

**AMENDMENT-IN-THE-NATURE-OF-A-SUBSTITUTE
TO H.R. 4954, AS REPORTED
OFFERED BY MRS. JOHNSON OF CONNECTICUT
AND MR. BILIRAKIS OF FLORIDA**

Strike all after the enacting clause and insert the following:

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

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

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

12 (c) BIPA; SECRETARY.—In this Act:

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

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

19 (d) TABLE OF CONTENTS.—The table of contents of this
20 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 and premiums.
- “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.
- Sec. 106. GAO study of the effectiveness of the new prescription drug program.

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

Subtitle A—Medicare+ Choice Revitalization

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

Subtitle B—Medicare+ Choice Competition Program

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

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

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



- Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 311. Relief for certain non-teaching hospitals.

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 401. Revision of acute care hospital payment updates.
- Sec. 402. 2-year increase in level of adjustment for indirect costs of medical education (IME).
- Sec. 403. Recognition of new medical technologies under inpatient hospital PPS.
- Sec. 404. Phase-in of Federal rate for hospitals in Puerto Rico.
- Sec. 405. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
- Sec. 406. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
- Sec. 407. Reference to provision for more frequent updates in the weights used in hospital market basket.
- Sec. 408. Reference to provision making improvements to critical access hospital program.
- Sec. 409. GAO study on improving the hospital wage index.

Subtitle B—Skilled Nursing Facility Services

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

Subtitle C—Hospice

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

Subtitle D—Other Provisions

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

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

- Sec. 501. Revision of updates for physicians' services.
- Sec. 502. Studies on access to physicians' services.
- Sec. 503. MedPAC report on payment for physicians' services.
- Sec. 504. 1-year extension of treatment of certain physician pathology services under medicare.
- Sec. 505. Physician fee schedule wage index revision.

Subtitle B—Other Services

- Sec. 511. Competitive acquisition of certain items and services.
- Sec. 512. Payment for ambulance services.
- Sec. 513. 2-year extension of moratorium on therapy caps; provisions relating to reports.
- Sec. 514. Coverage of an initial preventive physical examination.
- Sec. 515. Renal dialysis services.
- Sec. 516. Improved payment for certain mammography services.
- Sec. 517. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 518. Coverage of cholesterol and blood lipid screening.



TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

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

Subtitle B—Direct Graduate Medical Education

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

Subtitle C—Other Provisions

- Sec. 621. Modifications to Medicare Payment Advisory Commission (MedPAC).
- Sec. 622. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
- Sec. 623. Demonstration project for medical adult day care services.
- Sec. 624. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

- Sec. 701. Establishment of Medicare Benefits Administration.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

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

Subtitle B—Contracting Reform

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

Subtitle C—Education and Outreach

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

Subtitle D—Appeals and Recovery

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



Subtitle E—Miscellaneous Provisions

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

TITLE IX—MEDICAID PROVISIONS

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

**TITLE I—MEDICARE
PRESCRIPTION DRUG BENEFIT**

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

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

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

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

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT
PROGRAM

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

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

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



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

6 Such individuals shall have a choice of such plans under section
7 1860E(d).

8 “(b) GENERAL ELECTION PROCEDURES.—

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

20 “(2) ELECTION PERIODS.—

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

26 “(i) annual coordinated election periods; and

27 “(ii) special election periods.

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



1 “(B) INITIAL ELECTION PERIODS.—

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

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

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

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

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

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

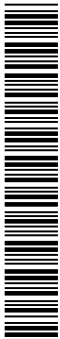
26 “(iv) in cases of individuals (as determined by
27 the Administrator) who become eligible for pre-
28 scription drug assistance under title XIX under
29 section 1935(d).

30 “(3) INFORMATION ON PLANS.—Information described
31 in section 1860C(b)(1) on prescription drug plans shall be
32 made available during open enrollment periods.

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

35 “(1) GUARANTEED ISSUE.—

36 “(A) IN GENERAL.—An eligible individual who is
37 eligible to elect qualified prescription drug coverage



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

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

13 “(2) COMMUNITY-RATED PREMIUM.—

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

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



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

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

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

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

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



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

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

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

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

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



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

3 “(E) DISCLOSURE.—

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

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

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

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

31 “(d) EFFECTIVE DATE OF ELECTIONS.—

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



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

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

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

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

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

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

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

29 “(2) LIMITS ON COST-SHARING.—

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

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



1 “(I) is equal to 20 percent; or
2 “(II) is actuarially equivalent (using proc-
3 esses established under subsection (e)) to an
4 average expected payment of 20 percent of
5 such costs.
6 “(ii) SECONDARY COPAYMENT RANGE.—For
7 costs above the amount specified in subparagraph
8 (C) and up to the initial coverage limit, the cost-
9 sharing—
10 “(I) is equal to 50 percent; or
11 “(II) is actuarially consistent (using proc-
12 esses established under subsection (e)) with an
13 average expected payment of 50 percent of
14 such costs.
15 “(B) USE OF TIERED COPAYMENTS.—Nothing in
16 this part shall be construed as preventing a PDP spon-
17 sor from applying tiered copayments, so long as such
18 tiered copayments are consistent with subparagraph
19 (A).
20 “(C) INITIAL COPAYMENT THRESHOLD.—The
21 amount specified in this subparagraph—
22 “(i) for 2005, is equal to \$1,000; or
23 “(ii) for a subsequent year, is equal to the
24 amount specified in this subparagraph for the pre-
25 vious year, increased by the annual percentage in-
26 crease described in paragraph (5) for the year in-
27 volved.
28 Any amount determined under clause (ii) that is not a
29 multiple of \$10 shall be rounded to the nearest mul-
30 tiple of \$10.
31 “(3) INITIAL COVERAGE LIMIT.—Subject to paragraph
32 (4), the coverage has an initial coverage limit on the max-
33 imum costs that may be recognized for payment
34 purposes—
35 “(A) for 2005, that is equal to \$2,000; or
36 “(B) for a subsequent year, that is equal to the
37 amount specified in this paragraph for the previous



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

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

6 “(4) CATASTROPHIC PROTECTION.—

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

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

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

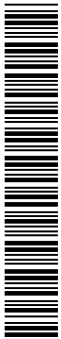
17 “(ii) for a subsequent year, is equal to the
18 amount specified in this subparagraph for the pre-
19 vious year, increased by the annual percentage in-
20 crease described in paragraph (5) for the year in-
21 volved.

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

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

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

33 “(ii) such costs shall be treated as incurred
34 only if they are paid by the individual (or by an-
35 other individual, such as a family member, on be-
36 half of the individual), under section 1860G, or
37 under title XIX and the individual (or other indi-



1 vidual) is not reimbursed through insurance or oth-
2 erwise, a group health plan, or other third-party
3 payment arrangement for such costs.

4 “(5) ANNUAL PERCENTAGE INCREASE.—For purposes
5 of this part, the annual percentage increase specified in
6 this paragraph for a year is equal to the annual percentage
7 increase in average per capita aggregate expenditures for
8 covered outpatient drugs in the United States for medicare
9 beneficiaries, as determined by the Administrator for the
10 12-month period ending in July of the previous year.

11 “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A pre-
12 scription drug plan or Medicare+ Choice plan may provide a
13 different prescription drug benefit design from the standard
14 coverage described in subsection (b) so long as the Adminis-
15 trator determines (based on an actuarial analysis by the Ad-
16 ministrator) that the following requirements are met and the
17 plan applies for, and receives, the approval of the Adminis-
18 trator for such benefit design:

19 “(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT
20 COVERAGE.—

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

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

35 “(C) ASSURING STANDARD PAYMENT FOR COSTS
36 AT INITIAL COVERAGE LIMIT.—The coverage is de-
37 signed, based upon an actuarially representative pat-



1 tern of utilization (as determined under subsection (e)),
2 to provide for the payment, with respect to costs in-
3 curred that are equal to the initial coverage limit under
4 subsection (b)(3), of an amount equal to at least the
5 sum of the following products:

6 “(i) FIRST COPAYMENT RANGE.—The product
7 of—

8 “(I) the amount by which the initial co-
9 payment threshold described in subsection
10 (b)(2)(C) exceeds the deductible described in
11 subsection (b)(1); and

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

15 “(ii) SECONDARY COPAYMENT RANGE.—The
16 product of—

17 “(I) the amount by which the initial cov-
18 erage limit described in subsection (b)(3) ex-
19 ceeds the initial copayment threshold described
20 in subsection (b)(2)(C); and

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

24 “(2) CATASTROPHIC PROTECTION.—The coverage pro-
25 vides for beneficiaries the catastrophic protection described
26 in subsection (b)(4).

27 “(d) ACCESS TO NEGOTIATED PRICES.—

28 “(1) IN GENERAL.—Under qualified prescription drug
29 coverage offered by a PDP sponsor or a Medicare+ Choice
30 organization, the sponsor or organization shall provide
31 beneficiaries with access to negotiated prices (including ap-
32 plicable discounts) used for payment for covered outpatient
33 drugs, regardless of the fact that no benefits may be pay-
34 able under the coverage with respect to such drugs because
35 of the application of cost-sharing or an initial coverage
36 limit (described in subsection (b)(3)). Insofar as a State
37 elects to provide medical assistance under title XIX for a



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

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

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

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

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

29 “(i) an actuarial valuation of standard cov-
30 erage and of the reinsurance subsidy payments
31 under section 1860H;

32 “(ii) the use of generally accepted actuarial
33 principles and methodologies; and

34 “(iii) applying the same methodology for de-
35 terminations of alternative coverage under sub-
36 section (c) as is used with respect to determina-



1 tions of standard coverage under subsection (b);
2 and

3 “(B) for determining annual percentage increases
4 described in subsection (b)(5).

5 “(2) USE OF OUTSIDE ACTUARIES.—Under the proc-
6 esses under paragraph (1)(A), PDP sponsors and
7 Medicare+ Choice organizations may use actuarial opinions
8 certified by independent, qualified actuaries to establish ac-
9 tuarial values, but the Administrator shall determine
10 whether such actuarial values meet the requirements under
11 subsection (c)(1).

12 “(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

19 “(B) a biological product described in clauses (i)
20 through (iii) of subparagraph (B) of such section or in-
21 sulin described in subparagraph (C) of such section,
22 and such term includes a vaccine licensed under section
23 351 of the Public Health Service Act and any use of a cov-
24 ered outpatient drug for a medically accepted indication (as
25 defined in section 1927(k)(6)).

26 “(2) EXCLUSIONS.—

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

33 “(B) AVOIDANCE OF DUPLICATE COVERAGE.—A
34 drug prescribed for an individual that would otherwise
35 be a covered outpatient drug under this part shall not
36 be so considered if payment for such drug is available



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

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

9 “(4) APPLICATION OF GENERAL EXCLUSION PROVI-
10 SIONS.—A prescription drug plan or Medicare+ Choice plan
11 may exclude from qualified prescription drug coverage any
12 covered outpatient drug—

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

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

17 Such exclusions are determinations subject to reconsider-
18 ation and appeal pursuant to section 1860C(f).

19 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALI-**
20 **FIED PRESCRIPTION DRUG COVERAGE.**

21 “(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS,
22 ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—
23 For provisions requiring guaranteed issue, community-rated
24 premiums, access to negotiated prices, and nondiscrimination,
25 see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and
26 1860F(b), respectively.

27 “(b) DISSEMINATION OF INFORMATION.—

28 “(1) GENERAL INFORMATION.—A PDP sponsor shall
29 disclose, in a clear, accurate, and standardized form to
30 each enrollee with a prescription drug plan offered by the
31 sponsor under this part at the time of enrollment and at
32 least annually thereafter, the information described in sec-
33 tion 1852(c)(1) relating to such plan. Such information in-
34 cludes the following:

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



1 “(B) How any formulary used by the sponsor
2 functions, including the drugs included in the for-
3 mulary.

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

8 “(D) Grievance and appeals procedures.

9 Such information shall also be made available on request
10 to prospective enrollees during annual open enrollment peri-
11 ods.

12 “(2) DISCLOSURE UPON REQUEST OF GENERAL COV-
13 ERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—
14 Upon request of an individual eligible to enroll under a pre-
15 scription drug plan, the PDP sponsor shall provide the in-
16 formation described in section 1852(c)(2) (other than sub-
17 paragraph (D)) to such individual.

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

24 “(4) CLAIMS INFORMATION.—Each PDP sponsor of-
25 fering a prescription drug plan must furnish to enrolled in-
26 dividuals in a form easily understandable to such individ-
27 uals an explanation of benefits (in accordance with section
28 1806(a) or in a comparable manner) and a notice of the
29 benefits in relation to initial coverage limit and annual out-
30 of-pocket threshold for the current year, whenever prescrip-
31 tion drug benefits are provided under this part (except that
32 such notice need not be provided more often than monthly).

33 “(c) ACCESS TO COVERED BENEFITS.—

34 “(1) ASSURING PHARMACY ACCESS.—

35 “(A) IN GENERAL.—The PDP sponsor of the pre-
36 scription drug plan shall secure the participation in its
37 network of a sufficient number of pharmacies that dis-



1 pense (other than by mail order) drugs directly to pa-
2 tients to ensure convenient access (as determined by
3 the Administrator and including adequate emergency
4 access) for enrolled beneficiaries, in accordance with
5 standards established under section 1860D(e) that en-
6 sure such convenient access.

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

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

13 “(ii) the plan may charge beneficiaries through
14 adjustments in premiums and copayments any ad-
15 ditional costs associated with the point-of-service
16 option.

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

19 “(2) USE OF STANDARDIZED TECHNOLOGY.—

20 “(A) IN GENERAL.—The PDP sponsor of a pre-
21 scription drug plan shall issue (and reissue, as appro-
22 priate) such a card (or other technology) that may be
23 used by an enrolled beneficiary to assure access to ne-
24 gotiated prices under section 1860B(d) for the pur-
25 chase of prescription drugs for which coverage is not
26 otherwise provided under the prescription drug plan.

27 “(B) STANDARDS.—

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

34 “(ii) APPLICATION OF ADVISORY TASK
35 FORCE.—The advisory task force established under
36 subsection (d)(3)(B)(ii) shall provide recommenda-



1 tions to the Administrator under such subsection
2 regarding the standards developed under clause (i).

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

7 “(A) PHARMACY AND THERAPEUTIC (P&T) COM-
8 MITTEE.—The sponsor must establish a pharmacy and
9 therapeutic committee that develops and reviews the
10 formulary. Such committee shall include at least one
11 practicing physician and at least one practicing phar-
12 macist both with expertise in the care of elderly or dis-
13 abled persons and a majority of its members shall con-
14 sist of individuals who are a practicing physician or a
15 practicing pharmacist (or both).

16 “(B) FORMULARY DEVELOPMENT.—In developing
17 and reviewing the formulary, the committee shall base
18 clinical decisions on the strength of scientific evidence
19 and standards of practice, including assessing peer-re-
20 viewed medical literature, such as randomized clinical
21 trials, pharmacoeconomic studies, outcomes research
22 data, and such other information as the committee de-
23 termines to be appropriate.

24 “(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC
25 CATEGORIES.—The formulary must include drugs with-
26 in each therapeutic category and class of covered out-
27 patient drugs (although not necessarily for all drugs
28 within such categories and classes).

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

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

36 “(F) GRIEVANCES AND APPEALS RELATING TO AP-
37 PLICATION OF FORMULARIES.—For provisions relating



1 to grievances and appeals of coverage, see subsections
2 (e) and (f).

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

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

7 “(A) an effective cost and drug utilization man-
8 agement program, including medically appropriate in-
9 centives to use generic drugs and therapeutic inter-
10 change, when appropriate;

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

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

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

22 “(2) MEDICATION THERAPY MANAGEMENT PRO-
23 GRAM.—

24 “(A) IN GENERAL.—A medication therapy man-
25 agement program described in this paragraph is a pro-
26 gram of drug therapy management and medication ad-
27 ministration that is designed to assure, with respect to
28 beneficiaries with chronic diseases (such as diabetes,
29 asthma, hypertension, and congestive heart failure) or
30 multiple prescriptions, that covered outpatient drugs
31 under the prescription drug plan are appropriately used
32 to achieve therapeutic goals and reduce the risk of ad-
33 verse events, including adverse drug interactions.

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

35 “(i) enhanced beneficiary understanding of
36 such appropriate use through beneficiary education,
37 counseling, and other appropriate means;



1 “(ii) increased beneficiary adherence with pre-
2 scription medication regimens through medication
3 refill reminders, special packaging, and other ap-
4 propriate means; and

5 “(iii) detection of patterns of overuse and
6 underuse of prescription drugs.

7 “(C) DEVELOPMENT OF PROGRAM IN COOPERA-
8 TION WITH LICENSED PHARMACISTS.—The program
9 shall be developed in cooperation with licensed and
10 practicing pharmacists and physicians.

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

17 “(3) ELECTRONIC PRESCRIPTION PROGRAM.—

18 “(A) IN GENERAL.—An electronic prescription
19 drug program described in this paragraph is a program
20 that includes at least the following components, con-
21 sistent with national standards established under sub-
22 paragraph (B):

23 “(i) ELECTRONIC TRANSMITTAL OF PRESCRIP-
24 TIONS.—Prescriptions are only received electroni-
25 cally, except in emergency cases and other excep-
26 tional circumstances recognized by the Adminis-
27 trator.

28 “(ii) PROVISION OF INFORMATION TO PRE-
29 SCRIBING HEALTH CARE PROFESSIONAL.—The pro-
30 gram provides, upon transmittal of a prescription
31 by a prescribing health care professional, for trans-
32 mittal by the pharmacist to the professional of in-
33 formation that includes—

34 “(I) information (to the extent available
35 and feasible) on the drugs being prescribed for
36 that patient and other information relating to
37 the medical history or condition of the patient



1 that may be relevant to the appropriate pre-
2 scription for that patient;

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

5 “(III) information on the drugs included
6 in the applicable formulary.

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

11 “(B) STANDARDS.—

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

18 “(ii) ADVISORY TASK FORCE.—In developing
19 such standards and the standards described in sub-
20 section (c)(2)(B)(i) the Administrator shall estab-
21 lish a task force that includes representatives of
22 physicians, hospitals, pharmacists, and technology
23 experts and representatives of the Departments of
24 Veterans Affairs and Defense and other appro-
25 priate Federal agencies to provide recommenda-
26 tions to the Administrator on such standards, in-
27 cluding recommendations relating to the following:

28 “(I) The range of available computerized
29 prescribing software and hardware and their
30 costs to develop and implement.

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

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

36 “(IV) The cost of implementing such sys-
37 tems in the range of hospital and physician of-



1 fice settings, including hardware, software, and
2 training costs.

3 “(V) Implementation issues as they relate
4 to part C of title XI, and current Federal and
5 State prescribing laws and regulations and
6 their impact on implementation of computer-
7 ized prescribing.

8 “(iii) DEADLINES.—

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

12 “(II) Such task force shall submit rec-
13 ommendations to Administrator by not later
14 than January 1, 2004.

15 “(III) The Administrator shall develop and
16 promulgate the national standards referred to
17 in clause (ii) by not later than January 1,
18 2005.

19 “(C) REFERENCE TO AVAILABILITY OF GRANT
20 FUNDS.—Grant funds are authorized under section
21 3990 of the Public Health Service Act to provide as-
22 sistance to health care providers in implementing elec-
23 tronic prescription drug programs.

24 “(4) TREATMENT OF ACCREDITATION.—Section
25 1852(e)(4) (relating to treatment of accreditation) shall
26 apply to prescription drug plans under this part with re-
27 spect to the following requirements, in the same manner as
28 they apply to Medicare+ Choice plans under part C with re-
29 spect to the requirements described in a clause of section
30 1852(e)(4)(B):

31 “(A) Paragraph (1) (including quality assurance),
32 including medication therapy management program
33 under paragraph (2).

34 “(B) Subsection (c)(1) (relating to access to cov-
35 ered benefits).

36 “(C) Subsection (g) (relating to confidentiality and
37 accuracy of enrollee records).



1 “(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL
2 PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor
3 shall provide that each pharmacy or other dispenser that
4 arranges for the dispensing of a covered outpatient drug
5 shall inform the beneficiary at the time of purchase of the
6 drug of any differential between the price of the prescribed
7 drug to the enrollee and the price of the lowest cost generic
8 drug covered under the plan that is therapeutically equiva-
9 lent and bioequivalent.

10 “(e) GRIEVANCE MECHANISM, COVERAGE DETERMINA-
11 TIONS, AND RECONSIDERATIONS.—

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

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

26 “(3) REQUEST FOR REVIEW OF TIERED FORMULARY
27 DETERMINATIONS.—In the case of a prescription drug plan
28 offered by a PDP sponsor that provides for tiered cost-
29 sharing for drugs included within a formulary and provides
30 lower cost-sharing for preferred drugs included within the
31 formulary, an individual who is enrolled in the plan may re-
32 quest coverage of a nonpreferred drug under the terms ap-
33 plicable for preferred drugs if the prescribing physician de-
34 termines that the preferred drug for treatment of the same
35 condition is not as effective for the individual or has ad-
36 verse effects for the individual.

37 “(f) APPEALS.—



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

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

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

21 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**
22 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**
23 **LISHMENT OF STANDARDS.**

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

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

31 “(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUB-
32 SIDIZED COVERAGE.—

33 “(A) IN GENERAL.—Subject to subparagraph (B)
34 and section 1860E(d)(2), the entity assumes full finan-
35 cial risk on a prospective basis for qualified prescrip-
36 tion drug coverage that it offers under a prescription



1 drug plan and that is not covered under section
2 1860H.

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

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

11 “(b) CONTRACT REQUIREMENTS.—

12 “(1) IN GENERAL.—The Administrator shall not per-
13 mit the election under section 1860A of a prescription drug
14 plan offered by a PDP sponsor under this part, and the
15 sponsor shall not be eligible for payments under section
16 1860G or 1860H, unless the Administrator has entered
17 into a contract under this subsection with the sponsor with
18 respect to the offering of such plan. Such a contract with
19 a sponsor may cover more than one prescription drug plan.
20 Such contract shall provide that the sponsor agrees to com-
21 ply with the applicable requirements and standards of this
22 part and the terms and conditions of payment as provided
23 for in this part.

24 “(2) NEGOTIATION REGARDING TERMS AND CONDI-
25 TIONS.—The Administrator shall have the same authority
26 to negotiate the terms and conditions of prescription drug
27 plans under this part as the Director of the Office of Per-
28 sonnel Management has with respect to health benefits
29 plans under chapter 89 of title 5, United States Code. In
30 negotiating the terms and conditions regarding premiums
31 for which information is submitted under section
32 1860F(a)(2), the Administrator shall take into account the
33 subsidy payments under section 1860H and the adjusted
34 community rate (as defined in section 1854(f)(3)) for the
35 benefits covered.

36 “(3) INCORPORATION OF CERTAIN MEDICARE+ CHOICE
37 CONTRACT REQUIREMENTS.—The following provisions of



1 section 1857 shall apply, subject to subsection (c)(5), to
2 contracts under this section in the same manner as they
3 apply to contracts under section 1857(a):

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

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

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

10 “(D) ADDITIONAL CONTRACT TERMS.—Section
11 1857(e); except that in applying section 1857(e)(2)
12 under this part—

13 “(i) such section shall be applied separately to
14 costs relating to this part (from costs under part
15 C);

16 “(ii) in no case shall the amount of the fee es-
17 tablished under this subparagraph for a plan ex-
18 ceed 20 percent of the maximum amount of the fee
19 that may be established under subparagraph (B) of
20 such section; and

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

23 “(E) INTERMEDIATE SANCTIONS.—Section
24 1857(g).

25 “(F) PROCEDURES FOR TERMINATION.—Section
26 1857(h).

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

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

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

33 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND
34 CHOICE.—

35 “(1) IN GENERAL.—In the case of an entity that seeks
36 to offer a prescription drug plan in a State, the Adminis-
37 trator shall waive the requirement of subsection (a)(1) that



1 the entity be licensed in that State if the Administrator de-
2 termines, based on the application and other evidence pre-
3 sented to the Administrator, that any of the grounds for
4 approval of the application described in paragraph (2) has
5 been met.

6 “(2) GROUNDS FOR APPROVAL.—The grounds for ap-
7 proval under this paragraph are the grounds for approval
8 described in subparagraph (B), (C), and (D) of section
9 1855(a)(2), and also include the application by a State of
10 any grounds other than those required under Federal law.

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

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

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

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

27 “(B) any reference to solvency standards shall be
28 treated as a reference to solvency standards established
29 under subsection (d).

30 “(d) SOLVENCY STANDARDS FOR NON-LICENSED SPON-
31 SORS.—

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



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

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

14 “(f) RELATION TO STATE LAWS.—

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

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

27 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**
28 **QUALIFIED PRESCRIPTION DRUG COV-**
29 **ERAGE.**

30 “(a) IN GENERAL.—The Administrator shall establish a
31 process for the selection of the prescription drug plan or
32 Medicare+ Choice plan which offer qualified prescription drug
33 coverage through which eligible individuals elect qualified pre-
34 scription drug coverage under this part.

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



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

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

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

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

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

23 “(1) CHOICE OF AT LEAST TWO PLANS IN EACH
24 AREA.—

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

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



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

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

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

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

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

21 “(4) REPORTS.—The Administrator shall, in each an-
22 nual report to Congress under section 1808(f), include in-
23 formation on the exercise of authority under this sub-
24 section. The Administrator also shall include such rec-
25 ommendations as may be appropriate to minimize the exer-
26 cise of such authority, including minimizing the assumption
27 of financial risk.

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

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

33 “(a) SUBMISSION OF BIDS, PREMIUMS, AND RELATED IN-
34 FORMATION.—

35 “(1) IN GENERAL.—Each PDP sponsor shall submit
36 to the Administrator the information described in para-
37 graph (2) in the same manner as information is submitted



1 by a Medicare+ Choice organization under section
2 1854(a)(1).

3 “(2) INFORMATION SUBMITTED.—The information de-
4 scribed in this paragraph is the following:

5 “(A) COVERAGE PROVIDED.—Information on the
6 qualified prescription drug coverage to be provided.

7 “(B) ACTUARIAL VALUE.—Information on the ac-
8 tuarial value of the coverage.

9 “(C) BID AND PREMIUM.—Information on the bid
10 and the premium for the coverage, including an actu-
11 arial certification of—

12 “(i) the actuarial basis for such bid and pre-
13 mium;

14 “(ii) the portion of such bid and premium at-
15 tributable to benefits in excess of standard cov-
16 erage; and

17 “(iii) the reduction in such bid and premium
18 resulting from the subsidy payments provided
19 under section 1860H.

20 “(D) ADDITIONAL INFORMATION.—Such other in-
21 formation as the Administrator may require to carry
22 out this part.

23 “(3) REVIEW OF INFORMATION AND APPROVAL OF
24 PREMIUMS.—The Administrator shall review the informa-
25 tion filed under paragraph (2) for the purpose of con-
26 ducting negotiations under section 1860D(b)(2). The Ad-
27 ministrator, using the information provided (including the
28 actuarial certification under paragraph (2)(C)) shall ap-
29 prove the premium submitted under this subsection only if
30 the premium accurately reflects both (A) the actuarial
31 value of the benefits provided, and (B) the 67 percent sub-
32 sidy provided under section 1860H for the standard ben-
33 efit. The Administrator shall apply actuarial principles to
34 approval of a premium under this part in a manner similar
35 to the manner in which those principles are applied in es-
36 tablishing the monthly part B premium under section
37 1839.



1 “(b) UNIFORM BID AND PREMIUM.—

2 “(1) IN GENERAL.—The bid and premium for a pre-
3 scription drug plan under this section may not vary among
4 individuals enrolled in the plan in the same service area.

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

8 “(c) COLLECTION.—

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

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

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

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

35 “(1) IN GENERAL.—If there is no standard prescrip-
36 tion drug coverage (as defined in paragraph (2)) offered in
37 an area, in the case of an individual who is eligible for a



1 premium subsidy under section 1860G and resides in the
2 area, the PDP sponsor of any prescription drug plan of-
3 fered in the area (and any Medicare+ Choice organization
4 that offers qualified prescription drug coverage in the area)
5 shall accept the benchmark bid amount (under section
6 1860G(b)(2)) as payment in full for the premium charge
7 for qualified prescription drug coverage.

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

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

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

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

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

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

36 “(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUC-
37 TION OF COST-SHARING FOR INDIVIDUALS WITH INCOME



1 ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POV-
2 ERTY LEVEL.—In the case of a subsidy eligible individual
3 who is determined to have income that exceeds 150 per-
4 cent, but does not exceed 175 percent, of the Federal pov-
5 erty level, the individual is entitled under this section to—

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

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

19 “(3) CONSTRUCTION.—Nothing in this section shall be
20 construed as preventing a PDP sponsor from reducing to
21 0 the cost-sharing otherwise applicable to generic drugs.

22 “(4) DETERMINATION OF ELIGIBILITY.—

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

27 “(i) is eligible to elect, and has elected, to ob-
28 tain qualified prescription drug coverage under this
29 part;

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

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

34 “(B) DETERMINATIONS.—The determination of
35 whether an individual residing in a State is a subsidy
36 eligible individual and the amount of such individual’s
37 income shall be determined under the State Medicaid



1 plan for the State under section 1935(a) or by the So-
2 cial Security Administration. In the case of a State
3 that does not operate such a medicaid plan (either
4 under title XIX or under a statewide waiver granted
5 under section 1115), such determination shall be made
6 under arrangements made by the Administrator. There
7 are authorized to be appropriated to the Social Security
8 Administration such sums as may be necessary for the
9 determination of eligibility under this subparagraph.

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

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

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

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

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

31 “(5) INDEXING DOLLAR AMOUNTS.—

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



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

9 “(b) PREMIUM SUBSIDY AMOUNT.—

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

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

20 “(A) a prescription drug plan that—

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

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

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

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



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

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

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

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

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

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

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

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

36 “(e) RELATION TO MEDICAID PROGRAM.—



1 in the aggregate is 30 percent of such total payments, for
2 excess costs incurred in providing qualified prescription
3 drug coverage—

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

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

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

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

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

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

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

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

27 “(c) REINSURANCE PAYMENT AMOUNT.—

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

33 “(A) For the portion of the individual’s gross cover-
34 ed prescription drug costs (as defined in paragraph
35 (3)) for the year that exceeds the initial copayment
36 threshold specified in section 1860B(b)(2)(C), but does
37 not exceed the initial coverage limit specified in section



1 1860B(b)(3), an amount equal to 30 percent of the al-
2 lowable costs (as defined in paragraph (2)) attributable
3 to such gross covered prescription drug costs.

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

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

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

31 “(4) INDEXING DOLLAR AMOUNTS.—

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

35 “(B) FOR 2006.—The dollar amounts applied
36 under paragraph (1) for 2006 shall be the dollar
37 amounts specified in such paragraph increased by the



1 annual percentage increase described in section
2 1860B(b)(5) for 2006.

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

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

15 “(d) ADJUSTMENT OF PAYMENTS.—

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

19 “(A) ESTIMATION OF PAYMENTS.—The Adminis-
20 trator shall estimate—

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

24 “(ii) the total payments to be made by quali-
25 fying entities for standard coverage under plans de-
26 scribed in subsection (b) during the year.

27 “(B) ADJUSTMENT.—The Administrator shall pro-
28 portionally adjust the payments made under sub-
29 sections (a)(2) and (c) for a coverage year in such
30 manner so that the total of the payments made under
31 such subsections for the year is equal to 30 percent of
32 the total payments described in subparagraph (A)(ii).

33 “(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To
34 the extent the Administrator determines it appropriate to
35 avoid risk selection, the payments made for direct subsidies
36 under subsection (a)(1) are subject to adjustment based
37 upon risk factors specified by the Administrator. Any such



1 risk adjustment shall be designed in a manner as to not re-
2 sult in a change in the aggregate payments made under
3 such subsection.

4 “(e) PAYMENT METHODS.—

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

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

15 “(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DE-
16 FINED.—

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

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

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

34 “(C) PROVISION OF CERTIFICATION OF PRESCRIP-
35 TION DRUG COVERAGE.—The sponsor of the plan shall
36 provide for issuance of certifications of the type de-
37 scribed in section 1860A(c)(2)(D).



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

5 “(A) enrolled under this part;

6 “(B) is covered under the plan; and

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

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

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

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

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

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

27 “(A) is enrolled with a prescription drug plan
28 under this part;

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

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

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



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

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

14 “(b) PAYMENTS FROM TRUST FUND.—

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

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

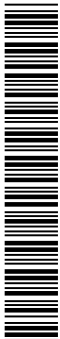
20 “(B) payments under section 1860H (relating to
21 subsidy payments); and

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

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

32 “(c) DEPOSITS INTO TRUST FUND.—

33 “(1) LOW-INCOME TRANSFER.—There is hereby trans-
34 ferred to the Trust Fund, from amounts appropriated for
35 Grants to States for Medicaid, amounts equivalent to the
36 aggregate amount of the reductions in payments under sec-



1 tion 1903(a)(1) attributable to the application of section
2 1935(c).

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

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

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

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

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

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

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

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

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

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

36 “(B) provides qualified prescription drug coverage;
37 and



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

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

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

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

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

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

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

20 “(4) any reference to part C included a reference to
21 this part.”.

22 (b) ADDITIONAL CONFORMING CHANGES.—

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

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

31 (A) by striking “and” at the end of subparagraph
32 (E);

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

35 (C) by adding at the end the following new sub-
36 paragraph:



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

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

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

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

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

32 “(B) providing a Medicare+ Choice organization
33 with direct and insurance subsidy payments for pro-
34 viding qualified prescription drug coverage under this
35 part, see section 1860H.

36 “(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—
37 Notwithstanding any other provision of this part, the an-



1 nual, coordinated election period under subsection (e)(3)(B)
2 for 2005 shall be the 6-month period beginning with No-
3 vember 2004.

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

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

11 (1) in subsection (a)(1)—

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

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

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

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

20 (2) in subsection (g)(1), by inserting “and section
21 1860A(c)(2)(B)” after “in this subsection”.

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

24 **SEC. 103. MEDICAID AMENDMENTS.**

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

27 (1) REQUIREMENT.—Section 1902(a) (42 U.S.C.
28 1396a(a)) is amended—

29 (A) by striking “and” at the end of paragraph
30 (64);

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

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

35 “(66) provide for making eligibility determinations
36 under section 1935(a).”.

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



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

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

5 “SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION
6 DRUG BENEFIT

7 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY
8 DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condi-
9 tion of its State plan under this title under section 1902(a)(66)
10 and receipt of any Federal financial assistance under section
11 1903(a), a State shall—

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

15 “(2) inform the Administrator of the Medicare Bene-
16 fits Administration of such determinations in cases in
17 which such eligibility is established; and

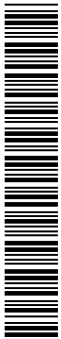
18 “(3) otherwise provide such Administrator with such
19 information as may be required to carry out part D of title
20 XVIII (including section 1860G).

21 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE
22 COSTS.—

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

31 “(A) For expenditures attributable to costs in-
32 curred during 2005, the otherwise applicable Federal
33 matching rate shall be increased by 10 percent of the
34 percentage otherwise payable (but for this subsection)
35 by the State.

36 “(B)(i) For expenditures attributable to costs in-
37 curred during 2006 and each subsequent year through



1 2013, the otherwise applicable Federal matching rate
2 shall be increased by the applicable percent (as defined
3 in clause (ii)) of the percentage otherwise payable (but
4 for this subsection) by the State.

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

7 “(I) 2006 is 20 percent; or

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

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

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

19 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RE-
20 SPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES
21 FOR DUALY ELIGIBLE INDIVIDUALS.—

22 (1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C.
23 1396b(a)(1)) is amended by inserting before the semicolon
24 the following: “, reduced by the amount computed under
25 section 1935(c)(1) for the State and the quarter”.

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

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

31 “(1) IN GENERAL.—For purposes of section
32 1903(a)(1), for a State that is one of the 50 States or the
33 District of Columbia for a calendar quarter in a year (be-
34 ginning with 2005) the amount computed under this sub-
35 section is equal to the product of the following:

36 “(A) MEDICARE SUBSIDIES.—The total amount of
37 payments made in the quarter under section 1860G



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

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

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

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

18 “(A) 2005 is 90 percent;

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

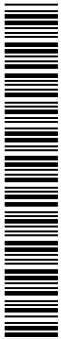
22 “(C) a year after 2013 is 0 percent.”.

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

26 “(d) ADDITIONAL PROVISIONS.—

27 “(1) MEDICAID AS SECONDARY PAYOR.—In the case of
28 an individual who is entitled to qualified prescription drug
29 coverage under a prescription drug plan under part D of
30 title XVIII (or under a Medicare+ Choice plan under part
31 C of such title) and medical assistance for prescribed drugs
32 under this title, medical assistance shall continue to be pro-
33 vided under this title for prescribed drugs to the extent
34 payment is not made under the prescription drug plan or
35 the Medicare+ Choice plan selected by the individual.

36 “(2) CONDITION.—A State may require, as a condition
37 for the receipt of medical assistance under this title with



1 respect to prescription drug benefits for an individual eligi-
2 ble to obtain qualified prescription drug coverage described
3 in paragraph (1), that the individual elect qualified pre-
4 scription drug coverage under section 1860A.”.

5 (d) TREATMENT OF TERRITORIES.—

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

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

11 (B) in subsection (c)(1), by inserting “subject to
12 subsection (e)” after “1903(a)(1)”;

13 (C) by adding at the end the following new sub-
14 section:

15 “(e) TREATMENT OF TERRITORIES.—

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

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

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

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

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

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

36 “(3) INCREASED AMOUNT.—



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

4 “(i) the aggregate amount specified in sub-
5 paragraph (B); and

6 “(ii) the amount specified in section
7 1108(g)(1) for that State, divided by the sum of
8 the amounts specified in such section for all such
9 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 aggre-
14 gate amount specified in this subparagraph for the
15 previous year increased by annual percentage in-
16 crease specified in section 1860B(b)(5) for the year
17 involved.

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

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

25 (e) AMENDMENT TO BEST PRICE.—Section
26 1927(c)(1)(C)(i) (42 U.S.C. 1396r-8(c)(1)(C)(i)) is amended—

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

28 (2) by striking the period at the end of subclause (IV)
29 and inserting “; and”; and

30 (3) by adding at the end the following new subclause:

31 “(V) any prices charged which are nego-
32 tiated by a prescription drug plan under part
33 D of title XVIII, by a Medicare+ Choice plan
34 under part C of such title with respect to cov-
35 ered outpatient drugs, or by a qualified retiree
36 prescription drug plan (as defined in section
37 1860H(f)(1)) with respect to such drugs on be-



1 half of individuals entitled to benefits under
2 part A or enrolled under part B of such title.”.

3 **SEC. 104. MEDIGAP TRANSITION.**

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

6 “(v) COVERAGE OF PRESCRIPTION DRUGS.—

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

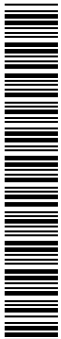
15 “(2) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN
16 PRESCRIPTION DRUG COVERAGE UNDER PART D.—

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

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

26 “(ii) may not discriminate in the pricing of
27 such policy, because of health status, claims experi-
28 ence, receipt of health care, or medical condition;
29 and

30 “(iii) may not impose an exclusion of benefits
31 based on a pre-existing condition under such policy,
32 in the case of an individual described in subparagraph
33 (B) who seeks to enroll under the policy not later than
34 63 days after the date of the termination of enrollment
35 described in such paragraph and who submits evidence
36 of the date of termination or disenrollment along with
37 the application for such medicare supplemental policy.



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

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

5 “(ii) at the time of such enrollment was en-
6 rolled and terminates enrollment in a medicare sup-
7 plemental policy which has a benefit package classi-
8 fied as ‘H’, ‘I’, or ‘J’ under the standards referred
9 to in subparagraph (A)(i) or terminates enrollment
10 in a policy to which such standards do not apply
11 but which provides benefits for prescription drugs.

