basis (as determined*
23 *by the Secretary) based on a dem-*
24 *onstration that the hospital will fill the*
25 *positions made available under this*

1 *clause and not to exceed an increase of*
2 *25 full-time equivalent positions with*
3 *respect to any hospital.*

4 “(V) *APPLICATION OF LOCALITY*
5 *ADJUSTED NATIONAL AVERAGE PER*
6 *RESIDENT AMOUNT.—With respect to*
7 *additional residency positions in a*
8 *hospital attributable to the increase*
9 *provided under this clause, notwith-*
10 *standing any other provision of this*
11 *subsection, the approved FTE resident*
12 *amount is deemed to be equal to the lo-*
13 *cality adjusted national average per*
14 *resident amount computed under sub-*
15 *paragraph (E) for that hospital.*

16 “(VI) *CONSTRUCTION.—Nothing*
17 *in this clause shall be construed as per-*
18 *mitting the redistribution of reductions*
19 *in residency positions attributable to*
20 *voluntary reduction programs under*
21 *paragraph (6) or as affecting the abil-*
22 *ity of a hospital to establish new med-*
23 *ical residency training programs*
24 *under subparagraph (H).*

1 “(iii) *RESIDENT LEVEL AND LIMIT DE-*
2 *FINED.—In this subparagraph:*

3 “(I) *RESIDENT LEVEL.—The term*
4 *‘resident level’ means, with respect to a*
5 *hospital, the total number of full-time*
6 *equivalent residents, before the applica-*
7 *tion of weighting factors (as deter-*
8 *mined under this paragraph), in the*
9 *fields of allopathic and osteopathic*
10 *medicine for the hospital.*

11 “(II) *OTHERWISE APPLICABLE*
12 *RESIDENT LIMIT.—The term ‘otherwise*
13 *applicable resident limit’ means, with*
14 *respect to a hospital, the limit other-*
15 *wise applicable under subparagraphs*
16 *(F)(i) and (H) on the resident level for*
17 *the hospital determined without regard*
18 *to this subparagraph.”.*

19 “(b) *NO APPLICATION OF INCREASE TO IME.—Section*
20 *1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is*
21 *amended by adding at the end the following: “The provi-*
22 *sions of clause (i) of subparagraph (I) of subsection (h)(4)*
23 *shall apply with respect to the first sentence of this clause*
24 *in the same manner as it applies with respect to subpara-*

1 *graph (F) of such subsection, but the provisions of clause*
2 *(ii) of such subparagraph shall not apply.”.*

3 *(c) REPORT ON EXTENSION OF APPLICATIONS UNDER*
4 *REDISTRIBUTION PROGRAM.—Not later than July 1, 2004,*
5 *the Secretary shall submit to Congress a report containing*
6 *recommendations regarding whether to extend the deadline*
7 *for applications for an increase in resident limits under*
8 *section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as*
9 *added by subsection (a)).*

10 ***Subtitle C—Other Provisions***

11 ***SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVI-*** 12 ***SORY COMMISSION (MEDPAC).***

13 *(a) EXAMINATION OF BUDGET CONSEQUENCES.—Sec-*
14 *tion 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding*
15 *at the end the following new paragraph:*

16 *“(8) EXAMINATION OF BUDGET CON-*
17 *SEQUENCES.—Before making any recommendations,*
18 *the Commission shall examine the budget con-*
19 *sequences of such recommendations, directly or*
20 *through consultation with appropriate expert enti-*
21 *ties.”.*

22 *(b) CONSIDERATION OF EFFICIENT PROVISION OF*
23 *SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–*
24 *6(b)(2)(B)(i)) is amended by inserting “the efficient provi-*
25 *sion of” after “expenditures for”.*

1 (c) *ADDITIONAL REPORTS.*—

2 (1) *DATA NEEDS AND SOURCES.*—*The Medicare*
3 *Payment Advisory Commission shall conduct a study,*
4 *and submit a report to Congress by not later than*
5 *June 1, 2003, on the need for current data, and*
6 *sources of current data available, to determine the sol-*
7 *veny and financial circumstances of hospitals and*
8 *other medicare providers of services. The Commission*
9 *shall examine data on uncompensated care, as well as*
10 *the sahre of uncompensated care accounted for by the*
11 *expenses for treating illegal aliens.*

12 (2) *USE OF TAX-RELATED RETURNS.*—*Using re-*
13 *turn information provided under Form 990 of the In-*
14 *ternal Revenue Service, the Commission shall submit*
15 *to Congress, by not later than June 1, 2003, a report*
16 *on the following:*

17 (A) *Investments and capital financing of*
18 *hospitals participating under the medicare pro-*
19 *gram and related foundations.*

20 (B) *Access to capital financing for private*
21 *and for not-for-profit hospitals.*

1 **SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MAN-**
2 **AGEMENT FOR CERTAIN MEDICARE BENE-**
3 **FICIARIES WITH DIABETES.**

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 impact on costs and health*
8 *outcomes of applying disease management to certain medi-*
9 *care beneficiaries with diagnosed diabetes. In no case may*
10 *the number of participants in the project exceed 30,000 at*
11 *any time.*

12 (b) *VOLUNTARY PARTICIPATION.*—

13 (1) *ELIGIBILITY.*—*Medicare beneficiaries are eli-*
14 *gible to participate in the project only if—*

15 (A) *they are Hispanic, as determined by the*
16 *Secretary;*

17 (B) *they meet specific medical criteria dem-*
18 *onstrating the appropriate diagnosis and the ad-*
19 *vanced nature of their disease;*

20 (C) *their physicians approve of participa-*
21 *tion in the project; and*

22 (D) *they are not enrolled in a*
23 *Medicare+Choice plan.*

24 (2) *BENEFITS.*—*A medicare beneficiary who is*
25 *enrolled in the project shall be eligible—*

1 (A) for disease management services related
2 to their diabetes; and

3 (B) for payment for all costs for prescrip-
4 tion drugs without regard to whether or not they
5 relate to the diabetes, except that the project may
6 provide for modest cost-sharing with respect to
7 prescription drug coverage.

8 (c) *CONTRACTS WITH DISEASE MANAGEMENT ORGA-*
9 *NIZATIONS.*—

10 (1) *IN GENERAL.*—*The Secretary of Health and*
11 *Human Services shall carry out the project through*
12 *contracts with up to three disease management orga-*
13 *nizations. The Secretary shall not enter into such a*
14 *contract with an organization unless the organization*
15 *demonstrates that it can produce improved health*
16 *outcomes and reduce aggregate medicare expenditures*
17 *consistent with paragraph (2).*

18 (2) *CONTRACT PROVISIONS.*—*Under such*
19 *contracts—*

20 (A) *such an organization shall be required*
21 *to provide for prescription drug coverage de-*
22 *scribed in subsection (b)(2)(B);*

23 (B) *such an organization shall be paid a fee*
24 *negotiated and established by the Secretary in a*
25 *manner so that (taking into account savings in*

1 *expenditures under parts A and B of the medi-*
2 *care program under title XVIII of the Social Se-*
3 *curity Act) there will be no net increase, and to*
4 *the extent practicable, there will be a net reduc-*
5 *tion in expenditures under the medicare pro-*
6 *gram as a result of the project; and*

7 *(C) such an organization shall guarantee,*
8 *through an appropriate arrangement with a re-*
9 *insurance company or otherwise, the prohibition*
10 *on net increases in expenditures described in*
11 *subparagraph (B).*

12 *(3) PAYMENTS.—Payments to such organizations*
13 *shall be made in appropriate proportion from the*
14 *Trust Funds established under title XVIII of the So-*
15 *cial Security Act.*

16 *(d) APPLICATION OF MEDIGAP PROTECTIONS TO DEM-*
17 *ONSTRATION PROJECT ENROLLEES.—(1) Subject to para-*
18 *graph (2), the provisions of section 1882(s)(3) (other than*
19 *clauses (i) through (iv) of subparagraph (B)) and*
20 *1882(s)(4) of the Social Security Act shall apply to enroll-*
21 *ment (and termination of enrollment) in the demonstration*
22 *project under this section, in the same manner as they*
23 *apply to enrollment (and termination of enrollment) with*
24 *a Medicare+Choice organization in a Medicare+Choice*
25 *plan.*

1 (2) *In applying paragraph (1)—*

2 (A) *any reference in clause (v) or (vi) of section*
3 1882(s)(3)(B) *of such Act to 12 months is deemed a*
4 *reference to the period of the demonstration project;*
5 *and*

6 (B) *the notification required under section*
7 1882(s)(3)(D) *of such Act shall be provided in a man-*
8 *ner specified by the Secretary of Health and Human*
9 *Services.*

10 (e) *DURATION.—The project shall last for not longer*
11 *than 3 years.*

12 (f) *WAIVER.—The Secretary of Health and Human*
13 *Services shall waive such provisions of title XVIII of the*
14 *Social Security Act as may be necessary to provide for pay-*
15 *ment for services under the project in accordance with sub-*
16 *section (c)(3).*

17 (g) *REPORT.—The Secretary of Health and Human*
18 *Services shall submit to Congress an interim report on the*
19 *project not later than 2 years after the date it is first imple-*
20 *mented and a final report on the project not later than 6*
21 *months after the date of its completion. Such reports shall*
22 *include information on the impact of the project on costs*
23 *and health outcomes and recommendations on the cost-effec-*
24 *tiveness of extending or expanding the project.*

1 (h) *WORKING GROUP ON MEDICARE DISEASE MAN-*
2 *AGEMENT PROGRAMS.*—*The Secretary shall establish within*
3 *the Department of Health and Human Services a working*
4 *group consisting of employees of the Department to carry*
5 *out the following:*

6 (1) *To oversee the project.*

7 (2) *To establish policy and criteria for medicare*
8 *disease management programs within the Depart-*
9 *ment, including the establishment of policy and cri-*
10 *teria for such programs.*

11 (3) *To identify targeted medical conditions and*
12 *targeted individuals.*

13 (4) *To select areas in which such programs are*
14 *carried out.*

15 (5) *To monitor health outcomes under such pro-*
16 *grams.*

17 (6) *To measure the effectiveness of such programs*
18 *in meeting any budget neutrality requirements.*

19 (7) *Otherwise to serve as a central focal point*
20 *within the Department for dissemination of informa-*
21 *tion on medicare disease management programs.*

22 (i) *GAO STUDY ON DISEASE MANAGEMENT PRO-*
23 *GRAMS.*—*The Comptroller General of the United States*
24 *shall conduct a study that compares disease management*
25 *programs under title XVIII of the Social Security Act with*

1 *such programs conducted in the private sector, including*
2 *the prevalence of such programs and programs for case*
3 *management. The study shall identify the cost-effectiveness*
4 *of such programs and any savings achieved by such pro-*
5 *grams. The Comptroller General shall submit a report on*
6 *such study to Congress by not later than 18 months after*
7 *the date of the enactment of this Act.*

8 **SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT**
9 **DAY CARE SERVICES.**

10 (a) *ESTABLISHMENT.*—*Subject to the succeeding provi-*
11 *sions of this section, the Secretary of Health and Human*
12 *Services shall establish a demonstration project (in this sec-*
13 *tion referred to as the “demonstration project”) under*
14 *which the Secretary shall, as part of a plan of an episode*
15 *of care for home health services established for a medicare*
16 *beneficiary, permit a home health agency, directly or under*
17 *arrangements with a medical adult day care facility, to*
18 *provide medical adult day care services as a substitute for*
19 *a portion of home health services that would otherwise be*
20 *provided in the beneficiary’s home.*

21 (b) *PAYMENT.*—

22 (1) *IN GENERAL.*—*The amount of payment for*
23 *an episode of care for home health services, a portion*
24 *of which consists of substitute medical adult day care*
25 *services, under the demonstration project shall be*

1 *made at a rate equal to 95 percent of the amount that*
2 *would otherwise apply for such home health services*
3 *under section 1895 of the Social Security Act (42*
4 *u.s.c. 1395fff). In no case may a home health agency,*
5 *or a medical adult day care facility under arrange-*
6 *ments with a home health agency, separately charge*
7 *a beneficiary for medical adult day care services fur-*
8 *nished under the plan of care.*

9 (2) *BUDGET NEUTRALITY FOR DEMONSTRATION*
10 *PROJECT.—Notwithstanding any other provision of*
11 *law, the Secretary shall provide for an appropriate*
12 *reduction in the aggregate amount of additional pay-*
13 *ments made under section 1895 of the Social Security*
14 *Act (42 U.S.C. 1395fff) to reflect any increase in*
15 *amounts expended from the Trust Funds as a result*
16 *of the demonstration project conducted under this sec-*
17 *tion.*

18 (c) *DEMONSTRATION PROJECT SITES.—The project es-*
19 *tablished under this section shall be conducted in not more*
20 *than 5 sites in States selected by the Secretary that license*
21 *or certify providers of services that furnish medical adult*
22 *day care services.*

23 (d) *DURATION.—The Secretary shall conduct the dem-*
24 *onstration project for a period of 3 years.*

1 (e) *VOLUNTARY PARTICIPATION.*—Participation of
2 *medicare beneficiaries in the demonstration project shall be*
3 *voluntary. The total number of such beneficiaries that may*
4 *participate in the project at any given time may not exceed*
5 *15,000.*

6 (f) *PREFERENCE IN SELECTING AGENCIES.*—In select-
7 *ing home health agencies to participate under the dem-*
8 *onstration project, the Secretary shall give preference to*
9 *those agencies that—*

10 (1) *are currently licensed or certified to furnish*
11 *medical adult day care services; and*

12 (2) *have furnished medical adult day care serv-*
13 *ices to medicare beneficiaries for a continuous 2-year*
14 *period before the beginning of the demonstration*
15 *project.*

16 (g) *WAIVER AUTHORITY.*—The Secretary may waive
17 *such requirements of title XVIII of the Social Security Act*
18 *as may be necessary for the purposes of carrying out the*
19 *demonstration project, other than waiving the requirement*
20 *that an individual be homebound in order to be eligible for*
21 *benefits for home health services.*

22 (h) *EVALUATION AND REPORT.*—The Secretary shall
23 *conduct an evaluation of the clinical and cost effectiveness*
24 *of the demonstration project. Not later 30 months after the*
25 *commencement of the project, the Secretary shall submit to*

1 Congress a report on the evaluation, and shall include in
2 the report the following:

3 (1) *An analysis of the patient outcomes and costs*
4 *of furnishing care to the medicare beneficiaries par-*
5 *ticipating in the project as compared to such out-*
6 *comes and costs to beneficiaries receiving only home*
7 *health services for the same health conditions.*

8 (2) *Such recommendations regarding the exten-*
9 *sion, expansion, or termination of the project as the*
10 *Secretary determines appropriate.*

11 (i) *DEFINITIONS.—In this section:*

12 (1) *HOME HEALTH AGENCY.—The term “home*
13 *health agency” has the meaning given such term in*
14 *section 1861(o) of the Social Security Act (42 U.S.C.*
15 *1395x(o)).*

16 (2) *MEDICAL ADULT DAY CARE FACILITY.—The*
17 *term “medical adult day care facility” means a facil-*
18 *ity that—*

19 (A) *has been licensed or certified by a State*
20 *to furnish medical adult day care services in the*
21 *State for a continuous 2-year period;*

22 (B) *is engaged in providing skilled nursing*
23 *services and other therapeutic services directly or*
24 *under arrangement with a home health agency;*

1 (C) meets such standards established by the
2 Secretary to assure quality of care and such
3 other requirements as the Secretary finds nec-
4 essary in the interest of the health and safety of
5 individuals who are furnished services in the fa-
6 cility; and

7 (D) provides medical adult day care serv-
8 ices.

9 (3) *MEDICAL ADULT DAY CARE SERVICES.*—The
10 term “medical adult day care services” means—

11 (A) home health service items and services
12 described in paragraphs (1) through (7) of sec-
13 tion 1861(m) furnished in a medical adult day
14 care facility;

15 (B) a program of supervised activities fur-
16 nished in a group setting in the facility that—

17 (i) meet such criteria as the Secretary
18 determines appropriate; and

19 (ii) is designed to promote physical
20 and mental health of the individuals; and

21 (C) such other services as the Secretary may
22 specify.

23 (4) *MEDICARE BENEFICIARY.*—The term “medi-
24 care beneficiary” means an individual entitled to

1 *benefits under part A of this title, enrolled under part*
 2 *B of this title, or both.*

3 **TITLE VII—MEDICARE BENEFITS**
 4 **ADMINISTRATION**

5 **SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS ADMIN-**
 6 **ISTRATION.**

7 (a) *IN GENERAL.*—*Title XVIII (42 U.S.C. 1395 et*
 8 *seq.), as amended by section 105, is amended by inserting*
 9 *after 1806 the following new section:*

10 “*MEDICARE BENEFITS ADMINISTRATION*

11 “*SEC. 1808. (a) ESTABLISHMENT.*—*There is estab-*
 12 *lished within the Department of Health and Human Serv-*
 13 *ices an agency to be known as the Medicare Benefits Admin-*
 14 *istration.*

15 “(b) *ADMINISTRATOR; DEPUTY ADMINISTRATOR;*
 16 *CHIEF ACTUARY.*—

17 “(1) *ADMINISTRATOR.*—

18 “(A) *IN GENERAL.*—*The Medicare Benefits*
 19 *Administration shall be headed by an adminis-*
 20 *trator to be known as the ‘Medicare Benefits Ad-*
 21 *ministrator’ (in this section referred to as the*
 22 *‘Administrator’) who shall be appointed by the*
 23 *President, by and with the advice and consent of*
 24 *the Senate. The Administrator shall be in direct*
 25 *line of authority to the Secretary.*

1 “(B) *COMPENSATION.*—*The Administrator*
2 *shall be paid at the rate of basic pay payable for*
3 *level III of the Executive Schedule under section*
4 *5314 of title 5, United States Code.*

5 “(C) *TERM OF OFFICE.*—*The Administrator*
6 *shall be appointed for a term of 5 years. In any*
7 *case in which a successor does not take office at*
8 *the end of an Administrator’s term of office, that*
9 *Administrator may continue in office until the*
10 *entry upon office of such a successor. An Admin-*
11 *istrator appointed to a term of office after the*
12 *commencement of such term may serve under*
13 *such appointment only for the remainder of such*
14 *term.*

15 “(D) *GENERAL AUTHORITY.*—*The Adminis-*
16 *trator shall be responsible for the exercise of all*
17 *powers and the discharge of all duties of the Ad-*
18 *ministration, and shall have authority and con-*
19 *trol over all personnel and activities thereof.*

20 “(E) *RULEMAKING AUTHORITY.*—*The Ad-*
21 *ministrator may prescribe such rules and regula-*
22 *tions as the Administrator determines necessary*
23 *or appropriate to carry out the functions of the*
24 *Administration. The regulations prescribed by*
25 *the Administrator shall be subject to the rule-*

1 *making procedures established under section 553*
2 *of title 5, United States Code.*

3 “(F) *AUTHORITY TO ESTABLISH ORGANIZA-*
4 *TIONAL UNITS.—The Administrator may estab-*
5 *lish, alter, consolidate, or discontinue such orga-*
6 *nizational units or components within the Ad-*
7 *ministration as the Administrator considers nec-*
8 *essary or appropriate, except as specified in this*
9 *section.*

10 “(G) *AUTHORITY TO DELEGATE.—The Ad-*
11 *ministrator may assign duties, and delegate, or*
12 *authorize successive redelegations of, authority to*
13 *act and to render decisions, to such officers and*
14 *employees of the Administration as the Adminis-*
15 *trator may find necessary. Within the limita-*
16 *tions of such delegations, redelegations, or as-*
17 *signments, all official acts and decisions of such*
18 *officers and employees shall have the same force*
19 *and effect as though performed or rendered by*
20 *the Administrator.*

21 “(2) *DEPUTY ADMINISTRATOR.—*

22 “(A) *IN GENERAL.—There shall be a Dep-*
23 *uty Administrator of the Medicare Benefits Ad-*
24 *ministration who shall be appointed by the*

1 *President, by and with the advice and consent of*
2 *the Senate.*

3 “(B) *COMPENSATION.*—*The Deputy Admin-*
4 *istrator shall be paid at the rate of basic pay*
5 *payable for level IV of the Executive Schedule*
6 *under section 5315 of title 5, United States Code.*

7 “(C) *TERM OF OFFICE.*—*The Deputy Ad-*
8 *ministrator shall be appointed for a term of 5*
9 *years. In any case in which a successor does not*
10 *take office at the end of a Deputy Administra-*
11 *tor’s term of office, such Deputy Administrator*
12 *may continue in office until the entry upon of-*
13 *fice of such a successor. A Deputy Administrator*
14 *appointed to a term of office after the commence-*
15 *ment of such term may serve under such ap-*
16 *pointment only for the remainder of such term.*

17 “(D) *DUTIES.*—*The Deputy Administrator*
18 *shall perform such duties and exercise such pow-*
19 *ers as the Administrator shall from time to time*
20 *assign or delegate. The Deputy Administrator*
21 *shall be Acting Administrator of the Administra-*
22 *tion during the absence or disability of the Ad-*
23 *ministrator and, unless the President designates*
24 *another officer of the Government as Acting Ad-*

1 *ministrator, in the event of a vacancy in the of-*
2 *fice of the Administrator.*

3 “(3) *CHIEF ACTUARY.—*

4 “(A) *IN GENERAL.—There is established in*
5 *the Administration the position of Chief Actua-*
6 *ary. The Chief Actuary shall be appointed by,*
7 *and in direct line of authority to, the Adminis-*
8 *trator of such Administration. The Chief Actua-*
9 *ry shall be appointed from among individuals*
10 *who have demonstrated, by their education and*
11 *experience, superior expertise in the actuarial*
12 *sciences. The Chief Actuary may be removed only*
13 *for cause.*

14 “(B) *COMPENSATION.—The Chief Actuary*
15 *shall be compensated at the highest rate of basic*
16 *pay for the Senior Executive Service under sec-*
17 *tion 5382(b) of title 5, United States Code.*

18 “(C) *DUTIES.—The Chief Actuary shall ex-*
19 *ercise such duties as are appropriate for the of-*
20 *fice of the Chief Actuary and in accordance with*
21 *professional standards of actuarial independence.*

22 “(4) *SECRETARIAL COORDINATION OF PROGRAM*
23 *ADMINISTRATION.—The Secretary shall ensure appro-*
24 *priate coordination between the Administrator and*
25 *the Administrator of the Centers for Medicare & Med-*

1 *icaid Services in carrying out the programs under*
2 *this title.*

3 “(c) *DUTIES; ADMINISTRATIVE PROVISIONS.—*

4 “(1) *DUTIES.—*

5 “(A) *GENERAL DUTIES.—The Adminis-*
6 *trator shall carry out parts C and D,*
7 *including—*

8 “(i) *negotiating, entering into, and en-*
9 *forcing, contracts with plans for the offering*
10 *of Medicare+Choice plans under part C, in-*
11 *cluding the offering of qualified prescription*
12 *drug coverage under such plans; and*

13 “(ii) *negotiating, entering into, and*
14 *enforcing, contracts with PDP sponsors for*
15 *the offering of prescription drug plans*
16 *under part D.*

17 “(B) *OTHER DUTIES.—The Administrator*
18 *shall carry out any duty provided for under part*
19 *C or part D, including demonstration projects*
20 *carried out in part or in whole under such parts,*
21 *the programs of all-inclusive care for the elderly*
22 *(PACE program) under section 1894, the social*
23 *health maintenance organization (SHMO) dem-*
24 *onstration projects (referred to in section 4104(c)*
25 *of the Balanced Budget Act of 1997), and*

1 through a Medicare+Choice project that dem-
2 onstrates the application of capitation payment
3 rates for frail elderly medicare beneficiaries
4 through the use of a interdisciplinary team and
5 through the provision of primary care services to
6 such beneficiaries by means of such a team at the
7 nursing facility involved).

8 “(C) *PRESCRIPTION DRUG CARD.*—*The Ad-*
9 *ministrator shall carry out section 1807 (relat-*
10 *ing to the medicare prescription drug discount*
11 *card endorsement program).*

12 “(D) *NONINTERFERENCE.*—*In carrying out*
13 *its duties with respect to the provision of quali-*
14 *fied prescription drug coverage to beneficiaries*
15 *under this title, the Administrator may not—*

16 “(i) *require a particular formulary or*
17 *institute a price structure for the reimburse-*
18 *ment of covered outpatient drugs;*

19 “(ii) *interfere in any way with nego-*
20 *tiations between PDP sponsors and*
21 *Medicare+Choice organizations and drug*
22 *manufacturers, wholesalers, or other sup-*
23 *pliers of covered outpatient drugs; and*

1 “(iii) otherwise interfere with the com-
2 petitive nature of providing such coverage
3 through such sponsors and organizations.

4 “(E) ANNUAL REPORTS.—Not later March
5 31 of each year, the Administrator shall submit
6 to Congress and the President a report on the
7 administration of parts C and D during the pre-
8 vious fiscal year.

9 “(2) STAFF.—

10 “(A) IN GENERAL.—The Administrator,
11 with the approval of the Secretary, may employ,
12 without regard to chapter 31 of title 5, United
13 States Code, other than sections 3110 and 3112,
14 such officers and employees as are necessary to
15 administer the activities to be carried out
16 through the Medicare Benefits Administration.
17 The Administrator shall employ staff with ap-
18 propriate and necessary expertise in negotiating
19 contracts in the private sector.

