

**AMENDMENT TO H.R.**  
**OFFERED BY MR. THOMAS**

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) spon-  
sors; contracts; establishment of standards.

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



- “Sec. 1860F. Submission of bids.
- “Sec. 1860G. Premium and cost-sharing subsidies for low-income individuals.
- “Sec. 1860H. Subsidies for all medicare beneficiaries for qualified prescription drug coverage.
- “Sec. 1860I. Medicare Prescription Drug Trust Fund.
- “Sec. 1860J. Definitions; treatment of references to provisions in part C.

- Sec. 102. Offering of qualified prescription drug coverage under the Medicare+ Choice program.
- Sec. 103. Medicaid amendments.
- Sec. 104. Medigap transition.
- Sec. 105. Medicare prescription drug discount card endorsement program.

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

Subtitle A—Medicare+ Choice Revitalization

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

Subtitle B—Medicare+ Choice Competition Program

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

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

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

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

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



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

Subtitle B—Skilled Nursing Facility Services

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

Subtitle C—Hospice

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

Subtitle D—Other Provisions

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

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

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

Subtitle B—Other Services

- Sec. 511. Competitive acquisition of certain items and services.
- Sec. 512. Payment for ambulance services.
- Sec. 513. 2-year extension of moratorium on therapy caps; provisions relating to reports.
- Sec. 514. Accelerated implementation of 20 percent coinsurance for hospital outpatient department (OPD) services; other OPD provisions.
- Sec. 515. Coverage of an initial preventive physical examination.
- Sec. 516. Renal dialysis services.
- Sec. 517. Improved payment for certain mammography services.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.
- Sec. 602. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.
- Sec. 603. Update in home health services.



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- Sec. 604. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
- Sec. 605. MedPAC study on medicare margins of home health agencies.

Subtitle B—Direct Graduate Medical Education

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

Subtitle C—Other Provisions

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

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

- Sec. 701. Establishment of Medicare Benefits Administration.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

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

Subtitle B—Contracting Reform

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

Subtitle C—Education and Outreach

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

Subtitle D—Appeals and Recovery

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

Subtitle E—Miscellaneous Provisions

- Sec. 841. Policy development regarding evaluation and management (E & M) documentation guidelines.
- Sec. 842. Improvement in oversight of technology and coverage.
- Sec. 843. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 844. EMTALA improvements.
- Sec. 845. Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group.



- Sec. 846. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.
- Sec. 847. Application of OSHA bloodborne pathogens standard to certain hospitals.
- Sec. 848. BIPA-related technical amendments and corrections.
- Sec. 849. Conforming authority to waive a program exclusion.
- Sec. 850. Treatment of certain dental claims.
- Sec. 851. Annual publication of list of national coverage determinations.

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

Subtitle A—Medicaid Provisions

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

Subtitle B—Internet Pharmacies

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

Subtitle C—Promotion of Electronic Prescription

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

Subtitle D—Treatment of Rare Diseases

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

Subtitle E—Other Provisions Relating to Drugs

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

“SUBPART 3—PHARMACIST WORKFORCE PROGRAMS

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

TITLE X—HEALTH-CARE RELATED TAX PROVISIONS

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

**TITLE I—MEDICARE  
PRESCRIPTION DRUG BENEFIT**

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

- (a) IN GENERAL.—Title XVIII is amended—
  - (1) by redesignating part D as part E; and

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

2 "PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT  
3 PROGRAM

4 "SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT;  
5 AND COVERAGE PERIOD.

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

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

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

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

24 "(b) GENERAL ELECTION PROCEDURES.—

25 "(1) IN GENERAL.—An individual eligible to make an  
26 election under subsection (a) may elect to enroll in a pre-  
27 scription drug plan under this part, or elect the option of  
28 qualified prescription drug coverage under a  
29 Medicare+ Choice plan under part C, and to change such  
30 election only in such manner and form as may be pre-  
31 scribed by regulations of the Administrator of the Medicare  
32 Benefits Administration (appointed under section 1808(b))  
33 (in this part referred to as the 'Medicare Benefits Adminis-  
34 trator') and only during an election period prescribed in or  
35 under this subsection.

36 "(2) ELECTION PERIODS.—



1           “(A) IN GENERAL.—Except as provided in this  
2 paragraph, the election periods under this subsection  
3 shall be the same as the coverage election periods  
4 under the Medicare+ Choice program under section  
5 1851(e), including—

6           “(i) annual coordinated election periods; and

7           “(ii) special election periods.

8 In applying the last sentence of section 1851(e)(4) (re-  
9 lating to discontinuance of a Medicare+ Choice election  
10 during the first year of eligibility) under this subpara-  
11 graph, in the case of an election described in such sec-  
12 tion in which the individual had elected or is provided  
13 qualified prescription drug coverage at the time of such  
14 first enrollment, the individual shall be permitted to en-  
15 roll in a prescription drug plan under this part at the  
16 time of the election of coverage under the original fee-  
17 for-service plan.

18           “(B) INITIAL ELECTION PERIODS.—

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

24           “(ii) INDIVIDUAL COVERED IN FUTURE.—In  
25 the case of an individual who is first entitled to  
26 benefits under part A or enrolled under part B  
27 after such date, there shall be an initial election pe-  
28 riod which is the same as the initial enrollment pe-  
29 riod under section 1837(d).

30           “(C) ADDITIONAL SPECIAL ELECTION PERIODS.—  
31 The Administrator shall establish special election  
32 periods—

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



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

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

8 “(iv) in cases of individuals (as determined by  
9 the Administrator) who become eligible for pre-  
10 scription drug assistance under title XIX under  
11 section 1935(d).