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

16 “(3) NEW STANDARDS.—In applying subsection
17 (p)(1)(E) (including permitting the NAIC to revise its
18 model regulations in response to changes in law) with re-
19 spect to the change in benefits resulting from title I of the
20 Medicare Modernization and Prescription Drug Act of
21 2002, with respect to policies issued to individuals who are
22 enrolled under part D, the changes in standards shall only
23 provide for substituting for the benefit packages that in-
24 cluded coverage for prescription drugs two benefit packages
25 that may provide for coverage of cost-sharing with respect
26 to qualified prescription drug coverage under such part, ex-
27 cept that such coverage may not cover the prescription
28 drug deductible under such part. The two benefit packages
29 shall be consistent with the following:

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

34 “(i) Coverage of 50 percent of the cost-sharing
35 otherwise applicable, except coverage of 100 per-
36 cent of any cost-sharing otherwise applicable for
37 preventive benefits.



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

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

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

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

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

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

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

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

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

25 “MEDICARE PRESCRIPTION DRUG DISCOUNT CARD
26 ENDORSEMENT PROGRAM

27 “SEC. 1807. (a) IN GENERAL.—The Secretary (or the
28 Medicare Benefits Administrator pursuant to section
29 1808(c)(3)(C)) shall establish a program—

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

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

34 “(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary
35 may not endorse a prescription drug discount card program
36 under this section unless the program meets the following re-
37 quirements:



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

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

8 “(3) BENEFICIARY SERVICES.—The program provides
9 pharmaceutical support services, such as education and
10 counseling, and services to prevent adverse drug inter-
11 actions.

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

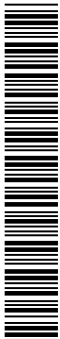
19 “(5) DEMONSTRATED EXPERIENCE.—The entity oper-
20 ating the program has demonstrated experience and exper-
21 tise in operating such a program or a similar program.

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

25 “(7) OPERATION OF ASSISTANCE PROGRAM.—The en-
26 tity meets such requirements relating to solvency, compli-
27 ance with financial reporting requirements, audit compli-
28 ance, and contractual guarantees as the Secretary finds
29 necessary for the participation of the sponsor in the low-
30 income assistance program under section 1807A.

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

34 “(9) ADDITIONAL BENEFICIARY PROTECTIONS.—The
35 program meets such additional requirements as the Sec-
36 retary identifies to protect and promote the interest of
37 medicare beneficiaries, including requirements that ensure



1 that beneficiaries are not charged more than the lower of
2 the negotiated retail price or the usual and customary
3 price.

4 The prices negotiated by a prescription drug discount card pro-
5 gram endorsed under this section shall (notwithstanding any
6 other provision of law) not be taken into account for the pur-
7 poses of establishing the best price under section
8 1927(c)(1)(C).

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

11 “(1) PROMOTION OF INFORMED CHOICE.—In order to
12 promote informed choice among endorsed prescription drug
13 discount card programs, the Secretary shall provide for the
14 dissemination of information which compares the prices
15 and services of such programs in a manner coordinated
16 with the dissemination of educational information on
17 Medicare+ Choice plans under part C.

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

22 “(3) USE OF MEDICARE TOLL-FREE NUMBER.—The
23 Secretary shall provide through the 1-800-medicare toll free
24 telephone number for the receipt and response to inquiries
25 and complaints concerning the program and programs en-
26 dorsed under this section.

27 “(4) SANCTIONS FOR ABUSIVE PRACTICES.—The Sec-
28 retary may implement intermediate sanctions or may re-
29 voke the endorsement of a program in the case of a pro-
30 gram that the Secretary determines no longer meets the re-
31 quirements of this section or that has engaged in false or
32 misleading marketing practices.

33 “(5) ENROLLMENT PRACTICES.—A medicare bene-
34 ficiary may not be enrolled in more than one endorsed pro-
35 gram at any time. A medicare beneficiary may change the
36 endorsed program in which the beneficiary is enrolled, but
37 may not make such change until the beneficiary has been



1 enrolled in a program for a minimum period of time speci-
2 fied by the Secretary.

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

7 “(e) ENDORSEMENT CONDITION.—The Secretary shall re-
8 quire, as condition of endorsement under of a prescription drug
9 discount card program under this section that the program im-
10 plement policies and procedures to safeguard the use and dis-
11 closure of program beneficiaries’ individually identifiable health
12 information in a manner consistent with the Federal regula-
13 tions (concerning the privacy of individually identifiable health
14 information) promulgated under section 264(c) of the Health
15 Insurance Portability and Accountability Act of 1996.

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

19 “TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE PROGRAM
20 FOR LOW-INCOME BENEFICIARIES

21 “SEC. 1807A. (a) PURPOSE.—The purpose of this section
22 is to provide low-income medicare beneficiaries with immediate
23 assistance in the purchase of covered outpatient prescription
24 drugs during the period before the program under part D be-
25 comes effective.

26 “(b) FUNDS AVAILABLE; ALLOTMENTS.—

27 “(1) APPROPRIATIONS; TOTAL ALLOTMENTS.—

28 “(A) APPROPRIATIONS.—For the purpose of car-
29 rying out this section, there is appropriated, out of any
30 money in the Treasury not otherwise appropriated—

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

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

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

34 “(2) ALLOTMENTS.—

35 “(A) AMONG RESIDENTS OF 50 STATES AND THE
36 DISTRICT OF COLUMBIA.—Subject to subparagraph
37 (B), the amount appropriated under subparagraph (A)



1 for each fiscal year shall be allotted among the 50
2 States and the District of Columbia based upon the
3 Secretary's estimate of each State's or District's pro-
4 portion of the total number of medicare beneficiaries
5 with income below 175 percent of the Federal poverty
6 line residing in all such States and the District. The
7 Secretary shall determine the amount of the allotment
8 for each such State and District not later than July 1,
9 2003.

10 “(B) AMONG RESIDENTS OF TERRITORIES.—Of
11 the amount appropriated under subparagraph (A) for a
12 fiscal year, the Secretary shall allot a percentage (de-
13 termined consistent with the allotment provided to ter-
14 ritories under the State children's health insurance pro-
15 gram under section 2104(c)) among the common-
16 wealths and territories described in section 2104(c)(3)
17 in the same proportion as the allotment proportion
18 under such program is allowed among such common-
19 wealths and territories.

20 “(3) AVAILABILITY OF AMOUNTS ALLOTTED.—
21 Amounts allotted with respect to a State pursuant to this
22 subsection for a fiscal year shall remain available for ex-
23 penditure through the end of the fiscal year in which bene-
24 fits are first available under part D. Any funds allotted to
25 States that are not obligated revert to the General Fund
26 of the Treasury.

27 “(4) LIMITATION.—In no case shall the total amount
28 of payments for assistance to eligible individuals (and ad-
29 ministrative costs) in a State for a fiscal year (and previous
30 fiscal years) under this section exceed the amount of the
31 allotments with respect to that State in that year (and pre-
32 vious fiscal years). Nothing in this section shall be con-
33 strued as preventing a State from providing, with its own
34 funds, pharmaceutical assistance that is in addition to the
35 assistance funded under this section.

36 “(c) ELIGIBILITY.—



1 “(1) IN GENERAL.—Taking into account the amounts
2 allotted with respect to each State under subsection (b) and
3 the minimum dollar value on assistance per eligible indi-
4 vidual specified by the Secretary under subsection (d)(3),
5 the Secretary shall establish guidelines for the establish-
6 ment by each State of eligibility standards consistent with
7 paragraph (2).

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

11 “(A) is entitled to benefits under part A or en-
12 rolled under part B;

13 “(B) has income that is at or below a percentage
14 (specified under the State eligibility plan under para-
15 graph (1), but not to exceed 175 percent) of the Fed-
16 eral poverty line; and

17 “(C) meets the resources requirement described in
18 section 1905(p)(1)(C);

19 “(D) is enrolled under a prescription drug dis-
20 count card program (or under an alternative program
21 authorized under subsection (d)(1)(B)); and

22 “(E) is not eligible for coverage of, or assistance
23 for, outpatient prescription drugs under any of the fol-
24 lowing:

25 “(i) A medicaid plan under title XIX (includ-
26 ing under any waiver approved under section
27 1115).

28 “(ii) Enrollment under a group health plan or
29 health insurance coverage.

30 “(iii) Enrollment under a medicare supple-
31 mental insurance policy.

32 “(iv) Chapter 55 of title 10, United States
33 Code (relating to medical and dental care for mem-
34 bers of the uniformed services).

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



1 “(vi) Enrollment under a plan under chapter
2 89 of title 5, United States Code (relating to the
3 Federal employees’ health benefits program).

4 “(vii) The Indian Health Care Improvement
5 Act (25 U.S.C. 1601 et seq.).

6 “(3) INCOME DETERMINATIONS.—The provisions of
7 section 1860G(4)(C) shall apply for purposes of applying
8 this subsection.

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

11 “(1) IN GENERAL.—

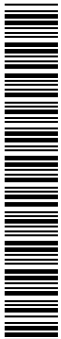
12 “(A) THROUGH PROGRAM SPONSOR.—Subject to
13 subparagraph (B), the assistance under this section to
14 an eligible individual shall be in the form of a discount
15 (as identified by the sponsor to the Secretary) provided
16 by the sponsor of a prescription drug discount card
17 program to eligible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

19 “(B) THROUGH ALTERNATIVE STATE PROGRAM.—
20 A State may apply to the Secretary for authorization
21 to provide the assistance under this section to an eligi-
22 ble individual through a State pharmaceutical assist-
23 ance program or private program of pharmaceutical as-
24 sistance. The Secretary shall not authorize the use of
25 such a program unless the Secretary finds that the
26 program—

27 “(i) was in existence before the date of the en-
28 actment of this section; and

29 “(ii) is reasonably designed to provide for
30 pharmaceutical assistance for a number of individ-
31 uals, and in a scope, that is not less than the num-
32 ber of individuals, and minimum required amount,
33 that would occur if the provisions of this subpara-
34 graph had not applied in the State.

35 “(2) GUIDANCE; MINIMUM LEVEL OF ASSISTANCE.—
36 The Secretary shall establish guidelines for how the pro-
37 gram under this section will operate. Based upon the ag-



1 gregate amount appropriated in each fiscal year and other
2 relevant factors, the Secretary shall establish a minimum
3 amount of assistance that is available, subject to paragraph
4 (4)(B), to each eligible individual for each calendar quarter
5 (or other period specified by the Secretary) and provide
6 guidance to sponsors regarding how assistance funds may
7 be provided to eligible individuals consistent with such
8 amount and funding limitations.

9 “(3) RELATIONSHIP TO DISCOUNTS.—The assistance
10 provided under this section is in addition to the discount
11 otherwise available to individuals enrolled in prescription
12 drug discount card programs who are not eligible individ-
13 uals.

14 “(4) LIMITATION ON ASSISTANCE.—

15 “(A) IN GENERAL.—The assistance under this sec-
16 tion for an eligible individual shall be limited to
17 assistance—

18 “(i) for covered outpatient drugs (as defined
19 in section 1860B(f)) and for enrollment fees im-
20 posed under prescription drug discount card pro-
21 grams; and

22 “(ii) for expenses incurred—

23 “(I) on and after the date the individual
24 is both enrolled in the prescription drug dis-
25 count card program and determined to be an
26 eligible individual under this section; and

27 “(II) before the date benefits are first
28 available under the program under part D.

29 “(B) AUTHORITY.—The Secretary shall take such
30 steps as may be necessary to assure compliance with
31 the expenditure limitations described in subsection
32 (b)(4).

33 “(e) PAYMENT OF FEDERAL SUBSIDY TO SPONSORS.—

34 “(1) IN GENERAL.—The Secretary shall make pay-
35 ment (within the allotments for each State, less the admin-
36 istrative payments made subsection (f)(2) to each State) to
37 the sponsor of the prescription drug discount card program



1 (or to a State or other entity operating a program under
2 subsection (d)(1)(B)) in which an eligible individual is en-
3 rolled of the amount of the assistance provided by the spon-
4 sor pursuant to this section.

5 “(2) PERIODIC PAYMENTS.—Payments under this sub-
6 section (and subsection (f)(2)) shall be made on a monthly
7 or other periodic installment basis, based upon estimates of
8 the Secretary and shall be reduced or increased to the ex-
9 tent of any overpayment or underpayment which the Sec-
10 retary determines was made under this section for any
11 prior period and with respect to which adjustment has not
12 already been made under this paragraph.

13 “(f) STATE RESPONSIBILITIES.—

14 “(1) ELIGIBILITY DETERMINATIONS.—As a condition
15 for the payment of Federal financial participation to a
16 State under section 1903(a) for periods during which as-
17 sistance is available under this section, the State must sub-
18 mit to the Secretary an eligibility plan under which the
19 State—

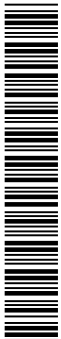
20 “(A) establishes eligibility standards consistent
21 with the provisions of this section;

22 “(B) conducts determinations of eligibility and in-
23 come in the same manner as the State is required to
24 make eligibility and income determinations described in
25 section 1860G(a)(4); and

26 “(C) communicates to the Secretary (or the Sec-
27 retary’s designee) determinations of eligibility or dis-
28 continuation of eligibility under this section.

29 The Secretary shall provide a method for communicating
30 with sponsors concerning the identity of eligible individuals.

31 “(2) COVERAGE OF ADMINISTRATIVE COSTS.—Of the
32 amount allotted with respect to a State under subsection
33 (b), the Secretary shall pay to the State the amount of its
34 administrative costs in carrying out this subsection, but not
35 to exceed 10 percent of the amount of such allotment to
36 the State. The provisions of subsection (e)(2) shall apply
37 to such payments.



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

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

5 “(2) PRESCRIPTION DRUG DISCOUNT CARD PRO-
6 GRAM.—The term ‘prescription drug discount card pro-
7 gram’ means such a program that is endorsed under sec-
8 tion 1807.

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

13 “(4) STATE.—The term ‘State’ has the meaning given
14 such term for purposes of title XIX.”

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

22 **SEC. 106. GAO STUDY OF THE EFFECTIVENESS OF THE**
23 **NEW PRESCRIPTION DRUG PROGRAM.**

24 (a) STUDY.—The Comptroller General of the United
25 States shall conduct a study on the effectiveness of the pre-
26 scription drug program provided under part D of title XVIII
27 of the Social Security Act. Such study shall—

28 (1) report—

29 (A) the percentage of eligible individuals who en-
30 rolled in the program;

31 (B) the demographic characteristics (including
32 health status) of such enrollees;

33 (C) the number and type of qualified prescription
34 drug coverage available to such individuals; and

35 (D) the premiums imposed for enrollment in dif-
36 ferent areas;



1 (2) evaluate the processes and methods developed by
2 the Administrator and the decisions reached by outside ac-
3 tuaries to determine the actuarial valuation of prescription
4 drug coverage; and

5 (3) assess whether the subsidy payments under such
6 part accomplished its stated goals of reducing premium lev-
7 els for all beneficiaries, reducing adverse selection, and pro-
8 moting participation of PDP sponsors.

9 (b) REPORT.—Not later January 1, 2006, the Comptroller
10 General shall submit a report to Congress on the study con-
11 ducted under subsection (a).

12 **TITLE II—MEDICARE+CHOICE RE-**
13 **VITALIZATION AND**
14 **MEDICARE+CHOICE COMPETI-**
15 **TION PROGRAM**
16 **Subtitle A—Medicare+Choice**
17 **Revitalization**

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

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

21 (1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C.
22 1395w-23(c)(1)) is amended by adding at the end the fol-
23 lowing:

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

26 “(i) IN GENERAL.—For 2003 and 2004, the
27 adjusted average per capita cost for the year in-
28 volved, determined under section 1876(a)(4) for the
29 Medicare+ Choice payment area for services cov-
30 ered under parts A and B for individuals entitled
31 to benefits under part A and enrolled under part
32 B who are not enrolled in a Medicare+ Choice plan
33 under this part for the year, but adjusted to ex-
34 clude costs attributable to payments under section
35 1886(h).



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

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

16 (b) REVISION OF BLEND.—

17 (1) REVISION OF NATIONAL AVERAGE USED IN CAL-
18 CULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42
19 U.S.C. 1395w-23(c)(4)(B)(i)(II)) is amended by inserting
20 “who (with respect to determinations for 2003 and for
21 2004) are enrolled in a Medicare+ Choice plan” after “the
22 average number of medicare beneficiaries”.

23 (2) CHANGE IN BUDGET NEUTRALITY.—Section
24 1853(c) (42 U.S.C. 1395w-23(c)) is amended—

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

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

29 (c) REVISION IN MINIMUM PERCENTAGE INCREASE FOR
30 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C. 1395w-
31 23(c)(1)(C)) is amended by striking clause (iv) and inserting
32 the following:

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



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

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

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

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

14 (2) by adding at the end the following new subpara-
15 graph:

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

29 (e) ANNOUNCEMENT OF REVISED MEDICARE+ CHOICE
30 PAYMENT RATES.—Within 4 weeks after the date of the enact-
31 ment of this Act, the Secretary shall determine, and shall an-
32 nounce (in a manner intended to provide notice to interested
33 parties) Medicare+ Choice capitation rates under section 1853
34 of the Social Security Act (42 U.S.C. 1395w-23) for 2003, re-
35 vised in accordance with the provisions of this section.

36 (f) MEDPAC STUDY OF AAPCC.—



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

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

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

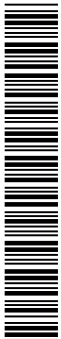
13 (C) the accuracy of risk adjustment methods in re-
14 flecting differences in costs of providing care to dif-
15 ferent groups of beneficiaries served under such pro-
16 gram.

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

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

32 **SEC. 202. MAKING PERMANENT CHANGE IN**
33 **MEDICARE+CHOICE REPORTING DEADLINES**
34 **AND ANNUAL, COORDINATED ELECTION PE-**
35 **RIOD.**

36 (a) CHANGE IN REPORTING DEADLINE.—Section
37 1854(a)(1) (42 U.S.C. 1395w-24(a)(1)), as amended by sec-



1 tion 532(b)(1) of the Public Health Security and Bioterrorism
2 Preparedness and Response Act of 2002, is amended by strik-
3 ing “2002, 2003, and 2004 (or July 1 of each other year)” and
4 inserting “2002 and each subsequent year (or July 1 of each
5 year before 2002)”.

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

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

22 (d) REQUIRING PROVISION OF AVAILABLE INFORMATION
23 COMPARING PLAN OPTIONS.—The first sentence of section
24 1851(d)(2)(A)(ii) (42 U.S.C. 1395w-21(d)(2)(A)(ii)) is amend-
25 ed by inserting before the period the following: “to the extent
26 such information is available at the time of preparation of ma-
27 terials for the mailing”.

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

29 (a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w-
30 26(b)(3)) is amended to read as follows:

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



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

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

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

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

16 “(4) SPECIALIZED MEDICARE+ CHOICE PLANS FOR
17 SPECIAL NEEDS BENEFICIARIES.—

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

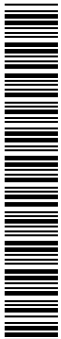
23 “(B) SPECIAL NEEDS BENEFICIARY.—The term
24 ‘special needs beneficiary’ means a Medicare+ Choice
25 eligible individual who—

26 “(i) is institutionalized (as defined by the Sec-
27 retary);

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

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

35 (c) RESTRICTION ON ENROLLMENT PERMITTED.—Section
36 1859 (42 U.S.C. 1395w-29) is amended by adding at the end
37 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 plan
4 (as defined in subsection (b)(4)), notwithstanding any other
5 provision of this part and in accordance with regulations of the
6 Secretary and for periods before January 1, 2007, the plan
7 may restrict the enrollment of individuals under the plan to in-
8 dividuals who are within one or more classes of special needs
9 beneficiaries.”.

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

18 (e) EFFECTIVE DATES.—

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

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

29 **SEC. 205. MEDICARE MSAS.**

30 (a) EXEMPTION FROM REPORTING ENROLLEE ENCOUN-
31 TER DATA.—

32 (1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C.
33 1395w-22(e)(1)) is amended by inserting “(other than
34 MSA plans)” after “Medicare+ Choice plans”.

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



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

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

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

10 (1) in the heading, by striking “ON A DEMONSTRATION
11 BASIS”;

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

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

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

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

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

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

25 (3) by striking clause (iii).

26 **SEC. 206. EXTENSION OF REASONABLE COST AND SHMO**
27 **CONTRACTS.**

28 (a) REASONABLE COST CONTRACTS.—

29 (1) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C.
30 1395mm(h)(5)(C)) is amended—

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

32 (B) by inserting before the period the following: “,
33 except (subject to clause (ii)) in the case of a contract
34 for an area which is not covered in the service area of
35 1 or more coordinated care Medicare+Choice plans
36 under part C”; and

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



1 “(ii) In the case in which—
2 “(I) a reasonable cost reimbursement contract includes
3 an area in its service area as of a date that is after Decem-
4 ber 31, 2003;
5 “(II) such area is no longer included in such service
6 area after such date by reason of the operation of clause
7 (i) because of the inclusion of such area within the service
8 area of a Medicare+ Choice plan; and
9 “(III) all Medicare+ Choice plans subsequently termi-
10 nate coverage in such area;
11 such reasonable cost reimbursement contract may be extended
12 and renewed to cover such area (so long as it is not included
13 in the service area of any Medicare+ Choice plan).”.

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

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

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

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



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

SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.

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

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

(2) in subsection (a)(1)(A)—

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

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

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

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

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

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

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

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

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

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

and the actuarial basis for determining such proportions.



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

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

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

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

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

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

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

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

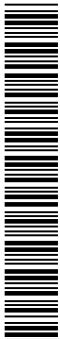
26 (A) by adding at the end of paragraph (1) the fol-
27 lowing new subparagraph:

28 “(C) BENEFICIARY REBATE RULE.—

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

34 (d) CONFORMING AMENDMENTS.—

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



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

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

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

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

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

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

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

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

35 (4) PERMITTING BENEFICIARY REBATES.—

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



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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

22 (2) CONFORMING AMENDMENTS.—

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

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

30 (ii) in subclauses (I) and (II), by inserting
31 “(or, in the case of a competitive-demonstration
32 area, described in section 1854(b)(4))” after “sec-
33 tion 1854(b)(3)(C)”.

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



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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

29 (a) CONFORMING AMENDMENTS RELATING TO BIDS.—

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

31 (A) in the heading of subsection (a), by inserting
32 “AND BID AMOUNTS” after “PREMIUMS”; and

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

35 (b) ADDITIONAL CONFORMING AMENDMENTS.—



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

35 “(B) BUDGET NEUTRALITY ADJUSTMENT.—In the
36 case of a State requesting an adjustment under this
37 paragraph, the Medicare Benefits Administrator shall



1 initially (and annually thereafter) adjust the payment
2 rates otherwise established under this section for
3 Medicare+ Choice payment areas in the State in a man-
4 ner so that the aggregate of the payments under this
5 section in the State shall not exceed the aggregate pay-
6 ments that would have been made under this section
7 for Medicare+ Choice payment areas in the State in the
8 absence of the adjustment under this paragraph.”.

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

12 **TITLE III—RURAL HEALTH CARE**
13 **IMPROVEMENTS**

14 **SEC. 301. REFERENCE TO FULL MARKET BASKET IN-**
15 **CREASE FOR SOLE COMMUNITY HOSPITALS.**

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

19 **SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOS-**
20 **PITAL (DSH) TREATMENT FOR RURAL HOS-**
21 **PITALS AND URBAN HOSPITALS WITH**
22 **FEWER THAN 100 BEDS.**

23 (a) BLENDING OF PAYMENT AMOUNTS.—

24 (1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C.
25 1395ww(d)(5)(F)) is amended by adding at the end the fol-
26 lowing new clause:

27 “(xiv)(I) In the case of discharges in a fiscal year begin-
28 ning on or after October 1, 2002, subject to subclause (II),
29 there shall be substituted for the disproportionate share adjust-
30 ment percentage otherwise determined under clause (iv) (other
31 than subclause (I)) or under clause (viii), (x), (xi), (xii), or
32 (xiii), the old blend proportion (specified under subclause (III))
33 of the disproportionate share adjustment percentage otherwise
34 determined under the respective clause and 100 percent minus
35 such old blend proportion of the disproportionate share adjust-
36 ment percentage determined under clause (vii) (relating to
37 large, urban hospitals).



1 “(II) Under subclause (I), the disproportionate share ad-
2 justment percentage shall not exceed 10 percent for a hospital
3 that is not classified as a rural referral center under subpara-
4 graph (C).

5 “(III) For purposes of subclause (I), the old blend propor-
6 tion for fiscal year 2003 is 80 percent, for each subsequent
7 year (through 2006) is the old blend proportion under this sub-
8 clause for the previous year minus 20 percentage points, and
9 for each year beginning with 2007 is 0 percent.”.

10 (2) CONFORMING AMENDMENTS.—Section
11 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

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

15 (B) in clause (viii), by striking “The formula” and
16 inserting “Subject to clause (xiv), the formula”; and

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

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

23 **SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STAND-**
24 **ARDIZED AMOUNT IN RURAL AND SMALL**
25 **URBAN AREAS TO ACHIEVE A SINGLE, UNI-**
26 **FORM STANDARDIZED AMOUNT.**

27 Section 1886(d)(3)(A)(iv) (42 U.S.C.
28 1395ww(d)(3)(A)(iv)) is amended—

29 (1) by striking “(iv) For discharges” and inserting
30 “(iv)(I) Subject to the succeeding provisions of this clause,
31 for discharges”; and

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

33 “(II) For discharges occurring during fiscal year
34 2003, the average standardized amount for hospitals lo-
35 cated other than in a large urban area shall be increased
36 by ½ of the difference between the average standardized
37 amount determined under subclause (I) for hospitals lo-



1 cated in large urban areas for such fiscal year and such
2 amount determined (without regard to this subclause) for
3 other hospitals for such fiscal year.

4 “(III) For discharges occurring in a fiscal year begin-
5 ning with fiscal year 2004, the Secretary shall compute an
6 average standardized amount for hospitals located in any
7 area within the United States and within each region equal
8 to the average standardized amount computed for the pre-
9 vious fiscal year under this subparagraph for hospitals lo-
10 cated in a large urban area (or, beginning with fiscal year
11 2005, for hospitals located in any area) increased by the
12 applicable percentage increase under subsection
13 (b)(3)(B)(i).”.

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

16 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After re-
17 vising the weights used in the hospital market basket under
18 section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C.
19 1395ww(b)(3)(B)(iii)) to reflect the most current data avail-
20 able, the Secretary shall establish a frequency for revising such
21 weights in such market basket to reflect the most current data
22 available more frequently than once every 5 years.

23 (b) REPORT.—Not later than October 1, 2003, the Sec-
24 retary shall submit a report to Congress on the frequency es-
25 tablished under subsection (a), including an explanation of the
26 reasons for, and options considered, in determining such fre-
27 quency.

28 **SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOS-**
29 **PITAL PROGRAM.**

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

33 (1) by striking “and” at the end of subparagraph (C);

34 (2) by adding “and” at the end of subparagraph (D);

35 and

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



1 “(E) inpatient critical access hospital services;”.

2 (b) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN
3 PAYMENT ADJUSTMENT.—Section 1834(g)(2) (42 U.S.C.
4 1395m(g)(2)) is amended by adding after and below subpara-
5 graph (B) the following:

6 “The Secretary may not require, as a condition for apply-
7 ing subparagraph (B) with respect to a critical access hos-
8 pital, that each physician providing professional services in
9 the hospital must assign billing rights with respect to such
10 services, except that such subparagraph shall not apply to
11 those physicians who have not assigned such billing
12 rights.”.

13 (c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS.—
14 Section 1820 (42 U.S.C. 1395i-4) is amended—

15 (1) in subsection (c)(2)(B)(iii), by inserting “subject
16 to paragraph (3)” after “(iii) provides”;

17 (2) by adding at the end of subsection (c) the fol-
18 lowing new paragraph:

19 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR
20 HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUA-
21 TIONS.—

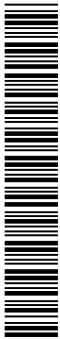
22 “(A) IN GENERAL.—Subject to subparagraph (C),
23 in the case of a hospital that demonstrates that it
24 meets the standards established under subparagraph
25 (B) and has not made the election described in sub-
26 section (f)(2)(A), the bed limitations otherwise applica-
27 ble under paragraph (2)(B)(iii) and subsection (f) shall
28 be increased by 5 beds.

29 “(B) STANDARDS.—The Secretary shall specify
30 standards for determining whether a critical access hos-
31 pital has sufficiently strong seasonal variations in pa-
32 tient admissions to justify the increase in bed limitation
33 provided under subparagraph (A).”; and

34 (3) in subsection (f)—

35 (A) by inserting “(1)” after “(f)”; and

36 (B) by adding at the end the following new para-
37 graph:



1 “(2)(A) A hospital may elect to treat the reference in
2 paragraph (1) to ‘15 beds’ as a reference to ‘25 beds’, but only
3 if no more than 10 beds in the hospital are at any time used
4 for non-acute care services. A hospital that makes such an elec-
5 tion is not eligible for the increase provided under subsection
6 (c)(3)(A).

7 “(B) The limitations in numbers of beds under the first
8 sentence of paragraph (1) are subject to adjustment under sub-
9 section (c)(3).”.

10 (d) 5-YEAR EXTENSION OF THE AUTHORIZATION FOR AP-
11 PROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j) (42
12 U.S.C. 1395i-4(j)) is amended by striking “through 2002” and
13 inserting “through 2007”.

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

23 (f) EFFECTIVE DATES.—

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

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

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



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

4 (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.
5 2763A-533) is amended—

6 (1) by striking “24-MONTH INCREASE BEGINNING
7 APRIL 1, 2001” and inserting “IN GENERAL”; and

8 (2) by striking “April 1, 2003” and inserting “Janu-
9 ary 1, 2005”.

10 (b) CONFORMING AMENDMENT.—Section 547(c)(2) of
11 BIPA (114 Stat. 2763A-553) is amended by striking “the pe-
12 riod beginning on April 1, 2001, and ending on September 30,
13 2002,” and inserting “a period under such section”.

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

18 For—

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

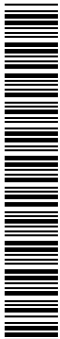
22 (2) provision of a rural hospice demonstration project,
23 see section 423.

24 **SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LO-**
25 **CATED IN RURAL OR SMALL URBAN AREAS**
26 **IN REDISTRIBUTION OF UNUSED GRADUATE**
27 **MEDICAL EDUCATION RESIDENCIES.**

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

31 **SEC. 309. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN**
32 **PAYMENTS FOR PHYSICIANS’ SERVICES.**

33 (a) STUDY.—The Comptroller General of the United
34 States shall conduct a study of differences in payment amounts
35 under the physician fee schedule under section 1848 of the So-
36 cial Security Act (42 U.S.C. 1395w-4) for physicians’ services
37 in different geographic areas. Such study shall include—



1 (1) an assessment of the validity of the geographic ad-
2 justment factors used for each component of the fee sched-
3 ule;

4 (2) an evaluation of the measures used for such ad-
5 justment, including the frequency of revisions; and

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

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

20 **SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COL-**
21 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**
22 **CALLY UNDERSERVED POPULATIONS.**

23 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.
24 1320a-7(b)(3)), as amended by section 101(b)(2), is
25 amended—

26 (1) in subparagraph (F), by striking “and” after the
27 semicolon at the end;

28 (2) in subparagraph (G), by striking the period at the
29 end and inserting “; and”; and

30 (3) by adding at the end the following new subpara-
31 graph:

32 “(H) any remuneration between a public or non-
33 profit private health center entity described under
34 clause (i) or (ii) of section 1905(l)(2)(B) and any indi-
35 vidual or entity providing goods, items, services, dona-
36 tions or loans, or a combination thereof, to such health
37 center entity pursuant to a contract, lease, grant, loan,



1 or other agreement, if such agreement contributes to
2 the ability of the health center entity to maintain or in-
3 crease the availability, or enhance the quality, of serv-
4 ices provided to a medically underserved population
5 served by the health center entity.”.

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

8 (1) ESTABLISHMENT.—

9 (A) IN GENERAL.—The Secretary of Health and
10 Human Services (in this subsection referred to as the
11 “Secretary”) shall establish, on an expedited basis,
12 standards relating to the exception described in section
13 1128B(b)(3)(H) of the Social Security Act, as added
14 by subsection (a), for health center entity arrangements
15 to the antikickback penalties.

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

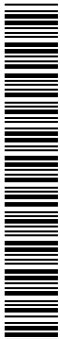
20 (i) Whether the arrangement between the
21 health center entity and the other party results in
22 savings of Federal grant funds or increased reve-
23 nues to the health center entity.

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

27 (iii) Whether the arrangement between the
28 health center entity and the other party protects a
29 health care professional’s independent medical
30 judgment regarding medically appropriate treat-
31 ment.

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

35 (2) INTERIM FINAL EFFECT.—No later than 180 days
36 after the date of enactment of this Act, the Secretary shall
37 publish a rule in the Federal Register consistent with the



1 factors under paragraph (1)(B). Such rule shall be effective
2 and final immediately on an interim basis, subject to such
3 change and revision, after public notice and opportunity
4 (for a period of not more than 60 days) for public com-
5 ment, as is consistent with this subsection.

6 **SEC. 311. RELIEF FOR CERTAIN NON-TEACHING HOS-**
7 **PITALS.**

8 (a) IN GENERAL.—In the case of a non-teaching hospital
9 that meets the condition of subsection (b), in each of fiscal
10 years 2003, 2004, and 2005 the amount of payment made to
11 the hospital under section 1886(d) of the Social Security Act
12 for discharges occurring during such fiscal year only shall be
13 increased as though the applicable percentage increase (other-
14 wise applicable to discharges occurring during such fiscal year
15 under section 1886(b)(3)(B)(i) of the Social Security Act (42
16 U.S.C. 1395ww(b)(3)(B)(i)) had been increased by 5 percent-
17 age points. The previous sentence shall be applied for each such
18 fiscal year separately without regard to its application in a pre-
19 vious fiscal year and shall not affect payment for discharges for
20 any hospital occurring during a fiscal year after fiscal year
21 2005.

22 (b) CONDITION.—A non-teaching hospital meets the condi-
23 tion of this subsection if—

24 (1) it is located in a rural area and the amount of the
25 aggregate payments under subsection (d) of section 1886
26 of the Social Security Act for hospitals located in rural
27 areas in the State for their cost reporting periods beginning
28 during fiscal year 1999 is less than the aggregate allowable
29 operating costs of inpatient hospital services (as defined in
30 subsection (a)(4) of such section) for all subsection (d) hos-
31 pitals in such areas in such State with respect to such cost
32 reporting periods; or

33 (2) it is located in an urban area and the amount of
34 the aggregate payments under subsection (d) of such sec-
35 tion for hospitals located in urban areas in the State for
36 their cost reporting periods beginning during fiscal year
37 1999 is less than 103 percent of the aggregate allowable



1 operating costs of inpatient hospital services (as defined in
2 subsection (a)(4) of such section) for all subsection (d) hos-
3 pitals in such areas in such State with respect to such cost
4 reporting periods.

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

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

9 (1) NON-TEACHING HOSPITAL.—The term “non-teach-
10 ing hospital” means, for a cost reporting period, a sub-
11 section (d) hospital (as defined in subsection (d)(1)(B) of
12 section 1886 of the Social Security Act, 42 U.S.C.
13 1395ww)) that is not receiving any additional payment
14 under subsection (d)(5)(B) of such section or a payment
15 under subsection (h) of such section for discharges occur-
16 ring during the period. A subsection (d) hospital that re-
17 ceives additional payments under subsection (d)(5)(B) or
18 (h) of such section shall, for purposes of this section, also
19 be treated as a non-teaching hospital unless a chairman of
20 a department in the medical school with which the hospital
21 is affiliated is serving or has been appointed as a clinical
22 chief of service in the hospital.

23 (2) RURAL; URBAN.—The terms “rural” and “urban”
24 have the meanings given such terms for purposes of section
25 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

26 **TITLE IV—PROVISIONS RELATING**
27 **TO PART A**
28 **Subtitle A—Inpatient Hospital**
29 **Services**

30 **SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAY-**
31 **MENT UPDATES.**

32 Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C.
33 1395ww(b)(3)(B)(i)) is amended to read as follows:

34 “(XVIII) for fiscal year 2003, the market basket per-
35 centage increase for sole community hospitals and such in-



1 crease minus 0.25 percentage points for other hospitals,
2 and”.

3 **SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT**
4 **FOR INDIRECT COSTS OF MEDICAL EDU-**
5 **CATION (IME).**

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

- 8 (1) in subclause (VI) by striking “and” at the end;
9 (2) by redesignating subclause (VII) as subclause
10 (IX);
11 (3) in subclause (IX) as so redesignated, by striking
12 “2002” and inserting “2004”; and
13 (4) by inserting after subclause (VI) the following new
14 subclause:

15 “(VII) during fiscal year 2003, ‘c’ is equal to 1.47;
16 “(VIII) during fiscal year 2004, ‘c’ is equal to
17 1.45; and”.

18 **SEC. 403. RECOGNITION OF NEW MEDICAL TECH-**
19 **NOLOGIES UNDER INPATIENT HOSPITAL**
20 **PPS.**

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

24 “(vii) Under the mechanism under this subparagraph, the
25 Secretary shall provide for the addition of new diagnosis and
26 procedure codes in April 1 of each year, but the addition of
27 such codes shall not require the Secretary to adjust the pay-
28 ment (or diagnosis-related group classification) under this sub-
29 section until the fiscal year that begins after such date.”.

30 (b) ELIGIBILITY STANDARD.—

31 (1) MINIMUM PERIOD FOR RECOGNITION OF NEW
32 TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C.
33 1395ww(d)(5)(K)(vi)) is amended—

- 34 (A) by inserting “(I)” after “(vi)”; and
35 (B) by adding at the end the following new sub-
36 clause:

37 “(II) Under such criteria, a service or technology shall not
38 be denied treatment as a new service or technology on the basis



1 of the period of time in which the service or technology has
2 been in use if such period ends before the end of the 2-to-3-
3 year period that begins on the effective date of implementation
4 of a code under ICD-9-CM (or a successor coding method-
5 ology) that enables the identification of a significant sample of
6 specific discharges in which the service or technology has been
7 used.”.

8 (2) ADJUSTMENT OF THRESHOLD.—Section
9 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is
10 amended by inserting “(applying a threshold specified by
11 the Secretary that is the lesser of 50 percent of the na-
12 tional average standardized amount for operating costs of
13 inpatient hospital services for all hospitals and all diag-
14 nosis-related groups or one standard deviation for the diag-
15 nosis-related group involved)” after “is inadequate”.

16 (3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—
17 Section 1886(d)(5)(K)(vi) (42 U.S.C.
18 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is
19 further amended by adding at the end the following sub-
20 clause:

21 “(III) The Secretary shall by regulation provide for fur-
22 ther clarification of the criteria applied to determine whether
23 a new service or technology represents an advance in medical
24 technology that substantially improves the diagnosis or treat-
25 ment of beneficiaries. Under such criteria, in determining
26 whether a new service or technology represents an advance in
27 medical technology that substantially improves the diagnosis or
28 treatment of beneficiaries, the Secretary shall deem a service
29 or technology as meeting such requirement if the service or
30 technology is a drug or biological that is designated under sec-
31 tion 506 or 526 of the Federal Food, Drug, and Cosmetic Act,
32 approved under section 314.510 or 601.41 of title 21, Code of
33 Federal Regulations, or designated for priority review when the
34 marketing application for such drug or biological was filed or
35 is a medical device for which an exemption has been granted
36 under section 520(m) of such Act, or for which priority review
37 has been provided under section 515(d)(5) of such Act.”.