20 “(B) FLEXIBILITY WITH RESPECT TO COM-
21 PENSATION.—

22 “(i) IN GENERAL.—The staff of the
23 Medicare Benefits Administration shall,
24 subject to clause (ii), be paid without regard
25 to the provisions of chapter 51 (other than

1 *section 5101) and chapter 53 (other than*
2 *section 5301) of such title (relating to clas-*
3 *sification and schedule pay rates).*

4 “(i) *MAXIMUM RATE.—In no case*
5 *may the rate of compensation determined*
6 *under clause (i) exceed the rate of basic pay*
7 *payable for level IV of the Executive Sched-*
8 *ule under section 5315 of title 5, United*
9 *States Code.*

10 “(C) *LIMITATION ON FULL-TIME EQUIVA-*
11 *LENT STAFFING FOR CURRENT CMS FUNCTIONS*
12 *BEING TRANSFERRED.—The Administrator may*
13 *not employ under this paragraph a number of*
14 *full-time equivalent employees, to carry out func-*
15 *tions that were previously conducted by the Cen-*
16 *ters for Medicare & Medicaid Services and that*
17 *are conducted by the Administrator by reason of*
18 *this section, that exceeds the number of such full-*
19 *time equivalent employees authorized to be em-*
20 *ployed by the Centers for Medicare & Medicaid*
21 *Services to conduct such functions as of the date*
22 *of the enactment of this Act.*

23 “(3) *REDELEGATION OF CERTAIN FUNCTIONS OF*
24 *THE CENTERS FOR MEDICARE & MEDICAID SERV-*
25 *ICES.—*

1 “(A) *IN GENERAL.*—*The Secretary, the Ad-*
2 *ministrator, and the Administrator of the Cen-*
3 *ters for Medicare & Medicaid Services shall es-*
4 *tablish an appropriate transition of responsi-*
5 *bility in order to redelegate the administration*
6 *of part C from the Secretary and the Adminis-*
7 *trator of the Centers for Medicare & Medicaid*
8 *Services to the Administrator as is appropriate*
9 *to carry out the purposes of this section.*

10 “(B) *TRANSFER OF DATA AND INFORMA-*
11 *TION.*—*The Secretary shall ensure that the Ad-*
12 *ministrator of the Centers for Medicare & Med-*
13 *icaid Services transfers to the Administrator of*
14 *the Medicare Benefits Administration such infor-*
15 *mation and data in the possession of the Admin-*
16 *istrator of the Centers for Medicare & Medicaid*
17 *Services as the Administrator of the Medicare*
18 *Benefits Administration requires to carry out the*
19 *duties described in paragraph (1).*

20 “(C) *CONSTRUCTION.*—*Insofar as a respon-*
21 *sibility of the Secretary or the Administrator of*
22 *the Centers for Medicare & Medicaid Services is*
23 *redelegated to the Administrator under this sec-*
24 *tion, any reference to the Secretary or the Ad-*
25 *ministrator of the Centers for Medicare & Med-*

1 *icaid Services in this title or title XI with re-*
2 *spect to such responsibility is deemed to be a ref-*
3 *erence to the Administrator.*

4 “(d) *OFFICE OF BENEFICIARY ASSISTANCE.—*

5 “(1) *ESTABLISHMENT.—The Secretary shall es-*
6 *tablish within the Medicare Benefits Administration*
7 *an Office of Beneficiary Assistance to coordinate*
8 *functions relating to outreach and education of medi-*
9 *care beneficiaries under this title, including the func-*
10 *tions described in paragraph (2). The Office shall be*
11 *separate operating division within the Administra-*
12 *tion.*

13 “(2) *DISSEMINATION OF INFORMATION ON BENE-*
14 *FITS AND APPEALS RIGHTS.—*

15 “(A) *DISSEMINATION OF BENEFITS INFOR-*
16 *MATION.—The Office of Beneficiary Assistance*
17 *shall disseminate, directly or through contract, to*
18 *medicare beneficiaries, by mail, by posting on*
19 *the Internet site of the Medicare Benefits Admin-*
20 *istration and through a toll-free telephone num-*
21 *ber, information with respect to the following:*

22 “(i) *Benefits, and limitations on pay-*
23 *ment (including cost-sharing, stop-loss pro-*
24 *visions, and formulary restrictions) under*
25 *parts C and D.*

1 “(ii) *Benefits, and limitations on pay-*
2 *ment under parts A and B, including infor-*
3 *mation on medicare supplemental policies*
4 *under section 1882.*

5 *Such information shall be presented in a manner*
6 *so that medicare beneficiaries may compare ben-*
7 *efits under parts A, B, D, and medicare supple-*
8 *mental policies with benefits under*
9 *Medicare+Choice plans under part C.*

10 “(B) *DISSEMINATION OF APPEALS RIGHTS*
11 *INFORMATION.—The Office of Beneficiary Assist-*
12 *ance shall disseminate to medicare beneficiaries*
13 *in the manner provided under subparagraph (A)*
14 *a description of procedural rights (including*
15 *grievance and appeals procedures) of bene-*
16 *ficiaries under the original medicare fee-for-serv-*
17 *ice program under parts A and B, the*
18 *Medicare+Choice program under part C, and*
19 *the Voluntary Prescription Drug Benefit Pro-*
20 *gram under part D.*

21 “(e) *MEDICARE POLICY ADVISORY BOARD.—*

22 “(1) *ESTABLISHMENT.—There is established*
23 *within the Medicare Benefits Administration the*
24 *Medicare Policy Advisory Board (in this section re-*
25 *ferred to the ‘Board’). The Board shall advise, consult*

1 *with, and make recommendations to the Adminis-*
2 *trator of the Medicare Benefits Administration with*
3 *respect to the administration of parts C and D, in-*
4 *cluding the review of payment policies under such*
5 *parts.*

6 “(2) *REPORTS.—*

7 “(A) *IN GENERAL.—With respect to matters*
8 *of the administration of parts C and D, the*
9 *Board shall submit to Congress and to the Ad-*
10 *ministrator of the Medicare Benefits Administra-*
11 *tion such reports as the Board determines appro-*
12 *priate. Each such report may contain such rec-*
13 *ommendations as the Board determines appro-*
14 *priate for legislative or administrative changes*
15 *to improve the administration of such parts, in-*
16 *cluding the topics described in subparagraph*
17 *(B). Each such report shall be published in the*
18 *Federal Register.*

19 “(B) *TOPICS DESCRIBED.—Reports required*
20 *under subparagraph (A) may include the fol-*
21 *lowing topics:*

22 “(i) *FOSTERING COMPETITION.—Rec-*
23 *ommendations or proposals to increase com-*
24 *petition under parts C and D for services*
25 *furnished to medicare beneficiaries.*

1 “(ii) *EDUCATION AND ENROLLMENT.*—
2 *Recommendations for the improvement to*
3 *efforts to provide medicare beneficiaries in-*
4 *formation and education on the program*
5 *under this title, and specifically parts C*
6 *and D, and the program for enrollment*
7 *under the title.*

8 “(iii) *IMPLEMENTATION OF RISK-AD-*
9 *JUSTMENT.*—*Evaluation of the implementa-*
10 *tion under section 1853(a)(3)(C) of the risk*
11 *adjustment methodology to payment rates*
12 *under that section to Medicare+Choice or-*
13 *ganizations offering Medicare+Choice plans*
14 *that accounts for variations in per capita*
15 *costs based on health status and other demo-*
16 *graphic factors.*

17 “(iv) *DISEASE MANAGEMENT PRO-*
18 *GRAMS.*—*Recommendations on the incorpo-*
19 *ration of disease management programs*
20 *under parts C and D.*

21 “(v) *RURAL ACCESS.*—*Recommendations*
22 *to improve competition and access to*
23 *plans under parts C and D in rural areas.*

24 “(C) *MAINTAINING INDEPENDENCE OF*
25 *BOARD.*—*The Board shall directly submit to*

1 *Congress reports required under subparagraph*
2 *(A). No officer or agency of the United States*
3 *may require the Board to submit to any officer*
4 *or agency of the United States for approval,*
5 *comments, or review, prior to the submission to*
6 *Congress of such reports.*

7 “(3) *DUTY OF ADMINISTRATOR OF MEDICARE*
8 *BENEFITS ADMINISTRATION.—With respect to any re-*
9 *port submitted by the Board under paragraph (2)(A),*
10 *not later than 90 days after the report is submitted,*
11 *the Administrator of the Medicare Benefits Adminis-*
12 *tration shall submit to Congress and the President an*
13 *analysis of recommendations made by the Board in*
14 *such report. Each such analysis shall be published in*
15 *the Federal Register.*

16 “(4) *MEMBERSHIP.—*

17 “(A) *APPOINTMENT.—Subject to the suc-*
18 *ceeding provisions of this paragraph, the Board*
19 *shall consist of seven members to be appointed as*
20 *follows:*

21 “(i) *Three members shall be appointed*
22 *by the President.*

23 “(ii) *Two members shall be appointed*
24 *by the Speaker of the House of Representa-*
25 *tives, with the advice of the chairmen and*

1 *the ranking minority members of the Com-*
2 *mittees on Ways and Means and on Energy*
3 *and Commerce of the House of Representa-*
4 *tives.*

5 “(iii) *Two members shall be appointed*
6 *by the President pro tempore of the Senate*
7 *with the advice of the chairman and the*
8 *ranking minority member of the Senate*
9 *Committee on Finance.*

10 “(B) *QUALIFICATIONS.—The members shall*
11 *be chosen on the basis of their integrity, impar-*
12 *tiality, and good judgment, and shall be individ-*
13 *uals who are, by reason of their education and*
14 *experience in health care benefits management,*
15 *exceptionally qualified to perform the duties of*
16 *members of the Board.*

17 “(C) *PROHIBITION ON INCLUSION OF FED-*
18 *ERAL EMPLOYEES.—No officer or employee of the*
19 *United States may serve as a member of the*
20 *Board.*

21 “(5) *COMPENSATION.—Members of the Board*
22 *shall receive, for each day (including travel time) they*
23 *are engaged in the performance of the functions of the*
24 *board, compensation at rates not to exceed the daily*
25 *equivalent to the annual rate in effect for level IV of*

1 *the Executive Schedule under section 5315 of title 5,*
2 *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 terms*
12 *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 serve*
17 *for more than 8 years.*

18 “(D) *VACANCY.*—*Any member appointed to*
19 *fill a vacancy occurring before the expiration of*
20 *the term for which the member’s predecessor was*
21 *appointed shall be appointed only for the re-*
22 *mainder of that term. A member may serve after*
23 *the expiration of that member’s term until a suc-*
24 *cessor has taken office. A vacancy in the Board*

1 *shall be filled in the manner in which the origi-*
2 *nal appointment was made.*

3 “(7) *CHAIR.*—*The Chair of the Board shall be*
4 *elected by the members. The term of office of the Chair*
5 *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 times*
8 *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 re-*
15 *gard to chapter 31 of title 5, United States Code,*
16 *such additional personnel as the Director con-*
17 *siders 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 “(i) *MAXIMUM RATE.*—*In no case*
2 *may the rate of compensation determined*
3 *under clause (i) exceed the rate of basic pay*
4 *payable for level IV of the Executive Sched-*
5 *ule under section 5315 of title 5, United*
6 *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 assistance*
12 *as it may require to carry out its functions.*

13 “(10) *CONTRACT AUTHORITY.*—*The Board may*
14 *contract with and compensate government and pri-*
15 *vate agencies or persons to carry out its duties under*
16 *this subsection, without regard to section 3709 of the*
17 *Revised Statutes (41 U.S.C. 5).*

18 “(f) *FUNDING.*—*There is authorized to be appro-*
19 *priated, in appropriate part from the Federal Hospital In-*
20 *surance Trust Fund and from the Federal Supplementary*
21 *Medical Insurance Trust Fund (including the Medicare*
22 *Prescription Drug Account), such sums as are necessary to*
23 *carry out this section.”.*

24 “(b) *EFFECTIVE DATE.*—

1 (1) *IN GENERAL.*—*The amendment made by sub-*
2 *section (a) shall take effect on the date of the enact-*
3 *ment of this Act.*

4 (2) *TIMING OF INITIAL APPOINTMENTS.*—*The Ad-*
5 *ministrator and Deputy Administrator of the Medi-*
6 *care Benefits Administration may not be appointed*
7 *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 years*
14 *beginning or after January 1, 2005.*

15 (4) *TRANSITION.*—*Before the date the Adminis-*
16 *trator of the Medicare Benefits Administration is ap-*
17 *pointed and assumes responsibilities under this sec-*
18 *tion and section 1807 of the Social Security Act, the*
19 *Secretary of Health and Human Services shall pro-*
20 *vide for the conduct of any responsibilities of such*
21 *Administrator that are otherwise provided under law.*

22 (c) *MISCELLANEOUS ADMINISTRATIVE PROVISIONS.*—

23 (1) *ADMINISTRATOR AS MEMBER OF THE BOARD*
24 *OF TRUSTEES OF THE MEDICARE TRUST FUNDS.*—
25 *Section 1817(b) and section 1841(b) (42 U.S.C.*

1 1395i(b), 1395t(b)) are each amended by striking
2 “and the Secretary of Health and Human Services,
3 all ex officio,” and inserting “the Secretary of Health
4 and Human Services, and the Administrator of the
5 Medicare Benefits Administration, all ex officio,”.

6 (2) INCREASE IN GRADE TO EXECUTIVE LEVEL
7 III FOR THE ADMINISTRATOR OF THE CENTERS FOR
8 MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDI-
9 CARE BENEFITS ADMINISTRATOR.—

10 (A) IN GENERAL.—Section 5314 of title 5,
11 United States Code, by adding at the end the fol-
12 lowing:

13 “Administrator of the Centers for Medicare &
14 Medicaid Services .

15 “Administrator of the Medicare Benefits Admin-
16 istration.”.

17 (B) CONFORMING AMENDMENT.—Section
18 5315 of such title is amended by striking “Ad-
19 ministrator of the Health Care Financing Ad-
20 ministration.”.

21 (C) EFFECTIVE DATE.—The amendments
22 made by this paragraph take effect on January
23 1, 2003.

1 **TITLE VIII—REGULATORY RE-**
2 **DUCTION AND CONTRACTING**
3 **REFORM**

4 **Subtitle A—Regulatory Reform**

5 **SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.**

6 (a) *CONSTRUCTION.*—Nothing in this title shall be
7 construed—

8 (1) *to compromise or affect existing legal rem-*
9 *edies for addressing fraud or abuse, whether it be*
10 *criminal prosecution, civil enforcement, or adminis-*
11 *trative remedies, including under sections 3729*
12 *through 3733 of title 31, United States Code (known*
13 *as the False Claims Act); or*

14 (2) *to prevent or impede the Department of*
15 *Health and Human Services in any way from its on-*
16 *going efforts to eliminate waste, fraud, and abuse in*
17 *the medicare program.*

18 *Furthermore, the consolidation of medicare administrative*
19 *contracting set forth in this Act does not constitute consoli-*
20 *ation of the Federal Hospital Insurance Trust Fund and*
21 *the Federal Supplementary Medical Insurance Trust Fund*
22 *or reflect any position on that issue.*

23 (b) *DEFINITION OF SUPPLIER.*—Section 1861 (42
24 *U.S.C. 1395x) is amended by inserting after subsection (c)*
25 *the following new subsection:*

1 *If the Secretary makes a finding under this paragraph, the*
2 *Secretary shall include such finding, and brief statement*
3 *of the reasons for such finding, in the issuance of such regu-*
4 *lation.*

5 “(3) *The Secretary shall coordinate issuance of new*
6 *regulations described in paragraph (1) relating to a cat-*
7 *egory of provider of services or suppliers based on an anal-*
8 *ysis of the collective impact of regulatory changes on that*
9 *category of providers or suppliers.*”.

10 (2) *GAO REPORT ON PUBLICATION OF REGULA-*
11 *TIONS ON A QUARTERLY BASIS.—Not later than 3*
12 *years after the date of the enactment of this Act, the*
13 *Comptroller General of the United States shall submit*
14 *to Congress a report on the feasibility of requiring*
15 *that regulations described in section 1871(d) of the*
16 *Social Security Act be promulgated on a quarterly*
17 *basis rather than on a monthly basis.*

18 (3) *EFFECTIVE DATE.—The amendment made by*
19 *paragraph (1) shall apply to regulations promulgated*
20 *on or after the date that is 30 days after the date of*
21 *the enactment of this Act.*

22 (b) *REGULAR TIMELINE FOR PUBLICATION OF FINAL*
23 *RULES.—*

1 (1) *IN GENERAL.*—Section 1871(a) (42 U.S.C.
2 1395hh(a)) is amended by adding at the end the fol-
3 lowing new paragraph:

4 “(3)(A) *The Secretary, in consultation with the Direc-*
5 *tor of the Office of Management and Budget, shall establish*
6 *and publish a regular timeline for the publication of final*
7 *regulations based on the previous publication of a proposed*
8 *regulation or an interim final regulation.*

9 “(B) *Such timeline may vary among different regula-*
10 *tions based on differences in the complexity of the regula-*
11 *tion, the number and scope of comments received, and other*
12 *relevant factors, but shall not be longer than 3 years except*
13 *under exceptional circumstances. If the Secretary intends*
14 *to vary such timeline with respect to the publication of a*
15 *final regulation, the Secretary shall cause to have published*
16 *in the Federal Register notice of the different timeline by*
17 *not later than the timeline previously established with re-*
18 *spect to such regulation. Such notice shall include a brief*
19 *explanation of the justification for such variation.*

20 “(C) *In the case of interim final regulations, upon the*
21 *expiration of the regular timeline established under this*
22 *paragraph for the publication of a final regulation after*
23 *opportunity for public comment, the interim final regula-*
24 *tion shall not continue in effect unless the Secretary pub-*
25 *lishes (at the end of the regular timeline and, if applicable,*

1 *at the end of each succeeding 1-year period) a notice of con-*
2 *tinuation of the regulation that includes an explanation of*
3 *why the regular timeline (and any subsequent 1-year exten-*
4 *sion) was not complied with. If such a notice is published,*
5 *the regular timeline (or such timeline as previously ex-*
6 *tended under this paragraph) for publication of the final*
7 *regulation shall be treated as having been extended for 1*
8 *additional year.*

9 “(D) *The Secretary shall annually submit to Congress*
10 *a report that describes the instances in which the Secretary*
11 *failed to publish a final regulation within the applicable*
12 *regular timeline under this paragraph and that provides*
13 *an explanation for such failures.”.*

14 (2) *EFFECTIVE DATE.—The amendment made by*
15 *paragraph (1) shall take effect on the date of the en-*
16 *actment of this Act. The Secretary shall provide for*
17 *an appropriate transition to take into account the*
18 *backlog of previously published interim final regula-*
19 *tions.*

20 (c) *LIMITATIONS ON NEW MATTER IN FINAL REGULA-*
21 *TIONS.—*

22 (1) *IN GENERAL.—Section 1871(a) (42 U.S.C.*
23 *1395hh(a)), as amended by subsection (b), is further*
24 *amended by adding at the end the following new*
25 *paragraph:*

1 “(4) If the Secretary publishes notice of proposed rule-
2 making relating to a regulation (including an interim final
3 regulation), insofar as such final regulation includes a pro-
4 vision that is not a logical outgrowth of such notice of pro-
5 posed rulemaking, that provision shall be treated as a pro-
6 posed regulation and shall not take effect until there is the
7 further opportunity for public comment and a publication
8 of the provision again as a final regulation.”.

9 (2) *EFFECTIVE DATE.*—The amendment made by
10 paragraph (1) shall apply to final regulations pub-
11 lished on or after the date of the enactment of this
12 Act.

13 **SEC. 803. COMPLIANCE WITH CHANGES IN REGULATIONS**
14 **AND POLICIES.**

15 (a) *NO RETROACTIVE APPLICATION OF SUBSTANTIVE*
16 *CHANGES.*—

17 (1) *IN GENERAL.*—Section 1871 (42 U.S.C.
18 1395hh), as amended by section 802(a), is amended
19 by adding at the end the following new subsection:

20 “(e)(1)(A) A substantive change in regulations, man-
21 ual instructions, interpretative rules, statements of policy,
22 or guidelines of general applicability under this title shall
23 not be applied (by extrapolation or otherwise) retroactively
24 to items and services furnished before the effective date of
25 the change, unless the Secretary determines that—

1 “(i) such retroactive application is necessary to
2 comply with statutory requirements; or

3 “(ii) failure to apply the change retroactively
4 would be contrary to the public interest.”.

5 (2) *EFFECTIVE DATE.*—The amendment made by
6 paragraph (1) shall apply to substantive changes
7 issued on or after the date of the enactment of this
8 Act.

9 (b) *TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE*
10 *CHANGES AFTER NOTICE.*—

11 (1) *IN GENERAL.*—Section 1871(e)(1), as added
12 by subsection (a), is amended by adding at the end
13 the following:

14 “(B)(i) Except as provided in clause (ii), a substantive
15 change referred to in subparagraph (A) shall not become
16 effective before the end of the 30-day period that begins on
17 the date that the Secretary has issued or published, as the
18 case may be, the substantive change.

19 “(ii) The Secretary may provide for such a substantive
20 change to take effect on a date that precedes the end of the
21 30-day period under clause (i) if the Secretary finds that
22 waiver of such 30-day period is necessary to comply with
23 statutory requirements or that the application of such 30-
24 day period is contrary to the public interest. If the Sec-
25 retary provides for an earlier effective date pursuant to this

1 *clause, the Secretary shall include in the issuance or publi-*
2 *cation of the substantive change a finding described in the*
3 *first sentence, and a brief statement of the reasons for such*
4 *finding.*

5 “(C) *No action shall be taken against a provider of*
6 *services or supplier with respect to noncompliance with*
7 *such a substantive change for items and services furnished*
8 *before the effective date of such a change.*”

9 (2) *EFFECTIVE DATE.*—*The amendment made by*
10 *paragraph (1) shall apply to compliance actions un-*
11 *dertaken on or after the date of the enactment of this*
12 *Act.*

13 (c) *RELIANCE ON GUIDANCE.*—

14 (1) *IN GENERAL.*—*Section 1871(e), as added by*
15 *subsection (a), is further amended by adding at the*
16 *end the following new paragraph:*

17 “(2)(A) *If—*

18 *“(i) a provider of services or supplier follows the*
19 *written guidance (which may be transmitted elec-*
20 *tronically) provided by the Secretary or by a medi-*
21 *care contractor (as defined in section 1889(g)) acting*
22 *within the scope of the contractor’s contract authority,*
23 *with respect to the furnishing of items or services and*
24 *submission of a claim for benefits for such items or*
25 *services with respect to such provider or supplier;*

1 “(ii) the Secretary determines that the provider
2 of services or supplier has accurately presented the
3 circumstances relating to such items, services, and
4 claim to the contractor in writing; and

5 “(iii) the guidance was in error;
6 the provider of services or supplier shall not be subject to
7 any sanction (including any penalty or requirement for re-
8 payment of any amount) if the provider of services or sup-
9 plier reasonably relied on such guidance.

10 “(B) Subparagraph (A) shall not be construed as pre-
11 venting the recoupment or repayment (without any addi-
12 tional penalty) relating to an overpayment insofar as the
13 overpayment was solely the result of a clerical or technical
14 operational error.”.

15 (2) *EFFECTIVE DATE.*—The amendment made by
16 paragraph (1) shall take effect on the date of the en-
17 actment of this Act but shall not apply to any sanc-
18 tion for which notice was provided on or before the
19 date of the enactment of this Act.

20 **SEC. 804. REPORTS AND STUDIES RELATING TO REGU-**
21 **LATORY REFORM.**

22 (a) *GAO STUDY ON ADVISORY OPINION AUTHORITY.*—
23 (1) *STUDY.*—The Comptroller General of the
24 United States shall conduct a study to determine the
25 feasibility and appropriateness of establishing in the

1 *Secretary authority to provide legally binding advisory*
2 *opinions on appropriate interpretation and ap-*
3 *plication of regulations to carry out the medicare pro-*
4 *gram under title XVIII of the Social Security Act.*
5 *Such study shall examine the appropriate timeframe*
6 *for issuing such advisory opinions, as well as the need*
7 *for additional staff and funding to provide such opin-*
8 *ions.*

9 (2) *REPORT.—The Comptroller General shall*
10 *submit to Congress a report on the study conducted*
11 *under paragraph (1) by not later than January 1,*
12 *2004.*

13 (b) *REPORT ON LEGAL AND REGULATORY INCONSIST-*
14 *ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by*
15 *section 803(a), is amended by adding at the end the fol-*
16 *lowing new subsection:*

17 “(f)(1) *Not later than 2 years after the date of the en-*
18 *actment of this subsection, and every 2 years thereafter, the*
19 *Secretary shall submit to Congress a report with respect*
20 *to the administration of this title and areas of inconsistency*
21 *or conflict among the various provisions under law and reg-*
22 *ulation.*

23 “(2) *In preparing a report under paragraph (1), the*
24 *Secretary shall collect—*

1 contractor with respect to the performance of any or
2 all of the functions described in paragraph (4) or
3 parts of those functions (or, to the extent provided in
4 a contract, to secure performance thereof by other en-
5 tities).

6 “(2) *ELIGIBILITY OF ENTITIES.*—An entity is el-
7 igible to enter into a contract with respect to the per-
8 formance of a particular function described in para-
9 graph (4) only if—

10 “(A) the entity has demonstrated capability
11 to carry out such function;

12 “(B) the entity complies with such conflict
13 of interest standards as are generally applicable
14 to Federal acquisition and procurement;

15 “(C) the entity has sufficient assets to fi-
16 nancially support the performance of such func-
17 tion; and

18 “(D) the entity meets such other require-
19 ments as the Secretary may impose.

20 “(3) *MEDICARE ADMINISTRATIVE CONTRACTOR*
21 *DEFINED.*—For purposes of this title and title XI—

22 “(A) *IN GENERAL.*—The term ‘medicare ad-
23 ministrative contractor’ means an agency, orga-
24 nization, or other person with a contract under
25 this section.

1 “(B) *APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.*—*With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the ‘appropriate’ medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.*

14 “(4) *FUNCTIONS DESCRIBED.*—*The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:*

20 “(A) *DETERMINATION OF PAYMENT AMOUNTS.*—*Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pur-*

1 *suant to this title to be made to providers of*
2 *services, suppliers and individuals.*

3 “(B) *MAKING PAYMENTS.*—*Making pay-*
4 *ments described in subparagraph (A) (including*
5 *receipt, disbursement, and accounting for funds*
6 *in making such payments).*

7 “(C) *BENEFICIARY EDUCATION AND ASSIST-*
8 *ANCE.*—*Providing education and outreach to in-*
9 *dividuals entitled to benefits under part A or en-*
10 *rolled under part B, or both, and providing as-*
11 *sistance to those individuals with specific issues,*
12 *concerns or problems.*

13 “(D) *PROVIDER CONSULTATIVE SERV-*
14 *ICES.*—*Providing consultative services to institu-*
15 *tions, agencies, and other persons to enable them*
16 *to establish and maintain fiscal records nec-*
17 *essary for purposes of this title and otherwise to*
18 *qualify as providers of services or suppliers.*

19 “(E) *COMMUNICATION WITH PROVIDERS.*—
20 *Communicating to providers of services and sup-*
21 *pliers any information or instructions furnished*
22 *to the medicare administrative contractor by the*
23 *Secretary, and facilitating communication be-*
24 *tween such providers and suppliers and the Sec-*
25 *retary.*

1 “(F) *PROVIDER EDUCATION AND TECHNICAL*
2 *ASSISTANCE.—Performing the functions relating*
3 *to provider education, training, and technical*
4 *assistance.*

5 “(G) *ADDITIONAL FUNCTIONS.—Performing*
6 *such other functions as are necessary to carry*
7 *out the purposes of this title.*

8 “(5) *RELATIONSHIP TO MIP CONTRACTS.—*

9 “(A) *NONDUPLICATION OF DUTIES.—In en-*
10 *tering into contracts under this section, the Sec-*
11 *retary shall assure that functions of medicare*
12 *administrative contractors in carrying out ac-*
13 *tivities under parts A and B do not duplicate*
14 *activities carried out under the Medicare Integ-*
15 *egrity Program under section 1893. The previous*
16 *sentence shall not apply with respect to the ac-*
17 *tivity described in section 1893(b)(5) (relating to*
18 *prior authorization of certain items of durable*
19 *medical equipment under section 1834(a)(15)).*

20 “(B) *CONSTRUCTION.—An entity shall not*
21 *be treated as a medicare administrative con-*
22 *tractor merely by reason of having entered into*
23 *a contract with the Secretary under section*
24 *1893.*

1 “(6) *APPLICATION OF FEDERAL ACQUISITION*
2 *REGULATION.—Except to the extent inconsistent with*
3 *a specific requirement of this title, the Federal Acqui-*
4 *sition Regulation applies to contracts under this title.*

5 “(b) *CONTRACTING REQUIREMENTS.—*

6 “(1) *USE OF COMPETITIVE PROCEDURES.—*

7 “(A) *IN GENERAL.—Except as provided in*
8 *laws with general applicability to Federal acqui-*
9 *sition and procurement or in subparagraph (B),*
10 *the Secretary shall use competitive procedures*
11 *when entering into contracts with medicare ad-*
12 *ministrative contractors under this section, tak-*
13 *ing into account performance quality as well as*
14 *price and other factors.*

15 “(B) *RENEWAL OF CONTRACTS.—The Sec-*
16 *retary may renew a contract with a medicare*
17 *administrative contractor under this section*
18 *from term to term without regard to section 5 of*
19 *title 41, United States Code, or any other provi-*
20 *sion of law requiring competition, if the medi-*
21 *care administrative contractor has met or ex-*
22 *ceeded the performance requirements applicable*
23 *with respect to the contract and contractor, ex-*
24 *cept that the Secretary shall provide for the ap-*
25 *plication of competitive procedures under such a*

1 *contract not less frequently than once every five*
2 *years.*

3 “(C) *TRANSFER OF FUNCTIONS.*—*The Sec-*
4 *retary may transfer functions among medicare*
5 *administrative contractors consistent with the*
6 *provisions of this paragraph. The Secretary shall*
7 *ensure that performance quality is considered in*
8 *such transfers. The Secretary shall provide pub-*
9 *lic notice (whether in the Federal Register or*
10 *otherwise) of any such transfer (including a de-*
11 *scription of the functions so transferred, a de-*
12 *scription of the providers of services and sup-*
13 *pliers affected by such transfer, and contact in-*
14 *formation for the contractors involved).*

15 “(D) *INCENTIVES FOR QUALITY.*—*The Sec-*
16 *retary shall provide incentives for medicare ad-*
17 *ministrative contractors to provide quality serv-*
18 *ice and to promote efficiency.*

19 “(2) *COMPLIANCE WITH REQUIREMENTS.*—*No*
20 *contract under this section shall be entered into with*
21 *any medicare administrative contractor unless the*
22 *Secretary finds that such medicare administrative*
23 *contractor will perform its obligations under the con-*
24 *tract efficiently and effectively and will meet such re-*
25 *quirements as to financial responsibility, legal au-*

1 *thority, quality of services provided, and other mat-*
2 *ters as the Secretary finds pertinent.*

3 *“(3) PERFORMANCE REQUIREMENTS.—*

4 *“(A) DEVELOPMENT OF SPECIFIC PERFORM-*
5 *ANCE REQUIREMENTS.—In developing contract*
6 *performance requirements, the Secretary shall*
7 *develop performance requirements applicable to*
8 *functions described in subsection (a)(4).*

9 *“(B) CONSULTATION.— In developing such*
10 *requirements, the Secretary may consult with*
11 *providers of services and suppliers, organizations*
12 *representing individuals entitled to benefits*
13 *under part A or enrolled under part B, or both,*
14 *and organizations and agencies performing func-*
15 *tions necessary to carry out the purposes of this*
16 *section with respect to such performance require-*
17 *ments.*

18 *“(C) INCLUSION IN CONTRACTS.—All con-*
19 *tractor performance requirements shall be set*
20 *forth in the contract between the Secretary and*
21 *the appropriate medicare administrative con-*
22 *tractor. Such performance requirements—*

23 *“(i) shall reflect the performance re-*
24 *quirements developed under subparagraph*

1 (A), but may include additional perform-
2 ance requirements;

3 “(ii) shall be used for evaluating con-
4 tractor performance under the contract; and

5 “(iii) shall be consistent with the writ-
6 ten statement of work provided under the
7 contract.