12 “(c) GUARANTEED ISSUE; COMMUNITY RATING; AND  
13 NONDISCRIMINATION.—

14 “(1) GUARANTEED ISSUE.—

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

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

29 “(2) COMMUNITY-RATED PREMIUM.—

30 “(A) IN GENERAL.—In the case of an individual  
31 who maintains (as determined under subparagraph (C))  
32 continuous prescription drug coverage since the date  
33 the individual first qualifies to elect prescription drug  
34 coverage under this part, a PDP sponsor or  
35 Medicare+ Choice organization offering a prescription  
36 drug plan or Medicare+ Choice plan that provides  
37 qualified prescription drug coverage and in which the





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

7 “(B) LATE ENROLLMENT PENALTY.—In the case  
8 of an individual who does not maintain such continuous  
9 prescription drug coverage (as described in subpara-  
10 graph (C)), a PDP sponsor or Medicare+ Choice orga-  
11 nization may (notwithstanding any provision in this  
12 title) adjust the premium otherwise applicable or im-  
13 pose a pre-existing condition exclusion with respect to  
14 qualified prescription drug coverage in a manner that  
15 reflects additional actuarial risk involved. Such a risk  
16 shall be established through an appropriate actuarial  
17 opinion of the type described in subparagraphs (A)  
18 through (C) of section 2103(c)(4).

19 “(C) CONTINUOUS PRESCRIPTION DRUG COV-  
20 ERAGE.—An individual is considered for purposes of  
21 this part to be maintaining continuous prescription  
22 drug coverage on and after the date the individual first  
23 qualifies to elect prescription drug coverage under this  
24 part if the individual establishes that as of such date  
25 the individual is covered under any of the following pre-  
26 scription drug coverage and before the date that is the  
27 last day of the 63-day period that begins on the date  
28 of termination of the particular prescription drug cov-  
29 erage involved (regardless of whether the individual  
30 subsequently obtains any of the following prescription  
31 drug coverage):

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

36 “(ii) MEDICAID PRESCRIPTION DRUG COV-  
37 ERAGE.—Prescription drug coverage under a med-



1           icaid plan under title XIX, including through the  
2           Program of All-inclusive Care for the Elderly  
3           (PACE) under section 1934, through a social  
4           health maintenance organization (referred to in  
5           section 4104(c) of the Balanced Budget Act of  
6           1997), or through a Medicare+ Choice project that  
7           demonstrates the application of capitation payment  
8           rates for frail elderly medicare beneficiaries  
9           through the use of a interdisciplinary team and  
10          through the provision of primary care services to  
11          such beneficiaries by means of such a team at the  
12          nursing facility involved.

13           “(iii) PRESCRIPTION DRUG COVERAGE UNDER  
14          GROUP HEALTH PLAN.—Any outpatient prescrip-  
15          tion drug coverage under a group health plan, in-  
16          cluding a health benefits plan under the Federal  
17          Employees Health Benefit Plan under chapter 89  
18          of title 5, United States Code, and a qualified re-  
19          tiree prescription drug plan as defined in section  
20          1860H(f)(1), but only if (subject to subparagraph  
21          (E)(ii)) the coverage provides benefits at least  
22          equivalent to the benefits under a qualified pre-  
23          scription drug plan.

24           “(iv) PRESCRIPTION DRUG COVERAGE UNDER  
25          CERTAIN MEDIGAP POLICIES.—Coverage under a  
26          medicare supplemental policy under section 1882  
27          that provides benefits for prescription drugs  
28          (whether or not such coverage conforms to the  
29          standards for packages of benefits under section  
30          1882(p)(1)), but only if the policy was in effect on  
31          January 1, 2005, and if (subject to subparagraph  
32          (E)(ii)) the coverage provides benefits at least  
33          equivalent to the benefits under a qualified pre-  
34          scription drug plan.

35           “(v) STATE PHARMACEUTICAL ASSISTANCE  
36          PROGRAM.—Coverage of prescription drugs under a  
37          State pharmaceutical assistance program, but only



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

4 “(vi) VETERANS’ COVERAGE OF PRESCRIPTION  
5 DRUGS.—Coverage of prescription drugs for vet-  
6 erans under chapter 17 of title 38, United States  
7 Code, but only if (subject to subparagraph (E)(ii))  
8 the coverage provides benefits at least equivalent to  
9 the benefits under a qualified prescription drug  
10 plan.

11 “(D) CERTIFICATION.—For purposes of carrying  
12 out this paragraph, the certifications of the type de-  
13 scribed in sections 2701(e) of the Public Health Service  
14 Act and in section 9801(e) of the Internal Revenue  
15 Code shall also include a statement for the period of  
16 coverage of whether the individual involved had pre-  
17 scription drug coverage described in subparagraph (C).

18 “(E) DISCLOSURE.—

19 “(i) IN GENERAL.—Each entity that offers  
20 coverage of the type described in clause (iii), (iv),  
21 (v), or (vi) of subparagraph (C) shall provide for  
22 disclosure, consistent with standards established by  
23 the Administrator, of whether such coverage pro-  
24 vides benefits at least equivalent to the benefits  
25 under a qualified prescription drug plan.

26 “(ii) WAIVER OF LIMITATIONS.—An individual  
27 may apply to the Administrator to waive the re-  
28 quirement that coverage of such type provide bene-  
29 fits at least equivalent to the benefits under a  
30 qualified prescription drug plan, if the individual  
31 establishes that the individual was not adequately  
32 informed that such coverage did not provide such  
33 level of benefits.

34 “(F) CONSTRUCTION.—Nothing in this section  
35 shall be construed as preventing the disenrollment of  
36 an individual from a prescription drug plan or a  
37 Medicare+ Choice plan based on the termination of an



1 election described in section 1851(g)(3), including for  
 2 non-payment of premiums or for other reasons speci-  
 3 fied in subsection (d)(3), which takes into account a  
 4 grace period described in section 1851(g)(3)(B)(i).

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

9 “(d) EFFECTIVE DATE OF ELECTIONS.—

10 “(1) IN GENERAL.—Except as provided in this section,  
 11 the Administrator shall provide that elections under sub-  
 12 section (b) take effect at the same time as the Adminis-  
 13 trator provides that similar elections under section 1851(e)  
 14 take effect under section 1851(f).

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

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

19 “(A) termination of coverage under both part A  
 20 and part B; and

21 “(B) termination of elections described in section  
 22 1851(g)(3) (including failure to pay required pre-  
 23 miums).

24 **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRE-**  
 25 **SCRIPTION DRUG COVERAGE.**

26 “(a) REQUIREMENTS.—

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

30 “(A) STANDARD COVERAGE WITH ACCESS TO NE-  
 31 GOTIATED PRICES.—Standard coverage (as defined in  
 32 subsection (b)) and access to negotiated prices under  
 33 subsection (d).