1 (4) PROCESS FOR PUBLIC INPUT.—Section
2 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended
3 by paragraph (1), is amended—

4 (A) in clause (i), by adding at the end the fol-
5 lowing: “Such mechanism shall be modified to meet the
6 requirements of clause (viii).”; and

7 (B) by adding at the end the following new clause:
8 “(viii) The mechanism established pursuant to clause (i)
9 shall be adjusted to provide, before publication of a proposed
10 rule, for public input regarding whether a new service or tech-
11 nology not described in the second sentence of clause (vi)(III)
12 represents an advance in medical technology that substantially
13 improves the diagnosis or treatment of beneficiaries as follows:

14 “(I) The Secretary shall make public and periodically
15 update a list of all the services and technologies for which
16 an application for additional payment under this subpara-
17 graph is pending.

18 “(II) The Secretary shall accept comments, rec-
19 ommendations, and data from the public regarding whether
20 the service or technology represents a substantial improve-
21 ment.

22 “(III) The Secretary shall provide for a meeting at
23 which organizations representing hospitals, physicians,
24 medicare beneficiaries, manufacturers, and any other inter-
25 ested party may present comments, recommendations, and
26 data to the clinical staff of the Centers for Medicare &
27 Medicaid Services before publication of a notice of proposed
28 rulemaking regarding whether service or technology rep-
29 resents a substantial improvement.”.

30 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Sec-
31 tion 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further
32 amended by adding at the end the following new clause:

33 “(ix) Before establishing any add-on payment under this
34 subparagraph with respect to a new technology, the Secretary
35 shall seek to identify one or more diagnosis-related groups as-
36 sociated with such technology, based on similar clinical or ana-
37 tomical characteristics and the cost of the technology. Within



1 such groups the Secretary shall assign an eligible new tech-
2 nology into a diagnosis-related group where the average costs
3 of care most closely approximate the costs of care of using the
4 new technology. In such case, no add-on payment under this
5 subparagraph shall be made with respect to such new tech-
6 nology and this clause shall not affect the application of para-
7 graph (4)(C)(iii).”.

8 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-
9 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.
10 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after “the
11 estimated average cost of such service or technology” the fol-
12 lowing: “(based on the marginal rate applied to costs under
13 subparagraph (A))”.

14 (e) EFFECTIVE DATE.—

15 (1) IN GENERAL.—The Secretary shall implement the
16 amendments made by this section so that they apply to
17 classification for fiscal years beginning with fiscal year
18 2004.

19 (2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL
20 YEAR 2003 THAT ARE DENIED.—In the case of an applica-
21 tion for a classification of a medical service or technology
22 as a new medical service or technology under section
23 1886(d)(5)(K) of the Social Security Act (42 U.S.C.
24 1395ww(d)(5)(K)) that was filed for fiscal year 2003 and
25 that is denied—

26 (A) the Secretary shall automatically reconsider
27 the application as an application for fiscal year 2004
28 under the amendments made by this section; and

29 (B) the maximum time period otherwise permitted
30 for such classification of the service or technology shall
31 be extended by 12 months.

32 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS**
33 **IN PUERTO RICO.**

34 Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is
35 amended—

36 (1) in subparagraph (A)—



1 (A) in clause (i), by striking “for discharges begin-
2 ning on or after October 1, 1997, 50 percent (and for
3 discharges between October 1, 1987, and September
4 30, 1997, 75 percent)” and inserting “the applicable
5 Puerto Rico percentage (specified in subparagraph
6 (E))”; and

7 (B) in clause (ii), by striking “for discharges be-
8 ginning in a fiscal year beginning on or after October
9 1, 1997, 50 percent (and for discharges between Octo-
10 ber 1, 1987, and September 30, 1997, 25 percent)”
11 and inserting “the applicable Federal percentage (spec-
12 ified in subparagraph (E))”; and

13 (2) by adding at the end the following new subpara-
14 graph:

15 “(E) For purposes of subparagraph (A), for discharges
16 occurring—

17 “(i) between October 1, 1987, and September 30,
18 1997, the applicable Puerto Rico percentage is 75 percent
19 and the applicable Federal percentage is 25 percent;

20 “(ii) on or after October 1, 1997, and before October
21 1, 2003, the applicable Puerto Rico percentage is 50 per-
22 cent and the applicable Federal percentage is 50 percent;

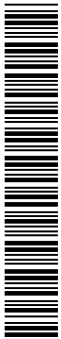
23 “(iii) during fiscal year 2004, the applicable Puerto
24 Rico percentage is 45 percent and the applicable Federal
25 percentage is 55 percent;

26 “(iv) during fiscal year 2005, the applicable Puerto
27 Rico percentage is 40 percent and the applicable Federal
28 percentage is 60 percent;

29 “(v) during fiscal year 2006, the applicable Puerto
30 Rico percentage is 35 percent and the applicable Federal
31 percentage is 65 percent;

32 “(vi) during fiscal year 2007, the applicable Puerto
33 Rico percentage is 30 percent and the applicable Federal
34 percentage is 70 percent; and

35 “(vii) on or after October 1, 2007, the applicable
36 Puerto Rico percentage is 25 percent and the applicable
37 Federal percentage is 75 percent.”.



1 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**
2 **HANCED DISPROPORTIONATE SHARE HOS-**
3 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**
4 **HOSPITALS AND URBAN HOSPITALS WITH**
5 **FEWER THAN 100 BEDS.**

6 For provision enhancing disproportionate share hospital
7 (DSH) treatment for rural hospitals and urban hospitals with
8 fewer than 100 beds, see section 302.

9 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-**
10 **YEAR PHASED-IN INCREASE IN THE STAND-**
11 **ARDIZED AMOUNT IN RURAL AND SMALL**
12 **URBAN AREAS TO ACHIEVE A SINGLE, UNI-**
13 **FORM STANDARDIZED AMOUNT.**

14 For provision phasing in over a 2-year period an increase
15 in the standardized amount for rural and small urban areas to
16 achieve a single, uniform, standardized amount, see section
17 303.

18 **SEC. 407. REFERENCE TO PROVISION FOR MORE FRE-**
19 **QUENT UPDATES IN THE WEIGHTS USED IN**
20 **HOSPITAL MARKET BASKET.**

21 For provision providing for more frequent updates in the
22 weights used in hospital market basket, see section 304.

23 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**
24 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**
25 **GRAM.**

26 For provision providing making improvements to critical
27 access hospital program, see section 305.

28 **SEC. 409. GAO STUDY ON IMPROVING THE HOSPITAL**
29 **WAGE INDEX.**

30 (a) STUDY.—

31 (1) IN GENERAL.—The Comptroller General of the
32 United States shall conduct a study on the improvements
33 that can be made in the measurement of regional dif-
34 ferences in hospital wages reflected in the hospital wage
35 index under section 1886(d) of the Social Security Act (42
36 U.S.C. 1395ww(d)).

37 (2) EXAMINATION OF USE OF METROPOLITAN STATIS-
38 TICAL AREAS (MSAS).—The study shall specifically examine
39 the use of metropolitan statistical areas for purposes of
40 computing and applying the wage index and whether the



1 boundaries of such areas accurately reflect local labor mar-
2 kets. In addition, the study shall examine whether regional
3 inequities are created as a result of infrequent updates of
4 such boundaries and policies of the Bureau of the Census
5 relating to commuting criteria.

6 (3) WAGE DATA.—The study shall specifically examine
7 the portions of the hospital cost reports relating to wages,
8 and methods for improving the accuracy of the wage data
9 and for reducing inequities resulting from differences
10 among hospitals in the reporting of wage data.

11 (b) CONSULTATION WITH OMB.—The Comptroller Gen-
12 eral shall consult with the Director of Office of Management
13 and Budget in conducting the study under subsection (a)(2).

14 (c) REPORT.—Not later than May 1, 2003, the Comp-
15 troller General shall submit to Congress a report on the study
16 conducted under subsection (a) and shall include in the report
17 such recommendations as may be appropriate on—

18 (1) changes in the definition of labor market areas
19 used for purposes of the area wage index under section
20 1886 of the Social Security Act; and

21 (2) improvements in methods for the collection of wage
22 data.

23 **Subtitle B—Skilled Nursing Facility** 24 **Services**

25 **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING** 26 **FACILITY SERVICES.**

27 (a) TEMPORARY INCREASE IN NURSING COMPONENT OF
28 PPS FEDERAL RATE.—Section 312(a) of BIPA is amended by
29 adding at the end the following new sentence: “The Secretary
30 of Health and Human Services shall increase by 12, 10, and
31 8 percent the nursing component of the case-mix adjusted Fed-
32 eral prospective payment rate specified in Tables 3 and 4 of
33 the final rule published in the Federal Register by the Health
34 Care Financing Administration on July 31, 2000 (65 Fed. Reg.
35 46770) and as subsequently updated under section
36 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C.



1 1395yy(e)(4)(E)(ii), effective for services furnished during fis-
2 cal years 2003, 2004, and 2005, respectively.”.

3 (b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

4 (1) IN GENERAL.—Paragraph (12) of section 1888(e)
5 (42 U.S.C. 1395yy(e)) is amended to read as follows:

6 “(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

7 “(A) IN GENERAL.—Subject to subparagraph (B),
8 in the case of a resident of a skilled nursing facility
9 who is afflicted with acquired immune deficiency syn-
10 drome (AIDS), the per diem amount of payment other-
11 wise applicable shall be increased by 128 percent to re-
12 flect increased costs associated with such residents.

13 “(B) SUNSET.—Subparagraph (A) shall not apply
14 on and after such date as the Secretary certifies that
15 there is an appropriate adjustment in the case mix
16 under paragraph (4)(G)(i) to compensate for the in-
17 creased costs associated with residents described in
18 such subparagraph.”.

19 (2) EFFECTIVE DATE.—The amendment made by
20 paragraph (1) shall apply to services furnished on or after
21 October 1, 2003.

22 **Subtitle C—Hospice**

23 **SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERV-** 24 **ICES.**

25 (a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—
26 Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

27 (1) by striking “and” at the end of paragraph (3);

28 (2) by striking the period at the end of paragraph (4)
29 and inserting “; and”; and

30 (3) by inserting after paragraph (4) the following new
31 paragraph:

32 “(5) for individuals who are terminally ill, have not
33 made an election under subsection (d)(1), and have not
34 previously received services under this paragraph, services
35 that are furnished by a physician who is either the medical
36 director or an employee of a hospice program and that con-
37 sist of—



1 “(A) an evaluation of the individual’s need for
2 pain and symptom management;

3 “(B) counseling the individual with respect to end-
4 of-life issues and care options; and

5 “(C) advising the individual regarding advanced
6 care planning.”.

7 (b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is
8 amended by adding at the end the following new paragraph:

9 “(4) The amount paid to a hospice program with respect
10 to the services under section 1812(a)(5) for which payment
11 may be made under this part shall be equal to an amount
12 equivalent to the amount established for an office or other out-
13 patient visit for evaluation and management associated with
14 presenting problems of moderate severity under the fee sched-
15 ule established under section 1848(b), other than the portion
16 of such amount attributable to the practice expense compo-
17 nent.”.

18 (c) CONFORMING AMENDMENT.—Section
19 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended
20 by inserting before the comma at the end the following: “and
21 services described in section 1812(a)(5)”.

22 (d) EFFECTIVE DATE.—The amendments made by this
23 section shall apply to services provided by a hospice program
24 on or after January 1, 2004.

25 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**
26 **PICE CARE FURNISHED IN A FRONTIER**
27 **AREA.**

28 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.
29 1395f(i)(1)) is amended by adding at the end the following new
30 subparagraph:

31 “(D) With respect to hospice care furnished in a frontier
32 area on or after January 1, 2003, and before January 1, 2008,
33 the payment rates otherwise established for such care shall be
34 increased by 10 percent. For purposes of this subparagraph,
35 the term ‘frontier area’ means a county in which the population
36 density is less than 7 persons per square mile.”.



1 (b) REPORT ON COSTS.—Not later than January 1, 2007,
2 the Comptroller General of the United States shall submit to
3 Congress a report on the costs of furnishing hospice care in
4 frontier areas. Such report shall include recommendations re-
5 garding the appropriateness of extending, and modifying, the
6 payment increase provided under the amendment made by sub-
7 section (a).

8 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

9 (a) IN GENERAL.—The Secretary shall conduct a dem-
10 onstration project for the delivery of hospice care to medicare
11 beneficiaries in rural areas. Under the project medicare bene-
12 ficiaries who are unable to receive hospice care in the home for
13 lack of an appropriate caregiver are provided such care in a fa-
14 cility of 20 or fewer beds which offers, within its walls, the full
15 range of services provided by hospice programs under section
16 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

17 (b) SCOPE OF PROJECT.—The Secretary shall conduct the
18 project under this section with respect to no more than 3 hos-
19 pice programs over a period of not longer than 5 years each.

20 (c) COMPLIANCE WITH CONDITIONS.—Under the dem-
21 onstration project—

22 (1) the hospice program shall comply with otherwise
23 applicable requirements, except that it shall not be required
24 to offer services outside of the home or to meet the require-
25 ments of section 1861(dd)(2)(A)(iii) of the Social Security
26 Act; and

27 (2) payments for hospice care shall be made at the
28 rates otherwise applicable to such care under title XVIII of
29 such Act.

30 The Secretary may require the program to comply with such
31 additional quality assurance standards for its provision of serv-
32 ices in its facility as the Secretary deems appropriate.

33 (d) REPORT.—Upon completion of the project, the Sec-
34 retary shall submit a report to Congress on the project and
35 shall include in the report recommendations regarding exten-
36 sion of such project to hospice programs serving rural areas.



Subtitle D—Other Provisions

SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the “project”) to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—The project shall cover at least 2 States and at least 3 contractors and shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract



1 under this section with an entity to the extent that the en-
2 tity is a fiscal intermediary under section 1816 of the So-
3 cial Security Act (42 U.S.C. 1395h), a carrier under sec-
4 tion 1842 of such Act (42 U.S.C. 1395u), or a Medicare
5 Administrative Contractor under section 1874A of such
6 Act.

7 (3) PREFERENCE FOR ENTITIES WITH DEM-
8 ONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In
9 awarding contracts to recovery audit contractors under this
10 section, the Secretary shall give preference to those entities
11 that the Secretary determines have demonstrated pro-
12 ficiency in recovery audits with private insurers or under
13 the medicaid program under title XIX of such Act.

14 (e) REPORT.—The Secretary of Health and Human Serv-
15 ices shall submit to Congress a report on the project not later
16 than 6 months after the date of its completion. Such reports
17 shall include information on the impact of the project on sav-
18 ings to the medicare program and recommendations on the
19 cost-effectiveness of extending or expanding the project.

20 **TITLE V—PROVISIONS RELATING**
21 **TO PART B**

22 **Subtitle A—Physicians' Services**

23 **SEC. 501. REVISION OF UPDATES FOR PHYSICIANS'**
24 **SERVICES.**

25 (a) UPDATE FOR 2003 THROUGH 2005.—

26 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.
27 1395w-4(d)) is amended by adding at the end the following
28 new paragraphs:

29 “(5) UPDATE FOR 2003.—The update to the single
30 conversion factor established in paragraph (1)(C) for 2003
31 is 2 percent.

32 “(6) SPECIAL RULES FOR UPDATE FOR 2004 AND
33 2005.—The following rules apply in determining the update
34 adjustment factors under paragraph (4)(B) for 2004 and
35 2005:

36 “(A) USE OF 2002 DATA IN DETERMINING ALLOW-
37 ABLE COSTS.—



1 “(i) The reference in clause (ii)(I) of such
2 paragraph to April 1, 1996, is deemed to be a ref-
3 erence to January 1, 2002.

4 “(ii) The allowed expenditures for 2002 is
5 deemed to be equal to the actual expenditures for
6 physicians’ services furnished during 2002, as esti-
7 mated by the Secretary.

8 “(B) 1 PERCENTAGE POINT INCREASE IN GDP
9 UNDER SGR.—The annual average percentage growth
10 in real gross domestic product per capita under sub-
11 section (f)(2)(C) for each of 2003, 2004, and 2005 is
12 deemed to be increased by 1 percentage point.”.

13 (2) CONFORMING AMENDMENT.—Paragraph (4)(B) of
14 such section is amended, in the matter before clause (i), by
15 inserting “and paragraph (6)” after “subparagraph (D)”.

16 (3) NOT TREATED AS CHANGE IN LAW AND REGULA-
17 TION IN SUSTAINABLE GROWTH RATE DETERMINATION.—
18 The amendments made by this subsection shall not be
19 treated as a change in law for purposes of applying section
20 1848(f)(2)(D) of the Social Security Act (42 U.S.C.
21 1395w-4(f)(2)(D)).

22 (b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING
23 GROSS DOMESTIC PRODUCT.—

24 (1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C.
25 1395w-4(f)(2)(C)) is amended—

26 (A) by striking “projected” and inserting “annual
27 average”; and

28 (B) by striking “from the previous applicable pe-
29 riod to the applicable period involved” and inserting
30 “during the 10-year period ending with the applicable
31 period involved”.

32 (2) EFFECTIVE DATE.—The amendment made by
33 paragraph (1) shall apply to computations of the sustain-
34 able growth rate for years beginning with 2002.

35 (c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Sec-
36 tion 1848(d)(4)(F) (42 U.S.C. 1395w-4(d)(4)(F)) is amended
37 by striking “subparagraph (A)” and all that follows and insert-



1 ing “subparagraph (A), for each of 2001 and 2002, of –0.2
2 percent.”

3 (d) GAO STUDY OF MEDICARE PAYMENT FOR INHALA-
4 TION THERAPY.—

5 (1) STUDY.—The Comptroller General of the United
6 States shall conduct a study to examine the adequacy of
7 current reimbursements for inhalation therapy under the
8 medicare program.

9 (2) REPORT.—Not later than May 1, 2003, the Comp-
10 troller General shall submit to Congress a report on the
11 study conducted under paragraph (1).

12 **SEC. 502. STUDIES ON ACCESS TO PHYSICIANS’ SERV-**
13 **ICES.**

14 (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-
15 CIANS’ SERVICES.—

16 (1) STUDY.—The Comptroller General of the United
17 States shall conduct a study on access of medicare bene-
18 ficiaries to physicians’ services under the medicare pro-
19 gram. The study shall include—

20 (A) an assessment of the use by beneficiaries of
21 such services through an analysis of claims submitted
22 by physicians for such services under part B of the
23 medicare program;

24 (B) an examination of changes in the use by bene-
25 ficiaries of physicians’ services over time;

26 (C) an examination of the extent to which physi-
27 cians are not accepting new medicare beneficiaries as
28 patients.

29 (2) REPORT.—Not later than 18 months after the
30 date of the enactment of this Act, the Comptroller General
31 shall submit to Congress a report on the study conducted
32 under paragraph (1). The report shall include a determina-
33 tion whether—

34 (A) data from claims submitted by physicians
35 under part B of the medicare program indicate poten-
36 tial access problems for medicare beneficiaries in cer-
37 tain geographic areas; and



1 (B) access by medicare beneficiaries to physicians'
2 services may have improved, remained constant, or de-
3 teriorated over time.

4 (b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

5 (1) STUDY.—The Secretary shall request the Institute
6 of Medicine of the National Academy of Sciences to con-
7 duct a study on the adequacy of the supply of physicians
8 (including specialists) in the United States and the factors
9 that affect such supply.

10 (2) REPORT TO CONGRESS.—Not later than 2 years
11 after the date of enactment of this section, the Secretary
12 shall submit to Congress a report on the results of the
13 study described in paragraph (1), including any rec-
14 ommendations for legislation.

15 **SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSI-**
16 **CIAANS' SERVICES.**

17 Not later than 1 year after the date of the enactment of
18 this Act, the Medicare Payment Advisory Commission shall
19 submit to Congress a report on the effect of refinements to the
20 practice expense component of payments for physicians' serv-
21 ices, after the transition to a full resource-based payment sys-
22 tem in 2002, under section 1848 of the Social Security Act (42
23 U.S.C. 1395w-4). Such report shall examine the following mat-
24 ters by physician specialty:

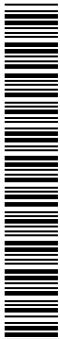
25 (1) The effect of such refinements on payment for
26 physicians' services.

27 (2) The interaction of the practice expense component
28 with other components of and adjustments to payment for
29 physicians' services under such section.

30 (3) The appropriateness of the amount of compensa-
31 tion by reason of such refinements.

32 (4) The effect of such refinements on access to care
33 by medicare beneficiaries to physicians' services.

34 (5) The effect of such refinements on physician par-
35 ticipation under the medicare program.



1 **SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CER-**
2 **TAIN PHYSICIAN PATHOLOGY SERVICES**
3 **UNDER MEDICARE.**

4 Section 542(c) of BIPA is amended by striking “2-year
5 period” and inserting “3-year period”.

6 **SEC. 505. PHYSICIAN FEE SCHEDULE WAGE INDEX REVI-**
7 **SION.**

8 (a) INDEX REVISION.—

9 (1) IN GENERAL.—Subject to paragraph (2), notwith-
10 standing any other provision of law, for purposes of pay-
11 ment under the physician fee schedule under section 1848
12 of the Social Security Act (42 U.S.C. 1395w-4) for physi-
13 cians’ services furnished during 2004, in no case may the
14 work geographic index otherwise calculated under sub-
15 section (e)(1)(A)(iii) of such section be less than 0.985.

16 (2) SECRETARIAL DISCRETION.—Paragraph (1) shall
17 not take effect or be in force if the Secretary determines,
18 taking into account the report of the Comptroller General
19 under subsection (b)(2), that there is no sound economic
20 rationale for the implementation of such paragraph.

21 (3) EXEMPTION FROM LIMITATION ON ANNUAL AD-
22 JUSTMENTS.—Any increase in expenditures attributable to
23 paragraph (1) during 2004 shall not be taken into account
24 in applying section 1848(c)(2)(B)(ii)(II) of the Social Secu-
25 rity Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)(II)) for that year.

26 (b) GAO REPORT.—

27 (1) EVALUATION.—As part of the study on geographic
28 differences in payments for physicians’ services conducted
29 under section 309, the Comptroller General shall evaluate
30 the following:

31 (A) Whether there is a sound economic basis for
32 the implementation of the adjustment under subsection
33 (a)(1) in those areas in which the adjustment applies.

34 (B) The effect of such adjustment on physician lo-
35 cation and retention in areas affected by such adjust-
36 ment, taking into account—



1 (i) differences in recruitment costs and reten-
2 tion rates for physicians, including specialists, be-
3 tween large urban areas and other areas; and

4 (ii) the mobility of physicians, including spe-
5 cialists, over the last decade.

6 (C) The appropriateness of establishing a floor of
7 1.0 for the work geographic index.

8 (2) REPORT.—By not later than September 1, 2003,
9 the Comptroller General shall submit to Congress and to
10 the Secretary a report on the evaluation conducted under
11 paragraph (1).

12 **Subtitle B—Other Services**

13 **SEC. 511. COMPETITIVE ACQUISITION OF CERTAIN** 14 **ITEMS AND SERVICES.**

15 (a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w-3) is
16 amended to read as follows:

17 “COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

18 “SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE AC-
19 QUISSION PROGRAMS.—

20 “(1) IMPLEMENTATION OF PROGRAMS.—

21 “(A) IN GENERAL.—The Secretary shall establish
22 and implement programs under which competitive ac-
23 quisition areas are established throughout the United
24 States for contract award purposes for the furnishing
25 under this part of competitively priced items and serv-
26 ices (described in paragraph (2)) for which payment is
27 made under this part. Such areas may differ for dif-
28 ferent items and services.

29 “(B) PHASED-IN IMPLEMENTATION.—The pro-
30 grams shall be phased-in among competitive acquisition
31 areas over a period of not longer than 3 years in a
32 manner so that the competition under the programs oc-
33 curs in—

34 “(i) at least $\frac{1}{3}$ of such areas in 2004; and

35 “(ii) at least $\frac{2}{3}$ of such areas in 2005.

36 “(C) WAIVER OF CERTAIN PROVISIONS.—In car-
37 rying out the programs, the Secretary may waive such



1 provisions of the Federal Acquisition Regulation as are
2 necessary for the efficient implementation of this sec-
3 tion, other than provisions relating to confidentiality of
4 information and such other provisions as the Secretary
5 determines appropriate.

6 “(2) ITEMS AND SERVICES DESCRIBED.—The items
7 and services referred to in paragraph (1) are the following:

8 “(A) DURABLE MEDICAL EQUIPMENT AND INHA-
9 LATION DRUGS USED IN CONNECTION WITH DURABLE
10 MEDICAL EQUIPMENT.—Covered items (as defined in
11 section 1834(a)(13)) for which payment is otherwise
12 made under section 1834(a), other than items used in
13 infusion, and inhalation drugs used in conjunction with
14 durable medical equipment.

15 “(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (de-
16 scribed in section 1861(s)(9)) for which payment is
17 otherwise made under section 1834(h) which require
18 minimal self-adjustment for appropriate use and does
19 not require expertise in trimming, bending, molding,
20 assembling, or customizing to fit to the patient.

21 “(3) EXEMPTION AUTHORITY.—In carrying out the
22 programs under this section, the Secretary may exempt—

23 “(A) areas that are not competitive due to low
24 population density; and

25 “(B) items and services for which the application
26 of competitive acquisition is not likely to result in sig-
27 nificant savings.

28 “(b) PROGRAM REQUIREMENTS.—

29 “(1) IN GENERAL.—The Secretary shall conduct a
30 competition among entities supplying items and services de-
31 scribed in subsection (a)(2) for each competitive acquisition
32 area in which the program is implemented under subsection
33 (a) with respect to such items and services.

34 “(2) CONDITIONS FOR AWARDED CONTRACT.—

35 “(A) IN GENERAL.—The Secretary may not award
36 a contract to any entity under the competition con-
37 ducted in an competitive acquisition area pursuant to



1 paragraph (1) to furnish such items or services unless
2 the Secretary finds all of the following:

3 “(i) The entity meets quality and financial
4 standards specified by the Secretary or developed
5 by accreditation entities or organizations recognized
6 by the Secretary.

7 “(ii) The total amounts to be paid under the
8 contract (including costs associated with the ad-
9 ministration of the contract) are expected to be less
10 than the total amounts that would otherwise be
11 paid.

12 “(iii) Beneficiary access to a choice of multiple
13 suppliers in the area is maintained.

14 “(iv) Beneficiary liability is limited to the ap-
15 plicable percentage of contract award price.

16 “(B) QUALITY STANDARDS.—The quality stand-
17 ards specified under subparagraph (A)(i) shall not be
18 less than the quality standards that would otherwise
19 apply if this section did not apply and shall include
20 consumer services standards. The Secretary shall con-
21 sult with an expert outside advisory panel composed of
22 an appropriate selection of representatives of physi-
23 cians, practitioners, and suppliers to review (and advise
24 the Secretary concerning) such quality standards.

25 “(3) CONTENTS OF CONTRACT.—

26 “(A) IN GENERAL.—A contract entered into with
27 an entity under the competition conducted pursuant to
28 paragraph (1) is subject to terms and conditions that
29 the Secretary may specify.

30 “(B) TERM OF CONTRACTS.—The Secretary shall
31 rebid contracts under this section not less often than
32 once every 3 years.

33 “(4) LIMIT ON NUMBER OF CONTRACTORS.—

34 “(A) IN GENERAL.—The Secretary may limit the
35 number of contractors in a competitive acquisition area
36 to the number needed to meet projected demand for
37 items and services covered under the contracts. In



1 awarding contracts, the Secretary shall take into ac-
2 count the ability of bidding entities to furnish items or
3 services in sufficient quantities to meet the anticipated
4 needs of beneficiaries for such items or services in the
5 geographic area covered under the contract on a timely
6 basis.

7 “(B) MULTIPLE WINNERS.—The Secretary shall
8 award contracts to more than one entity submitting a
9 bid in each area for an item or service.

10 “(5) PARTICIPATING CONTRACTORS.—Payment shall
11 not be made for items and services described in subsection
12 (a)(2) furnished by a contractor and for which competition
13 is conducted under this section unless—

14 “(A) the contractor has submitted a bid for such
15 items and services under this section; and

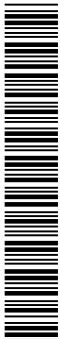
16 “(B) the Secretary has awarded a contract to the
17 contractor for such items and services under this sec-
18 tion.

19 “(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUT-
20 REACH AND COMPLAINT SERVICES.—The Secretary may
21 enter into a contract with an appropriate entity to address
22 complaints from beneficiaries who receive items and serv-
23 ices from an entity with a contract under this section and
24 to conduct appropriate education of and outreach to such
25 beneficiaries with respect to the program.

26 “(c) ANNUAL REPORTS.—The Secretary shall submit to
27 Congress an annual management report on the programs under
28 this section. Each such report shall include information on sav-
29 ings, reductions in cost-sharing, access to items and services,
30 and beneficiary satisfaction.

31 “(d) DEMONSTRATION PROJECT FOR CLINICAL LABORA-
32 TORY SERVICES.—

33 “(1) IN GENERAL.—The Secretary shall conduct a
34 demonstration project on the application of competitive ac-
35 quisition under this section to clinical diagnostic laboratory
36 tests—



1 “(A) for which payment is otherwise made under
2 section 1833(h) or 1834(d)(1) (relating to colorectal
3 cancer screening tests); and

4 “(B) which are furnished without a face-to-face
5 encounter between the individual and the hospital or
6 physician ordering the tests.

7 “(2) TERMS AND CONDITIONS.—Such project shall be
8 under the same conditions as are applicable to items and
9 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 later than
13 December 31, 2004; and

14 “(B) such progress and final reports on the
15 project after such date as the Secretary determines ap-
16 propriate.”.

17 (b) CONTINUATION OF CERTAIN DEMONSTRATION
18 PROJECTS.—Notwithstanding the amendment made by sub-
19 section (a), with respect to demonstration projects implemented
20 by the Secretary under section 1847 of the Social Security Act
21 (42 U.S.C. 1395w-3) (relating to the establishment of competi-
22 tive acquisition areas) that was in effect on the day before the
23 date of the enactment of this Act, each such demonstration
24 project may continue under the same terms and conditions ap-
25 plicable under that section as in effect on that date.

26 (c) REPORT ON DIFFERENCES IN PAYMENT FOR LABORA-
27 TORY SERVICES.—Not later than 18 months after the date of
28 the enactment of this Act, the Comptroller General of the
29 United States shall submit to Congress a report that analyzes
30 differences in reimbursement between public and private payors
31 for clinical diagnostic laboratory services.

32 **SEC. 512. PAYMENT FOR AMBULANCE SERVICES.**

33 (a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE
34 SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l)
35 (42 U.S.C. 1395m(l)) is amended—

36 (1) in paragraph (2)(E), by inserting “consistent with
37 paragraph (10)” after “in an efficient and fair manner”;



1 (2) by redesignating the paragraph (8) added by sec-
2 tion 221(a) of BIPA as paragraph (9); and

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

4 “(10) PHASE-IN PROVIDING FLOOR USING BLEND OF
5 FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In car-
6 rying out the phase-in under paragraph (2)(E) for each
7 level of service furnished in a year before January 1, 2007,
8 the portion of the payment amount that is based on the fee
9 schedule shall not be less than the following blended rate
10 of the fee schedule under paragraph (1) and of a regional
11 fee schedule for the region involved:

12 “(A) For 2003, the blended rate shall be based 20
13 percent on the fee schedule under paragraph (1) and
14 80 percent on the regional fee schedule.

15 “(B) For 2004, the blended rate shall be based 40
16 percent on the fee schedule under paragraph (1) and
17 60 percent on the regional fee schedule.

18 “(C) For 2005, the blended rate shall be based 60
19 percent on the fee schedule under paragraph (1) and
20 40 percent on the regional fee schedule.

21 “(D) For 2006, the blended rate shall be based 80
22 percent on the fee schedule under paragraph (1) and
23 20 percent on the regional fee schedule.

24 For purposes of this paragraph, the Secretary shall estab-
25 lish a regional fee schedule for each of the 9 Census divi-
26 sions using the methodology (used in establishing the fee
27 schedule under paragraph (1)) to calculate a regional con-
28 version factor and a regional mileage payment rate and
29 using the same payment adjustments and the same relative
30 value units as used in the fee schedule under such para-
31 graph.”.

32 (b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG
33 TRIPS.—Section 1834(l), as amended by subsection (a), is fur-
34 ther amended by adding at the end the following new para-
35 graph:

36 “(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG
37 TRIPS.—In the case of ground ambulance services fur-



1 nished on or after January 1, 2003, and before January 1,
2 2008, regardless of where the transportation originates, the
3 fee schedule established under this subsection shall provide
4 that, with respect to the payment rate for mileage for a
5 trip above 50 miles the per mile rate otherwise established
6 shall be increased by $\frac{1}{4}$ of the payment per mile otherwise
7 applicable to such miles.”.

8 (c) EFFECTIVE DATE.—The amendments made by this
9 section shall apply to ambulance services furnished on or after
10 January 1, 2003.

11 **SEC. 513. 2-YEAR EXTENSION OF MORATORIUM ON**
12 **THERAPY CAPS; PROVISIONS RELATING TO**
13 **REPORTS.**

14 (a) 2-YEAR EXTENSION OF MORATORIUM ON THERAPY
15 CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended
16 by striking “and 2002” and inserting “2002, 2003, and 2004”.

17 (b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAY-
18 MENT AND UTILIZATION OF OUTPATIENT THERAPY SERV-
19 ICES.—Not later than December 31, 2002, the Secretary shall
20 submit to Congress the reports required under section
21 4541(d)(2) of the Balanced Budget Act of 1997 (relating to al-
22 ternatives to a single annual dollar cap on outpatient therapy)
23 and under section 221(d) of the Medicare, Medicaid, and
24 SCHIP Balanced Budget Refinement Act of 1999 (relating to
25 utilization patterns for outpatient therapy).

26 (c) IDENTIFICATION OF CONDITIONS AND DISEASES JUS-
27 TIFYING WAIVER OF THERAPY CAP.—

28 (1) STUDY.—The Secretary shall request the Institute
29 of Medicine of the National Academy of Sciences to identify
30 conditions or diseases that should justify conducting an as-
31 sessment of the need to waive the therapy caps under sec-
32 tion 1833(g)(4) of the Social Security Act (42 U.S.C.
33 1395l(g)(4)).

34 (2) REPORTS TO CONGRESS.—Not later than Sep-
35 tember 1, 2003, the Secretary shall submit to Congress a
36 preliminary report on the conditions and diseases identified
37 under paragraph (1) and not later than December 31,



1 2003, a final report on the conditions and diseases so identified.
2

3 (d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL
4 THERAPIST SERVICES.—

5 (1) STUDY.—The Comptroller General of the United
6 States shall conduct a study on access to physical therapist
7 services in States authorizing such services without a physi-
8 cian referral and in States that require such a physician re-
9 ferral. The study shall—

10 (A) examine the use of and referral patterns for
11 physical therapist services for patients age 50 and older
12 in States that authorize such services without a physi-
13 cian referral and in States that require such a physi-
14 cian referral;

15 (B) examine the use of and referral patterns for
16 physical therapist services for patients who are medi-
17 care beneficiaries;

18 (C) examine the potential effect of prohibiting a
19 physician from referring patients to physical therapy
20 services owned by the physician and provided in the
21 physician's office;

22 (D) examine the delivery of physical therapists'
23 services within the facilities of Department of Defense;
24 and

25 (E) analyze the potential impact on medicare
26 beneficiaries and on expenditures under the medicare
27 program of eliminating the need for a physician refer-
28 ral and physician certification for physical therapist
29 services under the medicare program.

30 (2) REPORT.—The Comptroller General shall submit
31 to Congress a report on the study conducted under para-
32 graph (1) by not later than 1 year after the date of the
33 enactment of this Act.

34 **SEC. 514. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**
35 **ICAL EXAMINATION.**

36 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
37 1395x(s)(2)) is amended—



1 (1) in subparagraph (U), by striking “and” at the
2 end;

3 (2) in subparagraph (V), by inserting “and” at the
4 end; and

5 (3) by adding at the end the following new subpara-
6 graph:

7 “(W) an initial preventive physical examination (as de-
8 fined in subsection (ww));”.

9 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
10 1395x) is amended by adding at the end the following new sub-
11 section:

12 “Initial Preventive Physical Examination

13 “(ww) The term ‘initial preventive physical examination’
14 means physicians’ services consisting of a physical examination
15 with the goal of health promotion and disease detection and in-
16 cludes items and services (excluding clinical laboratory tests),
17 as determined by the Secretary, consistent with the rec-
18 ommendations of the United States Preventive Services Task
19 Force.”.

20 (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

21 (1) DEDUCTIBLE.—The first sentence of section
22 1833(b) (42 U.S.C. 1395l(b)) is amended—

23 (A) by striking “and” before “(6)”, and

24 (B) by inserting before the period at the end the
25 following: “, and (7) such deductible shall not apply
26 with respect to an initial preventive physical examina-
27 tion (as defined in section 1861(ww))”.

28 (2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C.
29 1395l(a)(1)) is amended—

30 (A) in clause (N), by inserting “(or 100 percent
31 in the case of an initial preventive physical examina-
32 tion, as defined in section 1861(ww))” after “80 per-
33 cent”; and

34 (B) in clause (O), by inserting “(or 100 percent
35 in the case of an initial preventive physical examina-
36 tion, as defined in section 1861(ww))” after “80 per-
37 cent”.



1 (d) PAYMENT AS PHYSICIANS' SERVICES.—Section
2 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
3 “(2)(W),” after “(2)(S),”.

4 (e) OTHER CONFORMING AMENDMENTS.—Section 1862(a)
5 (42 U.S.C. 1395y(a)) is amended—

6 (1) in paragraph (1)—

7 (A) by striking “and” at the end of subparagraph
8 (H);

9 (B) by striking the semicolon at the end of sub-
10 paragraph (I) and inserting “, and”; and

11 (C) by adding at the end the following new sub-
12 paragraph:

13 “(J) in the case of an initial preventive physical exam-
14 ination, which is performed not later than 6 months after
15 the date the individual's first coverage period begins under
16 part B;”; and

17 (2) in paragraph (7), by striking “or (H)” and insert-
18 ing “(H), or (J)”.

19 (f) EFFECTIVE DATE.—The amendments made by this
20 section shall apply to services furnished on or after January 1,
21 2004, but only for individuals whose coverage period begins on
22 or after such date.

23 **SEC. 515. RENAL DIALYSIS SERVICES.**

24 (a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT
25 SETTINGS.—Not later than 1 year after the date of the enact-
26 ment of this Act, the Comptroller General of the United States
27 shall submit to Congress a report containing—

28 (1) an analysis of the differences in costs of providing
29 renal dialysis services under the medicare program in home
30 settings and in facility settings;

31 (2) an assessment of the percentage of overhead costs
32 in home settings and in facility settings; and

33 (3) an evaluation of whether the charges for home di-
34 alysis supplies and equipment are reasonable and nec-
35 essary.

36 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDI-
37 ATRIC FACILITIES.—



1 (1) IN GENERAL.—Section 422(a)(2) of BIPA is
2 amended—

3 (A) in subparagraph (A), by striking “and (C)”
4 and inserting “, (C), and (D)”;

5 (B) in subparagraph (B), by striking “In the
6 case” and inserting “Subject to subparagraph (D), in
7 the case”; and

8 (C) by adding at the end the following new sub-
9 paragraph:

10 “(D) INAPPLICABILITY TO PEDIATRIC FACILI-
11 TIES.—Subparagraphs (A) and (B) shall not apply, as
12 of October 1, 2002, to pediatric facilities that do not
13 have an exception rate described in subparagraph (C)
14 in effect on such date. For purposes of this subpara-
15 graph, the term ‘pediatric facility’ means a renal facil-
16 ity at least 50 percent of whose patients are individuals
17 under 18 years of age.”.

18 (2) CONFORMING AMENDMENT.—The fourth sentence
19 of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended
20 by striking “The Secretary” and inserting “Subject to sec-
21 tion 422(a)(2) of the Medicare, Medicaid, and SCHIP Ben-
22 efits Improvement and Protection Act of 2000, the Sec-
23 retary”.

24 (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR
25 SERVICES FURNISHED IN 2004.—Notwithstanding any other
26 provision of law, with respect to payment under part B of title
27 XVIII of the Social Security Act for renal dialysis services fur-
28 nished in 2004, the composite payment rate otherwise estab-
29 lished under section 1881(b)(7) of such Act (42 U.S.C.
30 1395rr(b)(7)) shall be increased by 1.2 percent.