8 “(4) *INFORMATION REQUIREMENTS.*—The Sec-
9 retary shall not enter into a contract with a medicare
10 administrative contractor under this section unless
11 the contractor agrees—

12 “(A) to furnish to the Secretary such timely
13 information and reports as the Secretary may
14 find necessary in performing his functions under
15 this title; and

16 “(B) to maintain such records and afford
17 such access thereto as the Secretary finds nec-
18 essary to assure the correctness and verification
19 of the information and reports under subpara-
20 graph (A) and otherwise to carry out the pur-
21 poses of this title.

22 “(5) *SURETY BOND.*—A contract with a medi-
23 care administrative contractor under this section may
24 require the medicare administrative contractor, and
25 any of its officers or employees certifying payments or

1 *disbursing funds pursuant to the contract, or other-*
2 *wise participating in carrying out the contract, to*
3 *give surety bond to the United States in such amount*
4 *as the Secretary may deem appropriate.*

5 “(c) *TERMS AND CONDITIONS.*—

6 “(1) *IN GENERAL.*—*A contract with any medi-*
7 *care administrative contractor under this section may*
8 *contain such terms and conditions as the Secretary*
9 *finds necessary or appropriate and may provide for*
10 *advances of funds to the medicare administrative con-*
11 *tractor for the making of payments by it under sub-*
12 *section (a)(4)(B).*

13 “(2) *PROHIBITION ON MANDATES FOR CERTAIN*
14 *DATA COLLECTION.*—*The Secretary may not require,*
15 *as a condition of entering into, or renewing, a con-*
16 *tract under this section, that the medicare adminis-*
17 *trative contractor match data obtained other than in*
18 *its activities under this title with data used in the ad-*
19 *ministration of this title for purposes of identifying*
20 *situations in which the provisions of section 1862(b)*
21 *may apply.*

22 “(d) *LIMITATION ON LIABILITY OF MEDICARE ADMIN-*
23 *ISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.*—

24 “(1) *CERTIFYING OFFICER.*—*No individual des-*
25 *ignated pursuant to a contract under this section as*

1 *a certifying officer shall, in the absence of gross neg-*
2 *ligence or intent to defraud the United States, be lia-*
3 *ble with respect to any payments certified by the in-*
4 *dividual under this section.*

5 “(2) *DISBURSING OFFICER.*—*No disbursing offi-*
6 *cer shall, in the absence of gross negligence or intent*
7 *to defraud the United States, be liable with respect to*
8 *any payment by such officer under this section if it*
9 *was based upon an authorization (which meets the*
10 *applicable requirements for such internal controls es-*
11 *tablished by the Comptroller General) of a certifying*
12 *officer designated as provided in paragraph (1) of*
13 *this subsection.*

14 “(3) *LIABILITY OF MEDICARE ADMINISTRATIVE*
15 *CONTRACTOR.*—*No medicare administrative con-*
16 *tractor shall be liable to the United States for a pay-*
17 *ment by a certifying or disbursing officer unless in*
18 *connection with such payment or in the supervision*
19 *of or selection of such officer the medicare administra-*
20 *tive contractor acted with gross negligence.*

21 “(4) *INDEMNIFICATION BY SECRETARY.*—

22 “(A) *IN GENERAL.*—*Subject to subpara-*
23 *graphs (B) and (D), in the case of a medicare*
24 *administrative contractor (or a person who is a*
25 *director, officer, or employee of such a contractor*

1 or who is engaged by the contractor to partici-
2 pate directly in the claims administration proc-
3 ess) who is made a party to any judicial or ad-
4 ministrative proceeding arising from or relating
5 directly to the claims administration process
6 under this title, the Secretary may, to the extent
7 the Secretary determines to be appropriate and
8 as specified in the contract with the contractor,
9 indemnify the contractor and such persons.

10 “(B) *CONDITIONS.*—The Secretary may not
11 provide indemnification under subparagraph (A)
12 insofar as the liability for such costs arises di-
13 rectly from conduct that is determined by the ju-
14 dicial proceeding or by the Secretary to be crimi-
15 nal in nature, fraudulent, or grossly negligent. If
16 indemnification is provided by the Secretary
17 with respect to a contractor before a determina-
18 tion that such costs arose directly from such con-
19 duct, the contractor shall reimburse the Secretary
20 for costs of indemnification.

21 “(C) *SCOPE OF INDEMNIFICATION.*—Indem-
22 nification by the Secretary under subparagraph
23 (A) may include payment of judgments, settle-
24 ments (subject to subparagraph (D)), awards,
25 and costs (including reasonable legal expenses).

1 “(D) *WRITTEN APPROVAL FOR SETTLE-*
2 *MENTS.—A contractor or other person described*
3 *in subparagraph (A) may not propose to nego-*
4 *tiate a settlement or compromise of a proceeding*
5 *described in such subparagraph without the*
6 *prior written approval of the Secretary to nego-*
7 *tiate such settlement or compromise. Any indem-*
8 *nification under subparagraph (A) with respect*
9 *to amounts paid under a settlement or com-*
10 *promise of a proceeding described in such sub-*
11 *paragraph are conditioned upon prior written*
12 *approval by the Secretary of the final settlement*
13 *or compromise.*

14 “(E) *CONSTRUCTION.—Nothing in this*
15 *paragraph shall be construed—*

16 “(i) *to change any common law immu-*
17 *nity that may be available to a medicare*
18 *administrative contractor or person de-*
19 *scribed in subparagraph (A); or*

20 “(ii) *to permit the payment of costs*
21 *not otherwise allowable, reasonable, or allo-*
22 *cable under the Federal Acquisition Regula-*
23 *tions.”.*

24 “(2) *CONSIDERATION OF INCORPORATION OF CUR-*
25 *RENT LAW STANDARDS.—In developing contract per-*

1 1874A that provides for making payments under
2 this part”.

3 (5) Subsections (d) through (i) are repealed.

4 (6) Subsections (j) and (k) are each amended—

5 (A) by striking “An agreement with an
6 agency or organization under this section” and
7 inserting “A contract with a medicare adminis-
8 trative contractor under section 1874A with re-
9 spect to the administration of this part”; and

10 (B) by striking “such agency or organiza-
11 tion” and inserting “such medicare administra-
12 tive contractor” each place it appears.

13 (7) Subsection (l) is repealed.

14 (c) *CONFORMING AMENDMENTS TO SECTION 1842 (RE-*
15 *LATING TO CARRIERS).*—Section 1842 (42 U.S.C. 1395u)
16 *is amended as follows:*

17 (1) *The heading is amended to read as follows:*
18 “*PROVISIONS RELATING TO THE ADMINISTRATION OF PART*
19 *B*”.

20 (2) *Subsection (a) is amended to read as follows:*

21 “*(a) The administration of this part shall be conducted*
22 *through contracts with medicare administrative contractors*
23 *under section 1874A.*”.

24 (3) *Subsection (b) is amended—*

25 (A) *by striking paragraph (1);*

26 (B) *in paragraph (2)—*

- 1 (i) by striking subparagraphs (A) and
2 (B);
- 3 (ii) in subparagraph (C), by striking
4 “carriers” and inserting “medicare admin-
5 istrative contractors”; and
- 6 (iii) by striking subparagraphs (D)
7 and (E);
- 8 (C) in paragraph (3)—
- 9 (i) in the matter before subparagraph
10 (A), by striking “Each such contract shall
11 provide that the carrier” and inserting
12 “The Secretary”;
- 13 (ii) by striking “will” the first place it
14 appears in each of subparagraphs (A), (B),
15 (F), (G), (H), and (L) and inserting
16 “shall”;
- 17 (iii) in subparagraph (B), in the mat-
18 ter before clause (i), by striking “to the pol-
19 icyholders and subscribers of the carrier”
20 and inserting “to the policyholders and sub-
21 scribers of the medicare administrative con-
22 tractor”;
- 23 (iv) by striking subparagraphs (C),
24 (D), and (E);
- 25 (v) in subparagraph (H)—

1 (I) by striking “if it makes deter-
2 minations or payments with respect to
3 physicians’ services,” in the matter
4 preceding clause (i); and

5 (II) by striking “carrier” and in-
6 serting “medicare administrative con-
7 tractor” in clause (i);

8 (vi) by striking subparagraph (I);

9 (vii) in subparagraph (L), by striking
10 the semicolon and inserting a period;

11 (viii) in the first sentence, after sub-
12 paragraph (L), by striking “and shall con-
13 tain” and all that follows through the pe-
14 riod; and

15 (ix) in the seventh sentence, by insert-
16 ing “medicare administrative contractor,”
17 after “carrier,”; and

18 (D) by striking paragraph (5);

19 (E) in paragraph (6)(D)(iv), by striking
20 “carrier” and inserting “medicare administra-
21 tive contractor”; and

22 (F) in paragraph (7), by striking “the car-
23 rier” and inserting “the Secretary” each place it
24 appears.

25 (4) Subsection (c) is amended—

1 (A) by striking paragraph (1);

2 (B) in paragraph (2)(A), by striking “con-
3 tract under this section which provides for the
4 disbursement of funds, as described in subsection
5 (a)(1)(B),” and inserting “contract under section
6 1874A that provides for making payments under
7 this part”;

8 (C) in paragraph (3)(A), by striking “sub-
9 section (a)(1)(B)” and inserting “section
10 1874A(a)(3)(B)”;

11 (D) in paragraph (4), in the matter pre-
12 ceding subparagraph (A), by striking “carrier”
13 and inserting “medicare administrative con-
14 tractor”; and

15 (E) by striking paragraphs (5) and (6).

16 (5) Subsections (d), (e), and (f) are repealed.

17 (6) Subsection (g) is amended by striking “car-
18 rier or carriers” and inserting “medicare administra-
19 tive contractor or contractors”.

20 (7) Subsection (h) is amended—

21 (A) in paragraph (2)—

22 (i) by striking “Each carrier having
23 an agreement with the Secretary under sub-
24 section (a)” and inserting “The Secretary”;
25 and

1 (ii) by striking “Each such carrier”
2 and inserting “The Secretary”;

3 (B) in paragraph (3)(A)—

4 (i) by striking “a carrier having an
5 agreement with the Secretary under sub-
6 section (a)” and inserting “medicare ad-
7 ministrative contractor having a contract
8 under section 1874A that provides for mak-
9 ing payments under this part”; and

10 (ii) by striking “such carrier” and in-
11 serting “such contractor”;

12 (C) in paragraph (3)(B)—

13 (i) by striking “a carrier” and insert-
14 ing “a medicare administrative contractor”
15 each place it appears; and

16 (ii) by striking “the carrier” and in-
17 serting “the contractor” each place it ap-
18 pears; and

19 (D) in paragraphs (5)(A) and (5)(B)(iii),
20 by striking “carriers” and inserting “medicare
21 administrative contractors” each place it ap-
22 pears.

23 (8) Subsection (l) is amended—

1 (A) in paragraph (1)(A)(iii), by striking
2 “carrier” and inserting “medicare administra-
3 tive contractor”; and

4 (B) in paragraph (2), by striking “carrier”
5 and inserting “medicare administrative con-
6 tractor”.

7 (9) Subsection (p)(3)(A) is amended by striking
8 “carrier” and inserting “medicare administrative
9 contractor”.

10 (10) Subsection (q)(1)(A) is amended by striking
11 “carrier”.

12 (d) *EFFECTIVE DATE; TRANSITION RULE.*—

13 (1) *EFFECTIVE DATE.*—

14 (A) *IN GENERAL.*—*Except as otherwise pro-*
15 *vided in this subsection, the amendments made*
16 *by this section shall take effect on October 1,*
17 *2004, and the Secretary is authorized to take*
18 *such steps before such date as may be necessary*
19 *to implement such amendments on a timely*
20 *basis.*

21 (B) *CONSTRUCTION FOR CURRENT CON-*
22 *TRACTS.*—*Such amendments shall not apply to*
23 *contracts in effect before the date specified under*
24 *subparagraph (A) that continue to retain the*
25 *terms and conditions in effect on such date (ex-*

1 *cept as otherwise provided under this Act, other*
2 *than under this section) until such date as the*
3 *contract is let out for competitive bidding under*
4 *such amendments.*

5 (C) *DEADLINE FOR COMPETITIVE BID-*
6 *DING.—The Secretary shall provide for the let-*
7 *ting by competitive bidding of all contracts for*
8 *functions of medicare administrative contractors*
9 *for annual contract periods that begin on or*
10 *after October 1, 2009.*

11 (D) *WAIVER OF PROVIDER NOMINATION*
12 *PROVISIONS DURING TRANSITION.—During the*
13 *period beginning on the date of the enactment of*
14 *this Act and before the date specified under sub-*
15 *paragraph (A), the Secretary may enter into*
16 *new agreements under section 1816 of the Social*
17 *Security Act (42 U.S.C. 1395h) without regard*
18 *to any of the provider nomination provisions of*
19 *such section.*

20 (2) *GENERAL TRANSITION RULES.—The Sec-*
21 *retary shall take such steps, consistent with para-*
22 *graph (1)(B) and (1)(C), as are necessary to provide*
23 *for an appropriate transition from contracts under*
24 *section 1816 and section 1842 of the Social Security*

1 *Act (42 U.S.C. 1395h, 1395u) to contracts under sec-*
2 *tion 1874A, as added by subsection (a)(1).*

3 (3) *AUTHORIZING CONTINUATION OF MIP FUNC-*
4 *TIONS UNDER CURRENT CONTRACTS AND AGREEE-*
5 *MENTS AND UNDER ROLLOVER CONTRACTS.—The pro-*
6 *visions contained in the exception in section*
7 *1893(d)(2) of the Social Security Act (42 U.S.C.*
8 *1395ddd(d)(2)) shall continue to apply notwith-*
9 *standing the amendments made by this section, and*
10 *any reference in such provisions to an agreement or*
11 *contract shall be deemed to include a contract under*
12 *section 1874A of such Act, as inserted by subsection*
13 *(a)(1), that continues the activities referred to in such*
14 *provisions.*

15 (e) *REFERENCES.—On and after the effective date pro-*
16 *vided under subsection (d)(1), any reference to a fiscal*
17 *intermediary or carrier under title XI or XVIII of the So-*
18 *cial Security Act (or any regulation, manual instruction,*
19 *interpretative rule, statement of policy, or guideline issued*
20 *to carry out such titles) shall be deemed a reference to an*
21 *appropriate medicare administrative contractor (as pro-*
22 *vided under section 1874A of the Social Security Act).*

23 (f) *REPORTS ON IMPLEMENTATION.—*

24 (1) *PLAN FOR IMPLEMENTATION.—By not later*
25 *than October 1, 2003, the Secretary shall submit a re-*

1 *port to Congress and the Comptroller General of the*
2 *United States that describes the plan for implementa-*
3 *tion of the amendments made by this section. The*
4 *Comptroller General shall conduct an evaluation of*
5 *such plan and shall submit to Congress, not later*
6 *than 6 months after the date the report is received, a*
7 *report on such evaluation and shall include in such*
8 *report such recommendations as the Comptroller Gen-*
9 *eral deems appropriate.*

10 (2) *STATUS OF IMPLEMENTATION.—The Sec-*
11 *retary shall submit a report to Congress not later*
12 *than October 1, 2007, that describes the status of im-*
13 *plementation of such amendments and that includes*
14 *a description of the following:*

15 (A) *The number of contracts that have been*
16 *competitively bid as of such date.*

17 (B) *The distribution of functions among*
18 *contracts and contractors.*

19 (C) *A timeline for complete transition to*
20 *full competition.*

21 (D) *A detailed description of how the Sec-*
22 *retary has modified oversight and management*
23 *of medicare contractors to adapt to full competi-*
24 *tion.*

1 **SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY**
2 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**
3 **TORS.**

4 (a) *IN GENERAL.*—Section 1874A, as added by section
5 811(a)(1), is amended by adding at the end the following
6 new subsection:

7 “(e) *REQUIREMENTS FOR INFORMATION SECURITY.*—

8 “(1) *DEVELOPMENT OF INFORMATION SECURITY*
9 *PROGRAM.*—A medicare administrative contractor
10 that performs the functions referred to in subpara-
11 graphs (A) and (B) of subsection (a)(4) (relating to
12 determining and making payments) shall implement
13 a contractor-wide information security program to
14 provide information security for the operation and
15 assets of the contractor with respect to such functions
16 under this title. An information security program
17 under this paragraph shall meet the requirements for
18 information security programs imposed on Federal
19 agencies under section 3534(b)(2) of title 44, United
20 States Code (other than requirements under subpara-
21 graphs (B)(ii), (F)(iii), and (F)(iv) of such section).

22 “(2) *INDEPENDENT AUDITS.*—

23 “(A) *PERFORMANCE OF ANNUAL EVALUA-*
24 *TIONS.*—Each year a medicare administrative
25 contractor that performs the functions referred to
26 in subparagraphs (A) and (B) of subsection

1 (a)(4) (relating to determining and making pay-
2 ments) shall undergo an evaluation of the infor-
3 mation security of the contractor with respect to
4 such functions under this title. The evaluation
5 shall—

6 “(i) be performed by an entity that
7 meets such requirements for independence as
8 the Inspector General of the Department of
9 Health and Human Services may establish;
10 and

11 “(ii) test the effectiveness of informa-
12 tion security control techniques for an ap-
13 propriate subset of the contractor’s informa-
14 tion systems (as defined in section 3502(8)
15 of title 44, United States Code) relating to
16 such functions under this title and an as-
17 sessment of compliance with the require-
18 ments of this subsection and related infor-
19 mation security policies, procedures, stand-
20 ards and guidelines.

21 “(B) DEADLINE FOR INITIAL EVALUA-
22 TION.—

23 “(i) NEW CONTRACTORS.—In the case
24 of a medicare administrative contractor
25 covered by this subsection that has not pre-

1 *viously performed the functions referred to*
2 *in subparagraphs (A) and (B) of subsection*
3 *(a)(4) (relating to determining and making*
4 *payments) as a fiscal intermediary or car-*
5 *rier under section 1816 or 1842, the first*
6 *independent evaluation conducted pursuant*
7 *subparagraph (A) shall be completed prior*
8 *to commencing such functions.*

9 *“(ii) OTHER CONTRACTORS.—In the*
10 *case of a medicare administrative con-*
11 *tractor covered by this subsection that is not*
12 *described in clause (i), the first independent*
13 *evaluation conducted pursuant subpara-*
14 *graph (A) shall be completed within 1 year*
15 *after the date the contractor commences*
16 *functions referred to in clause (i) under this*
17 *section.*

18 *“(C) REPORTS ON EVALUATIONS.—*

19 *“(i) TO THE INSPECTOR GENERAL.—*
20 *The results of independent evaluations*
21 *under subparagraph (A) shall be submitted*
22 *promptly to the Inspector General of the*
23 *Department of Health and Human Services.*

24 *“(ii) TO CONGRESS.—The Inspector*
25 *General of Department of Health and*

1 *Human Services shall submit to Congress*
2 *annual reports on the results of such eval-*
3 *uations.”.*

4 *(b) APPLICATION OF REQUIREMENTS TO FISCAL*
5 *INTERMEDIARIES AND CARRIERS.—*

6 *(1) IN GENERAL.—The provisions of section*
7 *1874A(e)(2) of the Social Security Act (other than*
8 *subparagraph (B)), as added by subsection (a), shall*
9 *apply to each fiscal intermediary under section 1816*
10 *of the Social Security Act (42 U.S.C. 1395h) and*
11 *each carrier under section 1842 of such Act (42*
12 *U.S.C. 1395u) in the same manner as they apply to*
13 *medicare administrative contractors under such pro-*
14 *visions.*

15 *(2) DEADLINE FOR INITIAL EVALUATION.—In the*
16 *case of such a fiscal intermediary or carrier with an*
17 *agreement or contract under such respective section in*
18 *effect as of the date of the enactment of this Act, the*
19 *first evaluation under section 1874A(e)(2)(A) of the*
20 *Social Security Act (as added by subsection (a)), pur-*
21 *suant to paragraph (1), shall be completed (and a re-*
22 *port on the evaluation submitted to the Secretary) by*
23 *not later than 1 year after such date.*

1 **Subtitle C—Education and**
2 **Outreach**

3 **SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSIST-**
4 **ANCE.**

5 (a) *COORDINATION OF EDUCATION FUNDING.*—

6 (1) *IN GENERAL.*—*The Social Security Act is*
7 *amended by inserting after section 1888 the following*
8 *new section:*

9 “*PROVIDER EDUCATION AND TECHNICAL ASSISTANCE*

10 “*SEC. 1889. (a) COORDINATION OF EDUCATION FUND-*
11 *ING.*—*The Secretary shall coordinate the educational activi-*
12 *ties provided through medicare contractors (as defined in*
13 *subsection (g), including under section 1893) in order to*
14 *maximize the effectiveness of Federal education efforts for*
15 *providers of services and suppliers.”.*

16 (2) *EFFECTIVE DATE.*—*The amendment made by*
17 *paragraph (1) shall take effect on the date of the en-*
18 *actment of this Act.*

19 (3) *REPORT.*—*Not later than October 1, 2003,*
20 *the Secretary shall submit to Congress a report that*
21 *includes a description and evaluation of the steps*
22 *taken to coordinate the funding of provider education*
23 *under section 1889(a) of the Social Security Act, as*
24 *added by paragraph (1).*

1 **(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-**
2 **ANCE.**—

3 **(1) IN GENERAL.**—Section 1874A, as added by
4 section 811(a)(1) and as amended by section 812(a),
5 is amended by adding at the end the following new
6 subsection:

7 **“(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-**
8 **ANCE IN PROVIDER EDUCATION AND OUTREACH.**—In order
9 to give medicare administrative contractors an incentive to
10 implement effective education and outreach programs for
11 providers of services and suppliers, the Secretary shall de-
12 velop and implement a methodology to measure the specific
13 claims payment error rates of such contractors in the proc-
14 essing or reviewing of medicare claims.”.

15 **(2) APPLICATION TO FISCAL INTERMEDIARIES**
16 **AND CARRIERS.**—The provisions of section 1874A(f) of
17 the Social Security Act, as added by paragraph (1),
18 shall apply to each fiscal intermediary under section
19 1816 of the Social Security Act (42 U.S.C. 1395h)
20 and each carrier under section 1842 of such Act (42
21 U.S.C. 1395u) in the same manner as they apply to
22 medicare administrative contractors under such pro-
23 visions.

24 **(3) GAO REPORT ON ADEQUACY OF METHOD-**
25 **LOGY.**—Not later than October 1, 2003, the Comp-

1 *troller General of the United States shall submit to*
2 *Congress and to the Secretary a report on the ade-*
3 *quacy of the methodology under section 1874A(f) of*
4 *the Social Security Act, as added by paragraph (1),*
5 *and shall include in the report such recommendations*
6 *as the Comptroller General determines appropriate*
7 *with respect to the methodology.*

8 *(4) REPORT ON USE OF METHODOLOGY IN AS-*
9 *SESSING CONTRACTOR PERFORMANCE.—Not later*
10 *than October 1, 2003, the Secretary shall submit to*
11 *Congress a report that describes how the Secretary in-*
12 *tends to use such methodology in assessing medicare*
13 *contractor performance in implementing effective edu-*
14 *cation and outreach programs, including whether to*
15 *use such methodology as a basis for performance bo-*
16 *nus. The report shall include an analysis of the*
17 *sources of identified errors and potential changes in*
18 *systems of contractors and rules of the Secretary that*
19 *could reduce claims error rates.*

20 *(c) PROVISION OF ACCESS TO AND PROMPT RE-*
21 *SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-*
22 *TORS.—*

23 *(1) IN GENERAL.—Section 1874A, as added by*
24 *section 811(a)(1) and as amended by section 812(a)*

1 and subsection (b), is further amended by adding at
2 the end the following new subsection:

3 “(g) *COMMUNICATIONS WITH BENEFICIARIES, PRO-*
4 *VIDERS OF SERVICES AND SUPPLIERS.—*

5 “(1) *COMMUNICATION STRATEGY.—The Secretary*
6 *shall develop a strategy for communications with in-*
7 *dividuals entitled to benefits under part A or enrolled*
8 *under part B, or both, and with providers of services*
9 *and suppliers under this title.*

10 “(2) *RESPONSE TO WRITTEN INQUIRIES.—Each*
11 *medicare administrative contractor shall, for those*
12 *providers of services and suppliers which submit*
13 *claims to the contractor for claims processing and for*
14 *those individuals entitled to benefits under part A or*
15 *enrolled under part B, or both, with respect to whom*
16 *claims are submitted for claims processing, provide*
17 *general written responses (which may be through elec-*
18 *tronic transmission) in a clear, concise, and accurate*
19 *manner to inquiries of providers of services, suppliers*
20 *and individuals entitled to benefits under part A or*
21 *enrolled under part B, or both, concerning the pro-*
22 *grams under this title within 45 business days of the*
23 *date of receipt of such inquiries.*

24 “(3) *RESPONSE TO TOLL-FREE LINES.—The Sec-*
25 *retary shall ensure that each medicare administrative*

1 contractor shall provide, for those providers of services
2 and suppliers which submit claims to the contractor
3 for claims processing and for those individuals enti-
4 tled to benefits under part A or enrolled under part
5 B, or both, with respect to whom claims are submitted
6 for claims processing, a toll-free telephone number at
7 which such individuals, providers of services and sup-
8 pliers may obtain information regarding billing, cod-
9 ing, claims, coverage, and other appropriate informa-
10 tion under this title.