34 “(B) ACTUARIALLY EQUIVALENT COVERAGE WITH  
 35 ACCESS TO NEGOTIATED PRICES.—Coverage of covered  
 36 outpatient drugs which meets the alternative coverage  
 37 requirements of subsection (c) and access to negotiated



1 prices under subsection (d), but only if it is approved  
2 by the Administrator, as provided under subsection (c).

3 “(2) PERMITTING ADDITIONAL OUTPATIENT PRE-  
4 SCRIPTURE DRUG COVERAGE.—

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

12 “(B) DISAPPROVAL AUTHORITY.—The Adminis-  
13 trator shall review the offering of qualified prescription  
14 drug coverage under this part or part C. If the Admin-  
15 istrator finds that, in the case of a qualified prescrip-  
16 tion drug coverage under a prescription drug plan or  
17 a Medicare+ Choice plan, that the organization or spon-  
18 sor offering the coverage is engaged in activities in-  
19 tended to discourage enrollment of classes of eligible  
20 medicare beneficiaries obtaining coverage through the  
21 plan on the basis of their higher likelihood of utilizing  
22 prescription drug coverage, the Administrator may ter-  
23 minate the contract with the sponsor or organization  
24 under this part or part C.

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

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

33 “(1) DEDUCTIBLE.—The coverage has an annual  
34 deductible—

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

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



1           year increased by the percentage specified in paragraph  
2           (5) for the year involved.

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

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

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

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

15                  “(I) is equal to 20 percent; or

16                  “(II) is actuarially equivalent (using proc-  
17                  esses established under subsection (e)) to an  
18                  average expected payment of 20 percent of  
19                  such costs.

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

24                  “(I) is equal to 50 percent; or

25                  “(II) is actuarially consistent (using proc-  
26                  esses established under subsection (e)) with an  
27                  average expected payment of 50 percent of  
28                  such costs.

29          “(B) USE OF TIERED COPAYMENTS.—Nothing in  
30          this part shall be construed as preventing a PDP spon-  
31          sor from applying tiered copayments, so long as such  
32          tiered copayments are consistent with subparagraph  
33          (A).

34          “(C) INITIAL COPAYMENT THRESHOLD.—The  
35          amount specified in this subparagraph—

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



1                   “(ii) for a subsequent year, is equal to the  
2                   amount specified in this subparagraph for the pre-  
3                   vious year, increased by the annual percentage in-  
4                   crease described in paragraph (5) for the year in-  
5                   volved.

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

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

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

14                  “(B) for a subsequent year, that is equal to the  
15                  amount specified in this paragraph for the previous  
16                  year, increased by the annual percentage increase de-  
17                  scribed in paragraph (5) for the year involved.

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

21                  “(4) CATASTROPHIC PROTECTION.—

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

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

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

32                  “(ii) for a subsequent year, is equal to the  
33                  amount specified in this subparagraph for the pre-  
34                  vious year, increased by the annual percentage in-  
35                  crease described in paragraph (5) for the year in-  
36                  volved.



## 16

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

4 “(C) APPLICATION.—In applying subparagraph  
5 (A)—

6 “(i) incurred costs shall only include costs in-  
7 curred for the annual deductible (described in para-  
8 graph (1)), cost-sharing (described in paragraph  
9 (2)), and amounts for which benefits are not pro-  
10 vided because of the application of the initial cov-  
11 erage limit described in paragraph (3); and

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

17 “(5) ANNUAL PERCENTAGE INCREASE.—For purposes  
18 of this part, the annual percentage increase specified in  
19 this paragraph for a year is equal to the annual percentage  
20 increase in average per capita aggregate expenditures for  
21 covered outpatient drugs in the United States for medicare  
22 beneficiaries, as determined by the Administrator for the  
23 12-month period ending in July of the previous year.

24 “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A pre-  
25 scription drug plan or Medicare+ Choice plan may provide a  
26 different prescription drug benefit design from the standard  
27 coverage described in subsection (b) so long as the Adminis-  
28 trator determines (based on an actuarial analysis by the Ad-  
29 ministrator) that the following requirements are met and the  
30 plan applies for, and receives, the approval of the Adminis-  
31 trator for such benefit design:

32 “(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT  
33 COVERAGE.—

34 “(A) ASSURING EQUIVALENT VALUE OF TOTAL  
35 COVERAGE.—The actuarial value of the total coverage  
36 (as determined under subsection (e)) is at least equal





1 to the actuarial value (as so determined) of standard  
2 coverage.

3 “(B) ASSURING EQUIVALENT UNSUBSIDIZED  
4 VALUE OF COVERAGE.—The unsubsidized value of the  
5 coverage is at least equal to the unsubsidized value of  
6 standard coverage. For purposes of this subparagraph,  
7 the unsubsidized value of coverage is the amount by  
8 which the actuarial value of the coverage (as deter-  
9 mined under subsection (e)) exceeds the actuarial value  
10 of the subsidy payments under section 1860H with re-  
11 spect to such coverage.

12 “(C) ASSURING STANDARD PAYMENT FOR COSTS  
13 AT INITIAL COVERAGE LIMIT.—The coverage is de-  
14 signed, based upon an actuarially representative pat-  
15 tern of utilization (as determined under subsection (e)),  
16 to provide for the payment, with respect to costs in-  
17 curred that are equal to the initial coverage limit under  
18 subsection (b)(3), of an amount equal to at least the  
19 sum of the following products:

20 “(i) FIRST COPAYMENT RANGE.—The product  
21 of—

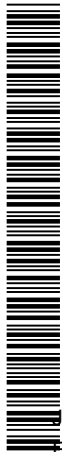
22 “(I) the amount by which the initial co-  
23 payment threshold described in subsection  
24 (b)(2)(C) exceeds the deductible described in  
25 subsection (b)(1); and

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

29 “(ii) SECONDARY COPAYMENT RANGE.—The  
30 product of—

31 “(I) the amount by which the initial cov-  
32 erage limit described in subsection (b)(3) ex-  
33 ceeds the initial copayment threshold described  
34 in subsection (b)(2)(C); and