31 **SEC. 516. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**
32 **RAPHY SERVICES.**

33 (a) EXCLUSION FROM OPD FEE SCHEDULE.—Section
34 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by
35 inserting before the period at the end the following: “and does
36 not include screening mammography (as defined in section



1 1861(jj)) and unilateral and bilateral diagnostic mammog-
2 raphy”.

3 (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diag-
4 nostic mammography performed on or after January 1, 2004,
5 for which payment is made under the physician fee schedule
6 under section 1848 of the Social Security Act (42 U.S.C.
7 1395w-4), the Secretary, based on the most recent cost data
8 available, shall provide for an appropriate adjustment in the
9 payment amount for the technical component of the diagnostic
10 mammography.

11 (c) EFFECTIVE DATE.—The amendment made by sub-
12 section (a) shall apply to mammography performed on or after
13 January 1, 2004.

14 **SEC. 517. WAIVER OF PART B LATE ENROLLMENT PEN-**
15 **ALTY FOR CERTAIN MILITARY RETIREES;**
16 **SPECIAL ENROLLMENT PERIOD.**

17 (a) WAIVER OF PENALTY.—

18 (1) IN GENERAL.—Section 1839(b) (42 U.S.C.
19 1395r(b)) is amended by adding at the end the following
20 new sentence: “No increase in the premium shall be ef-
21 fected for a month in the case of an individual who is 65
22 years of age or older, who enrolls under this part during
23 2001, 2002, or 2003, and who demonstrates to the Sec-
24 retary before December 31, 2003, that the individual is a
25 covered beneficiary (as defined in section 1072(5) of title
26 10, United States Code). The Secretary of Health and
27 Human Services shall consult with the Secretary of De-
28 fense in identifying individuals described in the previous
29 sentence.”.

30 (2) EFFECTIVE DATE.—The amendment made by
31 paragraph (1) shall apply to premiums for months begin-
32 ning with January 2003. The Secretary of Health and
33 Human Services shall establish a method for providing re-
34 bates of premium penalties paid for months on or after
35 January 2003 for which a penalty does not apply under
36 such amendment but for which a penalty was previously
37 collected.



1 (b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

2 (1) IN GENERAL.—In the case of any individual who,
3 as of the date of the enactment of this Act, is 65 years of
4 age or older, is eligible to enroll but is not enrolled under
5 part B of title XVIII of the Social Security Act, and is a
6 covered beneficiary (as defined in section 1072(5) of title
7 10, United States Code), the Secretary of Health and
8 Human Services shall provide for a special enrollment pe-
9 riod during which the individual may enroll under such
10 part. Such period shall begin as soon as possible after the
11 date of the enactment of this Act and shall end on Decem-
12 ber 31, 2003.

13 (2) COVERAGE PERIOD.—In the case of an individual
14 who enrolls during the special enrollment period provided
15 under paragraph (1), the coverage period under part B of
16 title XVIII of the Social Security Act shall begin on the
17 first day of the month following the month in which the in-
18 dividual enrolls.

19 **SEC. 518. COVERAGE OF CHOLESTEROL AND BLOOD**
20 **LIPID SCREENING.**

21 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
22 1395x(s)(2)), as amended by section 514(a), is amended—

23 (1) in subparagraph (V), by striking “and” at the end;

24 (2) in subparagraph (W), by inserting “and” at the
25 end; and

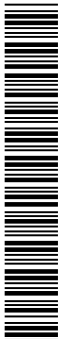
26 (3) by adding at the end the following new subpara-
27 graph:

28 “(X) cholesterol and other blood lipid screening
29 tests (as defined in subsection (XX));”.

30 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
31 1395x), as amended by section 514(b), is amended by adding
32 at the end the following new subsection:

33 “Cholesterol and Other Blood Lipid Screening Test

34 “(xx)(1) The term ‘cholesterol and other blood lipid
35 screening test’ means diagnostic testing of cholesterol and other
36 lipid levels of the blood for the purpose of early detection of
37 abnormal cholesterol and other lipid levels.



1 “(2) The Secretary shall establish standards, in consulta-
2 tion with appropriate organizations, regarding the frequency
3 and type of cholesterol and other blood lipid screening tests, ex-
4 cept that such frequency may not be more often than once
5 every 2 years.”.

6 (c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.
7 1395y(a)(1)), as amended by section 514(e), is amended

8 (1) by striking “and” at the end of subparagraph (I);

9 (2) by striking the semicolon at the end of subpara-
10 graph (J) and inserting “; and”; and

11 (3) by adding at the end the following new subpara-
12 graph:

13 “(K) in the case of a cholesterol and other blood lipid
14 screening test (as defined in section 1861(xx)(1)), which is
15 performed more frequently than is covered under section
16 1861(xx)(2).”.

17 (d) EFFECTIVE DATE.—The amendments made by this
18 section shall apply to tests furnished on or after January 1,
19 2004.

20 **TITLE VI—PROVISIONS RELATING**
21 **TO PARTS A AND B**
22 **Subtitle A—Home Health Services**

23 **SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN**
24 **PAYMENT RATES UNDER THE PROSPECTIVE**
25 **PAYMENT SYSTEM.**

26 (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.
27 1395fff(b)(3)(A)) is amended to read as follows:

28 “(A) INITIAL BASIS.—Under such system the Sec-
29 retary shall provide for computation of a standard pro-
30 spective payment amount (or amounts) as follows:

31 “(i) Such amount (or amounts) shall initially
32 be based on the most current audited cost report
33 data available to the Secretary and shall be com-
34 puted in a manner so that the total amounts pay-
35 able under the system for fiscal year 2001 shall be
36 equal to the total amount that would have been



1 made if the system had not been in effect and if
2 section 1861(v)(1)(L)(ix) had not been enacted.

3 “(ii) For fiscal year 2002 and for the first
4 quarter of fiscal year 2003, such amount (or
5 amounts) shall be equal to the amount (or
6 amounts) determined under this paragraph for the
7 previous fiscal year, updated under subparagraph
8 (B).

9 “(iii) For 2003, such amount (or amounts)
10 shall be equal to the amount (or amounts) deter-
11 mined under this paragraph for fiscal year 2002,
12 updated under subparagraph (B) for 2003.

13 “(iv) For 2004 and each subsequent year,
14 such amount (or amounts) shall be equal to the
15 amount (or amounts) determined under this para-
16 graph for the previous year, updated under sub-
17 paragraph (B).

18 Each such amount shall be standardized in a manner
19 that eliminates the effect of variations in relative case
20 mix and area wage adjustments among different home
21 health agencies in a budget neutral manner consistent
22 with the case mix and wage level adjustments provided
23 under paragraph (4)(A). Under the system, the Sec-
24 retary may recognize regional differences or differences
25 based upon whether or not the services or agency are
26 in an urbanized area.”.

27 (b) EFFECTIVE DATE.—The amendment made by sub-
28 section (a) shall take effect as if included in the amendments
29 made by section 501 of the Medicare, Medicaid, and SCHIP
30 Benefits Improvement and Protection Act of 2000 (as enacted
31 into law by section 1(a)(6) of Public Law 106-554).

32 **SEC. 602. UPDATE IN HOME HEALTH SERVICES.**

33 (a) CHANGE TO CALENDAR YEAR UPDATE.—

34 (1) IN GENERAL.—Section 1895(b) (42 U.S.C.
35 1395fff(b)(3)) is amended—

36 (A) in paragraph (3)(B)(i)—



1 (i) by striking “each fiscal year (beginning
2 with fiscal year 2002)” and inserting “fiscal year
3 2002 and for each subsequent year (beginning with
4 2003)”; and

5 (ii) by inserting “or year” after “the fiscal
6 year”;

7 (B) in paragraph (3)(B)(ii)—

8 (i) in subclause (II), by striking “fiscal year”
9 and inserting “year” and by redesignating such
10 subclause as subclause (III); and

11 (ii) in subclause (I), by striking “each of fiscal
12 years 2002 and 2003” and inserting the following:
13 “fiscal year 2002, the home health market basket
14 percentage increase (as defined in clause (iii))
15 minus 1.1 percentage points;

16 “(II) 2003”;

17 (C) in paragraph (3)(B)(iii), by inserting “or
18 year” after “fiscal year” each place it appears;

19 (D) in paragraph (3)(B)(iv)—

20 (i) by inserting “or year” after “fiscal year”
21 each place it appears; and

22 (ii) by inserting “or years” after “fiscal
23 years”; and

24 (E) in paragraph (5), by inserting “or year” after
25 “fiscal year”.

26 (2) TRANSITION RULE.—The standard prospective
27 payment amount (or amounts) under section 1895(b)(3) of
28 the Social Security Act for the calendar quarter beginning
29 on October 1, 2002, shall be such amount (or amounts) for
30 the previous calendar quarter.

31 (b) CHANGES IN UPDATES FOR 2003, 2004, AND 2005.—
32 Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as
33 amended by subsection (a)(1)(B), is amended—

34 (1) in subclause (II), by striking “the home health
35 market basket percentage increase (as defined in clause
36 (iii)) minus 1.1 percentage points” and inserting “2.0 per-
37 centage points”;



- 1 (2) by striking “or” at the end of subclause (II);
2 (3) by redesignating subclause (III) as subclause (V);
3 and

- 4 (4) by inserting after subclause (II) the following new
5 subclause:

6 “(III) 2004, 1.1 percentage points;
7 “(IV) 2005, 2.7 percentage points; or”.

8 (c) PAYMENT ADJUSTMENT.—

- 9 (1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C.
10 1395fff(b)(5)) is amended by striking “5 percent” and in-
11 serting “3 percent”.

- 12 (2) EFFECTIVE DATE.—The amendment made by
13 paragraph (1) shall apply to years beginning with 2003.

14 **SEC. 603. OASIS TASK FORCE; SUSPENSION OF CERTAIN**
15 **OASIS DATA COLLECTION REQUIREMENTS**
16 **PENDING TASK FORCE SUBMITTAL OF RE-**
17 **PORT.**

18 (a) ESTABLISHMENT.—The Secretary of Health and
19 Human Services shall establish and appoint a task force (to be
20 known as the “OASIS Task Force”) to examine the data col-
21 lection and reporting requirements under OASIS. For purposes
22 of this section, the term “OASIS” means the Outcome and As-
23 sessment Information Set required by reason of section 4602(e)
24 of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

25 (b) COMPOSITION.—The OASIS Task Force shall be com-
26 posed of the following:

27 (1) Staff of the Centers for Medicare & Medicaid Serv-
28 ices with expertise in post-acute care.

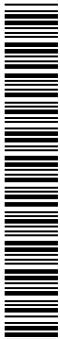
29 (2) Representatives of home health agencies.

30 (3) Health care professionals and research and health
31 care quality experts outside the Federal Government with
32 expertise in post-acute care.

33 (4) Advocates for individuals requiring home health
34 services.

35 (c) DUTIES.—

36 (1) REVIEW AND RECOMMENDATIONS.—The OASIS
37 Task Force shall review and make recommendations to the



1 Secretary regarding changes in OASIS to improve and sim-
2 plify data collection for purposes of—

3 (A) assessing the quality of home health services;
4 and

5 (B) providing consistency in classification of pa-
6 tients into home health resource groups (HHRGs) for
7 payment under section 1895 of the Social Security Act
8 (42 U.S.C. 1395fff).

9 (2) SPECIFIC ITEMS.—In conducting the review under
10 paragraph (1), the OASIS Task Force shall specifically
11 examine—

12 (A) the 41 outcome measures currently in use;

13 (B) the timing and frequency of data collection;
14 and

15 (C) the collection of information on comorbidities
16 and clinical indicators.

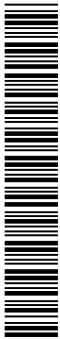
17 (3) REPORT.—The OASIS Task Force shall submit a
18 report to the Secretary containing its findings and rec-
19 ommendations for changes in OASIS by not later than 18
20 months after the date of the enactment of this Act.

21 (d) SUNSET.—The OASIS Task Force shall terminate 60
22 days after the date on which the report is submitted under sub-
23 section (c)(2).

24 (e) NONAPPLICATION OF FACA.—The provisions of the
25 Federal Advisory Committee Act shall not apply to the OASIS
26 Task Force.

27 (f) SUSPENSION OF OASIS REQUIREMENT FOR COLLEC-
28 TION OF DATA ON NON-MEDICARE AND NON-MEDICAID PA-
29 TIENTS PENDING TASK FORCE REPORT.—

30 (1) IN GENERAL.—During the period described in
31 paragraph (2), the Secretary of Health and Human Serv-
32 ices may not require, under section 4602(e) of the Bal-
33 anced Budget Act of 1997 or otherwise under OASIS, a
34 home health agency to gather or submit information that
35 relates to an individual who is not eligible for benefits
36 under either title XVIII or title XIX of the Social Security
37 Act.



1 (2) PERIOD OF SUSPENSION.—The period described in
2 this paragraph—

3 (A) begins on January 1, 2003, and

4 (B) ends on the last day of the 2nd month begin-
5 ning after the date the report is submitted under sub-
6 section (c)(2).

7 **SEC. 604. MEDPAC STUDY ON MEDICARE MARGINS OF**
8 **HOME HEALTH AGENCIES.**

9 (a) STUDY.—The Medicare Payment Advisory Commission
10 shall conduct a study of payment margins of home health agen-
11 cies under the home health prospective payment system under
12 section 1895 of the Social Security Act (42 U.S.C. 1395fff).
13 Such study shall examine whether systematic differences in
14 payment margins are related to differences in case mix (as
15 measured by home health resource groups (HHRGs)) among
16 such agencies. The study shall use the partial or full-year cost
17 reports filed by home health agencies.

18 (b) REPORT.—Not later than 2 years after the date of the
19 enactment of this Act, the Commission shall submit to Con-
20 gress a report on the study under subsection (a).

21 **SEC. 605. CLARIFICATION OF TREATMENT OF OCCA-**
22 **SIONAL ABSENCES IN DETERMINING**
23 **WHETHER AN INDIVIDUAL IS CONFINED TO**
24 **THE HOME.**

25 (a) IN GENERAL.—The penultimate sentence of section
26 1814(a) (42 U.S.C. 1395f(a) and the penultimate sentence of
27 section 1835(a) (42 U.S.C. 1395n(a)) are each amended to
28 read as follows: “Any other absence of an individual from the
29 home shall not so disqualify the individual if the absence is in-
30 frequent or of relatively short duration, such as an occasional
31 trip to the barber or a walk around the block, and is not incon-
32 sistent with the assessment underlying the individual’s plan of
33 care for home health services.”.

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



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fined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

“(II) REFERENCE PERIODS DEFINED.—In this clause, the term ‘reference periods’ means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

“(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

“(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

“(ii) REDISTRIBUTION.—

“(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

“(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of



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a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

“(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

“(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

“(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national av-



1 erage per resident amount computed under
2 subparagraph (E) for that hospital.

3 “(VI) CONSTRUCTION.—Nothing in this
4 clause shall be construed as permitting the re-
5 distribution of reductions in residency positions
6 attributable to voluntary reduction programs
7 under paragraph (6) or as affecting the ability
8 of a hospital to establish new medical residency
9 training programs under subparagraph (H).

10 “(iii) RESIDENT LEVEL AND LIMIT DE-
11 FINED.—In this subparagraph:

12 “(I) RESIDENT LEVEL.—The term ‘resi-
13 dent level’ means, with respect to a hospital,
14 the total number of full-time equivalent resi-
15 dents, before the application of weighting fac-
16 tors (as determined under this paragraph), in
17 the fields of allopathic and osteopathic medi-
18 cine for the hospital.

19 “(II) OTHERWISE APPLICABLE RESIDENT
20 LIMIT.—The term ‘otherwise applicable resi-
21 dent limit’ means, with respect to a hospital,
22 the limit otherwise applicable under subpara-
23 graphs (F)(i) and (H) on the resident level for
24 the hospital determined without regard to this
25 subparagraph.”.

26 (b) NO APPLICATION OF INCREASE TO IME.—Section
27 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended
28 by adding at the end the following: “The provisions of clause
29 (i) of subparagraph (I) of subsection (h)(4) shall apply with re-
30 spect to the first sentence of this clause in the same manner
31 as it applies with respect to subparagraph (F) of such sub-
32 section, but the provisions of clause (ii) of such subparagraph
33 shall not apply.”.

34 (c) REPORT ON EXTENSION OF APPLICATIONS UNDER
35 REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the
36 Secretary shall submit to Congress a report containing rec-
37 ommendations regarding whether to extend the deadline for ap-



1 plications for an increase in resident limits under section
2 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by
3 subsection (a)).

4 **Subtitle C—Other Provisions**

5 **SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT AD-** 6 **VISORY COMMISSION (MEDPAC).**

7 (a) EXAMINATION OF BUDGET CONSEQUENCES.—Section
8 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the
9 end the following new paragraph:

10 “(8) EXAMINATION OF BUDGET CONSEQUENCES.—Be-
11 fore making any recommendations, the Commission shall
12 examine the budget consequences of such recommendations,
13 directly or through consultation with appropriate expert en-
14 tities.”.

15 (b) CONSIDERATION OF EFFICIENT PROVISION OF SERV-
16 ICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–
17 6(b)(2)(B)(i)) is amended by inserting “the efficient provision
18 of” after “expenditures for”.

19 (c) ADDITIONAL REPORTS.—

20 (1) DATA NEEDS AND SOURCES.—The Medicare Pay-
21 ment Advisory Commission shall conduct a study, and sub-
22 mit a report to Congress by not later than June 1, 2003,
23 on the need for current data, and sources of current data
24 available, to determine the solvency and financial cir-
25 cumstances of hospitals and other medicare providers of
26 services. The Commission shall examine data on uncompen-
27 sated care, as well as the share of uncompensated care ac-
28 counted for by the expenses for treating illegal aliens.

29 (2) USE OF TAX-RELATED RETURNS.—Using return
30 information provided under Form 990 of the Internal Rev-
31 enue Service, the Commission shall submit to Congress, by
32 not later than June 1, 2003, a report on the following:

33 (A) Investments and capital financing of hospitals
34 participating under the medicare program and related
35 foundations.

36 (B) Access to capital financing for private and for
37 not-for-profit hospitals.



1 **SEC. 622. DEMONSTRATION PROJECT FOR DISEASE**
2 **MANAGEMENT FOR CERTAIN MEDICARE**
3 **BENEFICIARIES WITH DIABETES.**

4 (a) **IN GENERAL.**—The Secretary of Health and Human
5 Services shall conduct a demonstration project under this sec-
6 tion (in this section referred to as the “project”) to dem-
7 onstrate the impact on costs and health outcomes of applying
8 disease management to certain medicare beneficiaries with di-
9 agnosed diabetes. In no case may the number of participants
10 in the project exceed 30,000 at any time.

11 (b) **VOLUNTARY PARTICIPATION.**—

12 (1) **ELIGIBILITY.**—Medicare beneficiaries are eligible
13 to participate in the project only if—

14 (A) they are a member of a health disparity popu-
15 lation (as defined in section 485E(d) of the Public
16 Health Service Act), such as Hispanics;

17 (B) they meet specific medical criteria dem-
18 onstrating the appropriate diagnosis and the advanced
19 nature of their disease;

20 (C) their physicians approve of participation in the
21 project; and

22 (D) they are not enrolled in a Medicare+ Choice
23 plan.

24 (2) **BENEFITS.**—A medicare beneficiary who is en-
25 rolled in the project shall be eligible—

26 (A) for disease management services related to
27 their diabetes; and

28 (B) for payment for all costs for prescription
29 drugs without regard to whether or not they relate to
30 the diabetes, except that the project may provide for
31 modest cost-sharing with respect to prescription drug
32 coverage.

33 (c) **CONTRACTS WITH DISEASE MANAGEMENT ORGANIZA-**
34 **TIONS.**—

35 (1) **IN GENERAL.**—The Secretary of Health and
36 Human Services shall carry out the project through con-
37 tracts with up to three disease management organizations.



1 The Secretary shall not enter into such a contract with an
2 organization unless the organization demonstrates that it
3 can produce improved health outcomes and reduce aggregate
4 medicare expenditures consistent with paragraph (2).

5 (2) CONTRACT PROVISIONS.—Under such contracts—

6 (A) such an organization shall be required to provide
7 for prescription drug coverage described in sub-
8 section (b)(2)(B);

9 (B) such an organization shall be paid a fee negotiated
10 and established by the Secretary in a manner so
11 that (taking into account savings in expenditures under
12 parts A and B of the medicare program under title
13 XVIII of the Social Security Act) there will be no net
14 increase, and to the extent practicable, there will be a
15 net reduction in expenditures under the medicare pro-
16 gram as a result of the project; and

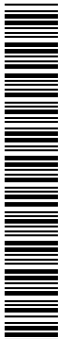
17 (C) such an organization shall guarantee, through
18 an appropriate arrangement with a reinsurance com-
19 pany or otherwise, the prohibition on net increases in
20 expenditures described in subparagraph (B).

21 (3) PAYMENTS.—Payments to such organizations shall
22 be made in appropriate proportion from the Trust Funds
23 established under title XVIII of the Social Security Act.

24 (d) APPLICATION OF MEDIGAP PROTECTIONS TO DEM-
25 ONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph
26 (2), the provisions of section 1882(s)(3) (other than clauses (i)
27 through (iv) of subparagraph (B)) and 1882(s)(4) of the Social
28 Security Act shall apply to enrollment (and termination of en-
29 rollment) in the demonstration project under this section, in
30 the same manner as they apply to enrollment (and termination
31 of enrollment) with a Medicare+ Choice organization in a
32 Medicare+ Choice plan.

33 (2) In applying paragraph (1)—

34 (A) any reference in clause (v) or (vi) of section
35 1882(s)(3)(B) of such Act to 12 months is deemed a ref-
36 erence to the period of the demonstration project; and



1 (B) the notification required under section
2 1882(s)(3)(D) of such Act shall be provided in a manner
3 specified by the Secretary of Health and Human Services.

4 (e) DURATION.—The project shall last for not longer than
5 3 years.

6 (f) WAIVER.—The Secretary of Health and Human Serv-
7 ices shall waive such provisions of title XVIII of the Social Se-
8 curity Act as may be necessary to provide for payment for serv-
9 ices under the project in accordance with subsection (c)(3).

10 (g) REPORT.—The Secretary of Health and Human Serv-
11 ices shall submit to Congress an interim report on the project
12 not later than 2 years after the date it is first implemented and
13 a final report on the project not later than 6 months after the
14 date of its completion. Such reports shall include information
15 on the impact of the project on costs and health outcomes and
16 recommendations on the cost-effectiveness of extending or ex-
17 panding the project.

18 (h) WORKING GROUP ON MEDICARE DISEASE MANAGE-
19 MENT PROGRAMS.—The Secretary shall establish within the
20 Department of Health and Human Services a working group
21 consisting of employees of the Department to carry out the fol-
22 lowing:

- 23 (1) To oversee the project.
- 24 (2) To establish policy and criteria for medicare dis-
25 ease management programs within the Department, includ-
26 ing the establishment of policy and criteria for such pro-
27 grams.
- 28 (3) To identify targeted medical conditions and tar-
29 geted individuals.
- 30 (4) To select areas in which such programs are carried
31 out.
- 32 (5) To monitor health outcomes under such programs.
- 33 (6) To measure the effectiveness of such programs in
34 meeting any budget neutrality requirements.
- 35 (7) Otherwise to serve as a central focal point within
36 the Department for dissemination of information on medi-
37 care disease management programs.



1 (i) GAO STUDY ON DISEASE MANAGEMENT PROGRAMS.—
2 The Comptroller General of the United States shall conduct a
3 study that compares disease management programs under title
4 XVIII of the Social Security Act with such programs conducted
5 in the private sector, including the prevalence of such programs
6 and programs for case management. The study shall identify
7 the cost-effectiveness of such programs and any savings
8 achieved by such programs. The Comptroller General shall submit
9 a report on such study to Congress by not later than 18
10 months after the date of the enactment of this Act.

11 **SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL**
12 **ADULT DAY CARE SERVICES.**

13 (a) ESTABLISHMENT.—Subject to the succeeding provi-
14 sions of this section, the Secretary of Health and Human Serv-
15 ices shall establish a demonstration project (in this section re-
16 ferred to as the “demonstration project”) under which the Sec-
17 retary shall, as part of a plan of an episode of care for home
18 health services established for a medicare beneficiary, permit a
19 home health agency, directly or under arrangements with a
20 medical adult day care facility, to provide medical adult day
21 care services as a substitute for a portion of home health serv-
22 ices that would otherwise be provided in the beneficiary’s home.

23 (b) PAYMENT.—

24 (1) IN GENERAL.—The amount of payment for an epi-
25 sode of care for home health services, a portion of which
26 consists of substitute medical adult day care services, under
27 the demonstration project shall be made at a rate equal to
28 95 percent of the amount that would otherwise apply for
29 such home health services under section 1895 of the Social
30 Security Act (42 u.s.c. 1395fff). In no case may a home
31 health agency, or a medical adult day care facility under
32 arrangements with a home health agency, separately charge
33 a beneficiary for medical adult day care services furnished
34 under the plan of care.

35 (2) BUDGET NEUTRALITY FOR DEMONSTRATION
36 PROJECT.—Notwithstanding any other provision of law, the
37 Secretary shall provide for an appropriate reduction in the



1 aggregate amount of additional payments made under sec-
2 tion 1895 of the Social Security Act (42 U.S.C. 1395fff)
3 to reflect any increase in amounts expended from the Trust
4 Funds as a result of the demonstration project conducted
5 under this section.

6 (c) DEMONSTRATION PROJECT SITES.—The project estab-
7 lished under this section shall be conducted in not more than
8 5 States selected by the Secretary that license or certify pro-
9 viders of services that furnish medical adult day care services.

10 (d) DURATION.—The Secretary shall conduct the dem-
11 onstration project for a period of 3 years.

12 (e) VOLUNTARY PARTICIPATION.—Participation of medi-
13 care beneficiaries in the demonstration project shall be vol-
14 untary. The total number of such beneficiaries that may par-
15 ticipate in the project at any given time may not exceed
16 15,000.

17 (f) PREFERENCE IN SELECTING AGENCIES.—In selecting
18 home health agencies to participate under the demonstration
19 project, the Secretary shall give preference to those agencies
20 that are currently licensed or certified through common owner-
21 ship and control to furnish medical adult day care services.

22 (g) WAIVER AUTHORITY.—The Secretary may waive such
23 requirements of title XVIII of the Social Security Act as may
24 be necessary for the purposes of carrying out the demonstra-
25 tion project, other than waiving the requirement that an indi-
26 vidual be homebound in order to be eligible for benefits for
27 home health services.

28 (h) EVALUATION AND REPORT.—The Secretary shall con-
29 duct an evaluation of the clinical and cost effectiveness of the
30 demonstration project. Not later 30 months after the com-
31 mencement of the project, the Secretary shall submit to Con-
32 gress a report on the evaluation, and shall include in the report
33 the following:

34 (1) An analysis of the patient outcomes and costs of
35 furnishing care to the medicare beneficiaries participating
36 in the project as compared to such outcomes and costs to



1 beneficiaries receiving only home health services for the
2 same health conditions.

3 (2) Such recommendations regarding the extension,
4 expansion, or termination of the project as the Secretary
5 determines appropriate.

6 (i) DEFINITIONS.—In this section:

7 (1) HOME HEALTH AGENCY.—The term “home health
8 agency” has the meaning given such term in section
9 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

10 (2) MEDICAL ADULT DAY CARE FACILITY.—The term
11 “medical adult day care facility” means a facility that—

12 (A) has been licensed or certified by a State to
13 furnish medical adult day care services in the State for
14 a continuous 2-year period;

15 (B) is engaged in providing skilled nursing serv-
16 ices and other therapeutic services directly or under ar-
17 rangement with a home health agency;

18 (C) meets such standards established by the Sec-
19 retary to assure quality of care and such other require-
20 ments as the Secretary finds necessary in the interest
21 of the health and safety of individuals who are fur-
22 nished services in the facility; and

23 (D) provides medical adult day care services.

24 (3) MEDICAL ADULT DAY CARE SERVICES.—The term
25 “medical adult day care services” means—

26 (A) home health service items and services de-
27 scribed in paragraphs (1) through (7) of section
28 1861(m) furnished in a medical adult day care facility;

29 (B) a program of supervised activities furnished in
30 a group setting in the facility that—

31 (i) meet such criteria as the Secretary deter-
32 mines appropriate; and

33 (ii) is designed to promote physical and mental
34 health of the individuals; and

35 (C) such other services as the Secretary may
36 specify.



1 (4) MEDICARE BENEFICIARY.—The term “medicare
2 beneficiary” means an individual entitled to benefits under
3 part A of this title, enrolled under part B of this title, or
4 both.

5 **SEC. 624. PUBLICATION ON FINAL WRITTEN GUIDANCE**
6 **CONCERNING PROHIBITIONS AGAINST DIS-**
7 **CRIMINATION BY NATIONAL ORIGIN WITH**
8 **RESPECT TO HEALTH CARE SERVICES.**

9 Not later than January 1, 2003, the Secretary shall issue
10 final written guidance concerning the application of the prohibi-
11 tion in title VI of the Civil Rights Act of 1964 against national
12 origin discrimination as it affects persons with limited English
13 proficiency with respect to access to health care services under
14 the medicare program.

15 **TITLE VII—MEDICARE BENEFITS**
16 **ADMINISTRATION**

17 **SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS AD-**
18 **MINISTRATION.**

19 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.),
20 as amended by section 105, is amended by inserting after 1806
21 the following new section:

22 “MEDICARE BENEFITS ADMINISTRATION

23 “SEC. 1808. (a) ESTABLISHMENT.—There is established
24 within the Department of Health and Human Services an agen-
25 cy to be known as the Medicare Benefits Administration.

26 “(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF
27 ACTUARY.—

28 “(1) ADMINISTRATOR.—

29 “(A) IN GENERAL.—The Medicare Benefits Ad-
30 ministration shall be headed by an administrator to be
31 known as the ‘Medicare Benefits Administrator’ (in
32 this section referred to as the ‘Administrator’) who
33 shall be appointed by the President, by and with the
34 advice and consent of the Senate. The Administrator
35 shall be in direct line of authority to the Secretary.

36 “(B) COMPENSATION.—The Administrator shall
37 be paid at the rate of basic pay payable for level III



1 of the Executive Schedule under section 5314 of title
2 5, United States Code.

3 “(C) TERM OF OFFICE.—The Administrator shall
4 be appointed for a term of 5 years. In any case in
5 which a successor does not take office at the end of an
6 Administrator’s term of office, that Administrator may
7 continue in office until the entry upon office of such a
8 successor. An Administrator appointed to a term of of-
9 fice after the commencement of such term may serve
10 under such appointment only for the remainder of such
11 term.

12 “(D) GENERAL AUTHORITY.—The Administrator
13 shall be responsible for the exercise of all powers and
14 the discharge of all duties of the Administration, and
15 shall have authority and control over all personnel and
16 activities thereof.

17 “(E) RULEMAKING AUTHORITY.—The Adminis-
18 trator may prescribe such rules and regulations as the
19 Administrator determines necessary or appropriate to
20 carry out the functions of the Administration. The reg-
21 ulations prescribed by the Administrator shall be sub-
22 ject to the rulemaking procedures established under
23 section 553 of title 5, United States Code.

24 “(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL
25 UNITS.—The Administrator may establish, alter, con-
26 solidate, or discontinue such organizational units or
27 components within the Administration as the Adminis-
28 trator considers necessary or appropriate, except as
29 specified in this section.

30 “(G) AUTHORITY TO DELEGATE.—The Adminis-
31 trator may assign duties, and delegate, or authorize
32 successive redelegations of, authority to act and to
33 render decisions, to such officers and employees of the
34 Administration as the Administrator may find nec-
35 essary. Within the limitations of such delegations, re-
36 delegations, or assignments, all official acts and deci-
37 sions of such officers and employees shall have the



1 same force and effect as though performed or rendered
2 by the Administrator.

3 “(2) DEPUTY ADMINISTRATOR.—

4 “(A) IN GENERAL.—There shall be a Deputy Ad-
5 ministrator of the Medicare Benefits Administration
6 who shall be appointed by the President, by and with
7 the advice and consent of the Senate.

8 “(B) COMPENSATION.—The Deputy Administrator
9 shall be paid at the rate of basic pay payable for level
10 IV of the Executive Schedule under section 5315 of
11 title 5, United States Code.

12 “(C) TERM OF OFFICE.—The Deputy Adminis-
13 trator shall be appointed for a term of 5 years. In any
14 case in which a successor does not take office at the
15 end of a Deputy Administrator’s term of office, such
16 Deputy Administrator may continue in office until the
17 entry upon office of such a successor. A Deputy Ad-
18 ministrator appointed to a term of office after the com-
19 mencement of such term may serve under such ap-
20 pointment only for the remainder of such term.

21 “(D) DUTIES.—The Deputy Administrator shall
22 perform such duties and exercise such powers as the
23 Administrator shall from time to time assign or dele-
24 gate. The Deputy Administrator shall be Acting Ad-
25 ministrator of the Administration during the absence or
26 disability of the Administrator and, unless the Presi-
27 dent designates another officer of the Government as
28 Acting Administrator, in the event of a vacancy in the
29 office of the Administrator.

30 “(3) CHIEF ACTUARY.—

31 “(A) IN GENERAL.—There is established in the
32 Administration the position of Chief Actuary. The
33 Chief Actuary shall be appointed by, and in direct line
34 of authority to, the Administrator of such Administra-
35 tion. The Chief Actuary shall be appointed from among
36 individuals who have demonstrated, by their education
37 and experience, superior expertise in the actuarial



1 sciences. The Chief Actuary may be removed only for
2 cause.

3 “(B) COMPENSATION.—The Chief Actuary shall
4 be compensated at the highest rate of basic pay for the
5 Senior Executive Service under section 5382(b) of title
6 5, United States Code.

7 “(C) DUTIES.—The Chief Actuary shall exercise
8 such duties as are appropriate for the office of the
9 Chief Actuary and in accordance with professional
10 standards of actuarial independence.

11 “(4) SECRETARIAL COORDINATION OF PROGRAM AD-
12 MINISTRATION.—The Secretary shall ensure appropriate
13 coordination between the Administrator and the Adminis-
14 trator of the Centers for Medicare & Medicaid Services in
15 carrying out the programs under this title.

16 “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

17 “(1) DUTIES.—

18 “(A) GENERAL DUTIES.—The Administrator shall
19 carry out parts C and D, including—

20 “(i) negotiating, entering into, and enforcing,
21 contracts with plans for the offering of
22 Medicare+ Choice plans under part C, including the
23 offering of qualified prescription drug coverage
24 under such plans; and

25 “(ii) negotiating, entering into, and enforcing,
26 contracts with PDP sponsors for the offering of
27 prescription drug plans under part D.

28 “(B) OTHER DUTIES.—The Administrator shall
29 carry out any duty provided for under part C or part
30 D, including demonstration projects carried out in part
31 or in whole under such parts, the programs of all-inclu-
32 sive care for the elderly (PACE program) under section
33 1894, the social health maintenance organization
34 (SHMO) demonstration projects (referred to in section
35 4104(c) of the Balanced Budget Act of 1997), and
36 through a Medicare+ Choice project that demonstrates
37 the application of capitation payment rates for frail el-



1 derly medicare beneficiaries through the use of a inter-
2 disciplinary team and through the provision of primary
3 care services to such beneficiaries by means of such a
4 team at the nursing facility involved).

5 “(C) PRESCRIPTION DRUG CARD.—The Adminis-
6 trator shall carry out section 1807 (relating to the
7 medicare prescription drug discount card endorsement
8 program).

9 “(D) NONINTERFERENCE.—In carrying out its
10 duties with respect to the provision of qualified pre-
11 scription drug coverage to beneficiaries under this title,
12 the Administrator may not—

13 “(i) require a particular formulary or institute
14 a price structure for the reimbursement of covered
15 outpatient drugs;

16 “(ii) interfere in any way with negotiations be-
17 tween PDP sponsors and Medicare+ Choice organi-
18 zations and drug manufacturers, wholesalers, or
19 other suppliers of covered outpatient drugs; and

20 “(iii) otherwise interfere with the competitive
21 nature of providing such coverage through such
22 sponsors and organizations.

23 “(E) ANNUAL REPORTS.—Not later March 31 of
24 each year, the Administrator shall submit to Congress
25 and the President a report on the administration of
26 parts C and D during the previous fiscal year.

27 “(2) STAFF.—

28 “(A) IN GENERAL.—The Administrator, with the
29 approval of the Secretary, may employ, without regard
30 to chapter 31 of title 5, United States Code, other than
31 sections 3110 and 3112, such officers and employees as
32 are necessary to administer the activities to be carried
33 out through the Medicare Benefits Administration. The
34 Administrator shall employ staff with appropriate and
35 necessary expertise in negotiating contracts in the pri-
36 vate sector.



1 “(B) FLEXIBILITY WITH RESPECT TO COMPENSA-
2 TION.—

3 “(i) IN GENERAL.—The staff of the Medicare
4 Benefits Administration shall, subject to clause (ii),
5 be paid without regard to the provisions of chapter
6 51 (other than section 5101) and chapter 53 (other
7 than section 5301) of such title (relating to classi-
8 fication and schedule pay rates).

9 “(ii) MAXIMUM RATE.—In no case may the
10 rate of compensation determined under clause (i)
11 exceed the rate of basic pay payable for level IV of
12 the Executive Schedule under section 5315 of title
13 5, United States Code.

14 “(C) LIMITATION ON FULL-TIME EQUIVALENT
15 STAFFING FOR CURRENT CMS FUNCTIONS BEING
16 TRANSFERRED.—The Administrator may not employ
17 under this paragraph a number of full-time equivalent
18 employees, to carry out functions that were previously
19 conducted by the Centers for Medicare & Medicaid
20 Services and that are conducted by the Administrator
21 by reason of this section, that exceeds the number of
22 such full-time equivalent employees authorized to be
23 employed by the Centers for Medicare & Medicaid Serv-
24 ices to conduct such functions as of the date of the en-
25 actment of this Act.

26 “(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE
27 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

28 “(A) IN GENERAL.—The Secretary, the Adminis-
29 trator, and the Administrator of the Centers for Medi-
30 care & Medicaid Services shall establish an appropriate
31 transition of responsibility in order to redelegate the
32 administration of part C from the Secretary and the
33 Administrator of the Centers for Medicare & Medicaid
34 Services to the Administrator as is appropriate to carry
35 out the purposes of this section.

36 “(B) TRANSFER OF DATA AND INFORMATION.—
37 The Secretary shall ensure that the Administrator of



1 the Centers for Medicare & Medicaid Services transfers
2 to the Administrator of the Medicare Benefits Adminis-
3 tration such information and data in the possession of
4 the Administrator of the Centers for Medicare & Med-
5 icaid Services as the Administrator of the Medicare
6 Benefits Administration requires to carry out the du-
7 ties described in paragraph (1).

8 “(C) CONSTRUCTION.—Insofar as a responsibility
9 of the Secretary or the Administrator of the Centers
10 for Medicare & Medicaid Services is redelegated to the
11 Administrator under this section, any reference to the
12 Secretary or the Administrator of the Centers for Medi-
13 care & Medicaid Services in this title or title XI with
14 respect to such responsibility is deemed to be a ref-
15 erence to the Administrator.

16 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

17 “(1) ESTABLISHMENT.—The Secretary shall establish
18 within the Medicare Benefits Administration an Office of
19 Beneficiary Assistance to coordinate functions relating to
20 outreach and education of medicare beneficiaries under this
21 title, including the functions described in paragraph (2).
22 The Office shall be separate operating division within the
23 Administration.