11 “(4) MONITORING OF CONTRACTOR RE-
12 SPONSES.—

13 “(A) IN GENERAL.—Each medicare admin-
14 istrative contractor shall, consistent with stand-
15 ards developed by the Secretary under subpara-
16 graph (B)—

17 “(i) maintain a system for identifying
18 who provides the information referred to in
19 paragraphs (2) and (3); and

20 “(ii) monitor the accuracy, consist-
21 ency, and timeliness of the information so
22 provided.

23 “(B) DEVELOPMENT OF STANDARDS.—

24 “(i) IN GENERAL.—The Secretary shall
25 establish and make public standards to

1 *monitor the accuracy, consistency, and*
2 *timeliness of the information provided in*
3 *response to written and telephone inquiries*
4 *under this subsection. Such standards shall*
5 *be consistent with the performance require-*
6 *ments established under subsection (b)(3).*

7 “(i) *EVALUATION.*—*In conducting*
8 *evaluations of individual medicare admin-*
9 *istrative contractors, the Secretary shall*
10 *take into account the results of the moni-*
11 *toring conducted under subparagraph (A)*
12 *taking into account as performance require-*
13 *ments the standards established under*
14 *clause (i). The Secretary shall, in consulta-*
15 *tion with organizations representing pro-*
16 *viders of services, suppliers, and individuals*
17 *entitled to benefits under part A or enrolled*
18 *under part B, or both, establish standards*
19 *relating to the accuracy, consistency, and*
20 *timeliness of the information so provided.*

21 “(C) *DIRECT MONITORING.*—*Nothing in this*
22 *paragraph shall be construed as preventing the*
23 *Secretary from directly monitoring the accuracy,*
24 *consistency, and timeliness of the information so*
25 *provided.”.*

1 (2) *EFFECTIVE DATE.*—*The amendment made by*
2 *paragraph (1) shall take effect October 1, 2003.*

3 (3) *APPLICATION TO FISCAL INTERMEDIARIES*
4 *AND CARRIERS.*—*The provisions of section 1874A(g)*
5 *of the Social Security Act, as added by paragraph*
6 *(1), shall apply to each fiscal intermediary under sec-*
7 *tion 1816 of the Social Security Act (42 U.S.C.*
8 *1395h) and each carrier under section 1842 of such*
9 *Act (42 U.S.C. 1395u) in the same manner as they*
10 *apply to medicare administrative contractors under*
11 *such provisions.*

12 (d) *IMPROVED PROVIDER EDUCATION AND TRAIN-*
13 *ING.*—

14 (1) *IN GENERAL.*—*Section 1889, as added by*
15 *subsection (a), is amended by adding at the end the*
16 *following new subsections:*

17 “(b) *ENHANCED EDUCATION AND TRAINING.*—

18 (1) *ADDITIONAL RESOURCES.*—*There are au-*
19 *thorized to be appropriated to the Secretary (in ap-*
20 *propriate part from the Federal Hospital Insurance*
21 *Trust Fund and the Federal Supplementary Medical*
22 *Insurance Trust Fund) \$25,000,000 for each of fiscal*
23 *years 2004 and 2005 and such sums as may be nec-*
24 *essary for succeeding fiscal years.*

1 “(2) *USE.*—*The funds made available under*
2 *paragraph (1) shall be used to increase the conduct by*
3 *medicare contractors of education and training of*
4 *providers of services and suppliers regarding billing,*
5 *coding, and other appropriate items and may also be*
6 *used to improve the accuracy, consistency, and timeli-*
7 *ness of contractor responses.*

8 “(c) *TAILORING EDUCATION AND TRAINING ACTIVI-*
9 *TIES FOR SMALL PROVIDERS OR SUPPLIERS.*—

10 “(1) *IN GENERAL.*—*Insofar as a medicare con-*
11 *tractor conducts education and training activities, it*
12 *shall tailor such activities to meet the special needs*
13 *of small providers of services or suppliers (as defined*
14 *in paragraph (2)).*

15 “(2) *SMALL PROVIDER OF SERVICES OR SUP-*
16 *PLIER.*—*In this subsection, the term ‘small provider*
17 *of services or supplier’ means—*

18 “(A) *a provider of services with fewer than*
19 *25 full-time-equivalent employees; or*

20 “(B) *a supplier with fewer than 10 full-*
21 *time-equivalent employees.”.*

22 “(2) *EFFECTIVE DATE.*—*The amendment made by*
23 *paragraph (1) shall take effect on October 1, 2003.*

24 “(e) *REQUIREMENT TO MAINTAIN INTERNET SITES.*—

1 (1) *IN GENERAL.*—Section 1889, as added by
2 subsection (a) and as amended by subsection (d), is
3 further amended by adding at the end the following
4 new subsection:

5 “(d) *INTERNET SITES; FAQs.*—The Secretary, and
6 each medicare contractor insofar as it provides services (in-
7 cluding claims processing) for providers of services or sup-
8 pliers, shall maintain an Internet site which—

9 “(1) provides answers in an easily accessible for-
10 mat to frequently asked questions, and

11 “(2) includes other published materials of the
12 contractor,

13 that relate to providers of services and suppliers under the
14 programs under this title (and title XI insofar as it relates
15 to such programs).”.

16 (2) *EFFECTIVE DATE.*—The amendment made by
17 paragraph (1) shall take effect on October 1, 2003.

18 (f) *ADDITIONAL PROVIDER EDUCATION PROVISIONS.*—

19 (1) *IN GENERAL.*—Section 1889, as added by
20 subsection (a) and as amended by subsections (d) and
21 (e), is further amended by adding at the end the fol-
22 lowing new subsections:

23 “(e) *ENCOURAGEMENT OF PARTICIPATION IN EDU-*
24 *CATION PROGRAM ACTIVITIES.*—A medicare contractor
25 may not use a record of attendance at (or failure to attend)

1 *educational activities or other information gathered during*
2 *an educational program conducted under this section or*
3 *otherwise by the Secretary to select or track providers of*
4 *services or suppliers for the purpose of conducting any type*
5 *of audit or prepayment review.*

6 “(f) *CONSTRUCTION.*—*Nothing in this section or sec-*
7 *tion 1893(g) shall be construed as providing for disclosure*
8 *by a medicare contractor of information that would com-*
9 *promise pending law enforcement activities or reveal find-*
10 *ings of law enforcement-related audits.*

11 “(g) *DEFINITIONS.*—*For purposes of this section, the*
12 *term ‘medicare contractor’ includes the following:*

13 “(1) *A medicare administrative contractor with*
14 *a contract under section 1874A, including a fiscal*
15 *intermediary with a contract under section 1816 and*
16 *a carrier with a contract under section 1842.*

17 “(2) *An eligible entity with a contract under sec-*
18 *tion 1893.*

19 *Such term does not include, with respect to activities of a*
20 *specific provider of services or supplier an entity that has*
21 *no authority under this title or title IX with respect to such*
22 *activities and such provider of services or supplier.”.*

23 (2) *EFFECTIVE DATE.*—*The amendment made by*
24 *paragraph (1) shall take effect on the date of the en-*
25 *actment of this Act.*

1 **SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**
2 **ONSTRATION PROGRAM.**

3 (a) *ESTABLISHMENT.*—

4 (1) *IN GENERAL.*—*The Secretary shall establish*
5 *a demonstration program (in this section referred to*
6 *as the “demonstration program”) under which tech-*
7 *nical assistance described in paragraph (2) is made*
8 *available, upon request and on a voluntary basis, to*
9 *small providers of services or suppliers in order to*
10 *improve compliance with the applicable requirements*
11 *of the programs under medicare program under title*
12 *XVIII of the Social Security Act (including provi-*
13 *sions of title XI of such Act insofar as they relate to*
14 *such title and are not administered by the Office of*
15 *the Inspector General of the Department of Health*
16 *and Human Services).*

17 (2) *FORMS OF TECHNICAL ASSISTANCE.*—*The*
18 *technical assistance described in this paragraph is—*

19 (A) *evaluation and recommendations re-*
20 *garding billing and related systems; and*

21 (B) *information and assistance regarding*
22 *policies and procedures under the medicare pro-*
23 *gram, including coding and reimbursement.*

24 (3) *SMALL PROVIDERS OF SERVICES OR SUP-*
25 *PLIERS.*—*In this section, the term “small providers of*
26 *services or suppliers” 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-time-
4 equivalent employees.

5 (b) *QUALIFICATION OF CONTRACTORS.*—In conducting
6 the demonstration program, the Secretary shall enter into
7 contracts with qualified organizations (such as peer review
8 organizations or entities described in section 1889(g)(2) of
9 the Social Security Act, as inserted by section 5(f)(1)) with
10 appropriate expertise with billing systems of the full range
11 of providers of services and suppliers to provide the tech-
12 nical assistance. In awarding such contracts, the Secretary
13 shall consider any prior investigations of the entity’s work
14 by the Inspector General of Department of Health and
15 Human Services or the Comptroller General of the United
16 States.

17 (c) *DESCRIPTION OF TECHNICAL ASSISTANCE.*—The
18 technical assistance provided under the demonstration pro-
19 gram shall include a direct and in-person examination of
20 billing systems and internal controls of small providers of
21 services or suppliers to determine program compliance and
22 to suggest more efficient or effective means of achieving such
23 compliance.

24 (d) *AVOIDANCE OF RECOVERY ACTIONS FOR PROB-*
25 *LEMS IDENTIFIED AS CORRECTED.*—The Secretary shall

1 *provide that, absent evidence of fraud and notwithstanding*
2 *any other provision of law, any errors found in a compli-*
3 *ance review for a small provider of services or supplier that*
4 *participates in the demonstration program shall not be sub-*
5 *ject to recovery action if the technical assistance personnel*
6 *under the program determine that—*

7 (1) *the problem that is the subject of the compli-*
8 *ance review has been corrected to their satisfaction*
9 *within 30 days of the date of the visit by such per-*
10 *sonnel to the small provider of services or supplier;*
11 *and*

12 (2) *such problem remains corrected for such pe-*
13 *riod as is appropriate.*

14 *The previous sentence applies only to claims filed as part*
15 *of the demonstration program and lasts only for the dura-*
16 *tion of such program and only as long as the small provider*
17 *of services or supplier is a participant in such program.*

18 (e) *GAO EVALUATION.—Not later than 2 years after*
19 *the date of the date the demonstration program is first im-*
20 *plemented, the Comptroller General, in consultation with*
21 *the Inspector General of the Department of Health and*
22 *Human Services, shall conduct an evaluation of the dem-*
23 *onstration program. The evaluation shall include a deter-*
24 *mination of whether claims error rates are reduced for*
25 *small providers of services or suppliers who participated*

1 *in the program and the extent of improper payments made*
2 *as a result of the demonstration program. The Comptroller*
3 *General shall submit a report to the Secretary and the Con-*
4 *gress on such evaluation and shall include in such report*
5 *recommendations regarding the continuation or extension*
6 *of the demonstration program.*

7 (f) *FINANCIAL PARTICIPATION BY PROVIDERS.—The*
8 *provision of technical assistance to a small provider of serv-*
9 *ices or supplier under the demonstration program is condi-*
10 *tioned upon the small provider of services or supplier pay-*
11 *ing an amount estimated (and disclosed in advance of a*
12 *provider's or supplier's participation in the program) to*
13 *be equal to 25 percent of the cost of the technical assistance.*

14 (g) *AUTHORIZATION OF APPROPRIATIONS.—There are*
15 *authorized to be appropriated to the Secretary (in appro-*
16 *priate part from the Federal Hospital Insurance Trust*
17 *Fund and the Federal Supplementary Medical Insurance*
18 *Trust Fund) to carry out the demonstration program—*

19 (1) *for fiscal year 2004, \$1,000,000, and*

20 (2) *for fiscal year 2005, \$6,000,000.*

21 **SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**
22 **BENEFICIARY OMBUDSMAN.**

23 (a) *MEDICARE PROVIDER OMBUDSMAN.—Section 1868*
24 *(42 U.S.C. 1395ee) is amended—*

1 (1) *by adding at the end of the heading the fol-*
2 *lowing: “; MEDICARE PROVIDER OMBUDSMAN”;*

3 (2) *by inserting “PRACTICING PHYSICIANS ADVI-*
4 *SORY COUNCIL.—(1)” after “(a)”;*

5 (3) *in paragraph (1), as so redesignated under*
6 *paragraph (2), by striking “in this section” and in-*
7 *serting “in this subsection”;*

8 (4) *by redesignating subsections (b) and (c) as*
9 *paragraphs (2) and (3), respectively; and*

10 (5) *by adding at the end the following new sub-*
11 *section:*

12 “(b) *MEDICARE PROVIDER OMBUDSMAN.—The Sec-*
13 *retary shall appoint within the Department of Health and*
14 *Human Services a Medicare Provider Ombudsman. The*
15 *Ombudsman shall—*

16 “(1) *provide assistance, on a confidential basis,*
17 *to providers of services and suppliers with respect to*
18 *complaints, grievances, and requests for information*
19 *concerning the programs under this title (including*
20 *provisions of title XI insofar as they relate to this*
21 *title and are not administered by the Office of the In-*
22 *pector General of the Department of Health and*
23 *Human Services) and in the resolution of unclear or*
24 *conflicting guidance given by the Secretary and medi-*
25 *care contractors to such providers of services and sup-*

1 *pliers regarding such programs and provisions and*
2 *requirements under this title and such provisions;*
3 *and*

4 *“(2) submit recommendations to the Secretary*
5 *for improvement in the administration of this title*
6 *and such provisions, including—*

7 *“(A) recommendations to respond to recur-*
8 *ring patterns of confusion in this title and such*
9 *provisions (including recommendations regard-*
10 *ing suspending imposition of sanctions where*
11 *there is widespread confusion in program ad-*
12 *ministration), and*

13 *“(B) recommendations to provide for an ap-*
14 *propriate and consistent response (including not*
15 *providing for audits) in cases of self-identified*
16 *overpayments by providers of services and sup-*
17 *pliers.*

18 *The Ombudsman shall not serve as an advocate for any in-*
19 *creases in payments or new coverage of services, but may*
20 *identify issues and problems in payment or coverage poli-*
21 *cies.”.*

22 *(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title*
23 *XVIII, as amended by sections 105 and 701, is amended*
24 *by inserting after section 1808 the following new section:*

1 “MEDICARE BENEFICIARY OMBUDSMAN

2 “SEC. 1809. (a) IN GENERAL.—The Secretary shall
3 appoint within the Department of Health and Human
4 Services a Medicare Beneficiary Ombudsman who shall
5 have expertise and experience in the fields of health care
6 and education of (and assistance to) individuals entitled
7 to benefits under this title.

8 “(b) DUTIES.—The Medicare Beneficiary Ombudsman
9 shall—

10 “(1) receive complaints, grievances, and requests
11 for information submitted by individuals entitled to
12 benefits under part A or enrolled under part B, or
13 both, with respect to any aspect of the medicare pro-
14 gram;

15 “(2) provide assistance with respect to com-
16 plaints, grievances, and requests referred to in para-
17 graph (1), including—

18 “(A) assistance in collecting relevant infor-
19 mation for such individuals, to seek an appeal of
20 a decision or determination made by a fiscal
21 intermediary, carrier, Medicare+Choice organi-
22 zation, or the Secretary; and

23 “(B) assistance to such individuals with
24 any problems arising from disenrollment from a
25 Medicare+Choice plan under part C; and

1 “(3) submit annual reports to Congress and the
2 Secretary that describe the activities of the Office and
3 that include such recommendations for improvement
4 in the administration of this title as the Ombudsman
5 determines appropriate.

6 The Ombudsman shall not serve as an advocate for any in-
7 creases in payments or new coverage of services, but may
8 identify issues and problems in payment or coverage poli-
9 cies.

10 “(c) WORKING WITH HEALTH INSURANCE COUN-
11 SELING PROGRAMS.—To the extent possible, the Ombuds-
12 man shall work with health insurance counseling programs
13 (receiving funding under section 4360 of Omnibus Budget
14 Reconciliation Act of 1990) to facilitate the provision of in-
15 formation to individuals entitled to benefits under part A
16 or enrolled under part B, or both regarding
17 Medicare+Choice plans and changes to those plans. Noth-
18 ing in this subsection shall preclude further collaboration
19 between the Ombudsman and such programs.”.

20 (c) DEADLINE FOR APPOINTMENT.—The Secretary
21 shall appoint the Medicare Provider Ombudsman and the
22 Medicare Beneficiary Ombudsman, under the amendments
23 made by subsections (a) and (b), respectively, by not later
24 than 1 year after the date of the enactment of this Act.

1 (d) *FUNDING.*—*There are authorized to be appro-*
2 *priated to the Secretary (in appropriate part from the Fed-*
3 *eral Hospital Insurance Trust Fund and the Federal Sup-*
4 *plementary Medical Insurance Trust Fund) to carry out*
5 *the provisions of subsection (b) of section 1868 of the Social*
6 *Security Act (relating to the Medicare Provider Ombuds-*
7 *man), as added by subsection (a)(5) and section 1809 of*
8 *such Act (relating to the Medicare Beneficiary Ombuds-*
9 *man), as added by subsection (b), such sums as are nec-*
10 *essary for fiscal year 2003 and each succeeding fiscal year.*

11 (e) *USE OF CENTRAL, TOLL-FREE NUMBER (1-800-*
12 *MEDICARE).*—

13 (1) *PHONE TRIAGE SYSTEM; LISTING IN MEDI-*
14 *CARE HANDBOOK INSTEAD OF OTHER TOLL-FREE*
15 *NUMBERS.*—*Section 1804(b) (42 U.S.C. 1395b–2(b))*
16 *is amended by adding at the end the following: “The*
17 *Secretary shall provide, through the toll-free number*
18 *1-800-MEDICARE, for a means by which individuals*
19 *seeking information about, or assistance with, such*
20 *programs who phone such toll-free number are trans-*
21 *ferred (without charge) to appropriate entities for the*
22 *provision of such information or assistance. Such toll-*
23 *free number shall be the toll-free number listed for*
24 *general information and assistance in the annual no-*

1 *Services provide advice and assistance to individuals enti-*
2 *tled to benefits under part A of title XVIII of the Social*
3 *Security Act, or enrolled under part B of such title, or both,*
4 *regarding the medicare program at the location of existing*
5 *local offices of the Social Security Administration.*

6 (b) *LOCATIONS.—*

7 (1) *IN GENERAL.—The demonstration program*
8 *shall be conducted in at least 6 offices or areas. Sub-*
9 *ject to paragraph (2), in selecting such offices and*
10 *areas, the Secretary shall provide preference for offices*
11 *with a high volume of visits by individuals referred*
12 *to in subsection (a).*

13 (2) *ASSISTANCE FOR RURAL BENEFICIARIES.—*
14 *The Secretary shall provide for the selection of at*
15 *least 2 rural areas to participate in the demonstra-*
16 *tion program. In conducting the demonstration pro-*
17 *gram in such rural areas, the Secretary shall provide*
18 *for medicare specialists to travel among local offices*
19 *in a rural area on a scheduled basis.*

20 (c) *DURATION.—The demonstration program shall be*
21 *conducted over a 3-year period.*

22 (d) *EVALUATION AND REPORT.—*

23 (1) *EVALUATION.—The Secretary shall provide*
24 *for an evaluation of the demonstration program. Such*
25 *evaluation shall include an analysis of—*

1 (A) utilization of, and satisfaction of those
2 individuals referred to in subsection (a) with, the
3 assistance provided under the program; and

4 (B) the cost-effectiveness of providing bene-
5 ficiary assistance through out-stationing medi-
6 care specialists at local offices of the Social Secu-
7 rity Administration.

8 (2) *REPORT.*—The Secretary shall submit to
9 Congress a report on such evaluation and shall in-
10 clude in such report recommendations regarding the
11 feasibility of permanently out-stationing medicare
12 specialists at local offices of the Social Security Ad-
13 ministration.

14 ***Subtitle D—Appeals and Recovery***

15 **SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDICARE**

16 **APPEALS.**

17 (a) *TRANSITION PLAN.*—

18 (1) *IN GENERAL.*—Not later than October 1,
19 2003, the Commissioner of Social Security and the
20 Secretary shall develop and transmit to Congress and
21 the Comptroller General of the United States a plan
22 under which the functions of administrative law
23 judges responsible for hearing cases under title XVIII
24 of the Social Security Act (and related provisions in
25 title XI of such Act) are transferred from the responsi-

1 *bility of the Commissioner and the Social Security*
2 *Administration to the Secretary and the Department*
3 *of Health and Human Services.*

4 (2) *GAO EVALUATION.—The Comptroller Gen-*
5 *eral of the United States shall evaluate the plan and,*
6 *not later than the date that is 6 months after the date*
7 *on which the plan is received by the Comptroller Gen-*
8 *eral, shall submit to Congress a report on such eval-*
9 *uation.*

10 (b) *TRANSFER OF ADJUDICATION AUTHORITY.—*

11 (1) *IN GENERAL.—Not earlier than July 1, 2004,*
12 *and not later than October 1, 2004, the Commissioner*
13 *of Social Security and the Secretary shall implement*
14 *the transition plan under subsection (a) and transfer*
15 *the administrative law judge functions described in*
16 *such subsection from the Social Security Administra-*
17 *tion to the Secretary.*

18 (2) *ASSURING INDEPENDENCE OF JUDGES.—The*
19 *Secretary shall assure the independence of adminis-*
20 *trative law judges performing the administrative law*
21 *judge functions transferred under paragraph (1) from*
22 *the Centers for Medicare & Medicaid Services and its*
23 *contractors.*

24 (3) *GEOGRAPHIC DISTRIBUTION.—The Secretary*
25 *shall provide for an appropriate geographic distribu-*

1 *tion of administrative law judges performing the ad-*
2 *ministrative law judge functions transferred under*
3 *paragraph (1) throughout the United States to ensure*
4 *timely access to such judges.*

5 (4) *HIRING AUTHORITY.*—*Subject to the amounts*
6 *provided in advance in appropriations Act, the Sec-*
7 *retary shall have authority to hire administrative law*
8 *judges to hear such cases, giving priority to those*
9 *judges with prior experience in handling medicare*
10 *appeals and in a manner consistent with paragraph*
11 *(3), and to hire support staff for such judges.*

12 (5) *FINANCING.*—*Amounts payable under law to*
13 *the Commissioner for administrative law judges per-*
14 *forming the administrative law judge functions trans-*
15 *ferred under paragraph (1) from the Federal Hospital*
16 *Insurance Trust Fund and the Federal Supple-*
17 *mentary Medical Insurance Trust Fund shall become*
18 *payable to the Secretary for the functions so trans-*
19 *ferred.*

20 (6) *SHARED RESOURCES.*—*The Secretary shall*
21 *enter into such arrangements with the Commissioner*
22 *as may be appropriate with respect to transferred*
23 *functions of administrative law judges to share office*
24 *space, support staff, and other resources, with appro-*

1 *appropriate reimbursement from the Trust Funds described*
2 *in paragraph (5).*

3 *(c) INCREASED FINANCIAL SUPPORT.—In addition to*
4 *any amounts otherwise appropriated, to ensure timely ac-*
5 *tion on appeals before administrative law judges and the*
6 *Departmental Appeals Board consistent with section 1869*
7 *of the Social Security Act (as amended by section 521 of*
8 *BIPA, 114 Stat. 2763A–534), there are authorized to be ap-*
9 *propriated (in appropriate part from the Federal Hospital*
10 *Insurance Trust Fund and the Federal Supplementary*
11 *Medical Insurance Trust Fund) to the Secretary such sums*
12 *as are necessary for fiscal year 2004 and each subsequent*
13 *fiscal year to—*

14 *(1) increase the number of administrative law*
15 *judges (and their staffs) under subsection (b)(4);*

16 *(2) improve education and training opportuni-*
17 *ties for administrative law judges (and their staffs);*
18 *and*

19 *(3) increase the staff of the Departmental Ap-*
20 *peals Board.*

21 *(d) CONFORMING AMENDMENT.—Section*
22 *1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by*
23 *section 522(a) of BIPA (114 Stat. 2763A–543), is amended*
24 *by striking “of the Social Security Administration”.*

1 **SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

2 (a) *EXPEDITED ACCESS TO JUDICIAL REVIEW.*—*Sec-*
3 *tion 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA,*
4 *is amended—*

5 (1) *in paragraph (1)(A), by inserting “, subject*
6 *to paragraph (2),” before “to judicial review of the*
7 *Secretary’s final decision”;*

8 (2) *in paragraph (1)(F)—*

9 (A) *by striking clause (ii);*

10 (B) *by striking “PROCEEDING” and all that*
11 *follows through “DETERMINATION” and inserting*
12 *“DETERMINATIONS AND RECONSIDERATIONS”;*
13 *and*

14 (C) *by redesignating subclauses (I) and (II)*
15 *as clauses (i) and (ii) and by moving the inden-*
16 *tation of such subclauses (and the matter that*
17 *follows) 2 ems to the left; and*

18 (3) *by adding at the end the following new para-*
19 *graph:*

20 “(2) *EXPEDITED ACCESS TO JUDICIAL RE-*
21 *VIEW.—*

22 “(A) *IN GENERAL.—The Secretary shall es-*
23 *tablish a process under which a provider of serv-*
24 *ices or supplier that furnishes an item or service*
25 *or an individual entitled to benefits under part*
26 *A or enrolled under part B, or both, who has*

1 *filed an appeal under paragraph (1) may obtain*
2 *access to judicial review when a review panel*
3 *(described in subparagraph (D)), on its own mo-*
4 *tion or at the request of the appellant, deter-*
5 *mines that no entity in the administrative ap-*
6 *peals process has the authority to decide the*
7 *question of law or regulation relevant to the mat-*
8 *ters in controversy and that there is no material*
9 *issue of fact in dispute. The appellant may make*
10 *such request only once with respect to a question*
11 *of law or regulation in a case of an appeal.*

12 “(B) *PROMPT DETERMINATIONS.—If, after*
13 *or coincident with appropriately filing a request*
14 *for an administrative hearing, the appellant re-*
15 *quests a determination by the appropriate review*
16 *panel that no review panel has the authority to*
17 *decide the question of law or regulations relevant*
18 *to the matters in controversy and that there is*
19 *no material issue of fact in dispute and if such*
20 *request is accompanied by the documents and*
21 *materials as the appropriate review panel shall*
22 *require for purposes of making such determina-*
23 *tion, such review panel shall make a determina-*
24 *tion on the request in writing within 60 days*
25 *after the date such review panel receives the re-*

1 *quest and such accompanying documents and*
2 *materials. Such a determination by such review*
3 *panel shall be considered a final decision and*
4 *not subject to review by the Secretary.*

5 “(C) *ACCESS TO JUDICIAL REVIEW.*—

6 “(i) *IN GENERAL.*—*If the appropriate*
7 *review panel—*

8 “(I) *determines that there are no*
9 *material issues of fact in dispute and*
10 *that the only issue is one of law or reg-*
11 *ulation that no review panel has the*
12 *authority to decide; or*

13 “(II) *fails to make such deter-*
14 *mination within the period provided*
15 *under subparagraph (B);*

16 *then the appellant may bring a civil action*
17 *as described in this subparagraph.*

18 “(ii) *DEADLINE FOR FILING.*—*Such*
19 *action shall be filed, in the case described*
20 *in—*

21 “(I) *clause (i)(I), within 60 days*
22 *of date of the determination described*
23 *in such subparagraph; or*

24 “(II) *clause (i)(II), within 60*
25 *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 ap-
8 plicant, 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 or
14 supplier seeks judicial review pursuant to
15 this paragraph, the amount in controversy
16 shall be subject to annual interest beginning
17 on the first day of the first month beginning
18 after the 60-day period as determined pur-
19 suant to clause (ii) and equal to the rate of
20 interest on obligations issued for purchase
21 by the Federal Hospital Insurance Trust
22 Fund and by the Federal Supplementary
23 Medical Insurance Trust Fund for the
24 month in which the civil action authorized
25 under this paragraph is commenced, to be

1 awarded by the reviewing court in favor of
2 the prevailing party. No interest awarded
3 pursuant to the preceding sentence shall be
4 deemed income or cost for the purposes of
5 determining reimbursement due providers of
6 services or suppliers under this Act.