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



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

4           “(d) ACCESS TO NEGOTIATED PRICES.—

5           “(1) IN GENERAL.—Under qualified prescription drug  
6           coverage offered by a PDP sponsor or a Medicare+ Choice  
7           organization, the sponsor or organization shall provide  
8           beneficiaries with access to negotiated prices (including ap-  
9           plicable discounts) used for payment for covered outpatient  
10          drugs, regardless of the fact that no benefits may be pay-  
11          able under the coverage with respect to such drugs because  
12          of the application of cost-sharing or an initial coverage  
13          limit (described in subsection (b)(3)). Insofar as a State  
14          elects to provide medical assistance under title XIX for a  
15          drug based on the prices negotiated by a prescription drug  
16          plan under this part, the requirements of section 1927 shall  
17          not apply to such drugs. The prices negotiated by a pre-  
18          scription drug plan under this part, by a Medicare+ Choice  
19          plan with respect to covered outpatient drugs, or by a  
20          qualified retiree prescription drug plan (as defined in sec-  
21          tion 1860H(f)(1)) with respect to such drugs on behalf of  
22          individuals entitled to benefits under part A or enrolled  
23          under part B, shall (notwithstanding any other provision of  
24          law) not be taken into account for the purposes of estab-  
25          lishing the best price under section 1927(c)(1)(C).

26          “(2) DISCLOSURE.—The PDP sponsor or  
27          Medicare+ Choice organization shall disclose to the Admin-  
28          istrator (in a manner specified by the Administrator) the  
29          extent to which discounts or rebates made available to the  
30          sponsor or organization by a manufacturer are passed  
31          through to enrollees through pharmacies and other dis-  
32          pensers or otherwise. The provisions of section  
33          1927(b)(3)(D) shall apply to information disclosed to the  
34          Administrator under this paragraph in the same manner as  
35          such provisions apply to information disclosed under such  
36          section.



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

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

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

7           “(i) an actuarial valuation of standard cov-  
8 erage and of the reinsurance subsidy payments  
9 under section 1860H;

10           “(ii) the use of generally accepted actuarial  
11 principles and methodologies; and

12           “(iii) applying the same methodology for de-  
13 terminations of alternative coverage under sub-  
14 section (c) as is used with respect to determina-  
15 tions of standard coverage under subsection (b);  
16 and

17           “(B) for determining annual percentage increases  
18 described in subsection (b)(5).

19           “(2) USE OF OUTSIDE ACTUARIES.—Under the proc-  
20 esses under paragraph (1)(A), PDP sponsors and  
21 Medicare+ Choice organizations may use actuarial opinions  
22 certified by independent, qualified actuaries to establish ac-  
23 tuarial values, but the Administrator shall determine  
24 whether such actuarial values meet the requirements under  
25 subsection (c)(1).

26           “(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

33           “(B) a biological product described in clauses (i)  
34 through (iii) of subparagraph (B) of such section or in-  
35 sulin described in subparagraph (C) of such section,  
36 and such term includes a vaccine licensed under section  
37 351 of the Public Health Service Act and any use of a cov-



1           ered outpatient drug for a medically accepted indication (as  
2           defined in section 1927(k)(6)).

3           “(2) EXCLUSIONS.—

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

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

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

22           “(4) APPLICATION OF GENERAL EXCLUSION PROVI-  
23           SIONS.—A prescription drug plan or Medicare+ Choice plan  
24           may exclude from qualified prescription drug coverage any  
25           covered outpatient drug—

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

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

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

32           **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALI-**  
33           **FIED PRESCRIPTION DRUG COVERAGE.**

34           “(a) GUARANTEED ISSUE, COMMUNITY-RELATED PRE-  
35           MIUMS, ACCESS TO NEGOTIATED PRICES, AND NON-  
36           DISCRIMINATION.—For provisions requiring guaranteed issue,  
37           community-rated premiums, access to negotiated prices, and



1 nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2),  
2 1860B(d), and 1860F(b), respectively.

3 “(b) DISSEMINATION OF INFORMATION.—

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

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

13 “(B) How any formulary used by the sponsor  
14 functions.

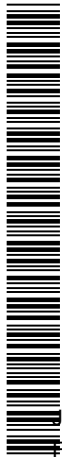
15 “(C) Co-payments and deductible requirements,  
16 including the identification of the tiered or other co-  
17 payment level applicable to each drug (or class of  
18 drugs).

19 “(D) Grievance and appeals procedures.

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

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

32 “(4) CLAIMS INFORMATION.—Each PDP sponsor of-  
33 fering a prescription drug plan must furnish to enrolled in-  
34 dividuals in a form easily understandable to such individ-  
35 uals an explanation of benefits (in accordance with section  
36 1806(a) or in a comparable manner) and a notice of the  
37 benefits in relation to initial coverage limit and annual out-



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

4 “(c) ACCESS TO COVERED BENEFITS.—

5 “(1) ASSURING PHARMACY ACCESS.—

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

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

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

21 “(ii) the plan may charge beneficiaries through  
22 adjustments in premiums and copayments any ad-  
23 ditional costs associated with the point-of-service  
24 option.

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

27 “(2) USE OF STANDARDIZED TECHNOLOGY.—

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

35 “(B) STANDARDS.—

36 “(i) DEVELOPMENT.—The Administrator shall  
37 provide for the development of national standards



1 relating to a standardized format for the card or  
2 other technology referred to in subparagraph (A).  
3 Such standards shall be compatible with standards  
4 established under part C of title XI.

5 “(ii) APPLICATION OF ADVISORY TASK  
6 FORCE.—The advisory task force established under  
7 subsection (d)(3)(B)(ii) shall provide recommenda-  
8 tions to the Administrator under such subsection  
9 regarding the standards developed under clause (i).

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

14 “(A) PHARMACY AND THERAPEUTIC (P&T) COM-  
15 MITTEE.—The sponsor must establish a pharmacy and  
16 therapeutic committee that develops and reviews the  
17 formulary. Such committee shall include at least one  
18 physician and at least one pharmacist both with exper-  
19 tise in the care of elderly or disabled persons and a ma-  
20 jority of its members shall consist of individuals who  
21 are a physician or a pharmacist (or both).

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

30 “(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC  
31 CATEGORIES.—The formulary must include drugs with-  
32 in each therapeutic category and class of covered out-  
33 patient drugs (although not necessarily for all drugs  
34 within such categories and classes).