24 “(2) DISSEMINATION OF INFORMATION ON BENEFITS
25 AND APPEALS RIGHTS.—

26 “(A) DISSEMINATION OF BENEFITS INFORMA-
27 TION.—The Office of Beneficiary Assistance shall dis-
28 seminate, directly or through contract, to medicare
29 beneficiaries, by mail, by posting on the Internet site
30 of the Medicare Benefits Administration and through a
31 toll-free telephone number, information with respect to
32 the following:

33 “(i) Benefits, and limitations on payment (in-
34 cluding cost-sharing, stop-loss provisions, and for-
35 mulary restrictions) under parts C and D.



1 “(ii) Benefits, and limitations on payment
2 under parts A and B, including information on
3 medicare supplemental policies under section 1882.
4 Such information shall be presented in a manner so
5 that medicare beneficiaries may compare benefits under
6 parts A, B, D, and medicare supplemental policies with
7 benefits under Medicare+ Choice plans under part C.

8 “(B) DISSEMINATION OF APPEALS RIGHTS INFOR-
9 MATION.—The Office of Beneficiary Assistance shall
10 disseminate to medicare beneficiaries in the manner
11 provided under subparagraph (A) a description of pro-
12 cedural rights (including grievance and appeals proce-
13 dures) of beneficiaries under the original medicare fee-
14 for-service program under parts A and B, the
15 Medicare+ Choice program under part C, and the Vol-
16 untary Prescription Drug Benefit Program under part
17 D.

18 “(e) MEDICARE POLICY ADVISORY BOARD.—

19 “(1) ESTABLISHMENT.—There is established within
20 the Medicare Benefits Administration the Medicare Policy
21 Advisory Board (in this section referred to the ‘Board’).
22 The Board shall advise, consult with, and make rec-
23 ommendations to the Administrator of the Medicare Bene-
24 fits Administration with respect to the administration of
25 parts C and D, including the review of payment policies
26 under such parts.

27 “(2) REPORTS.—

28 “(A) IN GENERAL.—With respect to matters of
29 the administration of parts C and D, the Board shall
30 submit to Congress and to the Administrator of the
31 Medicare Benefits Administration such reports as the
32 Board determines appropriate. Each such report may
33 contain such recommendations as the Board determines
34 appropriate for legislative or administrative changes to
35 improve the administration of such parts, including the
36 topics described in subparagraph (B). Each such report
37 shall be published in the Federal Register.



1 “(B) TOPICS DESCRIBED.—Reports required
2 under subparagraph (A) may include the following top-
3 ics:

4 “(i) FOSTERING COMPETITION.—Rec-
5 ommendations or proposals to increase competition
6 under parts C and D for services furnished to
7 medicare beneficiaries.

8 “(ii) EDUCATION AND ENROLLMENT.—Rec-
9 ommendations for the improvement to efforts to
10 provide medicare beneficiaries information and edu-
11 cation on the program under this title, and specifi-
12 cally parts C and D, and the program for enroll-
13 ment under the title.

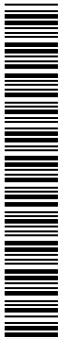
14 “(iii) IMPLEMENTATION OF RISK-ADJUST-
15 MENT.—Evaluation of the implementation under
16 section 1853(a)(3)(C) of the risk adjustment meth-
17 odology to payment rates under that section to
18 Medicare+ Choice organizations offering
19 Medicare+ Choice plans that accounts for variations
20 in per capita costs based on health status and other
21 demographic factors.

22 “(iv) DISEASE MANAGEMENT PROGRAMS.—
23 Recommendations on the incorporation of disease
24 management programs under parts C and D.

25 “(v) RURAL ACCESS.—Recommendations to
26 improve competition and access to plans under
27 parts C and D in rural areas.

28 “(C) MAINTAINING INDEPENDENCE OF BOARD.—
29 The Board shall directly submit to Congress reports re-
30 quired under subparagraph (A). No officer or agency of
31 the United States may require the Board to submit to
32 any officer or agency of the United States for approval,
33 comments, or review, prior to the submission to Con-
34 gress of such reports.

35 “(3) DUTY OF ADMINISTRATOR OF MEDICARE BENE-
36 FITS ADMINISTRATION.—With respect to any report sub-
37 mitted by the Board under paragraph (2)(A), not later



1 than 90 days after the report is submitted, the Adminis-
2 trator of the Medicare Benefits Administration shall submit
3 to Congress and the President an analysis of recommenda-
4 tions made by the Board in such report. Each such analysis
5 shall be published in the Federal Register.

6 “(4) MEMBERSHIP.—

7 “(A) APPOINTMENT.—Subject to the succeeding
8 provisions of this paragraph, the Board shall consist of
9 seven members to be appointed as follows:

10 “(i) Three members shall be appointed by the
11 President.

12 “(ii) Two members shall be appointed by the
13 Speaker of the House of Representatives, with the
14 advice of the chairmen and the ranking minority
15 members of the Committees on Ways and Means
16 and on Energy and Commerce of the House of
17 Representatives.

18 “(iii) Two members shall be appointed by the
19 President pro tempore of the Senate with the ad-
20 vice of the chairman and the ranking minority
21 member of the Senate Committee on Finance.

22 “(B) QUALIFICATIONS.—The members shall be
23 chosen on the basis of their integrity, impartiality, and
24 good judgment, and shall be individuals who are, by
25 reason of their education and experience in health care
26 benefits management, exceptionally qualified to perform
27 the duties of members of the Board.

28 “(C) PROHIBITION ON INCLUSION OF FEDERAL
29 EMPLOYEES.—No officer or employee of the United
30 States may serve as a member of the Board.

31 “(5) COMPENSATION.—Members of the Board shall
32 receive, for each day (including travel time) they are en-
33 gaged in the performance of the functions of the board,
34 compensation at rates not to exceed the daily equivalent to
35 the annual rate in effect for level IV of the Executive
36 Schedule under section 5315 of title 5, United States Code.

37 “(6) TERMS OF OFFICE.—



1 “(A) IN GENERAL.—The term of office of mem-
2 bers of the Board shall be 3 years.

3 “(B) TERMS OF INITIAL APPOINTEES.—As des-
4 ignated by the President at the time of appointment,
5 of the members first appointed—

6 “(i) one shall be appointed for a term of 1
7 year;

8 “(ii) three shall be appointed for terms of 2
9 years; and

10 “(iii) three shall be appointed for terms of 3
11 years.

12 “(C) REAPPOINTMENTS.—Any person appointed
13 as a member of the Board may not serve for more than
14 8 years.

15 “(D) VACANCY.—Any member appointed to fill a
16 vacancy occurring before the expiration of the term for
17 which the member’s predecessor was appointed shall be
18 appointed only for the remainder of that term. A mem-
19 ber may serve after the expiration of that member’s
20 term until a successor has taken office. A vacancy in
21 the Board shall be filled in the manner in which the
22 original appointment was made.

23 “(7) CHAIR.—The Chair of the Board shall be elected
24 by the members. The term of office of the Chair shall be
25 3 years.

26 “(8) MEETINGS.—The Board shall meet at the call of
27 the Chair, but in no event less than three times during
28 each fiscal year.

29 “(9) DIRECTOR AND STAFF.—

30 “(A) APPOINTMENT OF DIRECTOR.—The Board
31 shall have a Director who shall be appointed by the
32 Chair.

33 “(B) IN GENERAL.—With the approval of the
34 Board, the Director may appoint, without regard to
35 chapter 31 of title 5, United States Code, such addi-
36 tional personnel as the Director considers appropriate.



1 “(C) FLEXIBILITY WITH RESPECT TO COMPENSA-
2 TION.—

3 “(i) IN GENERAL.—The Director and staff of
4 the Board shall, subject to clause (ii), be paid with-
5 out regard to the provisions of chapter 51 and
6 chapter 53 of such title (relating to classification
7 and schedule pay rates).

8 “(ii) MAXIMUM RATE.—In no case may the
9 rate of compensation determined under clause (i)
10 exceed the rate of basic pay payable for level IV of
11 the Executive Schedule under section 5315 of title
12 5, United States Code.

13 “(D) ASSISTANCE FROM THE ADMINISTRATOR OF
14 THE MEDICARE BENEFITS ADMINISTRATION.—The Ad-
15 ministrators of the Medicare Benefits Administration
16 shall make available to the Board such information and
17 other assistance as it may require to carry out its func-
18 tions.

19 “(10) CONTRACT AUTHORITY.—The Board may con-
20 tract with and compensate government and private agencies
21 or persons to carry out its duties under this subsection,
22 without regard to section 3709 of the Revised Statutes (41
23 U.S.C. 5).

24 “(f) FUNDING.—There is authorized to be appropriated, in
25 appropriate part from the Federal Hospital Insurance Trust
26 Fund and from the Federal Supplementary Medical Insurance
27 Trust Fund (including the Medicare Prescription Drug Ac-
28 count), such sums as are necessary to carry out this section.”.

29 (b) EFFECTIVE DATE.—

30 (1) IN GENERAL.—The amendment made by sub-
31 section (a) shall take effect on the date of the enactment
32 of this Act.

33 (2) TIMING OF INITIAL APPOINTMENTS.—The Admin-
34 istrator and Deputy Administrator of the Medicare Bene-
35 fits Administration may not be appointed before March 1,
36 2003.



1 (3) DUTIES WITH RESPECT TO ELIGIBILITY DETER-
2 MINATIONS AND ENROLLMENT.—The Administrator of the
3 Medicare Benefits Administration shall carry out enroll-
4 ment under title XVIII of the Social Security Act, make
5 eligibility determinations under such title, and carry out
6 part C of such title for years beginning or after January
7 1, 2005.

8 (4) TRANSITION.—Before the date the Administrator
9 of the Medicare Benefits Administration is appointed and
10 assumes responsibilities under this section and section
11 1807 of the Social Security Act, the Secretary of Health
12 and Human Services shall provide for the conduct of any
13 responsibilities of such Administrator that are otherwise
14 provided under law.

15 (c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

16 (1) ADMINISTRATOR AS MEMBER OF THE BOARD OF
17 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section
18 1817(b) and section 1841(b) (42 U.S.C. 1395i(b),
19 1395t(b)) are each amended by striking “and the Secretary
20 of Health and Human Services, all ex officio,” and insert-
21 ing “the Secretary of Health and Human Services, and the
22 Administrator of the Medicare Benefits Administration, all
23 ex officio,”.

24 (2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR
25 THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE &
26 MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS AD-
27 MINISTRATOR.—

28 (A) IN GENERAL.—Section 5314 of title 5, United
29 States Code, by adding at the end the following:

30 “Administrator of the Centers for Medicare & Med-
31 icaid Services .

32 “Administrator of the Medicare Benefits Administra-
33 tion.”.

34 (B) CONFORMING AMENDMENT.—Section 5315 of
35 such title is amended by striking “Administrator of the
36 Health Care Financing Administration.”.



1 (C) EFFECTIVE DATE.—The amendments made by
2 this paragraph take effect on January 1, 2003.

3 **TITLE VIII—REGULATORY REDUC-**
4 **TION AND CONTRACTING RE-**
5 **FORM**

6 **Subtitle A—Regulatory Reform**

7 **SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.**

8 (a) CONSTRUCTION.—Nothing in this title shall be
9 construed—

10 (1) to compromise or affect existing legal remedies for
11 addressing fraud or abuse, whether it be criminal prosecu-
12 tion, civil enforcement, or administrative remedies, includ-
13 ing under sections 3729 through 3733 of title 31, United
14 States Code (known as the False Claims Act); or

15 (2) to prevent or impede the Department of Health
16 and Human Services in any way from its ongoing efforts
17 to eliminate waste, fraud, and abuse in the medicare pro-
18 gram.

19 Furthermore, the consolidation of medicare administrative con-
20 tracting set forth in this Act does not constitute consolidation
21 of the Federal Hospital Insurance Trust Fund and the Federal
22 Supplementary Medical Insurance Trust Fund or reflect any
23 position on that issue.

24 (b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C.
25 1395x) is amended by inserting after subsection (c) the fol-
26 lowing new subsection:

27 “Supplier

28 “(d) The term ‘supplier’ means, unless the context other-
29 wise requires, a physician or other practitioner, a facility, or
30 other entity (other than a provider of services) that furnishes
31 items or services under this title.”.

32 **SEC. 802. ISSUANCE OF REGULATIONS.**

33 (a) CONSOLIDATION OF PROMULGATION TO ONCE A
34 MONTH.—



1 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh)
2 is amended by adding at the end the following new sub-
3 section:

4 “(d)(1) Subject to paragraph (2), the Secretary shall issue
5 proposed or final (including interim final) regulations to carry
6 out this title only on one business day of every month.

7 “(2) The Secretary may issue a proposed or final regula-
8 tion described in paragraph (1) on any other day than the day
9 described in paragraph (1) if the Secretary—

10 “(A) finds that issuance of such regulation on another
11 day is necessary to comply with requirements under law; or

12 “(B) finds that with respect to that regulation the lim-
13 itation of issuance on the date described in paragraph (1)
14 is contrary to the public interest.

15 If the Secretary makes a finding under this paragraph, the
16 Secretary shall include such finding, and brief statement of the
17 reasons for such finding, in the issuance of such regulation.

18 “(3) The Secretary shall coordinate issuance of new regu-
19 lations described in paragraph (1) relating to a category of pro-
20 vider of services or suppliers based on an analysis of the collec-
21 tive impact of regulatory changes on that category of providers
22 or suppliers.”.

23 (2) GAO REPORT ON PUBLICATION OF REGULATIONS
24 ON A QUARTERLY BASIS.—Not later than 3 years after the
25 date of the enactment of this Act, the Comptroller General
26 of the United States shall submit to Congress a report on
27 the feasibility of requiring that regulations described in sec-
28 tion 1871(d) of the Social Security Act be promulgated on
29 a quarterly basis rather than on a monthly basis.

30 (3) EFFECTIVE DATE.—The amendment made by
31 paragraph (1) shall apply to regulations promulgated on or
32 after the date that is 30 days after the date of the enact-
33 ment of this Act.

34 (b) REGULAR TIMELINE FOR PUBLICATION OF FINAL
35 RULES.—



1 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
2 1395hh(a)) is amended by adding at the end the following
3 new paragraph:

4 “(3)(A) The Secretary, in consultation with the Director
5 of the Office of Management and Budget, shall establish and
6 publish a regular timeline for the publication of final regula-
7 tions based on the previous publication of a proposed regulation
8 or an interim final regulation.

9 “(B) Such timeline may vary among different regulations
10 based on differences in the complexity of the regulation, the
11 number and scope of comments received, and other relevant
12 factors, but shall not be longer than 3 years except under ex-
13 ceptional circumstances. If the Secretary intends to vary such
14 timeline with respect to the publication of a final regulation,
15 the Secretary shall cause to have published in the Federal Reg-
16 ister notice of the different timeline by not later than the
17 timeline previously established with respect to such regulation.
18 Such notice shall include a brief explanation of the justification
19 for such variation.

20 “(C) In the case of interim final regulations, upon the ex-
21 piration of the regular timeline established under this para-
22 graph for the publication of a final regulation after opportunity
23 for public comment, the interim final regulation shall not con-
24 tinue in effect unless the Secretary publishes (at the end of the
25 regular timeline and, if applicable, at the end of each suc-
26 ceeding 1-year period) a notice of continuation of the regulation
27 that includes an explanation of why the regular timeline (and
28 any subsequent 1-year extension) was not complied with. If
29 such a notice is published, the regular timeline (or such
30 timeline as previously extended under this paragraph) for publi-
31 cation of the final regulation shall be treated as having been
32 extended for 1 additional year.

33 “(D) The Secretary shall annually submit to Congress a
34 report that describes the instances in which the Secretary failed
35 to publish a final regulation within the applicable regular
36 timeline under this paragraph and that provides an explanation
37 for such failures.”.



1 (2) EFFECTIVE DATE.—The amendment made by
2 paragraph (1) shall take effect on the date of the enact-
3 ment of this Act. The Secretary shall provide for an appro-
4 priate transition to take into account the backlog of pre-
5 viously published interim final regulations.

6 (c) LIMITATIONS ON NEW MATTER IN FINAL REGULA-
7 TIONS.—

8 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
9 1395hh(a)), as amended by subsection (b), is further
10 amended by adding at the end the following new para-
11 graph:

12 “(4) If the Secretary publishes notice of proposed rule-
13 making relating to a regulation (including an interim final reg-
14 ulation), insofar as such final regulation includes a provision
15 that is not a logical outgrowth of such notice of proposed rule-
16 making, that provision shall be treated as a proposed regulation
17 and shall not take effect until there is the further opportunity
18 for public comment and a publication of the provision again as
19 a final regulation.”.

20 (2) EFFECTIVE DATE.—The amendment made by
21 paragraph (1) shall apply to final regulations published on
22 or after the date of the enactment of this Act.

23 **SEC. 803. COMPLIANCE WITH CHANGES IN REGULA-**
24 **TIONS AND POLICIES.**

25 (a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE
26 CHANGES.—

27 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh),
28 as amended by section 802(a), is amended by adding at the
29 end the following new subsection:

30 “(e)(1)(A) A substantive change in regulations, manual in-
31 structions, interpretative rules, statements of policy, or guide-
32 lines of general applicability under this title shall not be applied
33 (by extrapolation or otherwise) retroactively to items and serv-
34 ices furnished before the effective date of the change, unless
35 the Secretary determines that—

36 “(i) such retroactive application is necessary to comply
37 with statutory requirements; or



1 “(ii) failure to apply the change retroactively would be
2 contrary to the public interest.”.

3 (2) EFFECTIVE DATE.—The amendment made by
4 paragraph (1) shall apply to substantive changes issued on
5 or after the date of the enactment of this Act.

6 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE
7 CHANGES AFTER NOTICE.—

8 (1) IN GENERAL.—Section 1871(e)(1), as added by
9 subsection (a), is amended by adding at the end the fol-
10 lowing:

11 “(B)(i) Except as provided in clause (ii), a substantive
12 change referred to in subparagraph (A) shall not become effec-
13 tive before the end of the 30-day period that begins on the date
14 that the Secretary has issued or published, as the case may be,
15 the substantive change.

16 “(ii) The Secretary may provide for such a substantive
17 change to take effect on a date that precedes the end of the
18 30-day period under clause (i) if the Secretary finds that waiv-
19 er of such 30-day period is necessary to comply with statutory
20 requirements or that the application of such 30-day period is
21 contrary to the public interest. If the Secretary provides for an
22 earlier effective date pursuant to this clause, the Secretary
23 shall include in the issuance or publication of the substantive
24 change a finding described in the first sentence, and a brief
25 statement of the reasons for such finding.

26 “(C) No action shall be taken against a provider of serv-
27 ices or supplier with respect to noncompliance with such a sub-
28 stantive change for items and services furnished before the ef-
29 fective date of such a change.”.

30 (2) EFFECTIVE DATE.—The amendment made by
31 paragraph (1) shall apply to compliance actions undertaken
32 on or after the date of the enactment of this Act.

33 (c) RELIANCE ON GUIDANCE.—

34 (1) IN GENERAL.—Section 1871(e), as added by sub-
35 section (a), is further amended by adding at the end the
36 following new paragraph:

37 “(2)(A) If—



1 “(i) a provider of services or supplier follows the writ-
2 ten guidance (which may be transmitted electronically) pro-
3 vided by the Secretary or by a medicare contractor (as de-
4 fined in section 1889(g)) acting within the scope of the
5 contractor’s contract authority, with respect to the fur-
6 nishing of items or services and submission of a claim for
7 benefits for such items or services with respect to such pro-
8 vider or supplier;

9 “(ii) the Secretary determines that the provider of
10 services or supplier has accurately presented the cir-
11 cumstances relating to such items, services, and claim to
12 the contractor in writing; and

13 “(iii) the guidance was in error;
14 the provider of services or supplier shall not be subject to any
15 sanction (including any penalty or requirement for repayment
16 of any amount) if the provider of services or supplier reason-
17 ably relied on such guidance.

18 “(B) Subparagraph (A) shall not be construed as pre-
19 venting the recoupment or repayment (without any additional
20 penalty) relating to an overpayment insofar as the overpayment
21 was solely the result of a clerical or technical operational
22 error.”.

23 (2) EFFECTIVE DATE.—The amendment made by
24 paragraph (1) shall take effect on the date of the enact-
25 ment of this Act but shall not apply to any sanction for
26 which notice was provided on or before the date of the en-
27 actment of this Act.

28 **SEC. 804. REPORTS AND STUDIES RELATING TO REGU-**
29 **LATORY REFORM.**

30 (a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

31 (1) STUDY.—The Comptroller General of the United
32 States shall conduct a study to determine the feasibility
33 and appropriateness of establishing in the Secretary au-
34 thority to provide legally binding advisory opinions on ap-
35 propriate interpretation and application of regulations to
36 carry out the medicare program under title XVIII of the
37 Social Security Act. Such study shall examine the appro-



1 priate timeframe for issuing such advisory opinions, as well
2 as the need for additional staff and funding to provide such
3 opinions.

4 (2) REPORT.—The Comptroller General shall submit
5 to Congress a report on the study conducted under para-
6 graph (1) by not later than January 1, 2004.

7 (b) REPORT ON LEGAL AND REGULATORY INCONSIST-
8 ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by
9 section 803(a), is amended by adding at the end the following
10 new subsection:

11 “(f)(1) Not later than 2 years after the date of the enact-
12 ment of this subsection, and every 2 years thereafter, the Sec-
13 retary shall submit to Congress a report with respect to the ad-
14 ministration of this title and areas of inconsistency or conflict
15 among the various provisions under law and regulation.

16 “(2) In preparing a report under paragraph (1), the Sec-
17 retary shall collect—

18 “(A) information from individuals entitled to benefits
19 under part A or enrolled under part B, or both, providers
20 of services, and suppliers and from the Medicare Bene-
21 ficiary Ombudsman and the Medicare Provider Ombuds-
22 man with respect to such areas of inconsistency and con-
23 flict; and

24 “(B) information from medicare contractors that
25 tracks the nature of written and telephone inquiries.

26 “(3) A report under paragraph (1) shall include a descrip-
27 tion of efforts by the Secretary to reduce such inconsistency or
28 conflicts, and recommendations for legislation or administrative
29 action that the Secretary determines appropriate to further re-
30 duce such inconsistency or conflicts.”.

31 **Subtitle B—Contracting Reform**

32 **SEC. 811. INCREASED FLEXIBILITY IN MEDICARE AD-**
33 **MINISTRATION.**

34 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE AD-
35 MINISTRATION.—

36 (1) IN GENERAL.—Title XVIII is amended by insert-
37 ing after section 1874 the following new section:



1 “CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

2 “SEC. 1874A. (a) AUTHORITY.—

3 “(1) AUTHORITY TO ENTER INTO CONTRACTS.—The
4 Secretary may enter into contracts with any eligible entity
5 to serve as a medicare administrative contractor with re-
6 spect to the performance of any or all of the functions de-
7 scribed in paragraph (4) or parts of those functions (or, to
8 the extent provided in a contract, to secure performance
9 thereof by other entities).

10 “(2) ELIGIBILITY OF ENTITIES.—An entity is eligible
11 to enter into a contract with respect to the performance of
12 a particular function described in paragraph (4) only if—

13 “(A) the entity has demonstrated capability to
14 carry out such function;

15 “(B) the entity complies with such conflict of in-
16 terest standards as are generally applicable to Federal
17 acquisition and procurement;

18 “(C) the entity has sufficient assets to financially
19 support the performance of such function; and

20 “(D) the entity meets such other requirements as
21 the Secretary may impose.

22 “(3) MEDICARE ADMINISTRATIVE CONTRACTOR DE-
23 FINED.—For purposes of this title and title XI—

24 “(A) IN GENERAL.—The term ‘medicare adminis-
25 trative contractor’ means an agency, organization, or
26 other person with a contract under this section.

27 “(B) APPROPRIATE MEDICARE ADMINISTRATIVE
28 CONTRACTOR.—With respect to the performance of a
29 particular function in relation to an individual entitled
30 to benefits under part A or enrolled under part B, or
31 both, a specific provider of services or supplier (or class
32 of such providers of services or suppliers), the ‘appro-
33 priate’ medicare administrative contractor is the medi-
34 care administrative contractor that has a contract
35 under this section with respect to the performance of
36 that function in relation to that individual, provider of



1 services or supplier or class of provider of services or
2 supplier.

3 “(4) FUNCTIONS DESCRIBED.—The functions referred
4 to in paragraphs (1) and (2) are payment functions, pro-
5 vider services functions, and functions relating to services
6 furnished to individuals entitled to benefits under part A
7 or enrolled under part B, or both, as follows:

8 “(A) DETERMINATION OF PAYMENT AMOUNTS.—
9 Determining (subject to the provisions of section 1878
10 and to such review by the Secretary as may be provided
11 for by the contracts) the amount of the payments re-
12 quired pursuant to this title to be made to providers of
13 services, suppliers and individuals.

14 “(B) MAKING PAYMENTS.—Making payments de-
15 scribed in subparagraph (A) (including receipt, dis-
16 bursement, and accounting for funds in making such
17 payments).

18 “(C) BENEFICIARY EDUCATION AND ASSIST-
19 ANCE.—Providing education and outreach to individ-
20 uals entitled to benefits under part A or enrolled under
21 part B, or both, and providing assistance to those indi-
22 viduals with specific issues, concerns or problems.

23 “(D) PROVIDER CONSULTATIVE SERVICES.—Pro-
24 viding consultative services to institutions, agencies,
25 and other persons to enable them to establish and
26 maintain fiscal records necessary for purposes of this
27 title and otherwise to qualify as providers of services or
28 suppliers.

29 “(E) COMMUNICATION WITH PROVIDERS.—Com-
30 municating to providers of services and suppliers any
31 information or instructions furnished to the medicare
32 administrative contractor by the Secretary, and facili-
33 tating communication between such providers and sup-
34 pliers and the Secretary.

35 “(F) PROVIDER EDUCATION AND TECHNICAL AS-
36 SISTANCE.—Performing the functions relating to pro-
37 vider education, training, and technical assistance.



1 “(G) ADDITIONAL FUNCTIONS.—Performing such
2 other functions as are necessary to carry out the pur-
3 poses of this title.

4 “(5) RELATIONSHIP TO MIP CONTRACTS.—

5 “(A) NONDUPLICATION OF DUTIES.—In entering
6 into contracts under this section, the Secretary shall
7 assure that functions of medicare administrative con-
8 tractors in carrying out activities under parts A and B
9 do not duplicate activities carried out under the Medi-
10 care Integrity Program under section 1893. The pre-
11 vious sentence shall not apply with respect to the activ-
12 ity described in section 1893(b)(5) (relating to prior
13 authorization of certain items of durable medical equip-
14 ment under section 1834(a)(15)).

15 “(B) CONSTRUCTION.—An entity shall not be
16 treated as a medicare administrative contractor merely
17 by reason of having entered into a contract with the
18 Secretary under section 1893.

19 “(6) APPLICATION OF FEDERAL ACQUISITION REGULA-
20 TION.—Except to the extent inconsistent with a specific re-
21 quirement of this title, the Federal Acquisition Regulation
22 applies to contracts under this title.

23 “(b) CONTRACTING REQUIREMENTS.—

24 “(1) USE OF COMPETITIVE PROCEDURES.—

25 “(A) IN GENERAL.—Except as provided in laws
26 with general applicability to Federal acquisition and
27 procurement or in subparagraph (B), the Secretary
28 shall use competitive procedures when entering into
29 contracts with medicare administrative contractors
30 under this section, taking into account performance
31 quality as well as price and other factors.

32 “(B) RENEWAL OF CONTRACTS.—The Secretary
33 may renew a contract with a medicare administrative
34 contractor under this section from term to term with-
35 out regard to section 5 of title 41, United States Code,
36 or any other provision of law requiring competition, if
37 the medicare administrative contractor has met or ex-



1 ceded the performance requirements applicable with
2 respect to the contract and contractor, except that the
3 Secretary shall provide for the application of competi-
4 tive procedures under such a contract not less fre-
5 quently than once every five years.

6 “(C) TRANSFER OF FUNCTIONS.—The Secretary
7 may transfer functions among medicare administrative
8 contractors consistent with the provisions of this para-
9 graph. The Secretary shall ensure that performance
10 quality is considered in such transfers. The Secretary
11 shall provide public notice (whether in the Federal Reg-
12 ister or otherwise) of any such transfer (including a de-
13 scription of the functions so transferred, a description
14 of the providers of services and suppliers affected by
15 such transfer, and contact information for the contrac-
16 tors involved).

17 “(D) INCENTIVES FOR QUALITY.—The Secretary
18 shall provide incentives for medicare administrative
19 contractors to provide quality service and to promote
20 efficiency.

21 “(2) COMPLIANCE WITH REQUIREMENTS.—No con-
22 tract under this section shall be entered into with any
23 medicare administrative contractor unless the Secretary
24 finds that such medicare administrative contractor will per-
25 form its obligations under the contract efficiently and effec-
26 tively and will meet such requirements as to financial re-
27 sponsibility, legal authority, quality of services provided,
28 and other matters as the Secretary finds pertinent.

29 “(3) PERFORMANCE REQUIREMENTS.—

30 “(A) DEVELOPMENT OF SPECIFIC PERFORMANCE
31 REQUIREMENTS.—In developing contract performance
32 requirements, the Secretary shall develop performance
33 requirements applicable to functions described in sub-
34 section (a)(4).

35 “(B) CONSULTATION.— In developing such re-
36 quirements, the Secretary may consult with providers
37 of services and suppliers, organizations representing in-



1 individuals entitled to benefits under part A or enrolled
2 under part B, or both, and organizations and agencies
3 performing functions necessary to carry out the pur-
4 poses of this section with respect to such performance
5 requirements.

6 “(C) INCLUSION IN CONTRACTS.—All contractor
7 performance requirements shall be set forth in the con-
8 tract between the Secretary and the appropriate medi-
9 care administrative contractor. Such performance
10 requirements—

11 “(i) shall reflect the performance requirements
12 developed under subparagraph (A), but may in-
13 clude additional performance requirements;

14 “(ii) shall be used for evaluating contractor
15 performance under the contract; and

16 “(iii) shall be consistent with the written state-
17 ment of work provided under the contract.

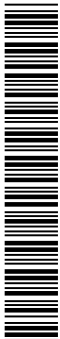
18 “(4) INFORMATION REQUIREMENTS.—The Secretary
19 shall not enter into a contract with a medicare administra-
20 tive contractor under this section unless the contractor
21 agrees—

22 “(A) to furnish to the Secretary such timely infor-
23 mation and reports as the Secretary may find nec-
24 essary in performing his functions under this title; and

25 “(B) to maintain such records and afford such ac-
26 cess thereto as the Secretary finds necessary to assure
27 the correctness and verification of the information and
28 reports under subparagraph (A) and otherwise to carry
29 out the purposes of this title.

30 “(5) SURETY BOND.—A contract with a medicare ad-
31 ministrative contractor under this section may require the
32 medicare administrative contractor, and any of its officers
33 or employees certifying payments or disbursing funds pur-
34 suant to the contract, or otherwise participating in carrying
35 out the contract, to give surety bond to the United States
36 in such amount as the Secretary may deem appropriate.

37 “(c) TERMS AND CONDITIONS.—



1 “(1) IN GENERAL.—A contract with any medicare ad-
2 ministrative contractor under this section may contain such
3 terms and conditions as the Secretary finds necessary or
4 appropriate and may provide for advances of funds to the
5 medicare administrative contractor for the making of pay-
6 ments by it under subsection (a)(4)(B).

7 “(2) PROHIBITION ON MANDATES FOR CERTAIN DATA
8 COLLECTION.—The Secretary may not require, as a condi-
9 tion of entering into, or renewing, a contract under this
10 section, that the medicare administrative contractor match
11 data obtained other than in its activities under this title
12 with data used in the administration of this title for pur-
13 poses of identifying situations in which the provisions of
14 section 1862(b) may apply.

15 “(d) LIMITATION ON LIABILITY OF MEDICARE ADMINIS-
16 TRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

17 “(1) CERTIFYING OFFICER.—No individual designated
18 pursuant to a contract under this section as a certifying of-
19 ficer shall, in the absence of gross negligence or intent to
20 defraud the United States, be liable with respect to any
21 payments certified by the individual under this section.

22 “(2) DISBURSING OFFICER.—No disbursing officer
23 shall, in the absence of gross negligence or intent to de-
24 fraud the United States, be liable with respect to any pay-
25 ment by such officer under this section if it was based upon
26 an authorization (which meets the applicable requirements
27 for such internal controls established by the Comptroller
28 General) of a certifying officer designated as provided in
29 paragraph (1) of this subsection.

30 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE CON-
31 TRACTOR.—No medicare administrative contractor shall be
32 liable to the United States for a payment by a certifying
33 or disbursing officer unless in connection with such pay-
34 ment or in the supervision of or selection of such officer
35 the medicare administrative contractor acted with gross
36 negligence.

37 “(4) INDEMNIFICATION BY SECRETARY.—



1 “(A) IN GENERAL.—Subject to subparagraphs (B)
2 and (D), in the case of a medicare administrative con-
3 tractor (or a person who is a director, officer, or em-
4 ployee of such a contractor or who is engaged by the
5 contractor to participate directly in the claims adminis-
6 tration process) who is made a party to any judicial or
7 administrative proceeding arising from or relating di-
8 rectly to the claims administration process under this
9 title, the Secretary may, to the extent the Secretary de-
10 termines to be appropriate and as specified in the con-
11 tract with the contractor, indemnify the contractor and
12 such persons.

13 “(B) CONDITIONS.—The Secretary may not pro-
14 vide indemnification under subparagraph (A) insofar as
15 the liability for such costs arises directly from conduct
16 that is determined by the judicial proceeding or by the
17 Secretary to be criminal in nature, fraudulent, or
18 grossly negligent. If indemnification is provided by the
19 Secretary with respect to a contractor before a deter-
20 mination that such costs arose directly from such con-
21 duct, the contractor shall reimburse the Secretary for
22 costs of indemnification.

23 “(C) SCOPE OF INDEMNIFICATION.—Indemnifica-
24 tion by the Secretary under subparagraph (A) may in-
25 clude payment of judgments, settlements (subject to
26 subparagraph (D)), awards, and costs (including rea-
27 sonable legal expenses).

28 “(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A
29 contractor or other person described in subparagraph
30 (A) may not propose to negotiate a settlement or com-
31 promise of a proceeding described in such subpara-
32 graph without the prior written approval of the Sec-
33 retary to negotiate such settlement or compromise. Any
34 indemnification under subparagraph (A) with respect to
35 amounts paid under a settlement or compromise of a
36 proceeding described in such subparagraph are condi-



1 tioned upon prior written approval by the Secretary of
2 the final settlement or compromise.

3 “(E) CONSTRUCTION.—Nothing in this paragraph
4 shall be construed—

5 “(i) to change any common law immunity that
6 may be available to a medicare administrative con-
7 tractor or person described in subparagraph (A); or

8 “(ii) to permit the payment of costs not other-
9 wise allowable, reasonable, or allocable under the
10 Federal Acquisition Regulations.”.

11 (2) CONSIDERATION OF INCORPORATION OF CURRENT
12 LAW STANDARDS.—In developing contract performance re-
13 quirements under section 1874A(b) of the Social Security
14 Act, as inserted by paragraph (1), the Secretary shall con-
15 sider inclusion of the performance standards described in
16 sections 1816(f)(2) of such Act (relating to timely proc-
17 essing of reconsiderations and applications for exemptions)
18 and section 1842(b)(2)(B) of such Act (relating to timely
19 review of determinations and fair hearing requests), as
20 such sections were in effect before the date of the enact-
21 ment of this Act.

22 (b) CONFORMING AMENDMENTS TO SECTION 1816 (RE-
23 LATING TO FISCAL INTERMEDIARIES).—Section 1816 (42
24 U.S.C. 1395h) is amended as follows:

25 (1) The heading is amended to read as follows:
26 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

27 (2) Subsection (a) is amended to read as follows:

28 “(a) The administration of this part shall be conducted
29 through contracts with medicare administrative contractors
30 under section 1874A.”.

31 (3) Subsection (b) is repealed.

32 (4) Subsection (c) is amended—

33 (A) by striking paragraph (1); and

34 (B) in each of paragraphs (2)(A) and (3)(A), by
35 striking “agreement under this section” and inserting
36 “contract under section 1874A that provides for mak-
37 ing payments under this part”.



1 (5) Subsections (d) through (i) are repealed.

2 (6) Subsections (j) and (k) are each amended—

3 (A) by striking “An agreement with an agency or
4 organization under this section” and inserting “A con-
5 tract with a medicare administrative contractor under
6 section 1874A with respect to the administration of
7 this part”; and

8 (B) by striking “such agency or organization” and
9 inserting “such medicare administrative contractor”
10 each place it appears.

11 (7) Subsection (l) is repealed.

12 (c) CONFORMING AMENDMENTS TO SECTION 1842 (RE-
13 LATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is
14 amended as follows:

15 (1) The heading is amended to read as follows:
16 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

17 (2) Subsection (a) is amended to read as follows:

18 “(a) The administration of this part shall be conducted
19 through contracts with medicare administrative contractors
20 under section 1874A.”.

21 (3) Subsection (b) is amended—

22 (A) by striking paragraph (1);

23 (B) in paragraph (2)—

24 (i) by striking subparagraphs (A) and (B);

25 (ii) in subparagraph (C), by striking “car-
26 riers” and inserting “medicare administrative con-
27 tractors”; and

28 (iii) by striking subparagraphs (D) and (E);

29 (C) in paragraph (3)—

30 (i) in the matter before subparagraph (A), by
31 striking “Each such contract shall provide that the
32 carrier” and inserting “The Secretary”;

33 (ii) by striking “will” the first place it appears
34 in each of subparagraphs (A), (B), (F), (G), (H),
35 and (L) and inserting “shall”;

36 (iii) in subparagraph (B), in the matter before
37 clause (i), by striking “to the policyholders and



1 subscribers of the carrier” and inserting “to the
2 policyholders and subscribers of the medicare ad-
3 ministrative contractor”;

4 (iv) by striking subparagraphs (C), (D), and
5 (E);

6 (v) in subparagraph (H)—

7 (I) by striking “if it makes determinations
8 or payments with respect to physicians’ serv-
9 ices,” in the matter preceding clause (i); and

10 (II) by striking “carrier” and inserting
11 “medicare administrative contractor” in clause
12 (i);

13 (vi) by striking subparagraph (I);

14 (vii) in subparagraph (L), by striking the
15 semicolon and inserting a period;

16 (viii) in the first sentence, after subparagraph
17 (L), by striking “and shall contain” and all that
18 follows through the period; and

19 (ix) in the seventh sentence, by inserting
20 “medicare administrative contractor,” after “car-
21 rier,”; and

22 (D) by striking paragraph (5);

23 (E) in paragraph (6)(D)(iv), by striking “carrier”
24 and inserting “medicare administrative contractor”;
25 and

26 (F) in paragraph (7), by striking “the carrier”
27 and inserting “the Secretary” each place it appears.

28 (4) Subsection (c) is amended—

29 (A) by striking paragraph (1);

30 (B) in paragraph (2)(A), by striking “contract
31 under this section which provides for the disbursement
32 of funds, as described in subsection (a)(1)(B),” and in-
33 serting “contract under section 1874A that provides for
34 making payments under this part”;

35 (C) in paragraph (3)(A), by striking “subsection
36 (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;



1 (D) in paragraph (4), in the matter preceding sub-
2 paragraph (A), by striking “carrier” and inserting
3 “medicare administrative contractor”; and

4 (E) by striking paragraphs (5) and (6).

5 (5) Subsections (d), (e), and (f) are repealed.

6 (6) Subsection (g) is amended by striking “carrier or
7 carriers” and inserting “medicare administrative contractor
8 or contractors”.