7 “(D) *REVIEW PANELS.*—For purposes of
8 this subsection, a ‘review panel’ is a panel con-
9 sisting of 3 members (who shall be administra-
10 tive law judges, members of the Departmental
11 Appeals Board, or qualified individuals associ-
12 ated with a qualified independent contractor (as
13 defined in subsection (c)(2)) or with another
14 independent entity) designated by the Secretary
15 for purposes of making determinations under
16 this paragraph.”.

17 (b) *APPLICATION TO PROVIDER AGREEMENT DETER-*
18 *MINATIONS.*—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1))
19 *is amended—*

20 (1) by inserting “(A)” after “(h)(1)”; and

21 (2) by adding at the end the following new sub-
22 paragraph:

23 “(B) An institution or agency described in subpara-
24 graph (A) that has filed for a hearing under subparagraph
25 (A) shall have expedited access to judicial review under this

1 *subparagraph in the same manner as providers of services,*
2 *suppliers, and individuals entitled to benefits under part*
3 *A or enrolled under part B, or both, may obtain expedited*
4 *access to judicial review under the process established under*
5 *section 1869(b)(2). Nothing in this subparagraph shall be*
6 *construed to affect the application of any remedy imposed*
7 *under section 1819 during the pendency of an appeal under*
8 *this subparagraph.”.*

9 (c) *EFFECTIVE DATE.*—*The amendments made by this*
10 *section shall apply to appeals filed on or after October 1,*
11 *2003.*

12 (d) *EXPEDITED REVIEW OF CERTAIN PROVIDER*
13 *AGREEMENT DETERMINATIONS.*—

14 (1) *TERMINATION AND CERTAIN OTHER IMME-*
15 *DIATE REMEDIES.*—*The Secretary shall develop and*
16 *implement a process to expedite proceedings under*
17 *sections 1866(h) of the Social Security Act (42 U.S.C.*
18 *1395cc(h)) in which the remedy of termination of*
19 *participation, or a remedy described in clause (i) or*
20 *(iii) of section 1819(h)(2)(B) of such Act (42 U.S.C.*
21 *1395i–3(h)(2)(B)) which is applied on an immediate*
22 *basis, has been imposed. Under such process priority*
23 *shall be provided in cases of termination.*

24 (2) *INCREASED FINANCIAL SUPPORT.*—*In addi-*
25 *tion to any amounts otherwise appropriated, to re-*

1 duce by 50 percent the average time for administra-
2 tive determinations on appeals under section 1866(h)
3 of the Social Security Act (42 U.S.C. 1395cc(h)),
4 there are authorized to be appropriated (in appro-
5 priate part from the Federal Hospital Insurance
6 Trust Fund and the Federal Supplementary Medical
7 Insurance Trust Fund) to the Secretary such addi-
8 tional sums for fiscal year 2004 and each subsequent
9 fiscal year as may be necessary. The purposes for
10 which such amounts are available include increasing
11 the number of administrative law judges (and their
12 staffs) and the appellate level staff at the Depart-
13 mental Appeals Board of the Department of Health
14 and Human Services and educating such judges and
15 staffs on long-term care issues.

16 **SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.**

17 (a) *REQUIRING FULL AND EARLY PRESENTATION OF*
18 *EVIDENCE.*—

19 (1) *IN GENERAL.*—Section 1869(b) (42 U.S.C.
20 1395ff(b)), as amended by BIPA and as amended by
21 section 832(a), is further amended by adding at the
22 end the following new paragraph:

23 “(3) *REQUIRING FULL AND EARLY PRESEN-*
24 *TATION OF EVIDENCE BY PROVIDERS.*—A provider of
25 services or supplier may not introduce evidence in

1 *any appeal under this section that was not presented*
2 *at the reconsideration conducted by the qualified*
3 *independent contractor under subsection (c), unless*
4 *there is good cause which precluded the introduction*
5 *of such evidence at or before that reconsideration.”.*

6 (2) *EFFECTIVE DATE.*—*The amendment made by*
7 *paragraph (1) shall take effect on October 1, 2003.*

8 (b) *USE OF PATIENTS’ MEDICAL RECORDS.*—*Section*
9 *1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended*
10 *by BIPA, is amended by inserting “(including the medical*
11 *records of the individual involved)” after “clinical experi-*
12 *ence”.*

13 (c) *NOTICE REQUIREMENTS FOR MEDICARE AP-*
14 *PEALS.*—

15 (1) *INITIAL DETERMINATIONS AND REDETER-*
16 *MINATIONS.*—*Section 1869(a) (42 U.S.C. 1395ff(a)),*
17 *as amended by BIPA, is amended by adding at the*
18 *end the following new paragraph:*

19 “(4) *REQUIREMENTS OF NOTICE OF DETERMINA-*
20 *TIONS AND REDETERMINATIONS.*—*A written notice of*
21 *a determination on an initial determination or on a*
22 *redetermination, insofar as such determination or re-*
23 *determination results in a denial of a claim for bene-*
24 *fits, shall include—*

1 “(A) the specific reasons for the determina-
2 tion, including—

3 “(i) upon request, the provision of the
4 policy, manual, or regulation used in mak-
5 ing the determination; and

6 “(ii) as appropriate in the case of a re-
7 determination, a summary of the clinical or
8 scientific evidence used in making the deter-
9 mination;

10 “(B) the procedures for obtaining addi-
11 tional information concerning the determination
12 or redetermination; and

13 “(C) notification of the right to seek a rede-
14 termination or otherwise appeal the determina-
15 tion and instructions on how to initiate such a
16 redetermination or appeal under this section.

17 *The written notice on a redetermination shall be pro-*
18 *vided in printed form and written in a manner cal-*
19 *culated to be understood by the individual entitled to*
20 *benefits under part A or enrolled under part B, or*
21 *both.”.*

22 (2) *RECONSIDERATIONS.—Section 1869(c)(3)(E)*
23 *(42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is*
24 *amended—*

1 (A) by inserting “be written in a manner
2 calculated to be understood by the individual en-
3 titled to benefits under part A or enrolled under
4 part B, or both, and shall include (to the extent
5 appropriate)” after “in writing, ”; and

6 (B) by inserting “and a notification of the
7 right to appeal such determination and instruc-
8 tions on how to initiate such appeal under this
9 section” after “such decision, ”.

10 (3) *APPEALS*.—Section 1869(d) (42 U.S.C.
11 1395ff(d)), as amended by BIPA, is amended—

12 (A) in the heading, by inserting “; NOTICE”
13 after “SECRETARY”; and

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

16 “(4) *NOTICE*.—Notice of the decision of an ad-
17 ministrative law judge shall be in writing in a man-
18 ner calculated to be understood by the individual en-
19 titled to benefits under part A or enrolled under part
20 B, or both, and shall include—

21 “(A) the specific reasons for the determina-
22 tion (including, to the extent appropriate, a
23 summary of the clinical or scientific evidence
24 used in making the determination);

1 “(B) the procedures for obtaining addi-
2 tional information concerning the decision; and

3 “(C) notification of the right to appeal the
4 decision and instructions on how to initiate such
5 an appeal under this section.”.

6 (4) *SUBMISSION OF RECORD FOR APPEAL.*—*Sec-*
7 *tion 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by*
8 *striking “prepare” and inserting “submit” and by*
9 *striking “with respect to” and all that follows through*
10 *“and relevant policies”.*

11 (d) *QUALIFIED INDEPENDENT CONTRACTORS.*—

12 (1) *ELIGIBILITY REQUIREMENTS OF QUALIFIED*
13 *INDEPENDENT CONTRACTORS.*—*Section 1869(c)(3) (42*
14 *U.S.C. 1395ff(c)(3)), as amended by BIPA, is*
15 *amended—*

16 (A) in subparagraph (A), by striking “suffi-
17 cient training and expertise in medical science
18 and legal matters” and inserting “sufficient
19 medical, legal, and other expertise (including
20 knowledge of the program under this title) and
21 sufficient staffing”; and

22 (B) by adding at the end the following new
23 subparagraph:

24 “(K) *INDEPENDENCE REQUIREMENTS.*—

1 “(i) *IN GENERAL.*—*Subject to clause*
2 *(ii), a qualified independent contractor*
3 *shall not conduct any activities in a case*
4 *unless the entity—*

5 “(I) *is not a related party (as de-*
6 *defined in subsection (g)(5));*

7 “(II) *does not have a material fa-*
8 *miliar, financial, or professional rela-*
9 *tionship with such a party in relation*
10 *to such case; and*

11 “(III) *does not otherwise have a*
12 *conflict of interest with such a party.*

13 “(ii) *EXCEPTION FOR REASONABLE*
14 *COMPENSATION.*—*Nothing in clause (i) shall*
15 *be construed to prohibit receipt by a quali-*
16 *fied independent contractor of compensation*
17 *from the Secretary for the conduct of activi-*
18 *ties under this section if the compensation*
19 *is provided consistent with clause (iii).*

20 “(iii) *LIMITATIONS ON ENTITY COM-*
21 *PENSATION.*—*Compensation provided by the*
22 *Secretary to a qualified independent con-*
23 *tractor in connection with reviews under*
24 *this section shall not be contingent on any*

1 *decision rendered by the contractor or by*
2 *any reviewing professional.”.*

3 (2) *ELIGIBILITY REQUIREMENTS FOR REVIEW-*
4 *ERS.—Section 1869 (42 U.S.C. 1395ff), as amended*
5 *by BIPA, is amended—*

6 (A) *by amending subsection (c)(3)(D) to*
7 *read as follows:*

8 “(D) *QUALIFICATIONS FOR REVIEWERS.—*
9 *The requirements of subsection (g) shall be met*
10 *(relating to qualifications of reviewing profes-*
11 *sionals).”; and*

12 (B) *by adding at the end the following new*
13 *subsection:*

14 “(g) *QUALIFICATIONS OF REVIEWERS.—*

15 “(1) *IN GENERAL.—In reviewing determinations*
16 *under this section, a qualified independent contractor*
17 *shall assure that—*

18 (A) *each individual conducting a review*
19 *shall meet the qualifications of paragraph (2);*

20 (B) *compensation provided by the con-*
21 *tractor to each such reviewer is consistent with*
22 *paragraph (3); and*

23 (C) *in the case of a review by a panel de-*
24 *scribed in subsection (c)(3)(B) composed of phy-*
25 *sicians or other health care professionals (each in*

1 *this subsection referred to as a ‘reviewing profes-*
2 *sional’), each reviewing professional meets the*
3 *qualifications described in paragraph (4) and,*
4 *where a claim is regarding the furnishing of*
5 *treatment by a physician (allopathic or osteo-*
6 *pathic) or the provision of items or services by*
7 *a physician (allopathic or osteopathic), each re-*
8 *viewing professional shall be a physician*
9 *(allopathic or osteopathic).*

10 “(2) *INDEPENDENCE.—*

11 “(A) *IN GENERAL.—Subject to subpara-*
12 *graph (B), each individual conducting a review*
13 *in a case shall—*

14 “(i) *not be a related party (as defined*
15 *in paragraph (5));*

16 “(ii) *not have a material familial, fi-*
17 *nancial, or professional relationship with*
18 *such a party in the case under review; and*

19 “(iii) *not otherwise have a conflict of*
20 *interest with such a party.*

21 “(B) *EXCEPTION.—Nothing in subpara-*
22 *graph (A) shall be construed to—*

23 “(i) *prohibit an individual, solely on*
24 *the basis of a participation agreement with*
25 *a fiscal intermediary, carrier, or other con-*

1 tractor, from serving as a reviewing profes-
2 sional if—

3 “(I) the individual is not involved
4 in the provision of items or services in
5 the case under review;

6 “(II) the fact of such an agree-
7 ment is disclosed to the Secretary and
8 the individual entitled to benefits
9 under part A or enrolled under part B,
10 or both, (or authorized representative)
11 and neither party objects; and

12 “(III) the individual is not an
13 employee of the intermediary, carrier,
14 or contractor and does not provide
15 services exclusively or primarily to or
16 on behalf of such intermediary, carrier,
17 or contractor;

18 “(ii) prohibit an individual who has
19 staff privileges at the institution where the
20 treatment involved takes place from serving
21 as a reviewer merely on the basis of having
22 such staff privileges if the existence of such
23 privileges is disclosed to the Secretary and
24 such individual (or authorized representa-
25 tive), and neither party objects; or

1 “(iii) prohibit receipt of compensation
2 by a reviewing professional from a con-
3 tractor if the compensation is provided con-
4 sistent with paragraph (3).

5 For purposes of this paragraph, the term ‘par-
6 ticipation agreement’ means an agreement relat-
7 ing to the provision of health care services by the
8 individual and does not include the provision of
9 services as a reviewer under this subsection.

10 “(3) *LIMITATIONS ON REVIEWER COMPENSA-*
11 *TION.*—Compensation provided by a qualified inde-
12 pendent contractor to a reviewer in connection with
13 a review under this section shall not be contingent on
14 the decision rendered by the reviewer.

15 “(4) *LICENSURE AND EXPERTISE.*—Each review-
16 ing professional shall be—

17 “(A) a physician (allopathic or osteopathic)
18 who is appropriately credentialed or licensed in
19 one or more States to deliver health care services
20 and has medical expertise in the field of practice
21 that is appropriate for the items or services at
22 issue; or

23 “(B) a health care professional who is le-
24 gally authorized in one or more States (in ac-
25 cordance with State law or the State regulatory

1 *mechanism provided by State law) to furnish the*
2 *health care items or services at issue and has*
3 *medical expertise in the field of practice that is*
4 *appropriate for such items or services.*

5 “(5) *RELATED PARTY DEFINED.*—*For purposes*
6 *of this section, the term ‘related party’ means, with*
7 *respect to a case under this title involving a specific*
8 *individual entitled to benefits under part A or en-*
9 *rolled under part B, or both, any of the following:*

10 “(A) *The Secretary, the medicare adminis-*
11 *trative contractor involved, or any fiduciary, of-*
12 *ficer, director, or employee of the Department of*
13 *Health and Human Services, or of such con-*
14 *tractor.*

15 “(B) *The individual (or authorized rep-*
16 *resentative).*

17 “(C) *The health care professional that pro-*
18 *vides the items or services involved in the case.*

19 “(D) *The institution at which the items or*
20 *services (or treatment) involved in the case are*
21 *provided.*

22 “(E) *The manufacturer of any drug or*
23 *other item that is included in the items or serv-*
24 *ices involved in the case.*

1 “(F) Any other party determined under any
2 regulations to have a substantial interest in the
3 case involved.”.

4 (3) *EFFECTIVE DATE.*—The amendments made
5 by paragraphs (1) and (2) shall be effective as if in-
6 cluded in the enactment of the respective provisions of
7 subtitle C of title V of BIPA, (114 Stat. 2763A–534).

8 (4) *TRANSITION.*—In applying section 1869(g) of
9 the Social Security Act (as added by paragraph (2)),
10 any reference to a medicare administrative contractor
11 shall be deemed to include a reference to a fiscal
12 intermediary under section 1816 of the Social Secu-
13 rity Act (42 U.S.C. 1395h) and a carrier under sec-
14 tion 1842 of such Act (42 U.S.C. 1395u).

15 **SEC. 834. PREPAYMENT REVIEW.**

16 (a) *IN GENERAL.*—Section 1874A, as added by section
17 811(a)(1) and as amended by sections 812(b), 821(b)(1),
18 and 821(c)(1), is further amended by adding at the end the
19 following new subsection:

20 “(h) *CONDUCT OF PREPAYMENT REVIEW.*—

21 “(1) *CONDUCT OF RANDOM PREPAYMENT RE-*
22 *VIEW.*—

23 “(A) *IN GENERAL.*—A medicare adminis-
24 trative contractor may conduct random prepay-
25 ment review only to develop a contractor-wide or

1 *program-wide claims payment error rates or*
2 *under such additional circumstances as may be*
3 *provided under regulations, developed in con-*
4 *sultation with providers of services and sup-*
5 *pliers.*

6 “(B) *USE OF STANDARD PROTOCOLS WHEN*
7 *CONDUCTING PREPAYMENT REVIEWS.—When a*
8 *medicare administrative contractor conducts a*
9 *random prepayment review, the contractor may*
10 *conduct such review only in accordance with a*
11 *standard protocol for random prepayment audits*
12 *developed by the Secretary.*

13 “(C) *CONSTRUCTION.—Nothing in this*
14 *paragraph shall be construed as preventing the*
15 *denial of payments for claims actually reviewed*
16 *under a random prepayment review.*

17 “(D) *RANDOM PREPAYMENT REVIEW.—For*
18 *purposes of this subsection, the term ‘random*
19 *prepayment review’ means a demand for the*
20 *production of records or documentation absent*
21 *cause with respect to a claim.*

22 “(2) *LIMITATIONS ON NON-RANDOM PREPAYMENT*
23 *REVIEW.—*

24 “(A) *LIMITATIONS ON INITIATION OF NON-*
25 *RANDOM PREPAYMENT REVIEW.—A medicare ad-*

1 *ministrative contractor may not initiate non-*
2 *random prepayment review of a provider of serv-*
3 *ices or supplier based on the initial identifica-*
4 *tion by that provider of services or supplier of*
5 *an improper billing practice unless there is a*
6 *likelihood of sustained or high level of payment*
7 *error (as defined in subsection (i)(3)(A)).*

8 “(B) *TERMINATION OF NON-RANDOM PRE-*
9 *PAYMENT REVIEW.—The Secretary shall issue*
10 *regulations relating to the termination, includ-*
11 *ing termination dates, of non-random prepay-*
12 *ment review. Such regulations may vary such a*
13 *termination date based upon the differences in*
14 *the circumstances triggering prepayment re-*
15 *view.”.*

16 (b) *EFFECTIVE DATE.—*

17 (1) *IN GENERAL.—Except as provided in this*
18 *subsection, the amendment made by subsection (a)*
19 *shall take effect 1 year after the date of the enactment*
20 *of this Act.*

21 (2) *DEADLINE FOR PROMULGATION OF CERTAIN*
22 *REGULATIONS.—The Secretary shall first issue regula-*
23 *tions under section 1874A(h) of the Social Security*
24 *Act, as added by subsection (a), by not later than 1*
25 *year after the date of the enactment of this Act.*

1 (3) *APPLICATION OF STANDARD PROTOCOLS FOR*
2 *RANDOM PREPAYMENT REVIEW.—Section*
3 *1874A(h)(1)(B) of the Social Security Act, as added*
4 *by subsection (a), shall apply to random prepayment*
5 *reviews conducted on or after such date (not later*
6 *than 1 year after the date of the enactment of this*
7 *Act) as the Secretary shall specify.*

8 (c) *APPLICATION TO FISCAL INTERMEDIARIES AND*
9 *CARRIERS.—The provisions of section 1874A(h) of the So-*
10 *cial Security Act, as added by subsection (a), shall apply*
11 *to each fiscal intermediary under section 1816 of the Social*
12 *Security Act (42 U.S.C. 1395h) and each carrier under sec-*
13 *tion 1842 of such Act (42 U.S.C. 1395u) in the same man-*
14 *ner as they apply to medicare administrative contractors*
15 *under such provisions.*

16 **SEC. 835. RECOVERY OF OVERPAYMENTS.**

17 (a) *IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd)*
18 *is amended by adding at the end the following new sub-*
19 *section:*

20 “(f) *RECOVERY OF OVERPAYMENTS.—*

21 “(1) *USE OF REPAYMENT PLANS.—*

22 “(A) *IN GENERAL.—If the repayment, with-*
23 *in 30 days by a provider of services or supplier,*
24 *of an overpayment under this title would con-*
25 *stitute a hardship (as defined in subparagraph*

1 *(B)), subject to subparagraph (C), upon request*
2 *of the provider of services or supplier the Sec-*
3 *retary shall enter into a plan with the provider*
4 *of services or supplier for the repayment*
5 *(through offset or otherwise) of such overpayment*
6 *over a period of at least 6 months but not longer*
7 *than 3 years (or not longer than 5 years in the*
8 *case of extreme hardship, as determined by the*
9 *Secretary). Interest shall accrue on the balance*
10 *through the period of repayment. Such plan shall*
11 *meet terms and conditions determined to be ap-*
12 *propriate by the Secretary.*

13 *“(B) HARDSHIP.—*

14 *“(i) IN GENERAL.—For purposes of*
15 *subparagraph (A), the repayment of an*
16 *overpayment (or overpayments) within 30*
17 *days is deemed to constitute a hardship if—*

18 *“(I) in the case of a provider of*
19 *services that files cost reports, the ag-*
20 *gregate amount of the overpayments*
21 *exceeds 10 percent of the amount paid*
22 *under this title to the provider of serv-*
23 *ices for the cost reporting period cov-*
24 *ered by the most recently submitted*
25 *cost report; or*

1 “(II) *in the case of another pro-*
2 *vider of services or supplier, the aggre-*
3 *gate amount of the overpayments ex-*
4 *ceeds 10 percent of the amount paid*
5 *under this title to the provider of serv-*
6 *ices or supplier for the previous cal-*
7 *endar year.*

8 “(ii) *RULE OF APPLICATION.—The*
9 *Secretary shall establish rules for the appli-*
10 *cation of this subparagraph in the case of a*
11 *provider of services or supplier that was not*
12 *paid under this title during the previous*
13 *year or was paid under this title only dur-*
14 *ing a portion of that year.*

15 “(iii) *TREATMENT OF PREVIOUS OVER-*
16 *PAYMENTS.—If a provider of services or*
17 *supplier has entered into a repayment plan*
18 *under subparagraph (A) with respect to a*
19 *specific overpayment amount, such payment*
20 *amount under the repayment plan shall not*
21 *be taken into account under clause (i) with*
22 *respect to subsequent overpayment amounts.*

23 “(C) *EXCEPTIONS.—Subparagraph (A)*
24 *shall not apply if—*

1 “(i) the Secretary has reason to suspect
2 that the provider of services or supplier
3 may file for bankruptcy or otherwise cease
4 to do business or discontinue participation
5 in the program under this title; or

6 “(ii) there is an indication of fraud or
7 abuse committed against the program.

8 “(D) IMMEDIATE COLLECTION IF VIOLATION
9 OF REPAYMENT PLAN.—If a provider of services
10 or supplier fails to make a payment in accord-
11 ance with a repayment plan under this para-
12 graph, the Secretary may immediately seek to
13 offset or otherwise recover the total balance out-
14 standing (including applicable interest) under
15 the repayment plan.

16 “(E) RELATION TO NO FAULT PROVISION.—
17 Nothing in this paragraph shall be construed as
18 affecting the application of section 1870(c) (re-
19 lating to no adjustment in the cases of certain
20 overpayments).

21 “(2) LIMITATION ON RECOUPMENT.—

22 “(A) IN GENERAL.—In the case of a pro-
23 vider of services or supplier that is determined to
24 have received an overpayment under this title
25 and that seeks a reconsideration by a qualified

1 *independent contractor on such determination*
2 *under section 1869(b)(1), the Secretary may not*
3 *take any action (or authorize any other person,*
4 *including any medicare contractor, as defined in*
5 *subparagraph (C)) to recoup the overpayment*
6 *until the date the decision on the reconsideration*
7 *has been rendered. If the provisions of section*
8 *1869(b)(1) (providing for such a reconsideration*
9 *by a qualified independent contractor) are not in*
10 *effect, in applying the previous sentence any ref-*
11 *erence to such a reconsideration shall be treated*
12 *as a reference to a redetermination by the fiscal*
13 *intermediary or carrier involved.*

14 “(B) *COLLECTION WITH INTEREST.—Inso-*
15 *far as the determination on such appeal is*
16 *against the provider of services or supplier, in-*
17 *terest on the overpayment shall accrue on and*
18 *after the date of the original notice of overpay-*
19 *ment. Insofar as such determination against the*
20 *provider of services or supplier is later reversed,*
21 *the Secretary shall provide for repayment of the*
22 *amount recouped plus interest at the same rate*
23 *as would apply under the previous sentence for*
24 *the period in which the amount was recouped.*

1 “(C) *MEDICARE CONTRACTOR DEFINED.*—
2 *For purposes of this subsection, the term ‘medi-*
3 *care contractor’ has the meaning given such term*
4 *in section 1889(g).*

5 “(3) *LIMITATION ON USE OF EXTRAPOLATION.*—
6 *A medicare contractor may not use extrapolation to*
7 *determine overpayment amounts to be recovered by*
8 *recoupment, offset, or otherwise unless—*

9 “(A) *there is a sustained or high level of*
10 *payment error (as defined by the Secretary by*
11 *regulation); or*

12 “(B) *documented educational intervention*
13 *has failed to correct the payment error (as deter-*
14 *mined by the Secretary).*

15 “(4) *PROVISION OF SUPPORTING DOCUMENTA-*
16 *TION.*—*In the case of a provider of services or sup-*
17 *plier with respect to which amounts were previously*
18 *overpaid, a medicare contractor may request the peri-*
19 *odic production of records or supporting documenta-*
20 *tion for a limited sample of submitted claims to en-*
21 *sure that the previous practice is not continuing.*

22 “(5) *CONSENT SETTLEMENT REFORMS.*—

23 “(A) *IN GENERAL.*—*The Secretary may use*
24 *a consent settlement (as defined in subparagraph*
25 *(D)) to settle a projected overpayment.*

1 “(B) *OPPORTUNITY TO SUBMIT ADDITIONAL*
2 *INFORMATION BEFORE CONSENT SETTLEMENT*
3 *OFFER.—Before offering a provider of services or*
4 *supplier a consent settlement, the Secretary*
5 *shall—*

6 “(i) *communicate to the provider of*
7 *services or supplier—*

8 “(I) *that, based on a review of the*
9 *medical records requested by the Sec-*
10 *retary, a preliminary evaluation of*
11 *those records indicates that there would*
12 *be an overpayment;*

13 “(II) *the nature of the problems*
14 *identified in such evaluation; and*

15 “(III) *the steps that the provider*
16 *of services or supplier should take to*
17 *address the problems; and*

18 “(ii) *provide for a 45-day period dur-*
19 *ing which the provider of services or sup-*
20 *plier may furnish additional information*
21 *concerning the medical records for the*
22 *claims that had been reviewed.*

23 “(C) *CONSENT SETTLEMENT OFFER.—The*
24 *Secretary shall review any additional informa-*
25 *tion furnished by the provider of services or sup-*

1 plier under subparagraph (B)(ii). Taking into
2 consideration such information, the Secretary
3 shall determine if there still appears to be an
4 overpayment. If so, the Secretary—

5 “(i) shall provide notice of such deter-
6 mination to the provider of services or sup-
7 plier, including an explanation of the rea-
8 son for such determination; and

9 “(ii) in order to resolve the overpay-
10 ment, may offer the provider of services or
11 supplier—

12 “(I) the opportunity for a statis-
13 tically valid random sample; or

14 “(II) a consent settlement.