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



## 24

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

5           “(F) GRIEVANCES AND APPEALS RELATING TO AP-  
6 PPLICATION OF FORMULARIES.—For provisions relating  
7 to grievances and appeals of coverage, see subsections  
8 (e) and (f).

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

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

13           “(A) an effective cost and drug utilization man-  
14 agement program, including medically appropriate in-  
15 centives to use generic drugs and therapeutic inter-  
16 change, when appropriate;

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

23           “(C) a program to control fraud, abuse, and  
24 waste.

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

28           “(2) MEDICATION THERAPY MANAGEMENT PRO-  
29 GRAM.—

30           “(A) IN GENERAL.—A medication therapy man-  
31 agement program described in this paragraph is a pro-  
32 gram of drug therapy management and medication ad-  
33 ministration that is designed to assure, with respect to  
34 beneficiaries with chronic diseases (such as diabetes,  
35 asthma, hypertension, and congestive heart failure) or  
36 multiple prescriptions, that covered outpatient drugs  
37 under the prescription drug plan are appropriately used





1 to achieve therapeutic goals and reduce the risk of ad-  
2 verse events, including adverse drug interactions.

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

4 “(i) enhanced beneficiary understanding of  
5 such appropriate use through beneficiary education,  
6 counseling, and other appropriate means;

7 “(ii) increased beneficiary adherence with pre-  
8 scription medication regimens through medication  
9 refill reminders, special packaging, and other ap-  
10 propriate means; and

11 “(iii) detection of patterns of overuse and  
12 underuse of prescription drugs.

13 “(C) DEVELOPMENT OF PROGRAM IN COOPERA-  
14 TION WITH LICENSED PHARMACISTS.—The program  
15 shall be developed in cooperation with licensed phar-  
16 macists and physicians.

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

23 “(3) ELECTRONIC PRESCRIPTION PROGRAM.—

24 “(A) IN GENERAL.—An electronic prescription  
25 drug program described in this paragraph is a program  
26 that includes at least the following components, con-  
27 sistent with national standards established under sub-  
28 paragraph (B):

29 “(i) ELECTRONIC TRANSMITTAL OF PRESCRIP-  
30 TIONS.—Prescriptions are only received electroni-  
31 cally, except in emergency cases and other excep-  
32 tional circumstances recognized by the Adminis-  
33 trator.

34 “(ii) PROVISION OF INFORMATION TO PRE-  
35 SCRIBING HEALTH CARE PROFESSIONAL.—The pro-  
36 gram provides, upon transmittal of a prescription  
37 by a prescribing health care professional, for trans-



1           mittal by the pharmacist to the professional of in-  
2           formation that includes—

3                   “(I) information (to the extent available  
4                   and feasible) on the drugs being prescribed for  
5                   that patient and other information relating to  
6                   the medical history or condition of the patient  
7                   that may be relevant to the appropriate pre-  
8                   scription for that patient;

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

11                   “(III) information on the drugs included  
12                   in the applicable formulary.

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

17           “(B) STANDARDS.—

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

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

34                           “(I) The range of available computerized  
35                           prescribing software and hardware and their  
36                           costs to develop and implement.



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

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

6                   “(IV) The cost of implementing such sys-  
7                   tems in the range of hospital and physician of-  
8                   fice settings, including hardware, software, and  
9                   training costs.

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

15                  “(iii) DEADLINES.—

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

19                         “(II) Such task force shall submit rec-  
20                         ommendations to Administrator by not later  
21                         than January 1, 2004.

22                         “(III) The Administrator shall develop and  
23                         promulgate the national standards referred to  
24                         in clause (ii) by not later than January 1,  
25                         2005.

26                         “(C) REFERENCE TO AVAILABILITY OF GRANT  
27                         FUNDS.—Grant funds are authorized under section  
28                         3990 of the Public Health Service Act to provide as-  
29                         sistance to health care providers in implementing elec-  
30                         tronic prescription drug programs.

31                         “(4) TREATMENT OF ACCREDITATION.—Section  
32                         1852(e)(4) (relating to treatment of accreditation) shall  
33                         apply to prescription drug plans under this part with re-  
34                         spect to the following requirements, in the same manner as  
35                         they apply to Medicare+ Choice plans under part C with re-  
36                         spect to the requirements described in a clause of section  
37                         1852(e)(4)(B):



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

4           “(B) Subsection (c)(1) (relating to access to cov-  
5           ered benefits).

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

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

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

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

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

33                 “(3) REQUEST FOR REVIEW OF TIERED FORMULARY  
34                 DETERMINATIONS.—In the case of a prescription drug plan  
35                 offered by a PDP sponsor that provides for tiered cost-  
36                 sharing for drugs included within a formulary and provides  
37                 lower cost-sharing for preferred drugs included within the



1 formulary, an individual who is enrolled in the plan may re-  
2 quest coverage of a nonpreferred drug under the terms ap-  
3 plicable for preferred drugs if the prescribing physician de-  
4 termines that the preferred drug for treatment of the same  
5 condition is not as effective for the individual or has ad-  
6 verse effects for the individual.

7 “(f) APPEALS.—

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

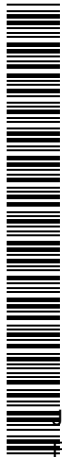
15 “(2) FORMULARY DETERMINATIONS.—An individual  
16 who is enrolled in a prescription drug plan offered by a  
17 PDP sponsor may appeal to obtain coverage for a covered  
18 outpatient drug that is not on a formulary of the sponsor  
19 if the prescribing physician determines that the formulary  
20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

22 “(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE  
23 RECORDS.—A PDP sponsor shall meet the requirements of sec-  
24 tion 1852(h) with respect to enrollees under this part in the  
25 same manner as such requirements apply to a  
26 Medicare+ Choice organization with respect to enrollees under  
27 part C.

28 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**  
29 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**  
30 **LISHMENT OF STANDARDS.**

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

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



1           “(2) ASSUMPTION OF FINANCIAL RISK.—

2                   “(A) IN GENERAL.—Subject to subparagraph (B)  
3 and section 1860E(d)(2), the entity assumes full finan-  
4 cial risk on a prospective basis for qualified prescrip-  
5 tion drug coverage that it offers under a prescription  
6 drug plan and that is not covered under section  
7 1860H.