9 (7) Subsection (h) is amended—

10 (A) in paragraph (2)—

11 (i) by striking “Each carrier having an agree-
12 ment with the Secretary under subsection (a)” and
13 inserting “The Secretary”; and

14 (ii) by striking “Each such carrier” and in-
15 sserting “The Secretary”;

16 (B) in paragraph (3)(A)—

17 (i) by striking “a carrier having an agreement
18 with the Secretary under subsection (a)” and in-
19 sserting “medicare administrative contractor having
20 a contract under section 1874A that provides for
21 making payments under this part”; and

22 (ii) by striking “such carrier” and inserting
23 “such contractor”;

24 (C) in paragraph (3)(B)—

25 (i) by striking “a carrier” and inserting “a
26 medicare administrative contractor” each place it
27 appears; and

28 (ii) by striking “the carrier” and inserting
29 “the contractor” each place it appears; and

30 (D) in paragraphs (5)(A) and (5)(B)(iii), by strik-
31 ing “carriers” and inserting “medicare administrative
32 contractors” each place it appears.

33 (8) Subsection (l) is amended—

34 (A) in paragraph (1)(A)(iii), by striking “carrier”
35 and inserting “medicare administrative contractor”;
36 and



1 (B) in paragraph (2), by striking “carrier” and in-
2 serting “medicare administrative contractor”.

3 (9) Subsection (p)(3)(A) is amended by striking “car-
4 rier” and inserting “medicare administrative contractor”.

5 (10) Subsection (q)(1)(A) is amended by striking “car-
6 rier”.

7 (d) EFFECTIVE DATE; TRANSITION RULE.—

8 (1) EFFECTIVE DATE.—

9 (A) IN GENERAL.—Except as otherwise provided
10 in this subsection, the amendments made by this sec-
11 tion shall take effect on October 1, 2004, and the Sec-
12 retary is authorized to take such steps before such date
13 as may be necessary to implement such amendments on
14 a timely basis.

15 (B) CONSTRUCTION FOR CURRENT CONTRACTS.—
16 Such amendments shall not apply to contracts in effect
17 before the date specified under subparagraph (A) that
18 continue to retain the terms and conditions in effect on
19 such date (except as otherwise provided under this Act,
20 other than under this section) until such date as the
21 contract is let out for competitive bidding under such
22 amendments.

23 (C) DEADLINE FOR COMPETITIVE BIDDING.—The
24 Secretary shall provide for the letting by competitive
25 bidding of all contracts for functions of medicare ad-
26 ministrative contractors for annual contract periods
27 that begin on or after October 1, 2009.

28 (D) WAIVER OF PROVIDER NOMINATION PROVI-
29 SIONS DURING TRANSITION.—During the period begin-
30 ning on the date of the enactment of this Act and be-
31 fore the date specified under subparagraph (A), the
32 Secretary may enter into new agreements under section
33 1816 of the Social Security Act (42 U.S.C. 1395h)
34 without regard to any of the provider nomination provi-
35 sions of such section.

36 (2) GENERAL TRANSITION RULES.—The Secretary
37 shall take such steps, consistent with paragraph (1)(B) and



1 (1)(C), as are necessary to provide for an appropriate tran-
2 sition from contracts under section 1816 and section 1842
3 of the Social Security Act (42 U.S.C. 1395h, 1395u) to
4 contracts under section 1874A, as added by subsection
5 (a)(1).

6 (3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS
7 UNDER CURRENT CONTRACTS AND AGREEMENTS AND
8 UNDER ROLLOVER CONTRACTS.—The provisions contained
9 in the exception in section 1893(d)(2) of the Social Secu-
10 rity Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply
11 notwithstanding the amendments made by this section, and
12 any reference in such provisions to an agreement or con-
13 tract shall be deemed to include a contract under section
14 1874A of such Act, as inserted by subsection (a)(1), that
15 continues the activities referred to in such provisions.

16 (e) REFERENCES.—On and after the effective date pro-
17 vided under subsection (d)(1), any reference to a fiscal inter-
18 mediary or carrier under title XI or XVIII of the Social Secu-
19 rity Act (or any regulation, manual instruction, interpretative
20 rule, statement of policy, or guideline issued to carry out such
21 titles) shall be deemed a reference to an appropriate medicare
22 administrative contractor (as provided under section 1874A of
23 the Social Security Act).

24 (f) REPORTS ON IMPLEMENTATION.—

25 (1) PLAN FOR IMPLEMENTATION.—By not later than
26 October 1, 2003, the Secretary shall submit a report to
27 Congress and the Comptroller General of the United States
28 that describes the plan for implementation of the amend-
29 ments made by this section. The Comptroller General shall
30 conduct an evaluation of such plan and shall submit to
31 Congress, not later than 6 months after the date the report
32 is received, a report on such evaluation and shall include
33 in such report such recommendations as the Comptroller
34 General deems appropriate.

35 (2) STATUS OF IMPLEMENTATION.—The Secretary
36 shall submit a report to Congress not later than October
37 1, 2007, that describes the status of implementation of



1 such amendments and that includes a description of the
2 following:

3 (A) The number of contracts that have been com-
4 petitively bid as of such date.

5 (B) The distribution of functions among contracts
6 and contractors.

7 (C) A timeline for complete transition to full com-
8 petition.

9 (D) A detailed description of how the Secretary
10 has modified oversight and management of medicare
11 contractors to adapt to full competition.

12 **SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY**
13 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**
14 **TORS.**

15 (a) IN GENERAL.—Section 1874A, as added by section
16 811(a)(1), is amended by adding at the end the following new
17 subsection:

18 “(e) REQUIREMENTS FOR INFORMATION SECURITY.—

19 “(1) DEVELOPMENT OF INFORMATION SECURITY PRO-
20 GRAM.—A medicare administrative contractor that per-
21 forms the functions referred to in subparagraphs (A) and
22 (B) of subsection (a)(4) (relating to determining and mak-
23 ing payments) shall implement a contractor-wide informa-
24 tion security program to provide information security for
25 the operation and assets of the contractor with respect to
26 such functions under this title. An information security
27 program under this paragraph shall meet the requirements
28 for information security programs imposed on Federal
29 agencies under section 3534(b)(2) of title 44, United States
30 Code (other than requirements under subparagraphs
31 (B)(ii), (F)(iii), and (F)(iv) of such section).

32 “(2) INDEPENDENT AUDITS.—

33 “(A) PERFORMANCE OF ANNUAL EVALUATIONS.—
34 Each year a medicare administrative contractor that
35 performs the functions referred to in subparagraphs
36 (A) and (B) of subsection (a)(4) (relating to deter-
37 mining and making payments) shall undergo an evalua-



1 tion of the information security of the contractor with
2 respect to such functions under this title. The evalua-
3 tion shall—

4 “(i) be performed by an entity that meets such
5 requirements for independence as the Inspector
6 General of the Department of Health and Human
7 Services may establish; and

8 “(ii) test the effectiveness of information secu-
9 rity control techniques for an appropriate subset of
10 the contractor’s information systems (as defined in
11 section 3502(8) of title 44, United States Code) re-
12 lating to such functions under this title and an as-
13 sessment of compliance with the requirements of
14 this subsection and related information security
15 policies, procedures, standards and guidelines.

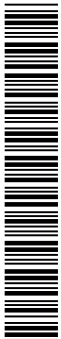
16 “(B) DEADLINE FOR INITIAL EVALUATION.—

17 “(i) NEW CONTRACTORS.—In the case of a
18 medicare administrative contractor covered by this
19 subsection that has not previously performed the
20 functions referred to in subparagraphs (A) and (B)
21 of subsection (a)(4) (relating to determining and
22 making payments) as a fiscal intermediary or car-
23 rier under section 1816 or 1842, the first inde-
24 pendent evaluation conducted pursuant subpara-
25 graph (A) shall be completed prior to commencing
26 such functions.

27 “(ii) OTHER CONTRACTORS.—In the case of a
28 medicare administrative contractor covered by this
29 subsection that is not described in clause (i), the
30 first independent evaluation conducted pursuant
31 subparagraph (A) shall be completed within 1 year
32 after the date the contractor commences functions
33 referred to in clause (i) under this section.

34 “(C) REPORTS ON EVALUATIONS.—

35 “(i) TO THE INSPECTOR GENERAL.—The re-
36 sults of independent evaluations under subpara-
37 graph (A) shall be submitted promptly to the In-



1 spector General of the Department of Health and
2 Human Services.

3 “(ii) TO CONGRESS.—The Inspector General
4 of Department of Health and Human Services shall
5 submit to Congress annual reports on the results of
6 such evaluations.”.

7 (b) APPLICATION OF REQUIREMENTS TO FISCAL INTER-
8 MEDIARIES AND CARRIERS.—

9 (1) IN GENERAL.—The provisions of section
10 1874A(e)(2) of the Social Security Act (other than sub-
11 paragraph (B)), as added by subsection (a), shall apply to
12 each fiscal intermediary under section 1816 of the Social
13 Security Act (42 U.S.C. 1395h) and each carrier under
14 section 1842 of such Act (42 U.S.C. 1395u) in the same
15 manner as they apply to medicare administrative contrac-
16 tors under such provisions.

17 (2) DEADLINE FOR INITIAL EVALUATION.—In the case
18 of such a fiscal intermediary or carrier with an agreement
19 or contract under such respective section in effect as of the
20 date of the enactment of this Act, the first evaluation
21 under section 1874A(e)(2)(A) of the Social Security Act
22 (as added by subsection (a)), pursuant to paragraph (1),
23 shall be completed (and a report on the evaluation sub-
24 mitted to the Secretary) by not later than 1 year after such
25 date.

26 **Subtitle C—Education and Outreach**

27 **SEC. 821. PROVIDER EDUCATION AND TECHNICAL AS-** 28 **SISTANCE.**

29 (a) COORDINATION OF EDUCATION FUNDING.—

30 (1) IN GENERAL.—The Social Security Act is amended
31 by inserting after section 1888 the following new section:

32 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

33 “SEC. 1889. (a) COORDINATION OF EDUCATION FUND-
34 ING.—The Secretary shall coordinate the educational activities
35 provided through medicare contractors (as defined in sub-
36 section (g), including under section 1893) in order to maximize



1 the effectiveness of Federal education efforts for providers of
2 services and suppliers.”.

3 (2) EFFECTIVE DATE.—The amendment made by
4 paragraph (1) shall take effect on the date of the enact-
5 ment of this Act.

6 (3) REPORT.—Not later than October 1, 2003, the
7 Secretary shall submit to Congress a report that includes
8 a description and evaluation of the steps taken to coordi-
9 nate the funding of provider education under section
10 1889(a) of the Social Security Act, as added by paragraph
11 (1).

12 (b) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-
13 ANCE.—

14 (1) IN GENERAL.—Section 1874A, as added by section
15 811(a)(1) and as amended by section 812(a), is amended
16 by adding at the end the following new subsection:

17 “(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-
18 ANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to
19 give medicare administrative contractors an incentive to imple-
20 ment effective education and outreach programs for providers
21 of services and suppliers, the Secretary shall develop and imple-
22 ment a methodology to measure the specific claims payment
23 error rates of such contractors in the processing or reviewing
24 of medicare claims.”.

25 (2) APPLICATION TO FISCAL INTERMEDIARIES AND
26 CARRIERS.—The provisions of section 1874A(f) of the So-
27 cial Security Act, as added by paragraph (1), shall apply
28 to each fiscal intermediary under section 1816 of the Social
29 Security Act (42 U.S.C. 1395h) and each carrier under
30 section 1842 of such Act (42 U.S.C. 1395u) in the same
31 manner as they apply to medicare administrative contrac-
32 tors under such provisions.

33 (3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—
34 Not later than October 1, 2003, the Comptroller General
35 of the United States shall submit to Congress and to the
36 Secretary a report on the adequacy of the methodology
37 under section 1874A(f) of the Social Security Act, as added



1 by paragraph (1), and shall include in the report such rec-
2 ommendations as the Comptroller General determines ap-
3 propriate with respect to the methodology.

4 (4) REPORT ON USE OF METHODOLOGY IN ASSESSING
5 CONTRACTOR PERFORMANCE.—Not later than October 1,
6 2003, the Secretary shall submit to Congress a report that
7 describes how the Secretary intends to use such method-
8 ology in assessing medicare contractor performance in im-
9 plementing effective education and outreach programs, in-
10 cluding whether to use such methodology as a basis for per-
11 formance bonuses. The report shall include an analysis of
12 the sources of identified errors and potential changes in
13 systems of contractors and rules of the Secretary that could
14 reduce claims error rates.

15 (c) PROVISION OF ACCESS TO AND PROMPT RESPONSES
16 FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

17 (1) IN GENERAL.—Section 1874A, as added by section
18 811(a)(1) and as amended by section 812(a) and sub-
19 section (b), is further amended by adding at the end the
20 following new subsection:

21 “(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS
22 OF SERVICES AND SUPPLIERS.—

23 “(1) COMMUNICATION STRATEGY.—The Secretary
24 shall develop a strategy for communications with individ-
25 uals entitled to benefits under part A or enrolled under
26 part B, or both, and with providers of services and sup-
27 pliers under this title.

28 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each medi-
29 care administrative contractor shall, for those providers of
30 services and suppliers which submit claims to the con-
31 tractor for claims processing and for those individuals enti-
32 tled to benefits under part A or enrolled under part B, or
33 both, with respect to whom claims are submitted for claims
34 processing, provide general written responses (which may
35 be through electronic transmission) in a clear, concise, and
36 accurate manner to inquiries of providers of services, sup-
37 pliers and individuals entitled to benefits under part A or



1 enrolled under part B, or both, concerning the programs
2 under this title within 45 business days of the date of re-
3 ceipt of such inquiries.

4 “(3) RESPONSE TO TOLL-FREE LINES.—The Secretary
5 shall ensure that each medicare administrative contractor
6 shall provide, for those providers of services and suppliers
7 which submit claims to the contractor for claims processing
8 and for those individuals entitled to benefits under part A
9 or enrolled under part B, or both, with respect to whom
10 claims are submitted for claims processing, a toll-free tele-
11 phone number at which such individuals, providers of serv-
12 ices and suppliers may obtain information regarding billing,
13 coding, claims, coverage, and other appropriate information
14 under this title.

15 “(4) MONITORING OF CONTRACTOR RESPONSES.—

16 “(A) IN GENERAL.—Each medicare administrative
17 contractor shall, consistent with standards developed by
18 the Secretary under subparagraph (B)—

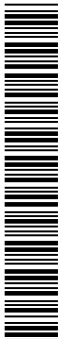
19 “(i) maintain a system for identifying who
20 provides the information referred to in paragraphs
21 (2) and (3); and

22 “(ii) monitor the accuracy, consistency, and
23 timeliness of the information so provided.

24 “(B) DEVELOPMENT OF STANDARDS.—

25 “(i) IN GENERAL.—The Secretary shall estab-
26 lish and make public standards to monitor the ac-
27 curacy, consistency, and timeliness of the informa-
28 tion provided in response to written and telephone
29 inquiries under this subsection. Such standards
30 shall be consistent with the performance require-
31 ments established under subsection (b)(3).

32 “(ii) EVALUATION.—In conducting evaluations
33 of individual medicare administrative contractors,
34 the Secretary shall take into account the results of
35 the monitoring conducted under subparagraph (A)
36 taking into account as performance requirements
37 the standards established under clause (i). The



1 Secretary shall, in consultation with organizations
2 representing providers of services, suppliers, and
3 individuals entitled to benefits under part A or en-
4 rolled under part B, or both, establish standards
5 relating to the accuracy, consistency, and timeliness
6 of the information so provided.

7 “(C) DIRECT MONITORING.—Nothing in this para-
8 graph shall be construed as preventing the Secretary
9 from directly monitoring the accuracy, consistency, and
10 timeliness of the information so provided.”.

11 (2) EFFECTIVE DATE.—The amendment made by
12 paragraph (1) shall take effect October 1, 2003.

13 (3) APPLICATION TO FISCAL INTERMEDIARIES AND
14 CARRIERS.—The provisions of section 1874A(g) of the So-
15 cial Security Act, as added by paragraph (1), shall apply
16 to each fiscal intermediary under section 1816 of the Social
17 Security Act (42 U.S.C. 1395h) and each carrier under
18 section 1842 of such Act (42 U.S.C. 1395u) in the same
19 manner as they apply to medicare administrative contrac-
20 tors under such provisions.

21 (d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

22 (1) IN GENERAL.—Section 1889, as added by sub-
23 section (a), is amended by adding at the end the following
24 new subsections:

25 “(b) ENHANCED EDUCATION AND TRAINING.—

26 “(1) ADDITIONAL RESOURCES.—There are authorized
27 to be appropriated to the Secretary (in appropriate part
28 from the Federal Hospital Insurance Trust Fund and the
29 Federal Supplementary Medical Insurance Trust Fund)
30 \$25,000,000 for each of fiscal years 2004 and 2005 and
31 such sums as may be necessary for succeeding fiscal years.

32 “(2) USE.—The funds made available under para-
33 graph (1) shall be used to increase the conduct by medicare
34 contractors of education and training of providers of serv-
35 ices and suppliers regarding billing, coding, and other ap-
36 propriate items and may also be used to improve the accu-
37 racy, consistency, and timeliness of contractor responses.



1 “(c) TAILORING EDUCATION AND TRAINING ACTIVITIES
2 FOR SMALL PROVIDERS OR SUPPLIERS.—

3 “(1) IN GENERAL.—Insofar as a medicare contractor
4 conducts education and training activities, it shall tailor
5 such activities to meet the special needs of small providers
6 of services or suppliers (as defined in paragraph (2)).

7 “(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—
8 In this subsection, the term ‘small provider of services or
9 supplier’ means—

10 “(A) a provider of services with fewer than 25 full-
11 time-equivalent employees; or

12 “(B) a supplier with fewer than 10 full-time-equiv-
13 alent employees.”.

14 (2) EFFECTIVE DATE.—The amendment made by
15 paragraph (1) shall take effect on October 1, 2003.

16 (e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

17 (1) IN GENERAL.—Section 1889, as added by sub-
18 section (a) and as amended by subsection (d), is further
19 amended by adding at the end the following new sub-
20 section:

21 “(d) INTERNET SITES; FAQs.—The Secretary, and each
22 medicare contractor insofar as it provides services (including
23 claims processing) for providers of services or suppliers, shall
24 maintain an Internet site which—

25 “(1) provides answers in an easily accessible format to
26 frequently asked questions, and

27 “(2) includes other published materials of the con-
28 tractor,

29 that relate to providers of services and suppliers under the pro-
30 grams under this title (and title XI insofar as it relates to such
31 programs).”.

32 (2) EFFECTIVE DATE.—The amendment made by
33 paragraph (1) shall take effect on October 1, 2003.

34 (f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

35 (1) IN GENERAL.—Section 1889, as added by sub-
36 section (a) and as amended by subsections (d) and (e), is



1 further amended by adding at the end the following new
2 subsections:

3 “(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION
4 PROGRAM ACTIVITIES.—A medicare contractor may not use a
5 record of attendance at (or failure to attend) educational activi-
6 ties or other information gathered during an educational pro-
7 gram conducted under this section or otherwise by the Sec-
8 retary to select or track providers of services or suppliers for
9 the purpose of conducting any type of audit or prepayment re-
10 view.

11 “(f) CONSTRUCTION.—Nothing in this section or section
12 1893(g) shall be construed as providing for disclosure by a
13 medicare contractor of information that would compromise
14 pending law enforcement activities or reveal findings of law en-
15 forcement-related audits.

16 “(g) DEFINITIONS.—For purposes of this section, the
17 term ‘medicare contractor’ includes the following:

18 “(1) A medicare administrative contractor with a con-
19 tract under section 1874A, including a fiscal intermediary
20 with a contract under section 1816 and a carrier with a
21 contract under section 1842.

22 “(2) An eligible entity with a contract under section
23 1893.

24 Such term does not include, with respect to activities of a spe-
25 cific provider of services or supplier an entity that has no au-
26 thority under this title or title IX with respect to such activities
27 and such provider of services or supplier.”.

28 (2) EFFECTIVE DATE.—The amendment made by
29 paragraph (1) shall take effect on the date of the enact-
30 ment of this Act.

31 **SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE**
32 **DEMONSTRATION PROGRAM.**

33 (a) ESTABLISHMENT.—

34 (1) IN GENERAL.—The Secretary shall establish a
35 demonstration program (in this section referred to as the
36 “demonstration program”) under which technical assist-
37 ance described in paragraph (2) is made available, upon re-



1 quest and on a voluntary basis, to small providers of serv-
2 ices or suppliers in order to improve compliance with the
3 applicable requirements of the programs under medicare
4 program under title XVIII of the Social Security Act (in-
5 cluding provisions of title XI of such Act insofar as they
6 relate to such title and are not administered by the Office
7 of the Inspector General of the Department of Health and
8 Human Services).

9 (2) FORMS OF TECHNICAL ASSISTANCE.—The tech-
10 nical assistance described in this paragraph is—

11 (A) evaluation and recommendations regarding
12 billing and related systems; and

13 (B) information and assistance regarding policies
14 and procedures under the medicare program, including
15 coding and reimbursement.

16 (3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—
17 In this section, the term “small providers of services or
18 suppliers” means—

19 (A) a provider of services with fewer than 25 full-
20 time-equivalent employees; or

21 (B) a supplier with fewer than 10 full-time-equiva-
22 lent employees.

23 (b) QUALIFICATION OF CONTRACTORS.—In conducting the
24 demonstration program, the Secretary shall enter into contracts
25 with qualified organizations (such as peer review organizations
26 or entities described in section 1889(g)(2) of the Social Secu-
27 rity Act, as inserted by section 5(f)(1)) with appropriate exper-
28 tise with billing systems of the full range of providers of serv-
29 ices and suppliers to provide the technical assistance. In award-
30 ing such contracts, the Secretary shall consider any prior inves-
31 tigations of the entity’s work by the Inspector General of De-
32 partment of Health and Human Services or the Comptroller
33 General of the United States.

34 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The tech-
35 nical assistance provided under the demonstration program
36 shall include a direct and in-person examination of billing sys-
37 tems and internal controls of small providers of services or sup-



1 pliers to determine program compliance and to suggest more
2 efficient or effective means of achieving such compliance.

3 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS
4 IDENTIFIED AS CORRECTED.—The Secretary shall provide
5 that, absent evidence of fraud and notwithstanding any other
6 provision of law, any errors found in a compliance review for
7 a small provider of services or supplier that participates in the
8 demonstration program shall not be subject to recovery action
9 if the technical assistance personnel under the program deter-
10 mine that—

11 (1) the problem that is the subject of the compliance
12 review has been corrected to their satisfaction within 30
13 days of the date of the visit by such personnel to the small
14 provider of services or supplier; and

15 (2) such problem remains corrected for such period as
16 is appropriate.

17 The previous sentence applies only to claims filed as part of the
18 demonstration program and lasts only for the duration of such
19 program and only as long as the small provider of services or
20 supplier is a participant in such program.

21 (e) GAO EVALUATION.—Not later than 2 years after the
22 date of the date the demonstration program is first imple-
23 mented, the Comptroller General, in consultation with the In-
24 spector General of the Department of Health and Human Serv-
25 ices, shall conduct an evaluation of the demonstration program.
26 The evaluation shall include a determination of whether claims
27 error rates are reduced for small providers of services or sup-
28 pliers who participated in the program and the extent of im-
29 proper payments made as a result of the demonstration pro-
30 gram. The Comptroller General shall submit a report to the
31 Secretary and the Congress on such evaluation and shall in-
32 clude in such report recommendations regarding the continu-
33 ation or extension of the demonstration program.

34 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The pro-
35 vision of technical assistance to a small provider of services or
36 supplier under the demonstration program is conditioned upon
37 the small provider of services or supplier paying an amount es-



1 timated (and disclosed in advance of a provider's or supplier's
2 participation in the program) to be equal to 25 percent of the
3 cost of the technical assistance.

4 (g) AUTHORIZATION OF APPROPRIATIONS.—There are au-
5 thorized to be appropriated to the Secretary (in appropriate
6 part from the Federal Hospital Insurance Trust Fund and the
7 Federal Supplementary Medical Insurance Trust Fund) to
8 carry out the demonstration program—

9 (1) for fiscal year 2004, \$1,000,000, and

10 (2) for fiscal year 2005, \$6,000,000.

11 **SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDI-**
12 **CARE BENEFICIARY OMBUDSMAN.**

13 (a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868
14 (42 U.S.C. 1395ee) is amended—

15 (1) by adding at the end of the heading the following:
16 “; MEDICARE PROVIDER OMBUDSMAN”;

17 (2) by inserting “PRACTICING PHYSICIANS ADVISORY
18 COUNCIL.—(1)” after “(a)”;

19 (3) in paragraph (1), as so redesignated under para-
20 graph (2), by striking “in this section” and inserting “in
21 this subsection”;

22 (4) by redesignating subsections (b) and (c) as para-
23 graphs (2) and (3), respectively; and

24 (5) by adding at the end the following new subsection:

25 “(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary
26 shall appoint within the Department of Health and Human
27 Services a Medicare Provider Ombudsman. The Ombudsman
28 shall—

29 “(1) provide assistance, on a confidential basis, to pro-
30 viders of services and suppliers with respect to complaints,
31 grievances, and requests for information concerning the
32 programs under this title (including provisions of title XI
33 insofar as they relate to this title and are not administered
34 by the Office of the Inspector General of the Department
35 of Health and Human Services) and in the resolution of
36 unclear or conflicting guidance given by the Secretary and
37 medicare contractors to such providers of services and sup-



1 pliers regarding such programs and provisions and require-
2 ments under this title and such provisions; and

3 “(2) submit recommendations to the Secretary for im-
4 provement in the administration of this title and such pro-
5 visions, including—

6 “(A) recommendations to respond to recurring
7 patterns of confusion in this title and such provisions
8 (including recommendations regarding suspending im-
9 position of sanctions where there is widespread confu-
10 sion in program administration), and

11 “(B) recommendations to provide for an appro-
12 priate and consistent response (including not providing
13 for audits) in cases of self-identified overpayments by
14 providers of services and suppliers.

15 The Ombudsman shall not serve as an advocate for any in-
16 creases in payments or new coverage of services, but may iden-
17 tify issues and problems in payment or coverage policies.”.

18 (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII,
19 as amended by sections 105 and 701, is amended by inserting
20 after section 1808 the following new section:

21 “MEDICARE BENEFICIARY OMBUDSMAN

22 “SEC. 1809. (a) IN GENERAL.—The Secretary shall ap-
23 point within the Department of Health and Human Services a
24 Medicare Beneficiary Ombudsman who shall have expertise and
25 experience in the fields of health care and education of (and
26 assistance to) individuals entitled to benefits under this title.

27 “(b) DUTIES.—The Medicare Beneficiary Ombudsman
28 shall—

29 “(1) receive complaints, grievances, and requests for
30 information submitted by individuals entitled to benefits
31 under part A or enrolled under part B, or both, with re-
32 spect to any aspect of the medicare program;

33 “(2) provide assistance with respect to complaints,
34 grievances, and requests referred to in paragraph (1),
35 including—

36 “(A) assistance in collecting relevant information
37 for such individuals, to seek an appeal of a decision or



1 determination made by a fiscal intermediary, carrier,
2 Medicare+ Choice organization, or the Secretary; and

3 “(B) assistance to such individuals with any prob-
4 lems arising from disenrollment from a
5 Medicare+ Choice plan under part C; and

6 “(3) submit annual reports to Congress and the Sec-
7 retary that describe the activities of the Office and that in-
8 clude such recommendations for improvement in the admin-
9 istration of this title as the Ombudsman determines appro-
10 priate.

11 The Ombudsman shall not serve as an advocate for any in-
12 creases in payments or new coverage of services, but may iden-
13 tify issues and problems in payment or coverage policies.

14 “(c) WORKING WITH HEALTH INSURANCE COUNSELING
15 PROGRAMS.—To the extent possible, the Ombudsman shall
16 work with health insurance counseling programs (receiving
17 funding under section 4360 of Omnibus Budget Reconciliation
18 Act of 1990) to facilitate the provision of information to indi-
19 viduals entitled to benefits under part A or enrolled under part
20 B, or both regarding Medicare+ Choice plans and changes to
21 those plans. Nothing in this subsection shall preclude further
22 collaboration between the Ombudsman and such programs.”.

23 (c) DEADLINE FOR APPOINTMENT.—The Secretary shall
24 appoint the Medicare Provider Ombudsman and the Medicare
25 Beneficiary Ombudsman, under the amendments made by sub-
26 sections (a) and (b), respectively, by not later than 1 year after
27 the date of the enactment of this Act.

28 (d) FUNDING.—There are authorized to be appropriated to
29 the Secretary (in appropriate part from the Federal Hospital
30 Insurance Trust Fund and the Federal Supplementary Medical
31 Insurance Trust Fund) to carry out the provisions of sub-
32 section (b) of section 1868 of the Social Security Act (relating
33 to the Medicare Provider Ombudsman), as added by subsection
34 (a)(5) and section 1809 of such Act (relating to the Medicare
35 Beneficiary Ombudsman), as added by subsection (b), such
36 sums as are necessary for fiscal year 2003 and each succeeding
37 fiscal year.



1 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-
2 MEDICARE).—

3 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE
4 HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—
5 Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by
6 adding at the end the following: “The Secretary shall pro-
7 vide, through the toll-free number 1-800-MEDICARE, for
8 a means by which individuals seeking information about, or
9 assistance with, such programs who phone such toll-free
10 number are transferred (without charge) to appropriate en-
11 tities for the provision of such information or assistance.
12 Such toll-free number shall be the toll-free number listed
13 for general information and assistance in the annual notice
14 under subsection (a) instead of the listing of numbers of
15 individual contractors.”.

16 (2) MONITORING ACCURACY.—

17 (A) STUDY.—The Comptroller General of the
18 United States shall conduct a study to monitor the ac-
19 curacy and consistency of information provided to indi-
20 viduals entitled to benefits under part A or enrolled
21 under part B, or both, through the toll-free number 1-
22 800-MEDICARE, including an assessment of whether
23 the information provided is sufficient to answer ques-
24 tions of such individuals. In conducting the study, the
25 Comptroller General shall examine the education and
26 training of the individuals providing information
27 through such number.

28 (B) REPORT.—Not later than 1 year after the
29 date of the enactment of this Act, the Comptroller Gen-
30 eral shall submit to Congress a report on the study
31 conducted under subparagraph (A).

32 **SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION**
33 **PROGRAM.**

34 (a) IN GENERAL.—The Secretary shall establish a dem-
35 onstration program (in this section referred to as the “dem-
36 onstration program”) under which medicare specialists em-
37 ployed by the Department of Health and Human Services pro-



1 vide advice and assistance to individuals entitled to benefits
2 under part A of title XVIII of the Social Security Act, or en-
3 rolled under part B of such title, or both, regarding the medi-
4 care program at the location of existing local offices of the So-
5 cial Security Administration.

6 (b) LOCATIONS.—

7 (1) IN GENERAL.—The demonstration program shall
8 be conducted in at least 6 offices or areas. Subject to para-
9 graph (2), in selecting such offices and areas, the Secretary
10 shall provide preference for offices with a high volume of
11 visits by individuals referred to in subsection (a).

12 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—The
13 Secretary shall provide for the selection of at least 2 rural
14 areas to participate in the demonstration program. In con-
15 ducting the demonstration program in such rural areas, the
16 Secretary shall provide for medicare specialists to travel
17 among local offices in a rural area on a scheduled basis.

18 (c) DURATION.—The demonstration program shall be con-
19 ducted over a 3-year period.

20 (d) EVALUATION AND REPORT.—

21 (1) EVALUATION.—The Secretary shall provide for an
22 evaluation of the demonstration program. Such evaluation
23 shall include an analysis of—

24 (A) utilization of, and satisfaction of those individ-
25 uals referred to in subsection (a) with, the assistance
26 provided under the program; and

27 (B) the cost-effectiveness of providing beneficiary
28 assistance through out-stationing medicare specialists
29 at local offices of the Social Security Administration.

30 (2) REPORT.—The Secretary shall submit to Congress
31 a report on such evaluation and shall include in such report
32 recommendations regarding the feasibility of permanently
33 out-stationing medicare specialists at local offices of the So-
34 cial Security Administration.



1 **Subtitle D—Appeals and Recovery**

2 **SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDI-**
3 **CARE APPEALS.**

4 (a) TRANSITION PLAN.—

5 (1) IN GENERAL.—Not later than October 1, 2003,
6 the Commissioner of Social Security and the Secretary
7 shall develop and transmit to Congress and the Comptroller
8 General of the United States a plan under which the func-
9 tions of administrative law judges responsible for hearing
10 cases under title XVIII of the Social Security Act (and re-
11 lated provisions in title XI of such Act) are transferred
12 from the responsibility of the Commissioner and the Social
13 Security Administration to the Secretary and the Depart-
14 ment of Health and Human Services.

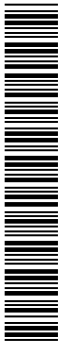
15 (2) GAO EVALUATION.—The Comptroller General of
16 the United States shall evaluate the plan and, not later
17 than the date that is 6 months after the date on which the
18 plan is received by the Comptroller General, shall submit
19 to Congress a report on such evaluation.

20 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

21 (1) IN GENERAL.—Not earlier than July 1, 2004, and
22 not later than October 1, 2004, the Commissioner of Social
23 Security and the Secretary shall implement the transition
24 plan under subsection (a) and transfer the administrative
25 law judge functions described in such subsection from the
26 Social Security Administration to the Secretary.

27 (2) ASSURING INDEPENDENCE OF JUDGES.—The Sec-
28 retary shall assure the independence of administrative law
29 judges performing the administrative law judge functions
30 transferred under paragraph (1) from the Centers for
31 Medicare & Medicaid Services and its contractors.

32 (3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall
33 provide for an appropriate geographic distribution of ad-
34 ministrative law judges performing the administrative law
35 judge functions transferred under paragraph (1) through-
36 out the United States to ensure timely access to such
37 judges.



1 (4) HIRING AUTHORITY.—Subject to the amounts pro-
2 vided in advance in appropriations Act, the Secretary shall
3 have authority to hire administrative law judges to hear
4 such cases, giving priority to those judges with prior experi-
5 ence in handling medicare appeals and in a manner con-
6 sistent with paragraph (3), and to hire support staff for
7 such judges.

8 (5) FINANCING.—Amounts payable under law to the
9 Commissioner for administrative law judges performing the
10 administrative law judge functions transferred under para-
11 graph (1) from the Federal Hospital Insurance Trust Fund
12 and the Federal Supplementary Medical Insurance Trust
13 Fund shall become payable to the Secretary for the func-
14 tions so transferred.

15 (6) SHARED RESOURCES.—The Secretary shall enter
16 into such arrangements with the Commissioner as may be
17 appropriate with respect to transferred functions of admin-
18 istrative law judges to share office space, support staff, and
19 other resources, with appropriate reimbursement from the
20 Trust Funds described in paragraph (5).

21 (c) INCREASED FINANCIAL SUPPORT.—In addition to any
22 amounts otherwise appropriated, to ensure timely action on ap-
23 peals before administrative law judges and the Departmental
24 Appeals Board consistent with section 1869 of the Social Secu-
25 rity Act (as amended by section 521 of BIPA, 114 Stat.
26 2763A–534), there are authorized to be appropriated (in appro-
27 priate part from the Federal Hospital Insurance Trust Fund
28 and the Federal Supplementary Medical Insurance Trust
29 Fund) to the Secretary such sums as are necessary for fiscal
30 year 2004 and each subsequent fiscal year to—

31 (1) increase the number of administrative law judges
32 (and their staffs) under subsection (b)(4);

33 (2) improve education and training opportunities for
34 administrative law judges (and their staffs); and

35 (3) increase the staff of the Departmental Appeals
36 Board.



1 (d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i)
2 (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of
3 BIPA (114 Stat. 2763A–543), is amended by striking “of the
4 Social Security Administration”.

5 **SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

6 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section
7 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is
8 amended—

9 (1) in paragraph (1)(A), by inserting “, subject to
10 paragraph (2),” before “to judicial review of the Sec-
11 retary’s final decision”;

12 (2) in paragraph (1)(F)—

13 (A) by striking clause (ii);

14 (B) by striking “PROCEEDING” and all that follows
15 through “DETERMINATION” and inserting “DETER-
16 MINATIONS AND RECONSIDERATIONS”; and

17 (C) by redesignating subclauses (I) and (II) as
18 clauses (i) and (ii) and by moving the indentation of
19 such subclauses (and the matter that follows) 2 ems to
20 the left; and

21 (3) by adding at the end the following new paragraph:
22 “(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

23 “(A) IN GENERAL.—The Secretary shall establish
24 a process under which a provider of services or supplier
25 that furnishes an item or service or an individual enti-
26 tled to benefits under part A or enrolled under part B,
27 or both, who has filed an appeal under paragraph (1)
28 may obtain access to judicial review when a review
29 panel (described in subparagraph (D)), on its own mo-
30 tion or at the request of the appellant, determines that
31 no entity in the administrative appeals process has the
32 authority to decide the question of law or regulation
33 relevant to the matters in controversy and that there
34 is no material issue of fact in dispute. The appellant
35 may make such request only once with respect to a
36 question of law or regulation in a case of an appeal.



1 “(B) PROMPT DETERMINATIONS.—If, after or co-
2 incident with appropriately filing a request for an ad-
3 ministrative hearing, the appellant requests a deter-
4 mination by the appropriate review panel that no re-
5 view panel has the authority to decide the question of
6 law or regulations relevant to the matters in con-
7 troversy and that there is no material issue of fact in
8 dispute and if such request is accompanied by the doc-
9 uments and materials as the appropriate review panel
10 shall require for purposes of making such determina-
11 tion, such review panel shall make a determination on
12 the request in writing within 60 days after the date
13 such review panel receives the request and such accom-
14 panying documents and materials. Such a determina-
15 tion by such review panel shall be considered a final de-
16 cision and not subject to review by the Secretary.

17 “(C) ACCESS TO JUDICIAL REVIEW.—

18 “(i) IN GENERAL.—If the appropriate review
19 panel—

20 “(I) determines that there are no material
21 issues of fact in dispute and that the only issue
22 is one of law or regulation that no review panel
23 has the authority to decide; or

24 “(II) fails to make such determination
25 within the period provided under subparagraph
26 (B);

27 then the appellant may bring a civil action as de-
28 scribed in this subparagraph.

29 “(ii) DEADLINE FOR FILING.—Such action
30 shall be filed, in the case described in—

31 “(I) clause (i)(I), within 60 days of date
32 of the determination described in such subpara-
33 graph; or

34 “(II) clause (i)(II), within 60 days of the
35 end of the period provided under subparagraph
36 (B) for the determination.



1 “(iii) VENUE.—Such action shall be brought
2 in the district court of the United States for the ju-
3 dicial district in which the appellant is located (or,
4 in the case of an action brought jointly by more
5 than one applicant, the judicial district in which
6 the greatest number of applicants are located) or in
7 the district court for the District of Columbia.

8 “(iv) INTEREST ON AMOUNTS IN CON-
9 TROVERSY.—Where a provider of services or sup-
10 plier seeks judicial review pursuant to this para-
11 graph, the amount in controversy shall be subject
12 to annual interest beginning on the first day of the
13 first month beginning after the 60-day period as
14 determined pursuant to clause (ii) and equal to the
15 rate of interest on obligations issued for purchase
16 by the Federal Hospital Insurance Trust Fund and
17 by the Federal Supplementary Medical Insurance
18 Trust Fund for the month in which the civil action
19 authorized under this paragraph is commenced, to
20 be awarded by the reviewing court in favor of the
21 prevailing party. No interest awarded pursuant to
22 the preceding sentence shall be deemed income or
23 cost for the purposes of determining reimbursement
24 due providers of services or suppliers under this
25 Act.

26 “(D) REVIEW PANELS.—For purposes of this sub-
27 section, a ‘review panel’ is a panel consisting of 3 mem-
28 bers (who shall be administrative law judges, members
29 of the Departmental Appeals Board, or qualified indi-
30 viduals associated with a qualified independent con-
31 tractor (as defined in subsection (c)(2)) or with another
32 independent entity) designated by the Secretary for
33 purposes of making determinations under this para-
34 graph.”.