15 The opportunity provided under clause (ii)(I)
16 does not waive any appeal rights with respect to
17 the alleged overpayment involved.

18 “(D) CONSENT SETTLEMENT DEFINED.—

19 For purposes of this paragraph, the term ‘con-
20 sent settlement’ means an agreement between the
21 Secretary and a provider of services or supplier
22 whereby both parties agree to settle a projected
23 overpayment based on less than a statistically
24 valid sample of claims and the provider of serv-

1 ices or supplier agrees not to appeal the claims
2 involved.

3 “(6) NOTICE OF OVER-UTILIZATION OF CODES.—

4 *The Secretary shall establish, in consultation with or-*
5 *ganizations representing the classes of providers of*
6 *services and suppliers, a process under which the Sec-*
7 *retary provides for notice to classes of providers of*
8 *services and suppliers served by the contractor in*
9 *cases in which the contractor has identified that par-*
10 *ticular billing codes may be overutilized by that class*
11 *of providers of services or suppliers under the pro-*
12 *grams under this title (or provisions of title XI inso-*
13 *far as they relate to such programs).*

14 “(7) PAYMENT AUDITS.—

15 “(A) WRITTEN NOTICE FOR POST-PAYMENT
16 AUDITS.—Subject to subparagraph (C), if a
17 medicare contractor decides to conduct a post-
18 payment audit of a provider of services or sup-
19 plier under this title, the contractor shall provide
20 the provider of services or supplier with written
21 notice (which may be in electronic form) of the
22 intent to conduct such an audit.

23 “(B) EXPLANATION OF FINDINGS FOR ALL
24 AUDITS.—Subject to subparagraph (C), if a
25 medicare contractor audits a provider of services

1 *or supplier under this title, the contractor*
2 *shall—*

3 “(i) *give the provider of services or*
4 *supplier a full review and explanation of*
5 *the findings of the audit in a manner that*
6 *is understandable to the provider of services*
7 *or supplier and permits the development of*
8 *an appropriate corrective action plan;*

9 “(ii) *inform the provider of services or*
10 *supplier of the appeal rights under this title*
11 *as well as consent settlement options (which*
12 *are at the discretion of the Secretary);*

13 “(iii) *give the provider of services or*
14 *supplier an opportunity to provide addi-*
15 *tional information to the contractor; and*

16 “(iv) *take into account information*
17 *provided, on a timely basis, by the provider*
18 *of services or supplier under clause (iii).*

19 “(C) *EXCEPTION.—Subparagraphs (A) and*
20 *(B) shall not apply if the provision of notice or*
21 *findings would compromise pending law enforce-*
22 *ment activities, whether civil or criminal, or re-*
23 *veal findings of law enforcement-related audits.*

24 “(8) *STANDARD METHODOLOGY FOR PROBE SAM-*
25 *PLING.—The Secretary shall establish a standard*

1 *methodology for medicare contractors to use in select-*
2 *ing a sample of claims for review in the case of an*
3 *abnormal billing pattern.”.*

4 *(b) EFFECTIVE DATES AND DEADLINES.—*

5 *(1) USE OF REPAYMENT PLANS.—Section*
6 *1893(f)(1) of the Social Security Act, as added by*
7 *subsection (a), shall apply to requests for repayment*
8 *plans made after the date of the enactment of this Act.*

9 *(2) LIMITATION ON RECOUPMENT.—Section*
10 *1893(f)(2) of the Social Security Act, as added by*
11 *subsection (a), shall apply to actions taken after the*
12 *date of the enactment of this Act.*

13 *(3) USE OF EXTRAPOLATION.—Section*
14 *1893(f)(3) of the Social Security Act, as added by*
15 *subsection (a), shall apply to statistically valid ran-*
16 *dom samples initiated after the date that is 1 year*
17 *after the date of the enactment of this Act.*

18 *(4) PROVISION OF SUPPORTING DOCUMENTA-*
19 *TION.—Section 1893(f)(4) of the Social Security Act,*
20 *as added by subsection (a), shall take effect on the*
21 *date of the enactment of this Act.*

22 *(5) CONSENT SETTLEMENT.—Section 1893(f)(5)*
23 *of the Social Security Act, as added by subsection (a),*
24 *shall apply to consent settlements entered into after*
25 *the date of the enactment of this Act.*

1 (6) *NOTICE OF OVERUTILIZATION.*—Not later
2 than 1 year after the date of the enactment of this
3 Act, the Secretary shall first establish the process for
4 notice of overutilization of billing codes under section
5 1893A(f)(6) of the Social Security Act, as added by
6 subsection (a).

7 (7) *PAYMENT AUDITS.*—Section 1893A(f)(7) of
8 the Social Security Act, as added by subsection (a),
9 shall apply to audits initiated after the date of the
10 enactment of this Act.

11 (8) *STANDARD FOR ABNORMAL BILLING PAT-*
12 *TERNS.*—Not later than 1 year after the date of the
13 enactment of this Act, the Secretary shall first estab-
14 lish a standard methodology for selection of sample
15 claims for abnormal billing patterns under section
16 1893(f)(8) of the Social Security Act, as added by
17 subsection (a).

18 **SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF AP-**

19 **PEAL.**

20 (a) *IN GENERAL.*—Section 1866 (42 U.S.C. 1395cc)
21 is amended—

22 (1) by adding at the end of the heading the fol-
23 lowing: “; ENROLLMENT PROCESSES”; and

24 (2) by adding at the end the following new sub-
25 section:

1 “(j) *ENROLLMENT PROCESS FOR PROVIDERS OF SERV-*
2 *ICES AND SUPPLIERS.*—

3 “(1) *ENROLLMENT PROCESS.*—

4 “(A) *IN GENERAL.*—*The Secretary shall es-*
5 *tablish by regulation a process for the enrollment*
6 *of providers of services and suppliers under this*
7 *title.*

8 “(B) *DEADLINES.*—*The Secretary shall es-*
9 *tablish by regulation procedures under which*
10 *there are deadlines for actions on applications*
11 *for enrollment (and, if applicable, renewal of en-*
12 *rollment). The Secretary shall monitor the per-*
13 *formance of medicare administrative contractors*
14 *in meeting the deadlines established under this*
15 *subparagraph.*

16 “(C) *CONSULTATION BEFORE CHANGING*
17 *PROVIDER ENROLLMENT FORMS.*—*The Secretary*
18 *shall consult with providers of services and sup-*
19 *pliers before making changes in the provider en-*
20 *rollment forms required of such providers and*
21 *suppliers to be eligible to submit claims for*
22 *which payment may be made under this title.*

23 “(2) *HEARING RIGHTS IN CASES OF DENIAL OR*
24 *NON-RENEWAL.*—*A provider of services or supplier*
25 *whose application to enroll (or, if applicable, to renew*

1 *enrollment) under this title is denied may have a*
2 *hearing and judicial review of such denial under the*
3 *procedures that apply under subsection (h)(1)(A) to a*
4 *provider of services that is dissatisfied with a deter-*
5 *mination by the Secretary.”.*

6 *(b) EFFECTIVE DATES.—*

7 *(1) ENROLLMENT PROCESS.—The Secretary shall*
8 *provide for the establishment of the enrollment process*
9 *under section 1866(j)(1) of the Social Security Act, as*
10 *added by subsection (a)(2), within 6 months after the*
11 *date of the enactment of this Act.*

12 *(2) CONSULTATION.—Section 1866(j)(1)(C) of*
13 *the Social Security Act, as added by subsection*
14 *(a)(2), shall apply with respect to changes in provider*
15 *enrollment forms made on or after January 1, 2003.*

16 *(3) HEARING RIGHTS.—Section 1866(j)(2) of the*
17 *Social Security Act, as added by subsection (a)(2),*
18 *shall apply to denials occurring on or after such date*
19 *(not later than 1 year after the date of the enactment*
20 *of this Act) as the Secretary specifies.*

21 **SEC. 837. PROCESS FOR CORRECTION OF MINOR ERRORS**
22 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**
23 **SUING APPEALS PROCESS.**

24 *The Secretary shall develop, in consultation with ap-*
25 *propriate medicare contractors (as defined in section*

1 1889(g) of the Social Security Act, as inserted by section
2 821(a)(1)) and representatives of providers of services and
3 suppliers, a process whereby, in the case of minor errors
4 or omissions (as defined by the Secretary) that are detected
5 in the submission of claims under the programs under title
6 XVIII of such Act, a provider of services or supplier is given
7 an opportunity to correct such an error or omission without
8 the need to initiate an appeal. Such process shall include
9 the ability to resubmit corrected 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. 1395ff(b)),
14 as amended by sections 521 and 522 of BIPA and section
15 833(d)(2)(B), is further amended by adding at the end the
16 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 medi-
21 care administrative contractor that has a con-
22 tract under section 1874A that provides for mak-
23 ing payments under this title with respect to eli-
24 gible items and services described in subpara-
25 graph (C), the Secretary shall establish a prior

1 *determination process that meets the require-*
2 *ments of this subsection and that shall be applied*
3 *by such contractor in the case of eligible request-*
4 *ers.*

5 “(B) *ELIGIBLE REQUESTER.*—*For purposes*
6 *of this subsection, each of the following shall be*
7 *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.*—*For*
21 *purposes of this subsection and subject to para-*
22 *graph (2), eligible items and services are items*
23 *and services which are physicians’ services (as*
24 *defined in paragraph (4)(A) of section 1848(f)*

1 *for purposes of calculating the sustainable*
2 *growth rate under such section).*

3 “(2) *SECRETARIAL FLEXIBILITY.*—*The Secretary*
4 *shall establish by regulation reasonable limits on the*
5 *categories of eligible items and services for which a*
6 *prior determination of coverage may be requested*
7 *under this subsection. In establishing such limits, the*
8 *Secretary may consider the dollar amount involved*
9 *with respect to the item or service, administrative*
10 *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 sub-*
14 *section an eligible requester may submit to the*
15 *contractor a request for a determination, before*
16 *the furnishing of an eligible item or service in-*
17 *volved as to whether the item or service is cov-*
18 *ered under this title consistent with the applica-*
19 *ble requirements of section 1862(a)(1)(A) (relat-*
20 *ing 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 the*
25 *medical necessity for the item or service, and*

1 *any other appropriate documentation. In the*
2 *case of a request submitted by an eligible re-*
3 *quester who is described in paragraph (1)(B)(ii),*
4 *the Secretary may require that the request also*
5 *be accompanied by a copy of the advance bene-*
6 *ficiary notice involved.*

7 “(4) *RESPONSE TO REQUEST.—*

8 “(A) *IN GENERAL.—Under such process, the*
9 *contractor shall provide the eligible requester*
10 *with written notice of a determination as to*
11 *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 in-*
16 *formation 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 coverage*
22 *determination.*

23 “(B) *DEADLINE TO RESPOND.—Such notice*
24 *shall be provided within the same time period as*
25 *the time period applicable to the contractor pro-*

1 *viding notice of initial determinations on a*
2 *claim for benefits under subsection (a)(2)(A).*

3 “(C) *INFORMING BENEFICIARY IN CASE OF*
4 *PHYSICIAN REQUEST.—In the case of a request*
5 *in which an eligible requester is not the indi-*
6 *vidual described in paragraph (1)(B)(ii), the*
7 *process shall provide that the individual to*
8 *whom the item or service is proposed to be fur-*
9 *nished shall be informed of any determination*
10 *described in clause (ii) (relating to a determina-*
11 *tion of non-coverage) and the right (referred to*
12 *in paragraph (6)(B)) to obtain the item or serv-*
13 *ice and have a claim submitted for the item or*
14 *service.*

15 “(5) *EFFECT OF DETERMINATIONS.—*

16 “(A) *BINDING NATURE OF POSITIVE DETER-*
17 *MINATION.—If the contractor makes the deter-*
18 *mination described in paragraph (4)(A)(i), such*
19 *determination shall be binding on the contractor*
20 *in the absence of fraud or evidence of misrepre-*
21 *sentation of facts presented to the contractor.*

22 “(B) *NOTICE AND RIGHT TO REDETERMINA-*
23 *TION 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 noncoverage
13 determination (if any) the determina-
14 tion is based, and the right to such a
15 redetermination.

16 “(ii) *DEADLINE FOR REDETERMINA-*
17 *TIONS.*—The contractor shall complete and
18 provide notice of such redetermination with-
19 in the same time period as the time period
20 applicable to the contractor providing notice
21 of redeterminations relating to a claim for
22 benefits under subsection (a)(3)(C)(ii).

23 “(6) *LIMITATION ON FURTHER REVIEW.*—

24 “(A) *IN GENERAL.*—Contractor determina-
25 tions described in paragraph (4)(A)(ii) or

1 (4)(A)(iii) (and redeterminations made under
2 paragraph (5)(B)), relating to pre-service claims
3 are not subject to further administrative appeal
4 or judicial review under this section or other-
5 wise.

6 “(B) DECISION NOT TO SEEK PRIOR DETER-
7 MINATION OR NEGATIVE DETERMINATION DOES
8 NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK
9 REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing
10 in this subsection shall be construed as affecting
11 the right of an individual who—

12 “(i) decides not to seek a prior deter-
13 mination under this subsection with respect
14 to items or services; or

15 “(ii) seeks such a determination and
16 has received a determination described in
17 paragraph (4)(A)(ii),
18 from receiving (and submitting a claim for) such
19 items services and from obtaining administrative
20 or judicial review respecting such claim under
21 the other applicable provisions of this section.
22 Failure to seek a prior determination under this
23 subsection with respect to items and services
24 shall not be taken into account in such adminis-
25 trative or judicial review.

1 “(C) *NO PRIOR DETERMINATION AFTER RE-*
2 *CEIPT OF SERVICES.*—Once an individual is pro-
3 *vided items and services, there shall be no prior*
4 *determination under this subsection with respect*
5 *to such items or services.”.*

6 **(b) *EFFECTIVE DATE; TRANSITION.***—

7 **(1) *EFFECTIVE DATE.***—The Secretary shall es-
8 *tablish the prior determination process under the*
9 *amendment made by subsection (a) in such a manner*
10 *as to provide for the acceptance of requests for deter-*
11 *minations under such process filed not later than 18*
12 *months after the date of the enactment of this Act.*

13 **(2) *TRANSITION.***—During the period in which
14 *the amendment made by subsection (a) has become ef-*
15 *fective but contracts are not provided under section*
16 *1874A of the Social Security Act with medicare ad-*
17 *ministrative contractors, any reference in section*
18 *1869(g) of such Act (as added by such amendment) to*
19 *such a contractor is deemed a reference to a fiscal*
20 *intermediary or carrier with an agreement under sec-*
21 *tion 1816, or contract under section 1842, respec-*
22 *tively, of such Act.*

23 **(3) *LIMITATION ON APPLICATION TO SGR.***—For
24 *purposes of applying section 1848(f)(2)(D) of the So-*
25 *cial Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the*

1 *amendment made by subsection (a) shall not be con-*
2 *sidered to be a change in law or regulation.*

3 *(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY*
4 *NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—*

5 *(1) DATA COLLECTION.—The Secretary shall es-*
6 *tablish a process for the collection of information on*
7 *the instances in which an advance beneficiary notice*
8 *(as defined in paragraph (4)) has been provided and*
9 *on instances in which a beneficiary indicates on such*
10 *a notice that the beneficiary does not intend to seek*
11 *to have the item or service that is the subject of the*
12 *notice furnished.*

13 *(2) OUTREACH AND EDUCATION.—The Secretary*
14 *shall establish a program of outreach and education*
15 *for beneficiaries and providers of services and other*
16 *persons on the appropriate use of advance beneficiary*
17 *notices and coverage policies under the medicare pro-*
18 *gram.*

19 *(3) GAO REPORT REPORT ON USE OF ADVANCE*
20 *BENEFICIARY NOTICES.—Not later than 18 months*
21 *after the date on which section 1869(g) of the Social*
22 *Security Act (as added by subsection (a)) takes effect,*
23 *the Comptroller General of the United States shall*
24 *submit to Congress a report on the use of advance*
25 *beneficiary notices under title XVIII of such Act.*

1 *Such report shall include information concerning the*
2 *providers of services and other persons that have pro-*
3 *vided such notices and the response of beneficiaries to*
4 *such notices.*

5 (4) *GAO REPORT ON USE OF PRIOR DETERMINA-*
6 *TION PROCESS.—Not later than 18 months after the*
7 *date on which section 1869(g) of the Social Security*
8 *Act (as added by subsection (a)) takes effect, the*
9 *Comptroller General of the United States shall submit*
10 *to Congress a report on the use of the prior deter-*
11 *mination process under such section. Such report*
12 *shall include—*

13 (A) *information concerning the types of*
14 *procedures for which a prior determination has*
15 *been sought, determinations made under the*
16 *process, and changes in receipt of services result-*
17 *ing from the application of such process; and*

18 (B) *an evaluation of whether the process*
19 *was useful for physicians (and other suppliers)*
20 *and beneficiaries, whether it was timely, and*
21 *whether the amount of information required was*
22 *burdensome to physicians and beneficiaries.*

23 (5) *ADVANCE BENEFICIARY NOTICE DEFINED.—*
24 *In this subsection, the term “advance beneficiary no-*
25 *tice” means a written notice provided under section*

1 1879(a) of the Social Security Act (42 U.S.C.
2 1395pp(a)) to an individual entitled to benefits under
3 part A or B of title XVIII of such Act before items
4 or services are furnished under such part in cases
5 where a provider of services or other person that
6 would furnish the item or service believes that pay-
7 ment will not be made for some or all of such items
8 or services under such title.

9 ***Subtitle E—Miscellaneous***
10 ***Provisions***

11 ***SEC. 841. POLICY DEVELOPMENT REGARDING EVALUATION***
12 ***AND MANAGEMENT (E & M) DOCUMENTATION***
13 ***GUIDELINES.***

14 (a) *IN GENERAL.*—*The Secretary may not implement*
15 *any new documentation guidelines for evaluation and man-*
16 *agement physician services under the title XVIII of the So-*
17 *cial Security Act on or after the date of the enactment of*
18 *this Act unless the Secretary—*

19 (1) *has developed the guidelines in collaboration*
20 *with practicing physicians (including both generalists*
21 *and specialists) and provided for an assessment of the*
22 *proposed guidelines by the physician community;*

23 (2) *has established a plan that contains specific*
24 *goals, including a schedule, for improving the use of*
25 *such guidelines;*

1 (3) *has conducted appropriate and representative*
2 *pilot projects under subsection (b) to test modifica-*
3 *tions to the evaluation and management documenta-*
4 *tion guidelines;*

5 (4) *finds that the objectives described in sub-*
6 *section (c) will be met in the implementation of such*
7 *guidelines; and*

8 (5) *has established, and is implementing, a pro-*
9 *gram to educate physicians on the use of such guide-*
10 *lines and that includes appropriate outreach.*

11 *The Secretary shall make changes to the manner in which*
12 *existing evaluation and management documentation guide-*
13 *lines are implemented to reduce paperwork burdens on phy-*
14 *sicians.*

15 **(b) PILOT PROJECTS TO TEST EVALUATION AND MAN-**
16 **AGEMENT DOCUMENTATION GUIDELINES.—**

17 (1) **IN GENERAL.—***The Secretary shall conduct*
18 *under this subsection appropriate and representative*
19 *pilot projects to test new evaluation and management*
20 *documentation guidelines referred to in subsection*
21 *(a).*

22 (2) **LENGTH AND CONSULTATION.—***Each pilot*
23 *project under this subsection shall—*

24 (A) *be voluntary;*

1 (B) be of sufficient length as determined by
2 the Secretary to allow for preparatory physician
3 and medicare contractor education, analysis,
4 and use and assessment of potential evaluation
5 and management guidelines; and

6 (C) be conducted, in development and
7 throughout the planning and operational stages
8 of the project, in consultation with practicing
9 physicians (including both generalists and spe-
10 cialists).

11 (3) *RANGE OF PILOT PROJECTS.*—Of the pilot
12 projects conducted under this subsection—

13 (A) at least one shall focus on a peer review
14 method by physicians (not employed by a medi-
15 care contractor) which evaluates medical record
16 information for claims submitted by physicians
17 identified as statistical outliers relative to defini-
18 tions published in the Current Procedures Ter-
19 minology (CPT) code book of the American Med-
20 ical Association;

21 (B) at least one shall focus on an alter-
22 native method to detailed guidelines based on
23 physician documentation of face to face encoun-
24 ter time with a patient;

1 (C) at least one shall be conducted for serv-
2 ices furnished in a rural area and at least one
3 for services furnished outside such an area; and

4 (D) at least one shall be conducted in a set-
5 ting where physicians bill under physicians'
6 services in teaching settings and at least one
7 shall be conducted in a setting other than a
8 teaching setting.

9 (4) *BANNING OF TARGETING OF PILOT PROJECT*
10 *PARTICIPANTS.*—Data collected under this subsection
11 shall not be used as the basis for overpayment de-
12 mands or post-payment audits. Such limitation ap-
13 plies only to claims filed as part of the pilot project
14 and lasts only for the duration of the pilot project
15 and only as long as the provider is a participant in
16 the pilot project.

17 (5) *STUDY OF IMPACT.*—Each pilot project shall
18 examine the effect of the new evaluation and manage-
19 ment documentation guidelines on—

20 (A) different types of physician practices,
21 including those with fewer than 10 full-time-
22 equivalent employees (including physicians); and

23 (B) the costs of physician compliance, in-
24 cluding education, implementation, auditing,
25 and monitoring.

1 (6) *PERIODIC REPORTS.*—*The Secretary shall*
2 *submit to Congress periodic reports on the pilot*
3 *projects under this subsection.*

4 (c) *OBJECTIVES FOR EVALUATION AND MANAGEMENT*
5 *GUIDELINES.*—*The objectives for modified evaluation and*
6 *management documentation guidelines developed by the*
7 *Secretary shall be to—*

8 (1) *identify clinically relevant documentation*
9 *needed to code accurately and assess coding levels ac-*
10 *curately;*

11 (2) *decrease the level of non-clinically pertinent*
12 *and burdensome documentation time and content in*
13 *the physician's medical record;*

14 (3) *increase accuracy by reviewers; and*

15 (4) *educate both physicians and reviewers.*

16 (d) *STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF*
17 *DOCUMENTATION FOR PHYSICIAN CLAIMS.*—

18 (1) *STUDY.*—*The Secretary shall carry out a*
19 *study of the matters described in paragraph (2).*

20 (2) *MATTERS DESCRIBED.*—*The matters referred*
21 *to in paragraph (1) are—*

22 (A) *the development of a simpler, alter-*
23 *native system of requirements for documentation*
24 *accompanying claims for evaluation and man-*
25 *agement physician services for which payment is*

1 *made under title XVIII of the Social Security*
2 *Act; and*

3 *(B) consideration of systems other than cur-*
4 *rent coding and documentation requirements for*
5 *payment for such physician services.*

6 (3) *CONSULTATION WITH PRACTICING PHYSI-*
7 *CIANs.—In designing and carrying out the study*
8 *under paragraph (1), the Secretary shall consult with*
9 *practicing physicians, including physicians who are*
10 *part of group practices and including both generalists*
11 *and specialists.*

12 (4) *APPLICATION OF HIPAA UNIFORM CODING RE-*
13 *QUIREMENTS.—In developing an alternative system*
14 *under paragraph (2), the Secretary shall consider re-*
15 *quirements of administrative simplification under*
16 *part C of title XI of the Social Security Act.*

17 (5) *REPORT TO CONGRESS.—(A) Not later than*
18 *October 1, 2004, the Secretary shall submit to Con-*
19 *gress a report on the results of the study conducted*
20 *under paragraph (1).*

21 *(B) The Medicare Payment Advisory Commis-*
22 *sion shall conduct an analysis of the results of the*
23 *study included in the report under subparagraph (A)*
24 *and shall submit a report on such analysis to Con-*
25 *gress.*

1 (e) *STUDY ON APPROPRIATE CODING OF CERTAIN EX-*
2 *TENDED OFFICE VISITS.*—*The Secretary shall conduct a*
3 *study of the appropriateness of coding in cases of extended*
4 *office visits in which there is no diagnosis made. Not later*
5 *than October 1, 2004, the Secretary shall submit a report*
6 *to Congress on such study and shall include recommenda-*
7 *tions on how to code appropriately for such visits in a man-*
8 *ner that takes into account the amount of time the physi-*
9 *cian spent with the patient.*

10 (f) *DEFINITIONS.*—*In this section—*

11 (1) *the term “rural area” has the meaning given*
12 *that term in section 1886(d)(2)(D) of the Social Secu-*
13 *rity Act, 42 U.S.C. 1395ww(d)(2)(D); and*

14 (2) *the term “teaching settings” are those set-*
15 *tings described in section 415.150 of title 42, Code of*
16 *Federal Regulations.*

17 **SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**
18 **AND COVERAGE.**

19 (a) *IMPROVED COORDINATION BETWEEN FDA AND*
20 *CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DE-*
21 *VICES.*—

22 (1) *IN GENERAL.*—*Upon request by an applicant*
23 *and to the extent feasible (as determined by the Sec-*
24 *retary), the Secretary shall, in the case of a class III*
25 *medical device that is subject to premarket approval*

1 *under section 515 of the Federal Food, Drug, and*
2 *Cosmetic Act, ensure the sharing of appropriate infor-*
3 *mation from the review for application for premarket*
4 *approval conducted by the Food and Drug Adminis-*
5 *tration for coverage decisions under title XVIII of the*
6 *Social Security Act.*

7 (2) *PUBLICATION OF PLAN.*—*Not later than 6*
8 *months after the date of the enactment of this Act, the*
9 *Secretary shall submit to appropriate Committees of*
10 *Congress a report that contains the plan for improv-*
11 *ing such coordination and for shortening the time lag*
12 *between the premarket approval by the Food and*
13 *Drug Administration and coding and coverage deci-*
14 *sions by the Centers for Medicare & Medicaid Serv-*
15 *ices.*

16 (3) *CONSTRUCTION.*—*Nothing in this subsection*
17 *shall be construed as changing the criteria for cov-*
18 *erage of a medical device under title XVIII of the So-*
19 *cial Security Act nor premarket approval by the Food*
20 *and Drug Administration and nothing in this sub-*
21 *section shall be construed to increase premarket ap-*
22 *proval application requirements under the Federal*
23 *Food, Drug, and Cosmetic Act.*

24 (b) *COUNCIL FOR TECHNOLOGY AND INNOVATION.*—
25 *Section 1868 (42 U.S.C. 1395ee), as amended by section*

1 823(a), is amended by adding at the end the following new
2 subsection:

3 “(c) *COUNCIL FOR TECHNOLOGY AND INNOVATION.*—

4 “(1) *ESTABLISHMENT.*—*The Secretary shall es-*
5 *tablish a Council for Technology and Innovation*
6 *within the Centers for Medicare & Medicaid Services*
7 *(in this section referred to as ‘CMS’).*

8 “(2) *COMPOSITION.*—*The Council shall be com-*
9 *posed of senior CMS staff and clinicians and shall be*
10 *chaired by the Executive Coordinator for Technology*
11 *and Innovation (appointed or designated under para-*
12 *graph (4)).*

13 “(3) *DUTIES.*—*The Council shall coordinate the*
14 *activities of coverage, coding, and payment processes*
15 *under this title with respect to new technologies and*
16 *procedures, including new drug therapies, and shall*
17 *coordinate the exchange of information on new tech-*
18 *nologies between CMS and other entities that make*
19 *similar decisions.*

20 “(4) *EXECUTIVE COORDINATOR FOR TECH-*
21 *NOLOGY AND INNOVATION.*—*The Secretary shall ap-*
22 *point (or designate) a noncareer appointee (as defined*
23 *in section 3132(a)(7) of title 5, United States Code)*
24 *who shall serve as the Executive Coordinator for Tech-*
25 *nology and Innovation. Such executive coordinator*

1 *shall report to the Administrator of CMS, shall chair*
2 *the Council, shall oversee the execution of its duties,*
3 *and shall serve as a single point of contact for outside*
4 *groups and entities regarding the coverage, coding,*
5 *and payment processes under this title.”.*

6 (c) *GAO STUDY ON IMPROVEMENTS IN EXTERNAL*
7 *DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT*
8 *PAYMENT SYSTEM.—*

9 (1) *STUDY.—The Comptroller General of the*
10 *United States shall conduct a study that analyzes*
11 *which external data can be collected in a shorter time*
12 *frame by the Centers for Medicare & Medicaid Serv-*
13 *ices for use in computing payments for inpatient hos-*
14 *pital services. The study may include an evaluation*
15 *of the feasibility and appropriateness of using of*
16 *quarterly samples or special surveys or any other*
17 *methods. The study shall include an analysis of*
18 *whether other executive agencies, such as the Bureau*
19 *of Labor Statistics in the Department of Commerce,*
20 *are best suited to collect this information.*

21 (2) *REPORT.—By not later than October 1,*
22 *2003, the Comptroller General shall submit a report*
23 *to Congress on the study under paragraph (1).*

24 (d) *IOM STUDY ON LOCAL COVERAGE DETERMINA-*
25 *TIONS.—*

1 (1) *STUDY.*—*The Secretary shall enter into an*
2 *arrangement with the Institute of Medicine of the Na-*
3 *tional Academy of Sciences under which the Institute*
4 *shall conduct a study on local coverage determina-*
5 *tions (including the application of local medical re-*
6 *view policies) under the medicare program under title*
7 *XVIII of the Social Security Act. Such study shall*
8 *examine—*

9 (A) *the consistency of the definitions used*
10 *in such determinations;*

11 (B) *the types of evidence on which such de-*
12 *terminations are based, including medical and*
13 *scientific evidence;*

14 (C) *the advantages and disadvantages of*
15 *local coverage decisionmaking, including the*
16 *flexibility it offers for ensuring timely patient*
17 *access to new medical technology for which data*
18 *are still be collected;*

19 (D) *the manner in which the local coverage*
20 *determination process is used to develop data*
21 *needed for a national coverage determination,*
22 *including the need for collection of such data*
23 *within a protocol and informed consent by indi-*
24 *viduals entitled to benefits under part A of title*

1 XVIII of the Social Security Act, or enrolled
2 under part B of such title, or both; and

3 (E) the advantages and disadvantages of
4 maintaining local medicare contractor advisory
5 committees that can advise on local coverage de-
6 cisions based on an open, collaborative public
7 process.