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

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

16           “(b) CONTRACT REQUIREMENTS.—

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

29                   “(2) NEGOTIATION REGARDING TERMS AND CONDI-  
30 TIONS.—The Administrator shall have the same authority  
31 to negotiate the terms and conditions of prescription drug  
32 plans under this part as the Director of the Office of Per-  
33 sonnel Management has with respect to health benefits  
34 plans under chapter 89 of title 5, United States Code. In  
35 negotiating the terms and conditions regarding premiums  
36 for which information is submitted under section  
37 1860F(a)(2), the Administrator shall take into account the



1 subsidy payments under section 1860H and the adjusted  
2 community rate (as defined in section 1854(f)(3)) for the  
3 benefits covered.

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

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

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

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

15 “(D) ADDITIONAL CONTRACT TERMS.—Section  
16 1857(e); except that in applying section 1857(e)(2)  
17 under this part—

18 “(i) such section shall be applied separately to  
19 costs relating to this part (from costs under part  
20 C);

21 “(ii) in no case shall the amount of the fee es-  
22 tablished under this subparagraph for a plan ex-  
23 ceed 20 percent of the maximum amount of the fee  
24 that may be established under subparagraph (B) of  
25 such section; and

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

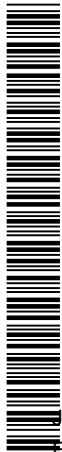
28 “(E) INTERMEDIATE SANCTIONS.—Section  
29 1857(g).

30 “(F) PROCEDURES FOR TERMINATION.—Section  
31 1857(h).

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

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

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



1 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND  
2 CHOICE.—

3 “(1) IN GENERAL.—In the case of an entity that seeks  
4 to offer a prescription drug plan in a State, the Adminis-  
5 trator shall waive the requirement of subsection (a)(1) that  
6 the entity be licensed in that State if the Administrator de-  
7 termines, based on the application and other evidence pre-  
8 sented to the Administrator, that any of the grounds for  
9 approval of the application described in paragraph (2) has  
10 been met.

11 “(2) GROUNDS FOR APPROVAL.—The grounds for ap-  
12 proval under this paragraph are the grounds for approval  
13 described in subparagraph (B), (C), and (D) of section  
14 1855(a)(2), and also include the application by a State of  
15 any grounds other than those required under Federal law.

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

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

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

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

32 “(B) any reference to solvency standards shall be  
33 treated as a reference to solvency standards established  
34 under subsection (d).

35 “(d) SOLVENCY STANDARDS FOR NON-LICENSED SPON-  
36 SORS.—





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

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

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

19          “(f) RELATION TO STATE LAWS.—

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

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

32                 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**  
 33                 **QUALIFIED PRESCRIPTION DRUG COV-**  
 34                 **ERAGE.**

35                 “(a) IN GENERAL.—The Administrator shall establish a  
 36                 process for the selection of the prescription drug plan or  
 37                 Medicare+ Choice plan which offer qualified prescription drug



1 coverage through which eligible individuals elect qualified pre-  
2 scription drug coverage under this part.

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

5 “(1) Annual, coordinated election periods, in which  
6 such individuals can change the qualifying plans through  
7 which they obtain coverage, in accordance with section  
8 1860A(b)(2).

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

15 “(3) Coordination of elections through filing with a  
16 Medicare+ Choice organization or a PDP sponsor, in the  
17 manner described in (and in coordination with) section  
18 1851(c)(2).

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

25 “(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRE-  
26 SCRIPTON DRUG COVERAGE.—

27 “(1) CHOICE OF AT LEAST TWO PLANS IN EACH  
28 AREA.—

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



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

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

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

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

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

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

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

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



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

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

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

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

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

13             “(B) Information on the actuarial value of the cov-  
14    erage.

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

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

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

20                 “(iii) the reduction in such bid resulting from  
21    the subsidy payments provided under section  
22    1860H.

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

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

28             “(b) UNIFORM BID.—

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

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

35             “(c) COLLECTION.—

36             “(1) USE AT BENEFICIARY’S OPTION OF WITH-  
37    HOLDING FROM SOCIAL SECURITY PAYMENT AND USE OF



1 ELECTRONIC FUNDS TRANSFER MECHANISM.—In accord-  
2 ance with regulations, a PDP sponsor shall permit each en-  
3 rollee, at the enrollee's option, to make payment of pre-  
4 miums through withholding from benefit payments in the  
5 manner provided under section 1840 with respect to  
6 monthly premiums under section 1839. In the case in  
7 which an enrollee does not elect such option, a PDP spon-  
8 sor may, in accordance with regulations, encourage enroll-  
9 ees to make payment of the premium established by the  
10 plan under this part through an electronic funds transfer  
11 mechanism, such as automatic charges of an account at a  
12 financial institution or a credit or debit card account. All  
13 such amounts shall be credited to the Medicare Prescrip-  
14 tion Drug Trust Fund.

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

19 “(3) PAYMENT OF PLANS.—PDP plans shall receive  
20 payment based on bid amounts in the same manner as  
21 Medicare+ Choice organizations receive payment based on  
22 bid amounts under section 1853(a)(1)(A)(ii) except that  
23 such payment shall be made from the Medicare Prescrip-  
24 tion Drug Trust Fund.

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

28 “(1) IN GENERAL.—If there is no standard prescrip-  
29 tion drug coverage (as defined in paragraph (2)) offered in  
30 an area, in the case of an individual who is eligible for a  
31 premium subsidy under section 1860G and resides in the  
32 area, the PDP sponsor of any prescription drug plan of-  
33 fered in the area (and any Medicare+ Choice organization  
34 that offers qualified prescription drug coverage in the area)  
35 shall accept the benchmark bid amount (under section  
36 1860G(b)(2)) as payment in full for the premium charge  
37 for qualified prescription drug coverage.



1           “(2) STANDARD PRESCRIPTION DRUG COVERAGE DE-  
2           FINED.—For purposes of this subsection, the term ‘stand-  
3           ard prescription drug coverage’ means qualified prescrip-  
4           tion drug coverage that is standard coverage or that has  
5           an actuarial value equivalent to the actuarial value for  
6           standard coverage.