35 (b) APPLICATION TO PROVIDER AGREEMENT DETERMINA-
36 TIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is
37 amended—



1 (1) by inserting “(A)” after “(h)(1)”; and

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

4 “(B) An institution or agency described in subparagraph
5 (A) that has filed for a hearing under subparagraph (A) shall
6 have expedited access to judicial review under this subpara-
7 graph in the same manner as providers of services, suppliers,
8 and individuals entitled to benefits under part A or enrolled
9 under part B, or both, may obtain expedited access to judicial
10 review under the process established under section 1869(b)(2).
11 Nothing in this subparagraph shall be construed to affect the
12 application of any remedy imposed under section 1819 during
13 the pendency of an appeal under this subparagraph.”

14 (c) EFFECTIVE DATE.—The amendments made by this
15 section shall apply to appeals filed on or after October 1, 2003.

16 (d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREE-
17 MENT DETERMINATIONS.—

18 (1) TERMINATION AND CERTAIN OTHER IMMEDIATE
19 REMEDIES.—The Secretary shall develop and implement a
20 process to expedite proceedings under sections 1866(h) of
21 the Social Security Act (42 U.S.C. 1395cc(h)) in which the
22 remedy of termination of participation, or a remedy de-
23 scribed in clause (i) or (iii) of section 1819(h)(2)(B) of
24 such Act (42 U.S.C. 1395i-3(h)(2)(B)) which is applied on
25 an immediate basis, has been imposed. Under such process
26 priority shall be provided in cases of termination.

27 (2) INCREASED FINANCIAL SUPPORT.—In addition to
28 any amounts otherwise appropriated, to reduce by 50 per-
29 cent the average time for administrative determinations on
30 appeals under section 1866(h) of the Social Security Act
31 (42 U.S.C. 1395cc(h)), there are authorized to be appro-
32 priated (in appropriate part from the Federal Hospital In-
33 surance Trust Fund and the Federal Supplementary Med-
34 ical Insurance Trust Fund) to the Secretary such addi-
35 tional sums for fiscal year 2004 and each subsequent fiscal
36 year as may be necessary. The purposes for which such
37 amounts are available include increasing the number of ad-



1 ministrative law judges (and their staffs) and the appellate
2 level staff at the Departmental Appeals Board of the De-
3 partment of Health and Human Services and educating
4 such judges and staffs on long-term care issues.

5 **SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.**

6 (a) REQUIRING FULL AND EARLY PRESENTATION OF EVI-
7 DENCE.—

8 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
9 1395ff(b)), as amended by BIPA and as amended by sec-
10 tion 832(a), is further amended by adding at the end the
11 following new paragraph:

12 “(3) REQUIRING FULL AND EARLY PRESENTATION OF
13 EVIDENCE BY PROVIDERS.—A provider of services or sup-
14 plier may not introduce evidence in any appeal under this
15 section that was not presented at the reconsideration con-
16 ducted by the qualified independent contractor under sub-
17 section (c), unless there is good cause which precluded the
18 introduction of such evidence at or before that reconsider-
19 ation.”.

20 (2) EFFECTIVE DATE.—The amendment made by
21 paragraph (1) shall take effect on October 1, 2003.

22 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section
23 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended
24 by BIPA, is amended by inserting “(including the medical
25 records of the individual involved)” after “clinical experience”.

26 (c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

27 (1) INITIAL DETERMINATIONS AND REDETERMINA-
28 TIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amend-
29 ed by BIPA, is amended by adding at the end the following
30 new paragraph:

31 “(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS
32 AND REDETERMINATIONS.—A written notice of a deter-
33 mination on an initial determination or on a redetermina-
34 tion, insofar as such determination or redetermination re-
35 sults in a denial of a claim for benefits, shall include—

36 “(A) the specific reasons for the determination,
37 including—



1 “(i) upon request, the provision of the policy,
2 manual, or regulation used in making the deter-
3 mination; and

4 “(ii) as appropriate in the case of a redeter-
5 mination, a summary of the clinical or scientific
6 evidence used in making the determination;

7 “(B) the procedures for obtaining additional infor-
8 mation concerning the determination or redetermina-
9 tion; and

10 “(C) notification of the right to seek a redeter-
11 mination or otherwise appeal the determination and in-
12 structions on how to initiate such a redetermination or
13 appeal under this section.

14 The written notice on a redetermination shall be provided
15 in printed form and written in a manner calculated to be
16 understood by the individual entitled to benefits under part
17 A or enrolled under part B, or both.”.

18 (2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42
19 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is
20 amended—

21 (A) by inserting “be written in a manner cal-
22 culated to be understood by the individual entitled to
23 benefits under part A or enrolled under part B, or
24 both, and shall include (to the extent appropriate)”
25 after “in writing, ”; and

26 (B) by inserting “and a notification of the right to
27 appeal such determination and instructions on how to
28 initiate such appeal under this section” after “such de-
29 cision, ”.

30 (3) APPEALS.—Section 1869(d) (42 U.S.C.
31 1395ff(d)), as amended by BIPA, is amended—

32 (A) in the heading, by inserting “; NOTICE” after
33 “SECRETARY”; and

34 (B) by adding at the end the following new para-
35 graph:

36 “(4) NOTICE.—Notice of the decision of an adminis-
37 trative law judge shall be in writing in a manner calculated



1 to be understood by the individual entitled to benefits
2 under part A or enrolled under part B, or both, and shall
3 include—

4 “(A) the specific reasons for the determination (in-
5 cluding, to the extent appropriate, a summary of the
6 clinical or scientific evidence used in making the deter-
7 mination);

8 “(B) the procedures for obtaining additional infor-
9 mation concerning the decision; and

10 “(C) notification of the right to appeal the deci-
11 sion and instructions on how to initiate such an appeal
12 under this section.”.

13 (4) SUBMISSION OF RECORD FOR APPEAL.—Section
14 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking
15 “prepare” and inserting “submit” and by striking “with re-
16 spect to” and all that follows through “and relevant poli-
17 cies”.

18 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

19 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDE-
20 PENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C.
21 1395ff(c)(3)), as amended by BIPA, is amended—

22 (A) in subparagraph (A), by striking “sufficient
23 training and expertise in medical science and legal mat-
24 ters” and inserting “sufficient medical, legal, and other
25 expertise (including knowledge of the program under
26 this title) and sufficient staffing”; and

27 (B) by adding at the end the following new sub-
28 paragraph:

29 “(K) INDEPENDENCE REQUIREMENTS.—

30 “(i) IN GENERAL.—Subject to clause (ii), a
31 qualified independent contractor shall not conduct
32 any activities in a case unless the entity—

33 “(I) is not a related party (as defined in
34 subsection (g)(5));

35 “(II) does not have a material familial, fi-
36 nancial, or professional relationship with such a
37 party in relation to such case; and



1 “(III) does not otherwise have a conflict of
2 interest with such a party.

3 “(ii) EXCEPTION FOR REASONABLE COM-
4 PENSATION.—Nothing in clause (i) shall be con-
5 strued to prohibit receipt by a qualified inde-
6 pendent contractor of compensation from the Sec-
7 retary for the conduct of activities under this sec-
8 tion if the compensation is provided consistent with
9 clause (iii).

10 “(iii) LIMITATIONS ON ENTITY COMPENSA-
11 TION.—Compensation provided by the Secretary to
12 a qualified independent contractor in connection
13 with reviews under this section shall not be contin-
14 gent on any decision rendered by the contractor or
15 by any reviewing professional.”.

16 (2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—
17 Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is
18 amended—

19 (A) by amending subsection (c)(3)(D) to read as
20 follows:

21 “(D) QUALIFICATIONS FOR REVIEWERS.—The re-
22 quirements of subsection (g) shall be met (relating to
23 qualifications of reviewing professionals).”; and

24 (B) by adding at the end the following new sub-
25 section:

26 “(g) QUALIFICATIONS OF REVIEWERS.—

27 “(1) IN GENERAL.—In reviewing determinations under
28 this section, a qualified independent contractor shall assure
29 that—

30 “(A) each individual conducting a review shall
31 meet the qualifications of paragraph (2);

32 “(B) compensation provided by the contractor to
33 each such reviewer is consistent with paragraph (3);
34 and

35 “(C) in the case of a review by a panel described
36 in subsection (c)(3)(B) composed of physicians or other
37 health care professionals (each in this subsection re-



1 ferred to as a ‘reviewing professional’), each reviewing
2 professional meets the qualifications described in para-
3 graph (4) and, where a claim is regarding the fur-
4 nishing of treatment by a physician (allopathic or os-
5 teopathic) or the provision of items or services by a
6 physician (allopathic or osteopathic), each reviewing
7 professional shall be a physician (allopathic or osteo-
8 pathic).

9 “(2) INDEPENDENCE.—

10 “(A) IN GENERAL.—Subject to subparagraph (B),
11 each individual conducting a review in a case shall—

12 “(i) not be a related party (as defined in para-
13 graph (5));

14 “(ii) not have a material familial, financial, or
15 professional relationship with such a party in the
16 case under review; and

17 “(iii) not otherwise have a conflict of interest
18 with such a party.

19 “(B) EXCEPTION.—Nothing in subparagraph (A)
20 shall be construed to—

21 “(i) prohibit an individual, solely on the basis
22 of a participation agreement with a fiscal inter-
23 mediary, carrier, or other contractor, from serving
24 as a reviewing professional if—

25 “(I) the individual is not involved in the
26 provision of items or services in the case under
27 review;

28 “(II) the fact of such an agreement is dis-
29 closed to the Secretary and the individual enti-
30 tled to benefits under part A or enrolled under
31 part B, or both, (or authorized representative)
32 and neither party objects; and

33 “(III) the individual is not an employee of
34 the intermediary, carrier, or contractor and
35 does not provide services exclusively or pri-
36 marily to or on behalf of such intermediary,
37 carrier, or contractor;



1 “(ii) prohibit an individual who has staff privi-
2 leges at the institution where the treatment in-
3 volved takes place from serving as a reviewer mere-
4 ly on the basis of having such staff privileges if the
5 existence of such privileges is disclosed to the Sec-
6 retary and such individual (or authorized represent-
7 ative), and neither party objects; or

8 “(iii) prohibit receipt of compensation by a re-
9 viewing professional from a contractor if the com-
10 pensation is provided consistent with paragraph
11 (3).

12 For purposes of this paragraph, the term ‘participation
13 agreement’ means an agreement relating to the provi-
14 sion of health care services by the individual and does
15 not include the provision of services as a reviewer
16 under this subsection.

17 “(3) LIMITATIONS ON REVIEWER COMPENSATION.—
18 Compensation provided by a qualified independent con-
19 tractor to a reviewer in connection with a review under this
20 section shall not be contingent on the decision rendered by
21 the reviewer.

22 “(4) LICENSURE AND EXPERTISE.—Each reviewing
23 professional shall be—

24 “(A) a physician (allopathic or osteopathic) who is
25 appropriately credentialed or licensed in one or more
26 States to deliver health care services and has medical
27 expertise in the field of practice that is appropriate for
28 the items or services at issue; or

29 “(B) a health care professional who is legally au-
30 thorized in one or more States (in accordance with
31 State law or the State regulatory mechanism provided
32 by State law) to furnish the health care items or serv-
33 ices at issue and has medical expertise in the field of
34 practice that is appropriate for such items or services.

35 “(5) RELATED PARTY DEFINED.—For purposes of this
36 section, the term ‘related party’ means, with respect to a
37 case under this title involving a specific individual entitled



1 to benefits under part A or enrolled under part B, or both,
2 any of the following:

3 “(A) The Secretary, the medicare administrative
4 contractor involved, or any fiduciary, officer, director,
5 or employee of the Department of Health and Human
6 Services, or of such contractor.

7 “(B) The individual (or authorized representative).

8 “(C) The health care professional that provides
9 the items or services involved in the case.

10 “(D) The institution at which the items or services
11 (or treatment) involved in the case are provided.

12 “(E) The manufacturer of any drug or other item
13 that is included in the items or services involved in the
14 case.

15 “(F) Any other party determined under any regu-
16 lations to have a substantial interest in the case in-
17 volved.”.

18 (3) EFFECTIVE DATE.—The amendments made by
19 paragraphs (1) and (2) shall be effective as if included in
20 the enactment of the respective provisions of subtitle C of
21 title V of BIPA, (114 Stat. 2763A–534).

22 (4) TRANSITION.—In applying section 1869(g) of the
23 Social Security Act (as added by paragraph (2)), any ref-
24 erence to a medicare administrative contractor shall be
25 deemed to include a reference to a fiscal intermediary
26 under section 1816 of the Social Security Act (42 U.S.C.
27 1395h) and a carrier under section 1842 of such Act (42
28 U.S.C. 1395u).

29 **SEC. 834. PREPAYMENT REVIEW.**

30 (a) IN GENERAL.—Section 1874A, as added by section
31 811(a)(1) and as amended by sections 812(b), 821(b)(1), and
32 821(c)(1), is further amended by adding at the end the fol-
33 lowing new subsection:

34 “(h) CONDUCT OF PREPAYMENT REVIEW.—

35 “(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

36 “(A) IN GENERAL.—A medicare administrative
37 contractor may conduct random prepayment review



1 only to develop a contractor-wide or program-wide
2 claims payment error rates or under such additional
3 circumstances as may be provided under regulations,
4 developed in consultation with providers of services and
5 suppliers.

6 “(B) USE OF STANDARD PROTOCOLS WHEN CON-
7 DUCTING PREPAYMENT REVIEWS.—When a medicare
8 administrative contractor conducts a random prepay-
9 ment review, the contractor may conduct such review
10 only in accordance with a standard protocol for random
11 prepayment audits developed by the Secretary.

12 “(C) CONSTRUCTION.—Nothing in this paragraph
13 shall be construed as preventing the denial of payments
14 for claims actually reviewed under a random prepay-
15 ment review.

16 “(D) RANDOM PREPAYMENT REVIEW.—For pur-
17 poses of this subsection, the term ‘random prepayment
18 review’ means a demand for the production of records
19 or documentation absent cause with respect to a claim.

20 “(2) LIMITATIONS ON NON-RANDOM PREPAYMENT RE-
21 VIEW.—

22 “(A) LIMITATIONS ON INITIATION OF NON-RAN-
23 DOM PREPAYMENT REVIEW.—A medicare administra-
24 tive contractor may not initiate non-random prepay-
25 ment review of a provider of services or supplier based
26 on the initial identification by that provider of services
27 or supplier of an improper billing practice unless there
28 is a likelihood of sustained or high level of payment
29 error (as defined in subsection (i)(3)(A)).

30 “(B) TERMINATION OF NON-RANDOM PREPAY-
31 MENT REVIEW.—The Secretary shall issue regulations
32 relating to the termination, including termination
33 dates, of non-random prepayment review. Such regula-
34 tions may vary such a termination date based upon the
35 differences in the circumstances triggering prepayment
36 review.”.

37 (b) EFFECTIVE DATE.—



1 (1) IN GENERAL.—Except as provided in this sub-
2 section, the amendment made by subsection (a) shall take
3 effect 1 year after the date of the enactment of this Act.

4 (2) DEADLINE FOR PROMULGATION OF CERTAIN REG-
5 ULATIONS.—The Secretary shall first issue regulations
6 under section 1874A(h) of the Social Security Act, as
7 added by subsection (a), by not later than 1 year after the
8 date of the enactment of this Act.

9 (3) APPLICATION OF STANDARD PROTOCOLS FOR RAN-
10 DOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of
11 the Social Security Act, as added by subsection (a), shall
12 apply to random prepayment reviews conducted on or after
13 such date (not later than 1 year after the date of the enact-
14 ment of this Act) as the Secretary shall specify.

15 (c) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-
16 RIERS.—The provisions of section 1874A(h) of the Social Secu-
17 rity Act, as added by subsection (a), shall apply to each fiscal
18 intermediary under section 1816 of the Social Security Act (42
19 U.S.C. 1395h) and each carrier under section 1842 of such Act
20 (42 U.S.C. 1395u) in the same manner as they apply to medi-
21 care administrative contractors under such provisions.

22 **SEC. 835. RECOVERY OF OVERPAYMENTS.**

23 (a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is
24 amended by adding at the end the following new subsection:

25 “(f) RECOVERY OF OVERPAYMENTS.—

26 “(1) USE OF REPAYMENT PLANS.—

27 “(A) IN GENERAL.—If the repayment, within 30
28 days by a provider of services or supplier, of an over-
29 payment under this title would constitute a hardship
30 (as defined in subparagraph (B)), subject to subpara-
31 graph (C), upon request of the provider of services or
32 supplier the Secretary shall enter into a plan with the
33 provider of services or supplier for the repayment
34 (through offset or otherwise) of such overpayment over
35 a period of at least 6 months but not longer than 3
36 years (or not longer than 5 years in the case of extreme
37 hardship, as determined by the Secretary). Interest



1 shall accrue on the balance through the period of re-
2 payment. Such plan shall meet terms and conditions
3 determined to be appropriate by the Secretary.

4 “(B) HARDSHIP.—

5 “(i) IN GENERAL.—For purposes of subpara-
6 graph (A), the repayment of an overpayment (or
7 overpayments) within 30 days is deemed to con-
8 stitute a hardship if—

9 “(I) in the case of a provider of services
10 that files cost reports, the aggregate amount of
11 the overpayments exceeds 10 percent of the
12 amount paid under this title to the provider of
13 services for the cost reporting period covered by
14 the most recently submitted cost report; or

15 “(II) in the case of another provider of
16 services or supplier, the aggregate amount of
17 the overpayments exceeds 10 percent of the
18 amount paid under this title to the provider of
19 services or supplier for the previous calendar
20 year.

21 “(ii) RULE OF APPLICATION.—The Secretary
22 shall establish rules for the application of this sub-
23 paragraph in the case of a provider of services or
24 supplier that was not paid under this title during
25 the previous year or was paid under this title only
26 during a portion of that year.

27 “(iii) TREATMENT OF PREVIOUS OVERPAY-
28 MENTS.—If a provider of services or supplier has
29 entered into a repayment plan under subparagraph
30 (A) with respect to a specific overpayment amount,
31 such payment amount under the repayment plan
32 shall not be taken into account under clause (i)
33 with respect to subsequent overpayment amounts.

34 “(C) EXCEPTIONS.—Subparagraph (A) shall not
35 apply if—

36 “(i) the Secretary has reason to suspect that
37 the provider of services or supplier may file for



1 bankruptcy or otherwise cease to do business or
2 discontinue participation in the program under this
3 title; or

4 “(ii) there is an indication of fraud or abuse
5 committed against the program.

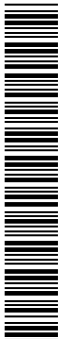
6 “(D) IMMEDIATE COLLECTION IF VIOLATION OF
7 REPAYMENT PLAN.—If a provider of services or sup-
8 plier fails to make a payment in accordance with a re-
9 payment plan under this paragraph, the Secretary may
10 immediately seek to offset or otherwise recover the
11 total balance outstanding (including applicable interest)
12 under the repayment plan.

13 “(E) RELATION TO NO FAULT PROVISION.—Noth-
14 ing in this paragraph shall be construed as affecting
15 the application of section 1870(c) (relating to no ad-
16 justment in the cases of certain overpayments).

17 “(2) LIMITATION ON RECOUPMENT.—

18 “(A) IN GENERAL.—In the case of a provider of
19 services or supplier that is determined to have received
20 an overpayment under this title and that seeks a recon-
21 sideration by a qualified independent contractor on
22 such determination under section 1869(b)(1), the Sec-
23 retary may not take any action (or authorize any other
24 person, including any medicare contractor, as defined
25 in subparagraph (C)) to recoup the overpayment until
26 the date the decision on the reconsideration has been
27 rendered. If the provisions of section 1869(b)(1) (pro-
28 viding for such a reconsideration by a qualified inde-
29 pendent contractor) are not in effect, in applying the
30 previous sentence any reference to such a reconsider-
31 ation shall be treated as a reference to a redetermina-
32 tion by the fiscal intermediary or carrier involved.

33 “(B) COLLECTION WITH INTEREST.—Insofar as
34 the determination on such appeal is against the pro-
35 vider of services or supplier, interest on the overpay-
36 ment shall accrue on and after the date of the original
37 notice of overpayment. Insofar as such determination



1 against the provider of services or supplier is later re-
2 versed, the Secretary shall provide for repayment of the
3 amount recouped plus interest at the same rate as
4 would apply under the previous sentence for the period
5 in which the amount was recouped.

6 “(C) MEDICARE CONTRACTOR DEFINED.—For
7 purposes of this subsection, the term ‘medicare con-
8 tractor’ has the meaning given such term in section
9 1889(g).

10 “(3) LIMITATION ON USE OF EXTRAPOLATION.—A
11 medicare contractor may not use extrapolation to determine
12 overpayment amounts to be recovered by recoupment, off-
13 set, or otherwise unless—

14 “(A) there is a sustained or high level of payment
15 error (as defined by the Secretary by regulation); or

16 “(B) documented educational intervention has
17 failed to correct the payment error (as determined by
18 the Secretary).

19 “(4) PROVISION OF SUPPORTING DOCUMENTATION.—
20 In the case of a provider of services or supplier with respect
21 to which amounts were previously overpaid, a medicare con-
22 tractor may request the periodic production of records or
23 supporting documentation for a limited sample of sub-
24 mitted claims to ensure that the previous practice is not
25 continuing.

26 “(5) CONSENT SETTLEMENT REFORMS.—

27 “(A) IN GENERAL.—The Secretary may use a con-
28 sent settlement (as defined in subparagraph (D)) to
29 settle a projected overpayment.

30 “(B) OPPORTUNITY TO SUBMIT ADDITIONAL IN-
31 FORMATION BEFORE CONSENT SETTLEMENT OFFER.—
32 Before offering a provider of services or supplier a con-
33 sent settlement, the Secretary shall—

34 “(i) communicate to the provider of services or
35 supplier—

36 “(I) that, based on a review of the medical
37 records requested by the Secretary, a prelimi-



1 nary evaluation of those records indicates that
2 there would be an overpayment;

3 “(II) the nature of the problems identified
4 in such evaluation; and

5 “(III) the steps that the provider of serv-
6 ices or supplier should take to address the
7 problems; and

8 “(ii) provide for a 45-day period during which
9 the provider of services or supplier may furnish ad-
10 ditional information concerning the medical records
11 for the claims that had been reviewed.

12 “(C) CONSENT SETTLEMENT OFFER.—The Sec-
13 retary shall review any additional information furnished
14 by the provider of services or supplier under subpara-
15 graph (B)(ii). Taking into consideration such informa-
16 tion, the Secretary shall determine if there still appears
17 to be an overpayment. If so, the Secretary—

18 “(i) shall provide notice of such determination
19 to the provider of services or supplier, including an
20 explanation of the reason for such determination;
21 and

22 “(ii) in order to resolve the overpayment, may
23 offer the provider of services or supplier—

24 “(I) the opportunity for a statistically
25 valid random sample; or

26 “(II) a consent settlement.

27 The opportunity provided under clause (ii)(I) does not
28 waive any appeal rights with respect to the alleged
29 overpayment involved.

30 “(D) CONSENT SETTLEMENT DEFINED.—For pur-
31 poses of this paragraph, the term ‘consent settlement’
32 means an agreement between the Secretary and a pro-
33 vider of services or supplier whereby both parties agree
34 to settle a projected overpayment based on less than a
35 statistically valid sample of claims and the provider of
36 services or supplier agrees not to appeal the claims in-
37 volved.



1 “(6) NOTICE OF OVER-UTILIZATION OF CODES.—The
2 Secretary shall establish, in consultation with organizations
3 representing the classes of providers of services and sup-
4 pliers, a process under which the Secretary provides for no-
5 tice to classes of providers of services and suppliers served
6 by the contractor in cases in which the contractor has iden-
7 tified that particular billing codes may be overutilized by
8 that class of providers of services or suppliers under the
9 programs under this title (or provisions of title XI insofar
10 as they relate to such programs).

11 “(7) PAYMENT AUDITS.—

12 “(A) WRITTEN NOTICE FOR POST-PAYMENT AU-
13 DITS.—Subject to subparagraph (C), if a medicare con-
14 tractor decides to conduct a post-payment audit of a
15 provider of services or supplier under this title, the con-
16 tractor shall provide the provider of services or supplier
17 with written notice (which may be in electronic form)
18 of the intent to conduct such an audit.

19 “(B) EXPLANATION OF FINDINGS FOR ALL AU-
20 DITS.—Subject to subparagraph (C), if a medicare con-
21 tractor audits a provider of services or supplier under
22 this title, the contractor shall—

23 “(i) give the provider of services or supplier a
24 full review and explanation of the findings of the
25 audit in a manner that is understandable to the
26 provider of services or supplier and permits the de-
27 velopment of an appropriate corrective action plan;

28 “(ii) inform the provider of services or supplier
29 of the appeal rights under this title as well as con-
30 sent settlement options (which are at the discretion
31 of the Secretary);

32 “(iii) give the provider of services or supplier
33 an opportunity to provide additional information to
34 the contractor; and

35 “(iv) take into account information provided,
36 on a timely basis, by the provider of services or
37 supplier under clause (iii).



1 “(C) EXCEPTION.—Subparagraphs (A) and (B)
2 shall not apply if the provision of notice or findings
3 would compromise pending law enforcement activities,
4 whether civil or criminal, or reveal findings of law en-
5 forcement-related audits.

6 “(8) STANDARD METHODOLOGY FOR PROBE SAM-
7 PLING.—The Secretary shall establish a standard method-
8 ology for medicare contractors to use in selecting a sample
9 of claims for review in the case of an abnormal billing pat-
10 tern.”.

11 (b) EFFECTIVE DATES AND DEADLINES.—

12 (1) USE OF REPAYMENT PLANS.—Section 1893(f)(1)
13 of the Social Security Act, as added by subsection (a), shall
14 apply to requests for repayment plans made after the date
15 of the enactment of this Act.

16 (2) LIMITATION ON RECOUPMENT.—Section
17 1893(f)(2) of the Social Security Act, as added by sub-
18 section (a), shall apply to actions taken after the date of
19 the enactment of this Act.

20 (3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of
21 the Social Security Act, as added by subsection (a), shall
22 apply to statistically valid random samples initiated after
23 the date that is 1 year after the date of the enactment of
24 this Act.

25 (4) PROVISION OF SUPPORTING DOCUMENTATION.—
26 Section 1893(f)(4) of the Social Security Act, as added by
27 subsection (a), shall take effect on the date of the enact-
28 ment of this Act.

29 (5) CONSENT SETTLEMENT.—Section 1893(f)(5) of
30 the Social Security Act, as added by subsection (a), shall
31 apply to consent settlements entered into after the date of
32 the enactment of this Act.

33 (6) NOTICE OF OVERUTILIZATION.—Not later than 1
34 year after the date of the enactment of this Act, the Sec-
35 retary shall first establish the process for notice of over-
36 utilization of billing codes under section 1893A(f)(6) of the
37 Social Security Act, as added by subsection (a).



1 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of the
2 Social Security Act, as added by subsection (a), shall apply
3 to audits initiated after the date of the enactment of this
4 Act.

5 (8) STANDARD FOR ABNORMAL BILLING PATTERNS.—
6 Not later than 1 year after the date of the enactment of
7 this Act, the Secretary shall first establish a standard
8 methodology for selection of sample claims for abnormal
9 billing patterns under section 1893(f)(8) of the Social Se-
10 curity Act, as added by subsection (a).

11 **SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF**
12 **APPEAL.**

13 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is
14 amended—

15 (1) by adding at the end of the heading the following:
16 “; ENROLLMENT PROCESSES”; and

17 (2) by adding at the end the following new subsection:

18 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERV-
19 ICES AND SUPPLIERS.—

20 “(1) ENROLLMENT PROCESS.—

21 “(A) IN GENERAL.—The Secretary shall establish
22 by regulation a process for the enrollment of providers
23 of services and suppliers under this title.

24 “(B) DEADLINES.—The Secretary shall establish
25 by regulation procedures under which there are dead-
26 lines for actions on applications for enrollment (and, if
27 applicable, renewal of enrollment). The Secretary shall
28 monitor the performance of medicare administrative
29 contractors in meeting the deadlines established under
30 this subparagraph.

31 “(C) CONSULTATION BEFORE CHANGING PRO-
32 VIDER ENROLLMENT FORMS.—The Secretary shall con-
33 sult with providers of services and suppliers before
34 making changes in the provider enrollment forms re-
35 quired of such providers and suppliers to be eligible to
36 submit claims for which payment may be made under
37 this title.



1 “(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-
2 RENEWAL.—A provider of services or supplier whose appli-
3 cation to enroll (or, if applicable, to renew enrollment)
4 under this title is denied may have a hearing and judicial
5 review of such denial under the procedures that apply
6 under subsection (h)(1)(A) to a provider of services that is
7 dissatisfied with a determination by the Secretary.”.

8 (b) EFFECTIVE DATES.—

9 (1) ENROLLMENT PROCESS.—The Secretary shall pro-
10 vide for the establishment of the enrollment process under
11 section 1866(j)(1) of the Social Security Act, as added by
12 subsection (a)(2), within 6 months after the date of the en-
13 actment of this Act.

14 (2) CONSULTATION.—Section 1866(j)(1)(C) of the So-
15 cial Security Act, as added by subsection (a)(2), shall apply
16 with respect to changes in provider enrollment forms made
17 on or after January 1, 2003.

18 (3) HEARING RIGHTS.—Section 1866(j)(2) of the So-
19 cial Security Act, as added by subsection (a)(2), shall apply
20 to denials occurring on or after such date (not later than
21 1 year after the date of the enactment of this Act) as the
22 Secretary specifies.

23 **SEC. 837. PROCESS FOR CORRECTION OF MINOR ER-**
24 **RORS AND OMISSIONS ON CLAIMS WITHOUT**
25 **PURSUING APPEALS PROCESS.**

26 The Secretary shall develop, in consultation with appro-
27 priate medicare contractors (as defined in section 1889(g) of
28 the Social Security Act, as inserted by section 821(a)(1)) and
29 representatives of providers of services and suppliers, a process
30 whereby, in the case of minor errors or omissions (as defined
31 by the Secretary) that are detected in the submission of claims
32 under the programs under title XVIII of such Act, a provider
33 of services or supplier is given an opportunity to correct such
34 an error or omission without the need to initiate an appeal.
35 Such process shall include the ability to resubmit corrected
36 claims.



1 **SEC. 838. PRIOR DETERMINATION PROCESS FOR CER-**
2 **TAIN ITEMS AND SERVICES; ADVANCE BENE-**
3 **FICIARY NOTICES.**

4 (a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as
5 amended by sections 521 and 522 of BIPA and section
6 833(d)(2)(B), is further amended by adding at the end the fol-
7 lowing new subsection:

8 “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN
9 ITEMS AND SERVICES.—

10 “(1) ESTABLISHMENT OF PROCESS.—

11 “(A) IN GENERAL.—With respect to a medicare
12 administrative contractor that has a contract under
13 section 1874A that provides for making payments
14 under this title with respect to eligible items and serv-
15 ices described in subparagraph (C), the Secretary shall
16 establish a prior determination process that meets the
17 requirements of this subsection and that shall be ap-
18 plied by such contractor in the case of eligible request-
19 ers.

20 “(B) ELIGIBLE REQUESTER.—For purposes of
21 this subsection, each of the following shall be an eligi-
22 ble requester:

23 “(i) A physician, but only with respect to eligi-
24 ble items and services for which the physician may
25 be paid directly.

26 “(ii) An individual entitled to benefits under
27 this title, but only with respect to an item or serv-
28 ice for which the individual receives, from the phy-
29 sician who may be paid directly for the item or
30 service, an advance beneficiary notice under section
31 1879(a) that payment may not be made (or may no
32 longer be made) for the item or service under this
33 title.

34 “(C) ELIGIBLE ITEMS AND SERVICES.—For pur-
35 poses of this subsection and subject to paragraph (2),
36 eligible items and services are items and services which
37 are physicians’ services (as defined in paragraph (4)(A)



1 of section 1848(f) for purposes of calculating the sus-
2 tainable growth rate under such section).

3 “(2) SECRETARIAL FLEXIBILITY.—The Secretary shall
4 establish by regulation reasonable limits on the categories
5 of eligible items and services for which a prior determina-
6 tion of coverage may be requested under this subsection. In
7 establishing such limits, the Secretary may consider the
8 dollar amount involved with respect to the item or service,
9 administrative costs and burdens, and other relevant fac-
10 tors.

11 “(3) REQUEST FOR PRIOR DETERMINATION.—

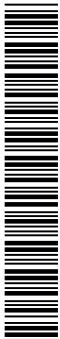
12 “(A) IN GENERAL.—Subject to paragraph (2),
13 under the process established under this subsection an
14 eligible requester may submit to the contractor a re-
15 quest for a determination, before the furnishing of an
16 eligible item or service involved as to whether the item
17 or service is covered under this title consistent with the
18 applicable requirements of section 1862(a)(1)(A) (relat-
19 ing to medical necessity).

20 “(B) ACCOMPANYING DOCUMENTATION.—The Sec-
21 retary may require that the request be accompanied by
22 a description of the item or service, supporting docu-
23 mentation relating to the medical necessity for the item
24 or service, and any other appropriate documentation.
25 In the case of a request submitted by an eligible re-
26 quester who is described in paragraph (1)(B)(ii), the
27 Secretary may require that the request also be accom-
28 panied by a copy of the advance beneficiary notice in-
29 volved.

30 “(4) RESPONSE TO REQUEST.—

31 “(A) IN GENERAL.—Under such process, the con-
32 tractor shall provide the eligible requester with written
33 notice of a determination as to whether—

- 34 “(i) the item or service is so covered;
35 “(ii) the item or service is not so covered; or
36 “(iii) the contractor lacks sufficient informa-
37 tion to make a coverage determination.



1 If the contractor makes the determination described in
2 clause (iii), the contractor shall include in the notice a
3 description of the additional information required to
4 make the coverage determination.

5 “(B) DEADLINE TO RESPOND.—Such notice shall
6 be provided within the same time period as the time pe-
7 riod applicable to the contractor providing notice of ini-
8 tial determinations on a claim for benefits under sub-
9 section (a)(2)(A).

10 “(C) INFORMING BENEFICIARY IN CASE OF PHYSI-
11 CIAN REQUEST.—In the case of a request in which an
12 eligible requester is not the individual described in
13 paragraph (1)(B)(ii), the process shall provide that the
14 individual to whom the item or service is proposed to
15 be furnished shall be informed of any determination de-
16 scribed in clause (ii) (relating to a determination of
17 non-coverage) and the right (referred to in paragraph
18 (6)(B)) to obtain the item or service and have a claim
19 submitted for the item or service.

20 “(5) EFFECT OF DETERMINATIONS.—

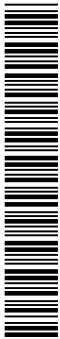
21 “(A) BINDING NATURE OF POSITIVE DETERMINA-
22 TION.—If the contractor makes the determination de-
23 scribed in paragraph (4)(A)(i), such determination
24 shall be binding on the contractor in the absence of
25 fraud or evidence of misrepresentation of facts pre-
26 sented to the contractor.

27 “(B) NOTICE AND RIGHT TO REDETERMINATION
28 IN CASE OF A DENIAL.—

29 “(i) IN GENERAL.—If the contractor makes
30 the determination described in paragraph
31 (4)(A)(ii)—

32 “(I) the eligible requester has the right to
33 a redetermination by the contractor on the de-
34 termination that the item or service is not so
35 covered; and

36 “(II) the contractor shall include in notice
37 under paragraph (4)(A) a brief explanation of



1 the basis for the determination, including on
2 what national or local coverage or noncoverage
3 determination (if any) the determination is
4 based, and the right to such a redetermination.

5 “(ii) DEADLINE FOR REDETERMINATIONS.—
6 The contractor shall complete and provide notice of
7 such redetermination within the same time period
8 as the time period applicable to the contractor pro-
9 viding notice of redeterminations relating to a
10 claim for benefits under subsection (a)(3)(C)(ii).

11 “(6) LIMITATION ON FURTHER REVIEW.—

12 “(A) IN GENERAL.—Contractor determinations de-
13 scribed in paragraph (4)(A)(ii) or (4)(A)(iii) (and rede-
14 terminations made under paragraph (5)(B)), relating
15 to pre-service claims are not subject to further adminis-
16 trative appeal or judicial review under this section or
17 otherwise.

18 “(B) DECISION NOT TO SEEK PRIOR DETERMINA-
19 TION OR NEGATIVE DETERMINATION DOES NOT IMPACT
20 RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT,
21 OR APPEAL RIGHTS.—Nothing in this subsection shall
22 be construed as affecting the right of an individual
23 who—

24 “(i) decides not to seek a prior determination
25 under this subsection with respect to items or serv-
26 ices; or

27 “(ii) seeks such a determination and has re-
28 ceived a determination described in paragraph
29 (4)(A)(ii),

30 from receiving (and submitting a claim for) such items
31 services and from obtaining administrative or judicial
32 review respecting such claim under the other applicable
33 provisions of this section. Failure to seek a prior deter-
34 mination under this subsection with respect to items
35 and services shall not be taken into account in such ad-
36 ministrative or judicial review.



1 “(C) NO PRIOR DETERMINATION AFTER RECEIPT
2 OF SERVICES.—Once an individual is provided items
3 and services, there shall be no prior determination
4 under this subsection with respect to such items or
5 services.”.

6 (b) EFFECTIVE DATE; TRANSITION.—

7 (1) EFFECTIVE DATE.—The Secretary shall establish
8 the prior determination process under the amendment
9 made by subsection (a) in such a manner as to provide for
10 the acceptance of requests for determinations under such
11 process filed not later than 18 months after the date of the
12 enactment of this Act.

13 (2) TRANSITION.—During the period in which the
14 amendment made by subsection (a) has become effective
15 but contracts are not provided under section 1874A of the
16 Social Security Act with medicare administrative contrac-
17 tors, any reference in section 1869(g) of such Act (as
18 added by such amendment) to such a contractor is deemed
19 a reference to a fiscal intermediary or carrier with an
20 agreement under section 1816, or contract under section
21 1842, respectively, of such Act.

22 (3) LIMITATION ON APPLICATION TO SGR.—For pur-
23 poses of applying section 1848(f)(2)(D) of the Social Secu-
24 rity Act (42 U.S.C. 1395w-4(f)(2)(D)), the amendment
25 made by subsection (a) shall not be considered to be a
26 change in law or regulation.

27 (c) PROVISIONS RELATING TO ADVANCE BENEFICIARY
28 NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

29 (1) DATA COLLECTION.—The Secretary shall establish
30 a process for the collection of information on the instances
31 in which an advance beneficiary notice (as defined in para-
32 graph (4)) has been provided and on instances in which a
33 beneficiary indicates on such a notice that the beneficiary
34 does not intend to seek to have the item or service that is
35 the subject of the notice furnished.

36 (2) OUTREACH AND EDUCATION.—The Secretary shall
37 establish a program of outreach and education for bene-



1 ficiaries and providers of services and other persons on the
2 appropriate use of advance beneficiary notices and coverage
3 policies under the medicare program.

4 (3) GAO REPORT REPORT ON USE OF ADVANCE BENE-
5 FICIARY NOTICES.—Not later than 18 months after the
6 date on which section 1869(g) of the Social Security Act
7 (as added by subsection (a)) takes effect, the Comptroller
8 General of the United States shall submit to Congress a re-
9 port on the use of advance beneficiary notices under title
10 XVIII of such Act. Such report shall include information
11 concerning the providers of services and other persons that
12 have provided such notices and the response of beneficiaries
13 to such notices.

14 (4) GAO REPORT ON USE OF PRIOR DETERMINATION
15 PROCESS.—Not later than 18 months after the date on
16 which section 1869(g) of the Social Security Act (as added
17 by subsection (a)) takes effect, the Comptroller General of
18 the United States shall submit to Congress a report on the
19 use of the prior determination process under such section.
20 Such report shall include—

21 (A) information concerning the types of proce-
22 dures for which a prior determination has been sought,
23 determinations made under the process, and changes in
24 receipt of services resulting from the application of
25 such process; and

26 (B) an evaluation of whether the process was use-
27 ful for physicians (and other suppliers) and bene-
28 ficiaries, whether it was timely, and whether the
29 amount of information required was burdensome to
30 physicians and beneficiaries.