8 (2) REPORT.—Such arrangement shall provide
9 that the Institute shall submit to the Secretary a re-
10 port on such study by not later than 3 years after the
11 date of the enactment of this Act. The Secretary shall
12 promptly transmit a copy of such report to Congress.

13 (e) METHODS FOR DETERMINING PAYMENT BASIS FOR
14 NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h))
15 is amended by adding at the end the following:

16 “(8)(A) The Secretary shall establish by regulation
17 procedures for determining the basis for, and amount of,
18 payment under this subsection for any clinical diagnostic
19 laboratory test with respect to which a new or substantially
20 revised HCPCS code is assigned on or after January 1,
21 2004 (in this paragraph referred to as ‘new tests’).

22 “(B) Determinations under subparagraph (A) shall be
23 made only after the Secretary—

24 “(i) makes available to the public (through an
25 Internet site and other appropriate mechanisms) a

1 *list that includes any such test for which establish-*
2 *ment of a payment amount under this subsection is*
3 *being considered for a year;*

4 *“(ii) on the same day such list is made avail-*
5 *able, causes to have published in the Federal Register*
6 *notice of a meeting to receive comments and rec-*
7 *ommendations (and data on which recommendations*
8 *are based) from the public on the appropriate basis*
9 *under this subsection for establishing payment*
10 *amounts for the tests on such list;*

11 *“(iii) not less than 30 days after publication of*
12 *such notice convenes a meeting, that includes rep-*
13 *resentatives of officials of the Centers for Medicare &*
14 *Medicaid Services involved in determining payment*
15 *amounts, to receive such comments and recommenda-*
16 *tions (and data on which the recommendations are*
17 *based);*

18 *“(iv) taking into account the comments and rec-*
19 *ommendations (and accompanying data) received at*
20 *such meeting, develops and makes available to the*
21 *public (through an Internet site and other appro-*
22 *prate mechanisms) a list of proposed determinations*
23 *with respect to the appropriate basis for establishing*
24 *a payment amount under this subsection for each*
25 *such code, together with an explanation of the reasons*

1 for each such determination, the data on which the
2 determinations are based, and a request for public
3 written comments on the proposed determination; and

4 “(v) taking into account the comments received
5 during the public comment period, develops and
6 makes available to the public (through an Internet
7 site and other appropriate mechanisms) a list of final
8 determinations of the payment amounts for such tests
9 under this subsection, together with the rationale for
10 each such determination, the data on which the deter-
11 minations are based, and responses to comments and
12 suggestions received from the public.

13 “(C) Under the procedures established pursuant to sub-
14 paragraph (A), the Secretary shall—

15 “(i) set forth the criteria for making determina-
16 tions under subparagraph (A); and

17 “(ii) make available to the public the data (other
18 than proprietary data) considered in making such de-
19 terminations.

20 “(D) The Secretary may convene such further public
21 meetings to receive public comments on payment amounts
22 for new tests under this subsection as the Secretary deems
23 appropriate.

24 “(E) For purposes of this paragraph:

1 “(i) The term ‘HCPCS’ refers to the Health Care
2 Procedure Coding System.

3 “(ii) A code shall be considered to be ‘substan-
4 tially revised’ if there is a substantive change to the
5 definition of the test or procedure to which the code
6 applies (such as a new analyte or a new methodology
7 for measuring an existing analyte-specific test).”.

8 **SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**
9 **ICES UNDER MEDICARE SECONDARY PAYOR**
10 **(MSP) PROVISIONS.**

11 (a) *IN GENERAL.*—The Secretary shall not require a
12 hospital (including a critical access hospital) to ask ques-
13 tions (or obtain information) relating to the application of
14 section 1862(b) of the Social Security Act (relating to medi-
15 care secondary payor provisions) in the case of reference
16 laboratory services described in subsection (b), if the Sec-
17 retary does not impose such requirement in the case of such
18 services furnished by an independent laboratory.

19 (b) *REFERENCE LABORATORY SERVICES DE-*
20 *SCRIBED.*—Reference laboratory services described in this
21 subsection are clinical laboratory diagnostic tests (or the
22 interpretation of such tests, or both) furnished without a
23 face-to-face encounter between the individual entitled to
24 benefits under part A or enrolled under part B, or both,

1 *and the hospital involved and in which the hospital submits*
2 *a claim only for such test or interpretation.*

3 **SEC. 844. EMTALA IMPROVEMENTS.**

4 *(a) PAYMENT FOR EMTALA-MANDATED SCREENING*
5 *AND STABILIZATION SERVICES.—*

6 *(1) IN GENERAL.—Section 1862 (42 U.S.C.*
7 *1395y) is amended by inserting after subsection (c)*
8 *the following new subsection:*

9 *“(d) For purposes of subsection (a)(1)(A), in the case*
10 *of any item or service that is required to be provided pursu-*
11 *ant to section 1867 to an individual who is entitled to bene-*
12 *fits under this title, determinations as to whether the item*
13 *or service is reasonable and necessary shall be made on the*
14 *basis of the information available to the treating physician*
15 *or practitioner (including the patient’s presenting symp-*
16 *toms or complaint) at the time the item or service was or-*
17 *dered or furnished by the physician or practitioner (and*
18 *not on the patient’s principal diagnosis). When making*
19 *such determinations with respect to such an item or service,*
20 *the Secretary shall not consider the frequency with which*
21 *the item or service was provided to the patient before or*
22 *after the time of the admission or visit.”.*

23 *(2) EFFECTIVE DATE.—The amendment made by*
24 *paragraph (1) shall apply to items and services fur-*
25 *nished on or after January 1, 2003.*

1 (b) *NOTIFICATION OF PROVIDERS WHEN EMTALA IN-*
2 *VESTIGATION CLOSED.*—Section 1867(d) (42 U.S.C. 42
3 U.S.C. 1395dd(d)) is amended by adding at the end the
4 following new paragraph:

5 “(4) *NOTICE UPON CLOSING AN INVESTIGA-*
6 *TION.*—The Secretary shall establish a procedure to
7 notify hospitals and physicians when an investigation
8 under this section is closed.”.

9 (c) *PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS*
10 *IN EMTALA CASES INVOLVING TERMINATION OF PARTICI-*
11 *PATION.*—

12 (1) *IN GENERAL.*—Section 1867(d)(3) (42 U.S.C.
13 1395dd(d)(3)) is amended—

14 (A) in the first sentence, by inserting “or in
15 terminating a hospital’s participation under this
16 title” after “in imposing sanctions under para-

17 graph (1)”; and

18 (B) by adding at the end the following new
19 sentences: “Except in the case in which a delay
20 would jeopardize the health or safety of individ-

21 uals, the Secretary shall also request such a re-

22 view before making a compliance determination
23 as part of the process of terminating a hospital’s
24 participation under this title for violations re-

25 lated to the appropriateness of a medical screen-

1 *ing examination, stabilizing treatment, or an*
2 *appropriate transfer as required by this section,*
3 *and shall provide a period of 5 days for such re-*
4 *view. The Secretary shall provide a copy of the*
5 *organization’s report to the hospital or physician*
6 *consistent with confidentiality requirements im-*
7 *posed on the organization under such part B.”.*

8 (2) *EFFECTIVE DATE.*—*The amendments made*
9 *by paragraph (1) shall apply to terminations of par-*
10 *ticipation initiated on or after the date of the enact-*
11 *ment of this Act.*

12 **SEC. 845. EMERGENCY MEDICAL TREATMENT AND LABOR**
13 **ACT (EMTALA) TECHNICAL ADVISORY GROUP.**

14 (a) *ESTABLISHMENT.*—*The Secretary shall establish a*
15 *Technical Advisory Group (in this section referred to as the*
16 *“Advisory Group”) to review issues related to the Emer-*
17 *gency Medical Treatment and Labor Act (EMTALA) and*
18 *its implementation. In this section, the term “EMTALA”*
19 *refers to the provisions of section 1867 of the Social Security*
20 *Act (42 U.S.C. 1395dd).*

21 (b) *MEMBERSHIP.*—*The Advisory Group shall be com-*
22 *posed of 19 members, including the Administrator of the*
23 *Centers for Medicare & Medicaid Services and the Inspector*
24 *General of the Department of Health and Human Services*
25 *and of which—*

1 (1) 4 shall be representatives of hospitals, includ-
2 ing at least one public hospital, that have experience
3 with the application of EMTALA and at least 2 of
4 which have not been cited for EMTALA violations;

5 (2) 7 shall be practicing physicians drawn from
6 the fields of emergency medicine, cardiology or
7 cardiothoracic surgery, orthopedic surgery, neuro-
8 surgery, obstetrics-gynecology, and psychiatry, with
9 not more than one physician from any particular
10 field;

11 (3) 2 shall represent patients;

12 (4) 2 shall be staff involved in EMTALA inves-
13 tigations from different regional offices of the Centers
14 for Medicare & Medicaid Services; and

15 (5) 1 shall be from a State survey office involved
16 in EMTALA investigations and 1 shall be from a
17 peer review organization, both of whom shall be from
18 areas other than the regions represented under para-
19 graph (4).

20 In selecting members described in paragraphs (1) through
21 (3), the Secretary shall consider qualified individuals nomi-
22 nated by organizations representing providers and patients.

23 (c) *GENERAL RESPONSIBILITIES.*—*The Advisory*
24 *Group—*

25 (1) shall review EMTALA regulations;

1 (2) *may provide advice and recommendations to*
2 *the Secretary with respect to those regulations and*
3 *their application to hospitals and physicians;*

4 (3) *shall solicit comments and recommendations*
5 *from hospitals, physicians, and the public regarding*
6 *the implementation of such regulations; and*

7 (4) *may disseminate information on the applica-*
8 *tion of such regulations to hospitals, physicians, and*
9 *the public.*

10 (d) *ADMINISTRATIVE MATTERS.—*

11 (1) *CHAIRPERSON.—The members of the Advi-*
12 *sory Group shall elect a member to serve as chair-*
13 *person of the Advisory Group for the life of the Advi-*
14 *sory Group.*

15 (2) *MEETINGS.—The Advisory Group shall first*
16 *meet at the direction of the Secretary. The Advisory*
17 *Group shall then meet twice per year and at such*
18 *other times as the Advisory Group may provide.*

19 (e) *TERMINATION.—The Advisory Group shall termi-*
20 *nate 30 months after the date of its first meeting.*

21 (f) *WAIVER OF ADMINISTRATIVE LIMITATION.—The*
22 *Secretary shall establish the Advisory Group notwith-*
23 *standing any limitation that may apply to the number of*
24 *advisory committees that may be established (within the*
25 *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 events,*
11 *or temporary travel of a patient outside a hospice pro-*
12 *gram’s service area, a hospice program may enter into ar-*
13 *rangements with another hospice program for the provision*
14 *by that other program of services described in paragraph*
15 *(2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II)*
16 *shall apply with respect to the services provided under such*
17 *arrangements.”.*

18 (b) *CONFORMING PAYMENT PROVISION.*—Section
19 1814(i) (42 U.S.C. 1395f(i)), as amended by section 421(b),
20 is amended by adding at the end the following new para-
21 graph:

22 “(5) *In the case of hospice care provided by a hospice*
23 *program under arrangements under section 1861(dd)(5)(D)*
24 *made by another hospice program, the hospice program that*
25 *made the arrangements shall bill and be paid for the hospice*
26 *care.”.*

1 (c) *EFFECTIVE DATE.*—*The amendments made by this*
2 *section shall apply to hospice care provided on or after the*
3 *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 “and”*
10 *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) the*
14 *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 Pathogens*
18 *standard under section 1910.1030 of title 29 of the*
19 *Code of Federal Regulations (or as subsequently redес-*
20 *ignated).”;* and

21 (2) *by adding at the end of subsection (b) the fol-*
22 *lowing 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 money*

1 *penalty in an amount described in subparagraph (B), but*
2 *is not subject to termination of an agreement under this*
3 *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 of*
10 *such Act.*

11 “(C) *A civil money penalty under this paragraph shall*
12 *be imposed and collected in the same manner as civil money*
13 *penalties under subsection (a) of section 1128A are imposed*
14 *and collected under that section.”.*

15 (b) *EFFECTIVE DATE.*—*The amendments made by this*
16 *subsection (a) shall apply to hospitals as of July 1, 2003.*

17 **SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND**
18 **CORRECTIONS.**

19 (a) *TECHNICAL AMENDMENTS RELATING TO ADVISORY*
20 *COMMITTEE UNDER BIPA SECTION 522.*—(1) *Subsection*
21 *(i) of section 1114 (42 U.S.C. 1314)—*

22 (A) *is transferred to section 1862 and added at*
23 *the end of such section; and*

24 (B) *is redesignated as subsection (j).*

25 (2) *Section 1862 (42 U.S.C. 1395y) is amended—*

1 (A) *in the last sentence of subsection (a), by*
2 *striking “established under section 1114(f)”*; and

3 (B) *in subsection (j), as so transferred and*
4 *redesignated—*

5 (i) *by striking “under subsection (f)”*; and

6 (ii) *by striking “section 1862(a)(1)” and*
7 *inserting “subsection (a)(1)”*.

8 (b) *TERMINOLOGY CORRECTIONS.—(1) Section*
9 *1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amend-*
10 *ed by section 521 of BIPA, is amended—*

11 (A) *in subclause (III), by striking “policy” and*
12 *inserting “determination”*; and

13 (B) *in subclause (IV), by striking “medical re-*
14 *view policies” and inserting “coverage determina-*
15 *tions”*.

16 (2) *Section 1852(a)(2)(C) (42 U.S.C. 1395w-*
17 *22(a)(2)(C)) is amended by striking “policy” and “POLICY”*
18 *and inserting “determination” each place it appears and*
19 *“DETERMINATION”, respectively*.

20 (c) *REFERENCE CORRECTIONS.—Section 1869(f)(4)*
21 *(42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA,*
22 *is amended—*

23 (1) *in subparagraph (A)(iv), by striking “sub-*
24 *clause (I), (II), or (III)” and inserting “clause (i),*
25 *(ii), or (iii)”*;

1 *would impose a hardship on individuals entitled to benefits*
2 *under part A of title XVIII or enrolled under part B of*
3 *such title, or both, the Secretary may waive the exclusion*
4 *under subsection (a)(1), (a)(3), or (a)(4) with respect to*
5 *that program in the case of an individual or entity that*
6 *is the sole community physician or sole source of essential*
7 *specialized services in a community.”.*

8 **SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.**

9 *(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is*
10 *amended by adding after subsection (g) the following new*
11 *subsection:*

12 *“(h)(1) Subject to paragraph (2), a group health plan*
13 *(as defined in subsection (a)(1)(A)(v)) providing supple-*
14 *mental or secondary coverage to individuals also entitled*
15 *to services under this title shall not require a medicare*
16 *claims determination under this title for dental benefits spe-*
17 *cifically excluded under subsection (a)(12) as a condition*
18 *of making a claims determination for such benefits under*
19 *the group health plan.*

20 *“(2) A group health plan may require a claims deter-*
21 *mination under this title in cases involving or appearing*
22 *to involve inpatient dental hospital services or dental serv-*
23 *ices expressly covered under this title pursuant to actions*
24 *taken by the Secretary.”.*

1 (b) *EFFECTIVE DATE.*—*The amendment made by sub-*
2 *section (a) shall take effect on the date that is 60 days after*
3 *the date of the enactment of this Act.*

4 **SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL**
5 **COVERAGE DETERMINATIONS.**

6 *The Secretary shall provide, in an appropriate annual*
7 *publication available to the public, a list of national cov-*
8 *erage determinations made under title XVIII of the Social*
9 *Security Act in the previous year and information on how*
10 *to get more information with respect to such determina-*
11 *tions.*

12 **TITLE IX—MEDICAID, PUBLIC**
13 **HEALTH, AND OTHER HEALTH**
14 **PROVISIONS**

15 **Subtitle A—Medicaid Provisions**

16 **SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE FU-**
17 **TURE OF MEDICAID.**

18 (a) *ESTABLISHMENT.*—*There is established a commis-*
19 *sion to be known as the National Bipartisan Commission*
20 *on the Future of Medicaid (in this section referred to as*
21 *the “Commission”).*

22 (b) *DUTIES OF THE COMMISSION.*—*The Commission*
23 *shall—*

1 (1) *review and analyze the long-term financial*
2 *condition of the medicaid program under title XIX of*
3 *the Social Security Act (42 U.S.C. 1396 et seq.);*

4 (2) *identify the factors that are causing, and the*
5 *consequences of, increases in costs under the medicaid*
6 *program, including—*

7 (A) *the impact of these cost increases upon*
8 *State budgets, funding for other State programs,*
9 *and levels of State taxes necessary to fund grow-*
10 *ing expenditures under the medicaid program;*

11 (B) *the financial obligations of the Federal*
12 *government arising from the Federal matching*
13 *requirement for expenditures under the medicaid*
14 *program; and*

15 (C) *the size and scope of the current pro-*
16 *gram and how the program has evolved over*
17 *time;*

18 (3) *analyze potential policies that will ensure*
19 *both the financial integrity of the medicaid program*
20 *and the provision of appropriate benefits under such*
21 *program;*

22 (4) *make recommendations for establishing in-*
23 *centives and structures to promote enhanced effi-*
24 *ciencies and ways of encouraging innovative State*
25 *policies under the medicaid program;*

1 (5) *make recommendations for establishing the*
2 *appropriate balance between benefits covered, pay-*
3 *ments to providers, State and Federal contributions*
4 *and, where appropriate, recipient cost-sharing obliga-*
5 *tions;*

6 (6) *make recommendations on the impact of pro-*
7 *moting increased utilization of competitive, private*
8 *enterprise models to contain program cost growth,*
9 *through enhanced utilization of private plans, phar-*
10 *macy benefit managers, and other methods currently*
11 *being used to contain private sector health-care costs;*

12 (7) *make recommendations on the financing of*
13 *prescription drug benefits currently covered under*
14 *medicaid programs, including analysis of the current*
15 *Federal manufacturer rebate program, its impact*
16 *upon both private market prices as well as those paid*
17 *by other government purchasers, recent State efforts to*
18 *negotiate additional supplemental manufacturer re-*
19 *bates and the ability of pharmacy benefit managers*
20 *to lower drug costs;*

21 (8) *review and analyze such other matters relat-*
22 *ing to the medicaid program as the Commission*
23 *deems appropriate; and*

24 (9) *analyze the impact of impending demo-*
25 *graphic changes upon medicaid benefits, including*

1 *long term care services, and make recommendations*
2 *for how best to appropriately divide State and Fed-*
3 *eral responsibilities for funding these benefits.*

4 *(c) MEMBERSHIP.—*

5 *(1) NUMBER AND APPOINTMENT.—The Commis-*
6 *sion shall be composed of 17 members, of whom—*

7 *(A) four shall be appointed by the Presi-*
8 *dent;*

9 *(B) six shall be appointed by the Majority*
10 *Leader of the Senate, in consultation with the*
11 *Minority Leader of the Senate, of whom not*
12 *more than 4 shall be of the same political party;*

13 *(C) six shall be appointed by the Speaker of*
14 *the House of Representatives, in consultation*
15 *with the Minority Leader of the House of Rep-*
16 *resentatives, of whom not more than 4 shall be*
17 *of the same political party; and*

18 *(D) one, who shall serve as Chairman of the*
19 *Commission, appointed jointly by the President,*
20 *Majority Leader of the Senate, and the Speaker*
21 *of the House of Representatives.*

22 *(2) DEADLINE FOR APPOINTMENT.—Members of*
23 *the Commission shall be appointed by not later than*
24 *December 1, 2002.*

1 (3) *TERMS OF APPOINTMENT.*—*The term of any*
2 *appointment under paragraph (1) to the Commission*
3 *shall be for the life of the Commission.*

4 (4) *MEETINGS.*—*The Commission shall meet at*
5 *the call of its Chairman or a majority of its members.*

6 (5) *QUORUM.*—*A quorum shall consist of 8 mem-*
7 *bers of the Commission, except that 4 members may*
8 *conduct a hearing under subsection (e).*

9 (6) *VACANCIES.*—*A vacancy on the Commission*
10 *shall be filled in the same manner in which the origi-*
11 *nal appointment was made not later than 30 days*
12 *after the Commission is given notice of the vacancy*
13 *and shall not affect the power of the remaining mem-*
14 *bers to execute the duties of the Commission.*

15 (7) *COMPENSATION.*—*Members of the Commis-*
16 *sion shall receive no additional pay, allowances, or*
17 *benefits by reason of their service on the Commission.*

18 (8) *EXPENSES.*—*Each member of the Commis-*
19 *sion shall receive travel expenses and per diem in lieu*
20 *of subsistence in accordance with sections 5702 and*
21 *5703 of title 5, United States Code.*

22 (d) *STAFF AND SUPPORT SERVICES.*—

23 (1) *EXECUTIVE DIRECTOR.*—

24 (A) *APPOINTMENT.*—*The Chairman shall*
25 *appoint an executive director of the Commission.*

1 (B) *COMPENSATION.*—*The executive director*
2 *shall be paid the rate of basic pay for level V of*
3 *the Executive Schedule.*

4 (2) *STAFF.*—*With the approval of the Commis-*
5 *sion, the executive director may appoint such per-*
6 *sonnel as the executive director considers appropriate.*

7 (3) *APPLICABILITY OF CIVIL SERVICE LAWS.*—
8 *The staff of the Commission shall be appointed with-*
9 *out regard to the provisions of title 5, United States*
10 *Code, governing appointments in the competitive serv-*
11 *ice, and shall be paid without regard to the provisions*
12 *of chapter 51 and subchapter III of chapter 53 of such*
13 *title (relating to classification and General Schedule*
14 *pay rates).*

15 (4) *EXPERTS AND CONSULTANTS.*—*With the ap-*
16 *proval of the Commission, the executive director may*
17 *procure temporary and intermittent services under*
18 *section 3109(b) of title 5, United States Code.*

19 (5) *PHYSICAL FACILITIES.*—*The Administrator*
20 *of the General Services Administration shall locate*
21 *suitable office space for the operation of the Commis-*
22 *sion. The facilities shall serve as the headquarters of*
23 *the Commission and shall include all necessary equip-*
24 *ment and incidentals required for the proper func-*
25 *tioning of the Commission.*

1 (e) *POWERS OF COMMISSION.*—

2 (1) *HEARINGS AND OTHER ACTIVITIES.*—*For the*
3 *purpose of carrying out its duties, the Commission*
4 *may hold such hearings and undertake such other ac-*
5 *tivities as the Commission determines to be necessary*
6 *to carry out its duties.*

7 (2) *STUDIES BY GAO.*—*Upon the request of the*
8 *Commission, the Comptroller General shall conduct*
9 *such studies or investigations as the Commission de-*
10 *termines to be necessary to carry out its duties.*

11 (3) *COST ESTIMATES BY CONGRESSIONAL BUDG-*
12 *ET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF*
13 *CMS.*—

14 (A) *The Director of the Congressional Budg-*
15 *et Office or the Chief Actuary of the Centers for*
16 *Medicare & Medicaid Services, or both, shall*
17 *provide to the Commission, upon the request of*
18 *the Commission, such cost estimates as the Com-*
19 *mission determines to be necessary to carry out*
20 *its duties.*

21 (B) *The Commission shall reimburse the*
22 *Director of the Congressional Budget Office for*
23 *expenses relating to the employment in the office*
24 *of the Director of such additional staff as may*
25 *be necessary for the Director to comply with re-*

1 *quests by the Commission under subparagraph*
2 *(A).*

3 *(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the*
4 *request of the Commission, the head of any Federal*
5 *agency is authorized to detail, without reimburse-*
6 *ment, any of the personnel of such agency to the Com-*
7 *mission to assist the Commission in carrying out its*
8 *duties. Any such detail shall not interrupt or other-*
9 *wise affect the civil service status or privileges of the*
10 *Federal employee.*

11 *(5) TECHNICAL ASSISTANCE.—Upon the request*
12 *of the Commission, the head of a Federal agency shall*
13 *provide such technical assistance to the Commission*
14 *as the Commission determines to be necessary to*
15 *carry out its duties.*

16 *(6) USE OF MAILS.—The Commission may use*
17 *the United States mails in the same manner and*
18 *under the same conditions as Federal agencies and*
19 *shall, for purposes of the frank, be considered a com-*
20 *mission of Congress as described in section 3215 of*
21 *title 39, United States Code.*

22 *(7) OBTAINING INFORMATION.—The Commission*
23 *may secure directly from any Federal agency infor-*
24 *mation necessary to enable it to carry out its duties,*
25 *if the information may be disclosed under section 552*

1 of title 5, United States Code. Upon request of the
2 Chairman of the Commission, the head of such agency
3 shall furnish such information to the Commission.

4 (8) *ADMINISTRATIVE SUPPORT SERVICES.*—Upon
5 the request of the Commission, the Administrator of
6 General Services shall provide to the Commission on
7 a reimbursable basis such administrative support
8 services as the Commission may request.

9 (9) *PRINTING.*—For purposes of costs relating to
10 printing and binding, including the cost of personnel
11 detailed from the Government Printing Office, the
12 Commission shall be deemed to be a committee of the
13 Congress.