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

9           “(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS  
10          WITH INCOME BELOW 175 PERCENT OF FEDERAL POVERTY  
11          LEVEL.—

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

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

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

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

36           “(A) an income-related premium subsidy deter-  
37          mined on a linear sliding scale ranging from 100 per-



1 cent of the amount described in subsection (b)(1) for  
 2 individuals with incomes at 150 percent of such level  
 3 to 0 percent of such amount for individuals with in-  
 4 comes at 175 percent of such level; and

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

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

15 “(4) DETERMINATION OF ELIGIBILITY.—

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

20 “(i) is eligible to elect, and has elected, to ob-  
 21 tain qualified prescription drug coverage under this  
 22 part;

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

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

27 “(B) DETERMINATIONS.—The determination of  
 28 whether an individual residing in a State is a subsidy  
 29 eligible individual and the amount of such individual’s  
 30 income shall be determined under the State medicaid  
 31 plan for the State under section 1935(a) or by the So-  
 32 cial Security Administration. In the case of a State  
 33 that does not operate such a medicaid plan (either  
 34 under title XIX or under a statewide waiver granted  
 35 under section 1115), such determination shall be made  
 36 under arrangements made by the Administrator. There  
 37 are authorized to be appropriated to the Social Security



1 Administration such sums as may be necessary for the  
2 determination of eligibility under this subparagraph.

3 “(C) INCOME DETERMINATIONS.—For purposes of  
4 applying this section—

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

7 “(ii) the term ‘Federal poverty line’ means the  
8 official poverty line (as defined by the Office of  
9 Management and Budget, and revised annually in  
10 accordance with section 673(2) of the Omnibus  
11 Budget Reconciliation Act of 1981) applicable to a  
12 family of the size involved.

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

19 “(E) TREATMENT OF CONFORMING MEDIGAP  
20 POLICIES.—For purposes of this section, the term  
21 ‘qualified prescription drug coverage’ includes a medi-  
22 care supplemental policy described in section  
23 1860H(b)(4).

24 “(5) INDEXING DOLLAR AMOUNTS.—

25 “(A) FOR 2006.—The dollar amounts applied  
26 under paragraphs (1)(B) and (2)(B) for 2006 shall be  
27 the dollar amounts specified in such paragraph in-  
28 creased by the annual percentage increase described in  
29 section 1860B(b)(5) for 2006.

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





## 41

1 “(b) PREMIUM SUBSIDY AMOUNT.—

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

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

12 “(A) a prescription drug plan that—

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

20 “(ii) provides alternative prescription drug  
21 coverage the actuarial value of which is greater  
22 than that of standard coverage, the bid amount de-  
23 scribed in clause (i) multiplied by the ratio of (I)  
24 the actuarial value of standard coverage, to (II) the  
25 actuarial value of the alternative coverage; or

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

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

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

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



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

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

12           “(1) the Administrator provides for a notification of  
 13           the PDP sponsor or Medicare+ Choice organization in-  
 14           volved that the individual is eligible for a subsidy and the  
 15           amount of the subsidy under subsection (a);

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

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

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

28           “(e) RELATION TO MEDICAID PROGRAM.—

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

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

36           “(3) COORDINATION.—The Administrator shall de-  
 37           velop and implement a plan for the coordination of pre-



1       scription drug benefits under this part with the benefits  
 2       provided under the medicaid program under title XIX, with  
 3       particular attention to insuring coordination of payments  
 4       and prevention of fraud and abuse. In developing and im-  
 5       plementing such plan, the Administrator shall involve the  
 6       Secretary, the States, the data processing industry, phar-  
 7       macists, and pharmaceutical manufacturers, and other ex-  
 8       perts.

9       **“SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**  
 10       **FICIARIES FOR QUALIFIED PRESCRIPTION**  
 11       **DRUG COVERAGE.**

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

21       “(1) DIRECT SUBSIDY.—In the case of an individual  
 22       enrolled in a prescription drug plan, Medicare+ Choice plan  
 23       that provides qualified prescription drug coverage, or quali-  
 24       fied retiree prescription drug plan, a direct subsidy equal  
 25       to 35 percent of the total payments made by a qualifying  
 26       entity for standard coverage under the respective plan.

27       “(2) SUBSIDY THROUGH REINSURANCE.—The reinsur-  
 28       ance payment amount (as defined in subsection (c)), which  
 29       in the aggregate is 30 percent of such total payments, for  
 30       excess costs incurred in providing qualified prescription  
 31       drug coverage—

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

34       “(B) for individuals enrolled with a  
 35       Medicare+ Choice plan that provides qualified prescrip-  
 36       tion drug coverage; and



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

3       This section constitutes budget authority in advance of appro-  
4       priations Acts and represents the obligation of the Adminis-  
5       trator to provide for the payment of amounts provided under  
6       this section.

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

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

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

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

19           “(c) REINSURANCE PAYMENT AMOUNT.—

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

25           “(A) For the portion of the individual’s gross cov-  
26      ered prescription drug costs (as defined in paragraph  
27      (3)) for the year that exceeds the initial copayment  
28      threshold specified in section 1860B(b)(2)(C), but does  
29      not exceed the initial coverage limit specified in section  
30      1860B(b)(3), an amount equal to 30 percent of the al-  
31      lowable costs (as defined in paragraph (2)) attributable  
32      to such gross covered prescription drug costs.

33           “(B) For the portion of the individual’s gross cov-  
34      ered prescription drug costs for the year that exceeds  
35      the annual out-of-pocket threshold specified in  
36      1860B(b)(4)(B), an amount equal to 80 percent of the



1           allowable costs attributable to such gross covered pre-  
2           scription drug costs.

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

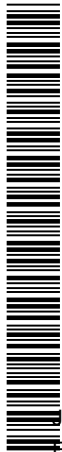
12          “(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—  
13          For purposes of this section, the term ‘gross covered pre-  
14          scription drug costs’ means, with respect to an enrollee  
15          with a qualifying entity under a plan described in sub-  
16          section (b) during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

24          “(4) INDEXING DOLLAR AMOUNTS.—

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

28                  “(B) FOR 2006.—The dollar amounts applied  
29                  under paragraph (1) for 2006 shall be the dollar  
30                  amounts specified in such paragraph increased by the  
31                  annual percentage increase described in section  
32                  1860B(b)(5) for 2006.