31 (5) ADVANCE BENEFICIARY NOTICE DEFINED.—In
32 this subsection, the term “advance beneficiary notice”
33 means a written notice provided under section 1879(a) of
34 the Social Security Act (42 U.S.C. 1395pp(a)) to an indi-
35 vidual entitled to benefits under part A or B of title XVIII
36 of such Act before items or services are furnished under
37 such part in cases where a provider of services or other



1 person that would furnish the item or service believes that
2 payment will not be made for some or all of such items or
3 services under such title.

4 **Subtitle E—Miscellaneous Provisions**

5 **SEC. 841. POLICY DEVELOPMENT REGARDING EVALUA-**
6 **TION AND MANAGEMENT (E & M) DOCU-**
7 **MENTATION GUIDELINES.**

8 (a) IN GENERAL.—The Secretary may not implement any
9 new documentation guidelines for evaluation and management
10 physician services under the title XVIII of the Social Security
11 Act on or after the date of the enactment of this Act unless
12 the Secretary—

13 (1) has developed the guidelines in collaboration with
14 practicing physicians (including both generalists and spe-
15 cialists) and provided for an assessment of the proposed
16 guidelines by the physician community;

17 (2) has established a plan that contains specific goals,
18 including a schedule, for improving the use of such guide-
19 lines;

20 (3) has conducted appropriate and representative pilot
21 projects under subsection (b) to test modifications to the
22 evaluation and management documentation guidelines;

23 (4) finds that the objectives described in subsection (c)
24 will be met in the implementation of such guidelines; and

25 (5) has established, and is implementing, a program to
26 educate physicians on the use of such guidelines and that
27 includes appropriate outreach.

28 The Secretary shall make changes to the manner in which ex-
29 isting evaluation and management documentation guidelines
30 are implemented to reduce paperwork burdens on physicians.

31 (b) PILOT PROJECTS TO TEST EVALUATION AND MAN-
32 AGEMENT DOCUMENTATION GUIDELINES.—

33 (1) IN GENERAL.—The Secretary shall conduct under
34 this subsection appropriate and representative pilot projects
35 to test new evaluation and management documentation
36 guidelines referred to in subsection (a).



1 (2) LENGTH AND CONSULTATION.—Each pilot project
2 under this subsection shall—

3 (A) be voluntary;

4 (B) be of sufficient length as determined by the
5 Secretary to allow for preparatory physician and medi-
6 care contractor education, analysis, and use and assess-
7 ment of potential evaluation and management guide-
8 lines; and

9 (C) be conducted, in development and throughout
10 the planning and operational stages of the project, in
11 consultation with practicing physicians (including both
12 generalists and specialists).

13 (3) RANGE OF PILOT PROJECTS.—Of the pilot projects
14 conducted under this subsection—

15 (A) at least one shall focus on a peer review meth-
16 od by physicians (not employed by a medicare con-
17 tractor) which evaluates medical record information for
18 claims submitted by physicians identified as statistical
19 outliers relative to definitions published in the Current
20 Procedures Terminology (CPT) code book of the Amer-
21 ican Medical Association;

22 (B) at least one shall focus on an alternative
23 method to detailed guidelines based on physician docu-
24 mentation of face to face encounter time with a patient;

25 (C) at least one shall be conducted for services
26 furnished in a rural area and at least one for services
27 furnished outside such an area; and

28 (D) at least one shall be conducted in a setting
29 where physicians bill under physicians' services in
30 teaching settings and at least one shall be conducted in
31 a setting other than a teaching setting.

32 (4) BANNING OF TARGETING OF PILOT PROJECT PAR-
33 TICIPANTS.—Data collected under this subsection shall not
34 be used as the basis for overpayment demands or post-pay-
35 ment audits. Such limitation applies only to claims filed as
36 part of the pilot project and lasts only for the duration of



1 the pilot project and only as long as the provider is a par-
2 ticipant in the pilot project.

3 (5) STUDY OF IMPACT.—Each pilot project shall ex-
4 amine the effect of the new evaluation and management
5 documentation guidelines on—

6 (A) different types of physician practices, includ-
7 ing those with fewer than 10 full-time-equivalent em-
8 ployees (including physicians); and

9 (B) the costs of physician compliance, including
10 education, implementation, auditing, and monitoring.

11 (6) PERIODIC REPORTS.—The Secretary shall submit
12 to Congress periodic reports on the pilot projects under this
13 subsection.

14 (c) OBJECTIVES FOR EVALUATION AND MANAGEMENT
15 GUIDELINES.—The objectives for modified evaluation and man-
16 agement documentation guidelines developed by the Secretary
17 shall be to—

18 (1) identify clinically relevant documentation needed to
19 code accurately and assess coding levels accurately;

20 (2) decrease the level of non-clinically pertinent and
21 burdensome documentation time and content in the physi-
22 cian's medical record;

23 (3) increase accuracy by reviewers; and

24 (4) educate both physicians and reviewers.

25 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOC-
26 UMENTATION FOR PHYSICIAN CLAIMS.—

27 (1) STUDY.—The Secretary shall carry out a study of
28 the matters described in paragraph (2).

29 (2) MATTERS DESCRIBED.—The matters referred to in
30 paragraph (1) are—

31 (A) the development of a simpler, alternative sys-
32 tem of requirements for documentation accompanying
33 claims for evaluation and management physician serv-
34 ices for which payment is made under title XVIII of
35 the Social Security Act; and



1 (B) consideration of systems other than current
2 coding and documentation requirements for payment
3 for such physician services.

4 (3) CONSULTATION WITH PRACTICING PHYSICIANS.—
5 In designing and carrying out the study under paragraph
6 (1), the Secretary shall consult with practicing physicians,
7 including physicians who are part of group practices and
8 including both generalists and specialists.

9 (4) APPLICATION OF HIPAA UNIFORM CODING RE-
10 QUIREMENTS.—In developing an alternative system under
11 paragraph (2), the Secretary shall consider requirements of
12 administrative simplification under part C of title XI of the
13 Social Security Act.

14 (5) REPORT TO CONGRESS.—(A) Not later than Octo-
15 ber 1, 2004, the Secretary shall submit to Congress a re-
16 port on the results of the study conducted under paragraph
17 (1).

18 (B) The Medicare Payment Advisory Commission shall
19 conduct an analysis of the results of the study included in
20 the report under subparagraph (A) and shall submit a re-
21 port on such analysis to Congress.

22 (e) STUDY ON APPROPRIATE CODING OF CERTAIN EX-
23 TENDED OFFICE VISITS.—The Secretary shall conduct a study
24 of the appropriateness of coding in cases of extended office vis-
25 its in which there is no diagnosis made. Not later than October
26 1, 2004, the Secretary shall submit a report to Congress on
27 such study and shall include recommendations on how to code
28 appropriately for such visits in a manner that takes into ac-
29 count the amount of time the physician spent with the patient.

30 (f) DEFINITIONS.—In this section—

31 (1) the term “rural area” has the meaning given that
32 term in section 1886(d)(2)(D) of the Social Security Act,
33 42 U.S.C. 1395ww(d)(2)(D); and

34 (2) the term “teaching settings” are those settings de-
35 scribed in section 415.150 of title 42, Code of Federal Reg-
36 ulations.



1 **SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECH-**
2 **NOLOGY AND COVERAGE.**

3 (a) IMPROVED COORDINATION BETWEEN FDA AND CMS
4 ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

5 (1) IN GENERAL.—Upon request by an applicant and
6 to the extent feasible (as determined by the Secretary), the
7 Secretary shall, in the case of a class III medical device
8 that is subject to premarket approval under section 515 of
9 the Federal Food, Drug, and Cosmetic Act, ensure the
10 sharing of appropriate information from the review for ap-
11 plication for premarket approval conducted by the Food
12 and Drug Administration for coverage decisions under title
13 XVIII of the Social Security Act.

14 (2) PUBLICATION OF PLAN.—Not later than 6 months
15 after the date of the enactment of this Act, the Secretary
16 shall submit to appropriate Committees of Congress a re-
17 port that contains the plan for improving such coordination
18 and for shortening the time lag between the premarket ap-
19 proval by the Food and Drug Administration and coding
20 and coverage decisions by the Centers for Medicare & Med-
21 icaid Services.

22 (3) CONSTRUCTION.—Nothing in this subsection shall
23 be construed as changing the criteria for coverage of a
24 medical device under title XVIII of the Social Security Act
25 nor premarket approval by the Food and Drug Administra-
26 tion and nothing in this subsection shall be construed to in-
27 crease premarket approval application requirements under
28 the Federal Food, Drug, and Cosmetic Act.

29 (b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Sec-
30 tion 1868 (42 U.S.C. 1395ee), as amended by section 823(a),
31 is amended by adding at the end the following new subsection:

32 “(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—
33 “(1) ESTABLISHMENT.—The Secretary shall establish
34 a Council for Technology and Innovation within the Cen-
35 ters for Medicare & Medicaid Services (in this section re-
36 ferred to as ‘CMS’).



1 “(2) COMPOSITION.—The Council shall be composed
2 of senior CMS staff and clinicians and shall be chaired by
3 the Executive Coordinator for Technology and Innovation
4 (appointed or designated under paragraph (4)).

5 “(3) DUTIES.—The Council shall coordinate the activi-
6 ties of coverage, coding, and payment processes under this
7 title with respect to new technologies and procedures, in-
8 cluding new drug therapies, and shall coordinate the ex-
9 change of information on new technologies between CMS
10 and other entities that make similar decisions.

11 “(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY
12 AND INNOVATION.—The Secretary shall appoint (or des-
13 ignate) a noncareer appointee (as defined in section
14 3132(a)(7) of title 5, United States Code) who shall serve
15 as the Executive Coordinator for Technology and Innova-
16 tion. Such executive coordinator shall report to the Admin-
17 istrator of CMS, shall chair the Council, shall oversee the
18 execution of its duties, and shall serve as a single point of
19 contact for outside groups and entities regarding the cov-
20 erage, coding, and payment processes under this title.”.

21 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA
22 COLLECTION FOR USE IN THE MEDICARE INPATIENT PAY-
23 MENT SYSTEM.—

24 (1) STUDY.—The Comptroller General of the United
25 States shall conduct a study that analyzes which external
26 data can be collected in a shorter time frame by the Cen-
27 ters for Medicare & Medicaid Services for use in computing
28 payments for inpatient hospital services. The study may in-
29 clude an evaluation of the feasibility and appropriateness of
30 using of quarterly samples or special surveys or any other
31 methods. The study shall include an analysis of whether
32 other executive agencies, such as the Bureau of Labor Sta-
33 tistics in the Department of Commerce, are best suited to
34 collect this information.

35 (2) REPORT.—By not later than October 1, 2003, the
36 Comptroller General shall submit a report to Congress on
37 the study under paragraph (1).



1 (d) IOM STUDY ON LOCAL COVERAGE DETERMINA-
2 TIONS.—

3 (1) STUDY.—The Secretary shall enter into an ar-
4 rangement with the Institute of Medicine of the National
5 Academy of Sciences under which the Institute shall con-
6 duct a study on local coverage determinations (including
7 the application of local medical review policies) under the
8 medicare program under title XVIII of the Social Security
9 Act. Such study shall examine—

10 (A) the consistency of the definitions used in such
11 determinations;

12 (B) the types of evidence on which such deter-
13 minations are based, including medical and scientific
14 evidence;

15 (C) the advantages and disadvantages of local cov-
16 erage decisionmaking, including the flexibility it offers
17 for ensuring timely patient access to new medical tech-
18 nology for which data are still be collected;

19 (D) the manner in which the local coverage deter-
20 mination process is used to develop data needed for a
21 national coverage determination, including the need for
22 collection of such data within a protocol and informed
23 consent by individuals entitled to benefits under part A
24 of title XVIII of the Social Security Act, or enrolled
25 under part B of such title, or both; and

26 (E) the advantages and disadvantages of main-
27 taining local medicare contractor advisory committees
28 that can advise on local coverage decisions based on an
29 open, collaborative public process.

30 (2) REPORT.—Such arrangement shall provide that
31 the Institute shall submit to the Secretary a report on such
32 study by not later than 3 years after the date of the enact-
33 ment of this Act. The Secretary shall promptly transmit a
34 copy of such report to Congress.

35 (e) METHODS FOR DETERMINING PAYMENT BASIS FOR
36 NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is
37 amended by adding at the end the following:



1 “(8)(A) The Secretary shall establish by regulation proce-
2 dures for determining the basis for, and amount of, payment
3 under this subsection for any clinical diagnostic laboratory test
4 with respect to which a new or substantially revised HCPCS
5 code is assigned on or after January 1, 2004 (in this para-
6 graph referred to as ‘new tests’).

7 “(B) Determinations under subparagraph (A) shall be
8 made only after the Secretary—

9 “(i) makes available to the public (through an Internet
10 site and other appropriate mechanisms) a list that includes
11 any such test for which establishment of a payment amount
12 under this subsection is being considered for a year;

13 “(ii) on the same day such list is made available,
14 causes to have published in the Federal Register notice of
15 a meeting to receive comments and recommendations (and
16 data on which recommendations are based) from the public
17 on the appropriate basis under this subsection for estab-
18 lishing payment amounts for the tests on such list;

19 “(iii) not less than 30 days after publication of such
20 notice convenes a meeting, that includes representatives of
21 officials of the Centers for Medicare & Medicaid Services
22 involved in determining payment amounts, to receive such
23 comments and recommendations (and data on which the
24 recommendations are based);

25 “(iv) taking into account the comments and rec-
26 ommendations (and accompanying data) received at such
27 meeting, develops and makes available to the public
28 (through an Internet site and other appropriate mecha-
29 nisms) a list of proposed determinations with respect to the
30 appropriate basis for establishing a payment amount under
31 this subsection for each such code, together with an expla-
32 nation of the reasons for each such determination, the data
33 on which the determinations are based, and a request for
34 public written comments on the proposed determination;
35 and

36 “(v) taking into account the comments received during
37 the public comment period, develops and makes available to



1 the public (through an Internet site and other appropriate
2 mechanisms) a list of final determinations of the payment
3 amounts for such tests under this subsection, together with
4 the rationale for each such determination, the data on
5 which the determinations are based, and responses to com-
6 ments and suggestions received from the public.

7 “(C) Under the procedures established pursuant to sub-
8 paragraph (A), the Secretary shall—

9 “(i) set forth the criteria for making determinations
10 under subparagraph (A); and

11 “(ii) make available to the public the data (other than
12 proprietary data) considered in making such determina-
13 tions.

14 “(D) The Secretary may convene such further public meet-
15 ings to receive public comments on payment amounts for new
16 tests under this subsection as the Secretary deems appropriate.

17 “(E) For purposes of this paragraph:

18 “(i) The term ‘HCPCS’ refers to the Health Care Pro-
19 cedure Coding System.

20 “(ii) A code shall be considered to be ‘substantially re-
21 vised’ if there is a substantive change to the definition of
22 the test or procedure to which the code applies (such as a
23 new analyte or a new methodology for measuring an exist-
24 ing analyte-specific test).”.

25 **SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN**
26 **SERVICES UNDER MEDICARE SECONDARY**
27 **PAYOR (MSP) PROVISIONS.**

28 (a) **IN GENERAL.**—The Secretary shall not require a hos-
29 pital (including a critical access hospital) to ask questions (or
30 obtain information) relating to the application of section
31 1862(b) of the Social Security Act (relating to medicare sec-
32 ondary payor provisions) in the case of reference laboratory
33 services described in subsection (b), if the Secretary does not
34 impose such requirement in the case of such services furnished
35 by an independent laboratory.

36 (b) **REFERENCE LABORATORY SERVICES DESCRIBED.**—
37 Reference laboratory services described in this subsection are



1 clinical laboratory diagnostic tests (or the interpretation of
2 such tests, or both) furnished without a face-to-face encounter
3 between the individual entitled to benefits under part A or en-
4 rolled under part B, or both, and the hospital involved and in
5 which the hospital submits a claim only for such test or inter-
6 pretation.

7 **SEC. 844. EMTALA IMPROVEMENTS.**

8 (a) PAYMENT FOR EMTALA-MANDATED SCREENING AND
9 STABILIZATION SERVICES.—

10 (1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is
11 amended by inserting after subsection (c) the following new
12 subsection:

13 “(d) For purposes of subsection (a)(1)(A), in the case of
14 any item or service that is required to be provided pursuant to
15 section 1867 to an individual who is entitled to benefits under
16 this title, determinations as to whether the item or service is
17 reasonable and necessary shall be made on the basis of the in-
18 formation available to the treating physician or practitioner (in-
19 cluding the patient’s presenting symptoms or complaint) at the
20 time the item or service was ordered or furnished by the physi-
21 cian or practitioner (and not on the patient’s principal diag-
22 nosis). When making such determinations with respect to such
23 an item or service, the Secretary shall not consider the fre-
24 quency with which the item or service was provided to the pa-
25 tient before or after the time of the admission or visit.”.

26 (2) EFFECTIVE DATE.—The amendment made by
27 paragraph (1) shall apply to items and services furnished
28 on or after January 1, 2003.

29 (b) NOTIFICATION OF PROVIDERS WHEN EMTALA IN-
30 VESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C.
31 1395dd(d)) is amended by adding at the end the following new
32 paragraph:

33 “(4) NOTICE UPON CLOSING AN INVESTIGATION.—The
34 Secretary shall establish a procedure to notify hospitals and
35 physicians when an investigation under this section is
36 closed.”.



1 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN
2 EMTALA CASES INVOLVING TERMINATION OF PARTICIPA-
3 TION.—

4 (1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C.
5 1395dd(d)(3)) is amended—

6 (A) in the first sentence, by inserting “or in termi-
7 nating a hospital’s participation under this title” after
8 “in imposing sanctions under paragraph (1)”; and

9 (B) by adding at the end the following new sen-
10 tences: “Except in the case in which a delay would
11 jeopardize the health or safety of individuals, the Sec-
12 retary shall also request such a review before making
13 a compliance determination as part of the process of
14 terminating a hospital’s participation under this title
15 for violations related to the appropriateness of a med-
16 ical screening examination, stabilizing treatment, or an
17 appropriate transfer as required by this section, and
18 shall provide a period of 5 days for such review. The
19 Secretary shall provide a copy of the organization’s re-
20 port to the hospital or physician consistent with con-
21 fidentiality requirements imposed on the organization
22 under such part B.”.

23 (2) EFFECTIVE DATE.—The amendments made by
24 paragraph (1) shall apply to terminations of participation
25 initiated on or after the date of the enactment of this Act.

26 **SEC. 845. EMERGENCY MEDICAL TREATMENT AND**
27 **LABOR ACT (EMTALA) TECHNICAL ADVISORY**
28 **GROUP.**

29 (a) ESTABLISHMENT.—The Secretary shall establish a
30 Technical Advisory Group (in this section referred to as the
31 “Advisory Group”) to review issues related to the Emergency
32 Medical Treatment and Labor Act (EMTALA) and its imple-
33 mentation. In this section, the term “EMTALA” refers to the
34 provisions of section 1867 of the Social Security Act (42 U.S.C.
35 1395dd).

36 (b) MEMBERSHIP.—The Advisory Group shall be com-
37 posed of 19 members, including the Administrator of the Cen-



1 ters for Medicare & Medicaid Services and the Inspector Gen-
2 eral of the Department of Health and Human Services and of
3 which—

4 (1) 4 shall be representatives of hospitals, including at
5 least one public hospital, that have experience with the ap-
6 plication of EMTALA and at least 2 of which have not
7 been cited for EMTALA violations;

8 (2) 7 shall be practicing physicians drawn from the
9 fields of emergency medicine, cardiology or cardiothoracic
10 surgery, orthopedic surgery, neurosurgery, obstetrics-gyne-
11 cology, and psychiatry, with not more than one physician
12 from any particular field;

13 (3) 2 shall represent patients;

14 (4) 2 shall be staff involved in EMTALA investiga-
15 tions from different regional offices of the Centers for
16 Medicare & Medicaid Services; and

17 (5) 1 shall be from a State survey office involved in
18 EMTALA investigations and 1 shall be from a peer review
19 organization, both of whom shall be from areas other than
20 the regions represented under paragraph (4).

21 In selecting members described in paragraphs (1) through (3),
22 the Secretary shall consider qualified individuals nominated by
23 organizations representing providers and patients.

24 (c) GENERAL RESPONSIBILITIES.—The Advisory Group—

25 (1) shall review EMTALA regulations;

26 (2) may provide advice and recommendations to the
27 Secretary with respect to those regulations and their appli-
28 cation to hospitals and physicians;

29 (3) shall solicit comments and recommendations from
30 hospitals, physicians, and the public regarding the imple-
31 mentation of such regulations; and

32 (4) may disseminate information on the application of
33 such regulations to hospitals, physicians, and the public.

34 (d) ADMINISTRATIVE MATTERS.—

35 (1) CHAIRPERSON.—The members of the Advisory
36 Group shall elect a member to serve as chairperson of the
37 Advisory Group for the life of the Advisory Group.



1 **SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHO-**
2 **GENS STANDARD TO CERTAIN HOSPITALS.**

3 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is
4 amended—

5 (1) in subsection (a)(1)—

6 (A) in subparagraph (R), by striking “and” at the
7 end;

8 (B) in subparagraph (S), by striking the period at
9 the end and inserting “, and”; and

10 (C) by inserting after subparagraph (S) the fol-
11 lowing new subparagraph:

12 “(T) in the case of hospitals that are not otherwise
13 subject to the Occupational Safety and Health Act of 1970,
14 to comply with the Bloodborne Pathogens standard under
15 section 1910.1030 of title 29 of the Code of Federal Regu-
16 lations (or as subsequently redesignated).”; and

17 (2) by adding at the end of subsection (b) the fol-
18 lowing new paragraph:

19 “(4)(A) A hospital that fails to comply with the require-
20 ment of subsection (a)(1)(T) (relating to the Bloodborne
21 Pathogens standard) is subject to a civil money penalty in an
22 amount described in subparagraph (B), but is not subject to
23 termination of an agreement under this section.

24 “(B) The amount referred to in subparagraph (A) is an
25 amount that is similar to the amount of civil penalties that may
26 be imposed under section 17 of the Occupational Safety and
27 Health Act of 1970 for a violation of the Bloodborne Pathogens
28 standard referred to in subsection (a)(1)(T) by a hospital that
29 is subject to the provisions of such Act.

30 “(C) A civil money penalty under this paragraph shall be
31 imposed and collected in the same manner as civil money pen-
32 alties under subsection (a) of section 1128A are imposed and
33 collected under that section.”.

34 (b) EFFECTIVE DATE.—The amendments made by this
35 subsection (a) shall apply to hospitals as of July 1, 2003.



1 **SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND**
2 **CORRECTIONS.**

3 (a) TECHNICAL AMENDMENTS RELATING TO ADVISORY
4 COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of
5 section 1114 (42 U.S.C. 1314)—

6 (A) is transferred to section 1862 and added at the
7 end of such section; and

8 (B) is redesignated as subsection (j).

9 (2) Section 1862 (42 U.S.C. 1395y) is amended—

10 (A) in the last sentence of subsection (a), by striking
11 “established under section 1114(f)”; and

12 (B) in subsection (j), as so transferred and
13 redesignated—

14 (i) by striking “under subsection (f)”; and

15 (ii) by striking “section 1862(a)(1)” and inserting
16 “subsection (a)(1)”.

17 (b) TERMINOLOGY CORRECTIONS.—(1) Section
18 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by
19 section 521 of BIPA, is amended—

20 (A) in subclause (III), by striking “policy” and insert-
21 ing “determination”; and

22 (B) in subclause (IV), by striking “medical review
23 policies” and inserting “coverage determinations”.

24 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C))
25 is amended by striking “policy” and “POLICY” and inserting
26 “determination” each place it appears and “DETERMINATION”,
27 respectively.

28 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42
29 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is
30 amended—

31 (1) in subparagraph (A)(iv), by striking “subclause
32 (I), (II), or (III)” and inserting “clause (i), (ii), or (iii)”;

33 (2) in subparagraph (B), by striking “clause (i)(IV)”
34 and “clause (i)(III)” and inserting “subparagraph (A)(iv)”
35 and “subparagraph (A)(iii)”, respectively; and

36 (3) in subparagraph (C), by striking “clause (i)”,
37 “subclause (IV)” and “subparagraph (A)” and inserting



1 “subparagraph (A)”, “clause (iv)” and “paragraph
2 (1)(A)”, respectively each place it appears.

3 (d) OTHER CORRECTIONS.—Effective as if included in the
4 enactment of section 521(c) of BIPA, section 1154(e) (42
5 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

6 (e) EFFECTIVE DATE.—Except as otherwise provided, the
7 amendments made by this section shall be effective as if in-
8 cluded in the enactment of BIPA.

9 **SEC. 849. CONFORMING AUTHORITY TO WAIVE A PRO-**
10 **GRAM EXCLUSION.**

11 The first sentence of section 1128(c)(3)(B) (42 U.S.C.
12 1320a-7(c)(3)(B)) is amended to read as follows: “Subject to
13 subparagraph (G), in the case of an exclusion under subsection
14 (a), the minimum period of exclusion shall be not less than five
15 years, except that, upon the request of the administrator of a
16 Federal health care program (as defined in section 1128B(f))
17 who determines that the exclusion would impose a hardship on
18 individuals entitled to benefits under part A of title XVIII or
19 enrolled under part B of such title, or both, the Secretary may
20 waive the exclusion under subsection (a)(1), (a)(3), or (a)(4)
21 with respect to that program in the case of an individual or en-
22 tity that is the sole community physician or sole source of es-
23 sential specialized services in a community.”.

24 **SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.**

25 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is
26 amended by adding after subsection (g) the following new sub-
27 section:

28 “(h)(1) Subject to paragraph (2), a group health plan (as
29 defined in subsection (a)(1)(A)(v)) providing supplemental or
30 secondary coverage to individuals also entitled to services under
31 this title shall not require a medicare claims determination
32 under this title for dental benefits specifically excluded under
33 subsection (a)(12) as a condition of making a claims deter-
34 mination for such benefits under the group health plan.

35 “(2) A group health plan may require a claims determina-
36 tion under this title in cases involving or appearing to involve
37 inpatient dental hospital services or dental services expressly



1 covered under this title pursuant to actions taken by the Sec-
2 retary.”.

3 (b) EFFECTIVE DATE.—The amendment made by sub-
4 section (a) shall take effect on the date that is 60 days after
5 the date of the enactment of this Act.

6 **SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL**
7 **COVERAGE DETERMINATIONS.**

8 The Secretary shall provide, in an appropriate annual pub-
9 lication available to the public, a list of national coverage deter-
10 minations made under title XVIII of the Social Security Act in
11 the previous year and information on how to get more informa-
12 tion with respect to such determinations.

13 **TITLE IX—MEDICAID PROVISIONS**

14 **SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE**
15 **FUTURE OF MEDICAID.**

16 (a) ESTABLISHMENT.—There is established a commission
17 to be known as the National Bipartisan Commission on the Fu-
18 ture of Medicaid (in this section referred to as the “Commis-
19 sion”).

20 (b) DUTIES OF THE COMMISSION.—The Commission
21 shall—

22 (1) review and analyze the long-term financial condi-
23 tion of the medicaid program under title XIX of the Social
24 Security Act (42 U.S.C. 1396 et seq.);

25 (2) identify the factors that are causing, and the con-
26 sequences of, increases in costs under the medicaid pro-
27 gram, including—

28 (A) the impact of these cost increases upon State
29 budgets, funding for other State programs, and levels
30 of State taxes necessary to fund growing expenditures
31 under the medicaid program;

32 (B) the financial obligations of the Federal gov-
33 ernment arising from the Federal matching require-
34 ment for expenditures under the medicaid program;
35 and

36 (C) the size and scope of the current program and
37 how the program has evolved over time;



1 (3) analyze potential policies that will ensure both the
2 financial integrity of the medicaid program and the provi-
3 sion of appropriate benefits under such program;

4 (4) make recommendations for establishing incentives
5 and structures to promote enhanced efficiencies and ways
6 of encouraging innovative State policies under the medicaid
7 program;

8 (5) make recommendations for establishing the appro-
9 priate balance between benefits covered, payments to pro-
10 viders, State and Federal contributions and, where appro-
11 priate, recipient cost-sharing obligations;

12 (6) make recommendations on the impact of pro-
13 moting increased utilization of competitive, private enter-
14 prise models to contain program cost growth, through en-
15 hanced utilization of private plans, pharmacy benefit man-
16 agers, and other methods currently being used to contain
17 private sector health-care costs;

18 (7) make recommendations on the financing of pre-
19 scription drug benefits currently covered under medicaid
20 programs, including analysis of the current Federal manu-
21 facturer rebate program, its impact upon both private mar-
22 ket prices as well as those paid by other government pur-
23 chasers, recent State efforts to negotiate additional supple-
24 mental manufacturer rebates and the ability of pharmacy
25 benefit managers to lower drug costs;

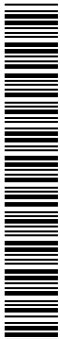
26 (8) review and analyze such other matters relating to
27 the medicaid program as the Commission deems appro-
28 priate; and

29 (9) analyze the impact of impending demographic
30 changes upon medicaid benefits, including long term care
31 services, and make recommendations for how best to appro-
32 priately divide State and Federal responsibilities for fund-
33 ing these benefits.

34 (c) MEMBERSHIP.—

35 (1) NUMBER AND APPOINTMENT.—The Commission
36 shall be composed of 17 members, of whom—

37 (A) four shall be appointed by the President;



1 (B) six shall be appointed by the Majority Leader
2 of the Senate, in consultation with the Minority Leader
3 of the Senate, of whom not more than 4 shall be of the
4 same political party;

5 (C) six shall be appointed by the Speaker of the
6 House of Representatives, in consultation with the Mi-
7 nority Leader of the House of Representatives, of
8 whom not more than 4 shall be of the same political
9 party; and

10 (D) one, who shall serve as Chairman of the Com-
11 mission, appointed jointly by the President, Majority
12 Leader of the Senate, and the Speaker of the House
13 of Representatives.

14 (2) DEADLINE FOR APPOINTMENT.—Members of the
15 Commission shall be appointed by not later than December
16 1, 2002.

17 (3) TERMS OF APPOINTMENT.—The term of any ap-
18 pointment under paragraph (1) to the Commission shall be
19 for the life of the Commission.

20 (4) MEETINGS.—The Commission shall meet at the
21 call of its Chairman or a majority of its members.

22 (5) QUORUM.—A quorum shall consist of 8 members
23 of the Commission, except that 4 members may conduct a
24 hearing under subsection (e).

25 (6) VACANCIES.—A vacancy on the Commission shall
26 be filled in the same manner in which the original appoint-
27 ment was made not later than 30 days after the Commis-
28 sion is given notice of the vacancy and shall not affect the
29 power of the remaining members to execute the duties of
30 the Commission.

31 (7) COMPENSATION.—Members of the Commission
32 shall receive no additional pay, allowances, or benefits by
33 reason of their service on the Commission.

34 (8) EXPENSES.—Each member of the Commission
35 shall receive travel expenses and per diem in lieu of subsist-
36 ence in accordance with sections 5702 and 5703 of title 5,
37 United States Code.



1 (d) STAFF AND SUPPORT SERVICES.—

2 (1) EXECUTIVE DIRECTOR.—

3 (A) APPOINTMENT.—The Chairman shall appoint
4 an executive director of the Commission.

5 (B) COMPENSATION.—The executive director shall
6 be paid the rate of basic pay for level V of the Execu-
7 tive Schedule.

8 (2) STAFF.—With the approval of the Commission,
9 the executive director may appoint such personnel as the
10 executive director considers appropriate.

11 (3) APPLICABILITY OF CIVIL SERVICE LAWS.—The
12 staff of the Commission shall be appointed without regard
13 to the provisions of title 5, United States Code, governing
14 appointments in the competitive service, and shall be paid
15 without regard to the provisions of chapter 51 and sub-
16 chapter III of chapter 53 of such title (relating to classi-
17 fication and General Schedule pay rates).

18 (4) EXPERTS AND CONSULTANTS.—With the approval
19 of the Commission, the executive director may procure tem-
20 porary and intermittent services under section 3109(b) of
21 title 5, United States Code.

22 (5) PHYSICAL FACILITIES.—The Administrator of the
23 General Services Administration shall locate suitable office
24 space for the operation of the Commission. The facilities
25 shall serve as the headquarters of the Commission and
26 shall include all necessary equipment and incidentals re-
27 quired for the proper functioning of the Commission.

28 (e) POWERS OF COMMISSION.—

29 (1) HEARINGS AND OTHER ACTIVITIES.—For the pur-
30 pose of carrying out its duties, the Commission may hold
31 such hearings and undertake such other activities as the
32 Commission determines to be necessary to carry out its du-
33 ties.

34 (2) STUDIES BY GAO.—Upon the request of the Com-
35 mission, the Comptroller General shall conduct such studies
36 or investigations as the Commission determines to be nec-
37 essary to carry out its duties.



1 (3) COST ESTIMATES BY CONGRESSIONAL BUDGET OF-
2 FICE AND OFFICE OF THE CHIEF ACTUARY OF CMS.—

3 (A) The Director of the Congressional Budget Of-
4 fice or the Chief Actuary of the Centers for Medicare
5 & Medicaid Services, or both, shall provide to the Com-
6 mission, upon the request of the Commission, such cost
7 estimates as the Commission determines to be nec-
8 essary to carry out its duties.

9 (B) The Commission shall reimburse the Director
10 of the Congressional Budget Office for expenses relat-
11 ing to the employment in the office of the Director of
12 such additional staff as may be necessary for the Direc-
13 tor to comply with requests by the Commission under
14 subparagraph (A).

15 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon the re-
16 quest of the Commission, the head of any Federal agency
17 is authorized to detail, without reimbursement, any of the
18 personnel of such agency to the Commission to assist the
19 Commission in carrying out its duties. Any such detail shall
20 not interrupt or otherwise affect the civil service status or
21 privileges of the Federal employee.

22 (5) TECHNICAL ASSISTANCE.—Upon the request of the
23 Commission, the head of a Federal agency shall provide
24 such technical assistance to the Commission as the Com-
25 mission determines to be necessary to carry out its duties.

26 (6) USE OF MAILS.—The Commission may use the
27 United States mails in the same manner and under the
28 same conditions as Federal agencies and shall, for purposes
29 of the frank, be considered a commission of Congress as
30 described in section 3215 of title 39, United States Code.

31 (7) OBTAINING INFORMATION.—The Commission may
32 secure directly from any Federal agency information nec-
33 essary to enable it to carry out its duties, if the information
34 may be disclosed under section 552 of title 5, United States
35 Code. Upon request of the Chairman of the Commission,
36 the head of such agency shall furnish such information to
37 the Commission.



1 (8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the
2 request of the Commission, the Administrator of General
3 Services shall provide to the Commission on a reimbursable
4 basis such administrative support services as the Commis-
5 sion may request.

6 (9) PRINTING.—For purposes of costs relating to
7 printing and binding, including the cost of personnel de-
8 tailed from the Government Printing Office, the Commis-
9 sion shall be deemed to be a committee of the Congress.

10 (f) REPORT.—Not later than March 1, 2004, the Commis-
11 sion shall submit a report to the President and Congress which
12 shall contain a detailed statement of the recommendations,
13 findings, and conclusions of the Commission.

14 (g) TERMINATION.—The Commission shall terminate 30
15 days after the date of submission of the report required in sub-
16 section (f).

17 (h) AUTHORIZATION OF APPROPRIATIONS.—There are au-
18 thorized to be appropriated \$1,500,000 to carry out this sec-
19 tion.

20 **SEC. 902. DISPROPORTIONATE SHARE HOSPITAL (DSH)**
21 **PAYMENTS.**

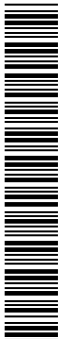
22 Section 1923(f)(3) (42 U.S.C. 1396r-4(f)(3)) is
23 amended—

24 (1) in subparagraph (A), by amending subparagraph
25 (A) to read as follows:

26 “(A) IN GENERAL.—The DSH allotment for any
27 State—

28 “(i) for fiscal year 2003 is equal to the DSH
29 allotment for the State for fiscal year 2001 under
30 the table in paragraph (2), without regard to para-
31 graph (4), increased, subject to subparagraph (B)
32 and paragraph (5), by the percentage change in the
33 consumer price index for all urban consumers (all
34 items; U.S. city average), for fiscal year 2001; and

35 “(ii) for each succeeding fiscal year is equal to
36 the DSH allotment for the State for the previous
37 fiscal year under this subparagraph increased, sub-



1 ject to subparagraph (B) and paragraph (5), by 1.7
2 percent or, in the case of fiscal years beginning
3 with the fiscal year specified in subparagraph (C)
4 for that State, the percentage change in the con-
5 sumer price index for all urban consumers (all
6 items; U.S. city average), for the previous fiscal
7 year.”; and

8 (2) by adding at the end the following new subpara-
9 graph:

10 “(C) FISCAL YEAR SPECIFIED.—For purposes of
11 subparagraph (A)(ii), the fiscal year specified in this
12 subparagraph for a State is the first fiscal year for
13 which the Secretary estimates that the DSH allotment
14 for that State will equal (or no longer exceed) the DSH
15 allotment for that State under the law as in effect be-
16 fore the date of the enactment of this subparagraph.”.

17 **SEC. 903. MEDICAID PHARMACY ASSISTANCE PROGRAM.**

18 Title XIX is amended—

19 (1) by redesignating section 1935 as section 1936; and

20 (2) by inserting after section 1934 the following new
21 section:

22 “PHARMACY ASSISTANCE PROGRAM

23 “SEC. 1936. (a) IN GENERAL.—A State plan under this
24 title may provide assistance, consistent with this section, to
25 pharmacies in implementing the new prescription drug benefit
26 under part D of title XVIII.

27 “(b) USE OF FUNDS.—Such grants may be provided to as-
28 sist pharmacies—

29 “(1) in complying with requirements relating to elec-
30 tronic prescribing;

31 “(2) in prospective drug utilization review; and

32 “(3) in developing innovative medication therapy man-
33 agement programs using information technology.

34 “(c) CONDITION FOR RECEIPT.—A pharmacy is not eligi-
35 ble for a grant under this section unless the pharmacy dem-
36 onstrates how it will operate a program that will work effec-
37 tively with patients to reduce adverse drug reactions and med-



1 ical errors. No grant shall be awarded under this section before
2 January 1, 2004.

3 (d) PRIORITIES.—In awarding grants under this section, a
4 State shall take into account and give priority to the needs of
5 small or rural pharmacies and to pharmacies which service un-
6 derserved areas.

7 “(e) FUNDING.—

8 “(1) TREATMENT AS MEDICAL ASSISTANCE.—Subject
9 to paragraph (2), amounts provided under grants by a
10 State under this section (and the reasonable administrative
11 expenses of a State in carrying out this section, not to ex-
12 ceed 10 percent of the total amount awarded as grants by
13 a State) shall be treated as the provision of medical assist-
14 ance for purposes of section 1903. In applying section
15 1903(a)(1) with respect to such assistance, the Federal
16 medical assistance percentage is deemed to be 100 percent.

17 “(2) LIMITATION AND ALLOTMENT.—

18 “(A) LIMITATION.—The total amount for which
19 Federal financial participation is available under sec-
20 tion 1903(a) for grants and administrative expenses
21 under this section in calendar quarters in any fiscal
22 year is limited to \$150,000,000 in each of fiscal years
23 2004 through 2007.

24 “(B) ALLOCATION.—The Secretary shall provide a
25 method for the allocation of the amount of funds de-
26 scribed in subparagraph (A) in each fiscal year among
27 the States. Such method shall take into account the
28 distribution among States of priority pharmacies speci-
29 fied in subsection (d).

30 “(3) REQUIREMENT FOR APPLICATION.—The pre-
31 ceding provisions of this section shall only apply to a State
32 if the State has filed with the Secretary an amendment to
33 its State plan that provides for the awarding of grants
34 under this section that is consistent with the requirements
35 of this section.”