14 (f) *REPORT.*—Not later than March 1, 2004, the Com-
15 mission shall submit a report to the President and Congress
16 which shall contain a detailed statement of only those the
17 recommendations, findings, and conclusions of the Commis-
18 sion.

19 (g) *TERMINATION.*—The Commission shall terminate
20 30 days after the date of submission of the report required
21 in subsection (f).

22 (h) *AUTHORIZATION OF APPROPRIATIONS.*—There are
23 authorized to be appropriated \$1,500,000 to carry out this
24 section.

1 **SEC. 902. GAO STUDY ON MEDICAID DRUG PAYMENT SYS-**
2 **TEM.**

3 (a) *STUDY.*—*The Comptroller General of the United*
4 *States shall conduct a study on the reimbursement under*
5 *the medicaid program for covered outpatient drugs. Such*
6 *study shall examine—*

7 (1) *the extent to which such reimbursements for*
8 *a drug exceed the acquisition costs for that drug;*

9 (2) *the services and resources associated with dis-*
10 *persing a prescription and any additional payments*
11 *available to compensate for expenses for these services*
12 *and resources; and*

13 (3) *efforts undertaken by States to change the*
14 *levels of such reimbursement and the price data they*
15 *use in effecting such change.*

16 (b) *REPORT.*—*Not later than 1 year after the date of*
17 *the enactment of this Act, the Comptroller General shall*
18 *submit to Congress a report on the study conducted under*
19 *subsection (a) and shall include in such report such rec-*
20 *ommendations for changes for legislative or administrative*
21 *action regarding medicaid reimbursement methodologies for*
22 *outpatient prescription drugs, and their application to the*
23 *medicare program, as the Comptroller General deems ap-*
24 *propriate.*

1 **Subtitle B—Internet Pharmacies**

2 **SEC. 911. FINDINGS.**

3 *The Congress finds as follows:*

4 (1) *Legitimate Internet sellers of prescription*
5 *drugs can offer substantial benefits to consumers.*
6 *These potential benefits include convenience, privacy,*
7 *valuable information, competitive prices, and person-*
8 *alized services.*

9 (2) *Unlawful Internet sellers of prescription*
10 *drugs may dispense inappropriate, contaminated,*
11 *counterfeit, or subpotent prescription drugs that could*
12 *put at risk the health and safety of consumers.*

13 (3) *Unlawful Internet sellers have exposed con-*
14 *sumers to significant health risks by knowingly filling*
15 *invalid prescriptions, such as prescriptions based*
16 *solely on an online questionnaire, or by dispensing*
17 *prescription drugs without any prescription.*

18 (4) *Consumers may have difficulty distin-*
19 *guishing legitimate from unlawful Internet sellers, as*
20 *well as foreign from domestic Internet sellers, of pre-*
21 *scription drugs.*

1 **SEC. 912. AMENDMENT TO FEDERAL FOOD, DRUG, AND COS-**
2 **METIC ACT.**

3 (a) *IN GENERAL.*—Chapter V of the Federal Food,
4 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended
5 by inserting after section 503A the following:

6 **“SEC. 503B. INTERNET PRESCRIPTION DRUG SALES.**

7 “(a) *DEFINITIONS.*—For purposes of this section:

8 “(1) *CONSUMER.*—The term ‘consumer’ means a
9 person (other than an entity licensed or otherwise au-
10 thorized under Federal or State law as a pharmacy
11 or to dispense or distribute prescription drugs) that
12 purchases or seeks to purchase prescription drugs
13 through the Internet.

14 “(2) *HOME PAGE.*—The term ‘home page’ means
15 the entry point or main web page for an Internet site.

16 “(3) *INTERNET.*—The term ‘Internet’ means col-
17 lectively the myriad of computer and telecommuni-
18 cations facilities, including equipment and operating
19 software, which comprise the interconnected world-
20 wide network of networks that employ the Trans-
21 mission Control Protocol/Internet Protocol, or any
22 predecessor or successor protocols to such protocol, to
23 communicate information of all kinds by wire or
24 radio, including electronic mail.

25 “(4) *INTERSTATE INTERNET SELLER.*—

1 “(A) *IN GENERAL.*—*The term ‘interstate*
2 *Internet seller’ means a person whether in the*
3 *United States or abroad, that engages in, offers*
4 *to engage in, or causes the delivery or sale of a*
5 *prescription drug through the Internet and has*
6 *such drug delivered directly to the consumer via*
7 *the Postal Service, or any private or commercial*
8 *interstate carrier to a consumer in the United*
9 *States who is residing in a State other than the*
10 *State in which the seller’s place of business is lo-*
11 *located. This definition excludes a person who only*
12 *delivers a prescription drug to a consumer, such*
13 *as an interstate carrier service.*

14 “(B) *EXEMPTION.*—*With respect to the con-*
15 *sumer involved, the term ‘interstate Internet sell-*
16 *er’ does not include a person described in sub-*
17 *paragraph (A) whose place of business is located*
18 *within 75 miles of the consumer.*

19 “(5) *LINK.*—*The term ‘link’ means either a tex-*
20 *tual or graphical marker on a web page that, when*
21 *clicked on, takes the consumer to another part of the*
22 *Internet, such as to another web page or a different*
23 *area on the same web page, or from an electronic mes-*
24 *sage to a web page.*

1 “(6) *PHARMACY*.—The term ‘pharmacy’ means
2 any place licensed or otherwise authorized as a phar-
3 macy under State law.

4 “(7) *PRESCRIBER*.—The term ‘prescriber’ means
5 an individual, licensed or otherwise authorized under
6 applicable Federal and State law to issue prescrip-
7 tions for prescription drugs.

8 “(8) *PRESCRIPTION DRUG*.—The term ‘prescrip-
9 tion drug’ means a drug under section 503(b)(1).

10 “(9) *VALID PRESCRIPTION*.—The term ‘valid pre-
11 scription’ means a prescription that meets the re-
12 quirements of section 503(b)(1) and other applicable
13 Federal and State law.

14 “(10) *WEB SITE; SITE*.—The terms ‘web site’ and
15 ‘site’ mean a specific location on the Internet that is
16 determined by Internet protocol numbers or by a do-
17 main name.

18 “(b) *REQUIREMENTS FOR INTERSTATE INTERNET*
19 *SELLERS*.—

20 “(1) *IN GENERAL*.—Each interstate Internet sell-
21 er shall comply with the requirements of this sub-
22 section with respect to the sale of, or the offer to sell,
23 prescription drugs through the Internet and shall at
24 all times display on its web site information in ac-
25 cordance with paragraph (2).

1 “(2) *WEB SITE DISCLOSURE INFORMATION.*—An
2 *interstate Internet seller shall post in a visible and*
3 *clear manner (as determined by regulation) on the*
4 *home page of its web site, or on a page directly linked*
5 *to such home page—*

6 “(A) *the street address of the interstate*
7 *Internet seller’s place of business, and the tele-*
8 *phone number of such place of business;*

9 “(B) *each State in which the interstate*
10 *Internet seller is licensed or otherwise authorized*
11 *as a pharmacy, or if the interstate Internet seller*
12 *is not licensed or otherwise authorized by a State*
13 *as a pharmacy, each State in which the inter-*
14 *state Internet seller is licensed or otherwise au-*
15 *thorized to dispense prescription drugs, and the*
16 *type of State license or authorization;*

17 “(C) *in the case of an interstate Internet*
18 *seller that makes referrals to or solicits on behalf*
19 *of a prescriber, the name of each prescriber, the*
20 *street address of each such prescriber’s place of*
21 *business, the telephone number of such place of*
22 *business, each State in which each such pre-*
23 *scriber is licensed or otherwise authorized to pre-*
24 *scribe prescription drugs, and the type of such li-*
25 *cence or authorization; and*

1 “(D) a statement that the interstate Inter-
2 net seller will dispense prescription drugs only
3 upon a valid prescription.

4 “(3) *DATE OF POSTING.*—Information required
5 to be posted under paragraph (2) shall be posted by
6 an interstate Internet seller—

7 “(A) not later than 90 days after the effec-
8 tive date of this section if the web site of such
9 seller is in operation as of such date; or

10 “(B) on the date of the first day of oper-
11 ation of such seller’s web site if such site goes
12 into operation after such date.

13 “(4) *QUALIFYING STATEMENTS.*—An interstate
14 Internet seller shall not indicate in any manner that
15 posting disclosure information on its web site sig-
16 nifies that the Federal Government has made any de-
17 termination on the legitimacy of the interstate Inter-
18 net seller or its business.

19 “(5) *DISCLOSURE TO STATE LICENSING*
20 *BOARDS.*—An interstate Internet seller licensed or
21 otherwise authorized to dispense prescription drugs in
22 accordance with applicable State law shall notify
23 each State entity that granted such licensure or au-
24 thorization that it is an interstate Internet seller, the
25 name of its business, the Internet address of its busi-

1 *ness, the street address of its place of business, and the*
2 *telephone number of such place of business.*

3 “(6) *REGULATIONS.*—*The Secretary is author-*
4 *ized to promulgate such regulations as are necessary*
5 *to carry out the provisions of this subsection. In*
6 *issuing such regulations, the Secretary—*

7 “(A) *shall take into consideration disclosure*
8 *formats used by existing interstate Internet seller*
9 *certification programs; and*

10 “(B) *shall in defining the term ‘place of*
11 *business’ include provisions providing that such*
12 *place is a single location at which employees of*
13 *the business perform job functions, and not a*
14 *post office box or similar locale.”.*

15 (b) *PROHIBITED ACTS.*—*Section 301 of the Federal*
16 *Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended*
17 *by adding at the end the following:*

18 “(bb) *The failure to post information required under*
19 *section 503B(b)(2) or for knowingly making a materially*
20 *false statement when posting such information as required*
21 *under such section or violating section 503B(b)(4).”.*

22 **SEC. 913. PUBLIC EDUCATION.**

23 *The Secretary of Health and Human Services shall en-*
24 *gage in activities to educate the public about the dangers*
25 *of purchasing prescription drugs from unlawful Internet*

1 *sources. The Secretary should educate the public about effec-*
2 *tive public and private sector consumer protection efforts,*
3 *as appropriate, with input from the public and private sec-*
4 *tors, as appropriate.*

5 **SEC. 914. STUDY REGARDING COORDINATION OF REGU-**
6 **LATORY ACTIVITIES.**

7 *Not later than 180 days after the date of enactment*
8 *of this Act, the Secretary of Health and Human Services,*
9 *after consultation with the Attorney General, shall submit*
10 *to Congress a report providing recommendations for coordi-*
11 *nating the activities of Federal agencies regarding inter-*
12 *state Internet sellers that operate from foreign countries and*
13 *for coordinating the activities of the Federal Government*
14 *with the activities of governments of foreign countries re-*
15 *garding such interstate Internet sellers.*

16 **SEC. 915. EFFECTIVE DATE.**

17 *The amendments made by this subtitle shall take effect*
18 *1 year after the date of enactment of this Act, except that*
19 *the authority of the Secretary of Health and Human Serv-*
20 *ices to commence the process of rulemaking is effective on*
21 *the date of enactment of this Act.*

1 ***Subtitle C—Promotion of Electronic***
2 ***Prescription***

3 ***SEC. 921. PROGRAM OF GRANTS TO HEALTH CARE PRO-***
4 ***VIDERS TO IMPLEMENT ELECTRONIC PRE-***
5 ***SCRIPTION DRUG PROGRAMS.***

6 *Part P of title III of the Public Health Service Act*
7 *is amended by inserting after section 399N the following*
8 *new section:*

9 ***“SEC. 399O. GRANTS TO HEALTH CARE PROVIDERS TO IM-***
10 ***PLEMENT ELECTRONIC PRESCRIPTION DRUG***
11 ***PROGRAMS.***

12 *“(a) IN GENERAL.—The Secretary is authorized to*
13 *make grants for the purpose of assisting health care pro-*
14 *viders who prescribe drugs and biologicals in implementing*
15 *electronic prescription programs described in section*
16 *1860C(d)(3) of the Social Security Act.*

17 *“(b) APPLICATION.—No grant may be made under this*
18 *section except pursuant to a grant application that is sub-*
19 *mitted in a time, manner, and form approved by the Sec-*
20 *retary.*

21 *“(c) AUTHORIZATION OF APPROPRIATIONS.—There are*
22 *authorized to be appropriated for fiscal year 2004, such*
23 *sums as may be appropriate to carry out this section.”.*

1 ***Subtitle D—Treatment of Rare***
2 ***Diseases***

3 ***SEC. 931. NIH OFFICE OF RARE DISEASES AT NATIONAL IN-***
4 ***STITUTES OF HEALTH.***

5 *Title IV of the Public Health Service Act (42 U.S.C.*
6 *281 et seq.), as amended by Public Law 107–84, is amended*
7 *by inserting after section 404E the following:*

8 “OFFICE OF RARE DISEASES

9 “SEC. 404F. (a) *ESTABLISHMENT.*—*There is estab-*
10 *lished within the Office of the Director of NIH an office*
11 *to be known as the Office of Rare Diseases (in this section*
12 *referred to as the ‘Office’), which shall be headed by a Direc-*
13 *tor (in this section referred to as the ‘Director’), appointed*
14 *by the Director of NIH.*

15 “(b) *DUTIES.*—

16 “(1) *IN GENERAL.*—*The Director of the Office*
17 *shall carry out the following:*

18 “(A) *The Director shall recommend an*
19 *agenda for conducting and supporting research*
20 *on rare diseases through the national research*
21 *institutes and centers. The agenda shall provide*
22 *for a broad range of research and education ac-*
23 *tivities, including scientific workshops and*
24 *symposia to identify research opportunities for*
25 *rare diseases.*

1 “(B) *The Director shall, with respect to rare*
2 *diseases, promote coordination and cooperation*
3 *among the national research institutes and cen-*
4 *ters and entities whose research is supported by*
5 *such institutes.*

6 “(C) *The Director, in collaboration with the*
7 *directors of the other relevant institutes and cen-*
8 *ters of the National Institutes of Health, may*
9 *enter into cooperative agreements with and make*
10 *grants for regional centers of excellence on rare*
11 *diseases in accordance with section 404G.*

12 “(D) *The Director shall promote the suffi-*
13 *cient allocation of the resources of the National*
14 *Institutes of Health for conducting and sup-*
15 *porting research on rare diseases.*

16 “(E) *The Director shall promote and en-*
17 *courage the establishment of a centralized clear-*
18 *inghouse for rare and genetic disease informa-*
19 *tion that will provide understandable informa-*
20 *tion about these diseases to the public, medical*
21 *professionals, patients and families.*

22 “(F) *The Director shall biennially prepare*
23 *a report that describes the research and edu-*
24 *cation activities on rare diseases being conducted*
25 *or supported through the national research insti-*

1 *tutes and centers, and that identifies particular*
2 *projects or types of projects that should in the fu-*
3 *ture be conducted or supported by the national*
4 *research institutes and centers or other entities*
5 *in the field of research on rare diseases.*

6 “(G) *The Director shall prepare the NIH*
7 *Director’s annual report to Congress on rare dis-*
8 *ease research conducted by or supported through*
9 *the national research institutes and centers.*

10 “(2) *PRINCIPAL ADVISOR REGARDING ORPHAN*
11 *DISEASES.—With respect to rare diseases, the Director*
12 *shall serve as the principal advisor to the Director of*
13 *NIH and shall provide advice to other relevant agen-*
14 *cies. The Director shall provide liaison with national*
15 *and international patient, health and scientific orga-*
16 *nizations concerned with rare diseases.*

17 “(c) *DEFINITION.—For purposes of this section, the*
18 *term ‘rare disease’ means any disease or condition that af-*
19 *fects less than 200,000 persons in the United States.*

20 “(d) *AUTHORIZATION OF APPROPRIATIONS.—For the*
21 *purpose of carrying out this section, there are authorized*
22 *to be appropriated such sums as already have been appro-*
23 *priated for fiscal year 2002, and \$4,000,000 for each of the*
24 *fiscal years 2003 through 2006.”.*

1 **SEC. 932. RARE DISEASE REGIONAL CENTERS OF EXCEL-**
2 **LENCE.**

3 *Title IV of the Public Health Service Act (42 U.S.C.*
4 *281 et seq.), as amended by section 931, is further amended*
5 *by inserting after section 404F the following:*

6 “*RARE DISEASE REGIONAL CENTERS OF EXCELLENCE*

7 “*SEC. 404G. (a) COOPERATIVE AGREEMENTS AND*
8 *GRANTS.—*

9 “*(1) IN GENERAL.—The Director of the Office of*
10 *Rare Diseases (in this section referred to as the ‘Di-*
11 *rector’), in collaboration with the directors of the*
12 *other relevant institutes and centers of the National*
13 *Institutes of Health, may enter into cooperative agree-*
14 *ments with and make grants to public or private non-*
15 *profit entities to pay all or part of the cost of plan-*
16 *ning, establishing, or strengthening, and providing*
17 *basic operating support for regional centers of excel-*
18 *lence for clinical research into, training in, and dem-*
19 *onstration of diagnostic, prevention, control, and*
20 *treatment methods for rare diseases.*

21 “*(2) POLICIES.—A cooperative agreement or*
22 *grant under paragraph (1) shall be entered into in*
23 *accordance with policies established by the Director of*
24 *NIH.*

25 “*(b) COORDINATION WITH OTHER INSTITUTES.—The*
26 *Director shall coordinate the activities under this section*

1 *with similar activities conducted by other national research*
2 *institutes, centers and agencies of the National Institutes*
3 *of Health and by the Food and Drug Administration to*
4 *the extent that such institutes, centers and agencies have*
5 *responsibilities that are related to rare diseases.*

6 “(c) *USES FOR FEDERAL PAYMENTS UNDER COOPER-*
7 *ATIVE AGREEMENTS OR GRANTS.—Federal payments made*
8 *under a cooperative agreement or grant under subsection*
9 *(a) may be used for—*

10 “(1) *staffing, administrative, and other basic op-*
11 *erating costs, including such patient care costs as are*
12 *required for research;*

13 “(2) *clinical training, including training for al-*
14 *lied health professionals, continuing education for*
15 *health professionals and allied health professions per-*
16 *sonnel, and information programs for the public with*
17 *respect to rare diseases; and*

18 “(3) *clinical research and demonstration pro-*
19 *grams.*

20 “(d) *PERIOD OF SUPPORT; ADDITIONAL PERIODS.—*
21 *Support of a center under subsection (a) may be for a pe-*
22 *riod of not to exceed 5 years. Such period may be extended*
23 *by the Director for additional periods of not more than 5*
24 *years if the operations of such center have been reviewed*
25 *by an appropriate technical and scientific peer review*

1 *group established by the Director and if such group has rec-*
2 *ommended to the Director that such period should be ex-*
3 *tended.*

4 “(e) *AUTHORIZATION OF APPROPRIATIONS.—For the*
5 *purpose of carrying out this section, there are authorized*
6 *to be appropriated such sums as already have been appro-*
7 *priated for fiscal year 2002, and \$20,000,000 for each of*
8 *the fiscal years 2003 through 2006.*”.

9 ***Subtitle E—Other Provisions***
10 ***Relating to Drugs***

11 ***SEC. 941. GAO STUDY REGARDING DIRECT-TO-CONSUMER***
12 ***ADVERTISING OF PRESCRIPTION DRUGS.***

13 (a) *IN GENERAL.—The Comptroller General of the*
14 *United States shall conduct a study for the purpose of*
15 *determining—*

16 (1) *whether and to what extent there have been*
17 *increases in utilization rates of prescription drugs*
18 *that are attributable to guidance regarding direct-to-*
19 *consumer advertising of such drugs that has been*
20 *issued by the Food and Drug Administration under*
21 *section 502(n) of the Federal Food, Drug, and Cos-*
22 *metic Act; and*

23 (2) *if so, whether and to what extent such in-*
24 *creased utilization rates have resulted in increases in*

1 *the costs of public or private health plans, health in-*
2 *surance, or other health programs.*

3 *(b) CERTAIN DETERMINATIONS.—The study under*
4 *subsection (a) shall include determinations of the following:*

5 *(1) The extent to which advertisements referred*
6 *to in such subsection have resulted in effective con-*
7 *sumer education about the prescription drugs in-*
8 *volved, including an understanding of the risks of the*
9 *drugs relative to the benefits.*

10 *(2) The extent of consumer satisfaction with such*
11 *advertisements.*

12 *(3) The extent of physician satisfaction with the*
13 *advertisements, including determining whether physi-*
14 *cians believe that the advertisements interfere with the*
15 *exercise of their medical judgment by influencing con-*
16 *sumers to prefer advertised drugs over alternative*
17 *therapies.*

18 *(4) The extent to which the advertisements have*
19 *resulted in increases in health care costs for tax-*
20 *payers, for employers, or for consumers due to con-*
21 *sumer decisions to seek advertised drugs rather than*
22 *lower-costs alternative therapies.*

23 *(5) The extent to which the advertisements have*
24 *resulted in decreases in health care costs for tax-*
25 *payers, for employers, or for consumers due to de-*

1 *creased hospitalization rates, fewer physician visits*
2 *(not related to hospitalization), lower treatment costs,*
3 *or reduced instances of employee absences to care for*
4 *family members with diseases or disorders.*

5 *(c) REPORT.—Not later than two years after the date*
6 *of the enactment of this Act, the Comptroller General of the*
7 *United States shall submit to the Congress a report pro-*
8 *viding the findings of the study under subsection (a).*

9 **SEC. 942. CERTAIN HEALTH PROFESSIONS PROGRAMS RE-**
10 **GARDING PRACTICE OF PHARMACY.**

11 *Part E of title VII of the Public Health Service Act*
12 *(42 U.S.C. 294n et seq.) is amended by adding at the end*
13 *the following subpart:*

14 **“Subpart 3—Pharmacist Workforce Programs**

15 **“SEC. 771. PUBLIC SERVICE ANNOUNCEMENTS.**

16 *“(a) PUBLIC SERVICE ANNOUNCEMENTS.—*

17 *“(1) IN GENERAL.—The Secretary shall develop*
18 *and issue public service announcements that advertise*
19 *and promote the pharmacist profession, highlight the*
20 *advantages and rewards of being a pharmacist, and*
21 *encourage individuals to enter the pharmacist profes-*
22 *sion.*

23 *“(2) METHOD.—The public service announce-*
24 *ments described in subsection (a) shall be broadcast*
25 *through appropriate media outlets, including tele-*

1 *vision or radio, in a manner intended to reach as*
2 *wide and diverse an audience as possible.*

3 *“(b) STATE AND LOCAL PUBLIC SERVICE ANNOUNCE-*
4 *MENTS.—*

5 *“(1) IN GENERAL.—The Secretary shall award*
6 *grants to entities to support State and local adver-*
7 *tising campaigns through appropriate media outlets*
8 *to promote the pharmacist profession, highlight the*
9 *advantages and rewards of being a pharmacist, and*
10 *encourage individuals to enter the pharmacist profes-*
11 *sion.*

12 *“(2) USE OF FUNDS.—An entity that receives a*
13 *grant under subsection (a) shall use funds received*
14 *through such grant to acquire local television and*
15 *radio time, place advertisements in local newspapers,*
16 *and post information on billboards or on the Internet,*
17 *in order to—*

18 *“(A) advertise and promote the pharmacist*
19 *profession;*

20 *“(B) promote pharmacist education pro-*
21 *grams;*

22 *“(C) inform the public of public assistance*
23 *regarding such education programs;*

1 “(D) highlight individuals in the commu-
2 nity that are presently practicing as phar-
3 macists to recruit new pharmacists; and

4 “(E) provide any other information to re-
5 cruit individuals for the pharmacist profession.

6 “(3) *METHOD.*—The campaigns described in
7 subsection (a) shall be broadcast on television or
8 radio, placed in newspapers as advertisements, or
9 posted on billboards or the Internet, in a manner in-
10 tended to reach as wide and diverse an audience as
11 possible.

12 **“SEC. 772. DEMONSTRATION PROJECT.**

13 “(a) *IN GENERAL.*—The Secretary shall establish a
14 demonstration project to enhance the participation of indi-
15 viduals who are pharmacists in the National Health Service
16 Corps Loan Repayment Program described in section 338B.

17 “(b) *SERVICES.*—Services that may be provided by
18 pharmacists pursuant to the demonstration project estab-
19 lished under this section include medication therapy man-
20 agement services to assure that medications are used appro-
21 priately by patients, to enhance patients’ understanding of
22 the appropriate use of medications, to increase patients’ ad-
23 herence to prescription medication regimens, to reduce the
24 risk of adverse events associated with medications, and to
25 reduce the need for other costly medical services through bet-

1 *ter management of medication therapy. Such services may*
2 *include case management, disease management, drug ther-*
3 *apy management, patient training and education, coun-*
4 *seling, drug therapy problem resolution, medication admin-*
5 *istration, the provision of special packaging, or other serv-*
6 *ices that enhance the use of prescription medications.*

7 “(c) *PROCEDURE.*—*The Secretary may not provide as-*
8 *sistance to an individual under this section unless the indi-*
9 *vidual agrees to comply with all requirements described in*
10 *sections 338B and 338D.*

11 “(d) *LIMITATIONS.*—*The demonstration project de-*
12 *scribed in this section shall provide for the participation*
13 *of—*

14 “(1) *individuals to provide services in rural and*
15 *urban areas; and*

16 “(2) *enough individuals to allow the Secretary to*
17 *properly analyze the effectiveness of such project.*

18 “(e) *DESIGNATIONS.*—*The demonstration project de-*
19 *scribed in this section, and any pharmacists who are se-*
20 *lected to participate in such project, shall not be considered*
21 *by the Secretary in the designation of a health professional*
22 *shortage area under section 332 during fiscal years 2003*
23 *through 2005.*

1 “(f) *RULE OF CONSTRUCTION.*—*This section shall not*
2 *be construed to require any State to participate in the*
3 *project described in this section.*

4 “(g) *REPORT.*—*The Secretary shall prepare and sub-*
5 *mit a report on the project to—*

6 “(1) *the Committee on Health, Education,*
7 *Labor, and Pensions of the Senate;*

8 “(2) *the Subcommittee on Labor, Health and*
9 *Human Services, and Education of the Committee on*
10 *Appropriations of the Senate;*

11 “(3) *the Committee on Energy and Commerce of*
12 *the House of Representatives; and*

13 “(4) *the Subcommittee on Labor, Health and*
14 *Human Services, and Education of the Committee on*
15 *Appropriations of the House of Representatives.*

16 **“SEC. 773. INFORMATION TECHNOLOGY.**

17 “(a) *GRANTS AND CONTRACTS.*—*The Secretary may*
18 *make awards of grants or contracts to qualifying schools*
19 *of pharmacy for the purpose of assisting such schools in*
20 *acquiring and installing computer-based systems to provide*
21 *pharmaceutical education. Education provided through*
22 *such systems may be graduate education, professional edu-*
23 *cation, or continuing education. The computer-based sys-*
24 *tems may be designed to provide on-site education, or edu-*

1 *cation at remote sites (commonly referred to as distance*
2 *learning), or both.*

3 “(b) *QUALIFYING SCHOOL OF PHARMACY.—For pur-*
4 *poses of this section, the term ‘qualifying school of phar-*
5 *macy’ means a school of pharmacy (as defined in section*
6 *799B) that requires students to serve in a clinical rotation*
7 *in which pharmacist services are part of the curriculum.*

8 **“SEC. 774. AUTHORIZATION OF APPROPRIATIONS.**

9 “*For the purpose of carrying out this subpart, there*
10 *are authorized to be appropriated such sums as may be nec-*
11 *essary for each of the fiscal years 2003 through 2006.”.*

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