33                  “(C) FOR SUBSEQUENT YEARS.—The dollar  
34                  amounts applied under paragraph (1) for a year after  
35                  2006 shall be the amounts (under this paragraph) ap-  
36                  plied under paragraph (1) for the preceding year in-  
37                  creased by the annual percentage increase described in



1 section 1860B(b)(5) (relating to growth in medicare  
2 prescription drug costs per beneficiary) for the year in-  
3 volved.

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

8 “(d) ADJUSTMENT OF PAYMENTS.—

9 “(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO  
10 ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REIN-  
11 SURANCE.—

12 “(A) ESTIMATION OF PAYMENTS.—The Adminis-  
13 trator shall estimate—

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

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

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

26 “(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To  
27 the extent the Administrator determines it appropriate to  
28 avoid risk selection, the payments made for direct subsidies  
29 under subsection (a)(1) are subject to adjustment based  
30 upon risk factors specified by the Administrator. Any such  
31 risk adjustment shall be designed in a manner as to not re-  
32 sult in a change in the aggregate payments made under  
33 such subsection.

34 “(e) PAYMENT METHODS.—

35 “(1) IN GENERAL.—Payments under this section shall  
36 be based on such a method as the Administrator deter-  
37 mines. The Administrator may establish a payment method



1 by which interim payments of amounts under this section  
2 are made during a year based on the Administrator's best  
3 estimate of amounts that will be payable after obtaining all  
4 of the information.

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

8 "(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DE-  
9 FINED.—

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

16 "(A) ASSURANCE.—The sponsor of the plan shall  
17 annually attest, and provide such assurances as the Ad-  
18 ministrator may require, that the coverage meets or ex-  
19 ceeds the requirements for qualified prescription drug  
20 coverage.

21 "(B) AUDITS.—The sponsor (and the plan) shall  
22 maintain, and afford the Administrator access to, such  
23 records as the Administrator may require for purposes  
24 of audits and other oversight activities necessary to en-  
25 sure the adequacy of prescription drug coverage, and  
26 the accuracy of payments made.

27 "(C) PROVISION OF CERTIFICATION OF PRESCRIP-  
28 TION DRUG COVERAGE.—The sponsor of the plan shall  
29 provide for issuance of certifications of the type de-  
30 scribed in section 1860A(c)(2)(D).

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

35 "(A) enrolled under this part;

36 "(B) is covered under the plan; and



1           “(C) is eligible to obtain qualified prescription  
2 drug coverage under section 1860A but did not elect  
3 such coverage under this part (either through a pre-  
4 scription drug plan or through a Medicare+ Choice  
5 plan).

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

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

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

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

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

21           “(A) is enrolled with a prescription drug plan  
22 under this part;

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

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

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

32           **“SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST**  
33           **FUND.**

34           “(a) IN GENERAL.—There is created on the books of the  
35 Treasury of the United States a trust fund to be known as the  
36 ‘Medicare Prescription Drug Trust Fund’ (in this section re-  
37 ferred to as the ‘Trust Fund’). The Trust Fund shall consist





1 of such gifts and bequests as may be made as provided in sec-  
 2 tion 201(i)(1), and such amounts as may be deposited in, or  
 3 appropriated to, such fund as provided in this part. Except as  
 4 otherwise provided in this section, the provisions of subsections  
 5 (b) through (i) of section 1841 shall apply to the Trust Fund  
 6 in the same manner as they apply to the Federal Supple-  
 7 mentary Medical Insurance Trust Fund under such section.

8 “(b) PAYMENTS FROM TRUST FUND.—

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

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

14 “(B) payments under section 1860H (relating to  
 15 subsidy payments); and

16 “(C) payments with respect to administrative ex-  
 17 penses under this part in accordance with section  
 18 201(g).

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

26 “(c) DEPOSITS INTO TRUST FUND.—

27 “(1) LOW-INCOME TRANSFER.—There is hereby trans-  
 28 ferred to the Trust Fund, from amounts appropriated for  
 29 Grants to States for Medicaid, amounts equivalent to the  
 30 aggregate amount of the reductions in payments under sec-  
 31 tion 1903(a)(1) attributable to the application of section  
 32 1935(c).

33 “(2) APPROPRIATIONS TO COVER GOVERNMENT CON-  
 34 TRIBUTIONS.—There are authorized to be appropriated  
 35 from time to time, out of any moneys in the Treasury not  
 36 otherwise appropriated, to the Trust Fund, an amount  
 37 equivalent to the amount of payments made from the Trust



1 Fund under subsection (b), reduced by the amount trans-  
2 ferred to the Trust Fund under paragraph (1).

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

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

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

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

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

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

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

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

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

29 “(B) provides qualified prescription drug coverage;  
30 and

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

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

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



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

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

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

10           “(3) any reference to a contract under section 1857  
11 included a reference to a contract under section 1860D(b);  
12 and

13           “(4) any reference to part C included a reference to  
14 this part.”.

15           (b) ADDITIONAL CONFORMING CHANGES.—

16           (1) CONFORMING REFERENCES TO PREVIOUS PART  
17 D.—Any reference in law (in effect before the date of the  
18 enactment of this Act) to part D of title XVIII of the So-  
19 cial Security Act is deemed a reference to part E of such  
20 title (as in effect after such date).

21           (2) CONFORMING AMENDMENT PERMITTING WAIVER  
22 OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C.  
23 1320a-7b(b)(3)) is amended—

24           (A) by striking “and” at the end of subparagraph  
25 (E);

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

28           (C) by adding at the end the following new sub-  
29 paragraph:

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

32           (3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not  
33 later than 6 months after the date of the enactment of this  
34 Act, the Secretary of Health and Human Services shall  
35 submit to the appropriate committees of Congress a legisla-  
36 tive proposal providing for such technical and conforming



1 amendments in the law as are required by the provisions  
2 of this subtitle.

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

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

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

15 “(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

16 “(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COV-  
17 ERAGE.—

18 “(A) IN GENERAL.—A Medicare+ Choice organiza-  
19 tion may not offer prescription drug coverage (other  
20 than that required under parts A and B) to an enrollee  
21 under a Medicare+ Choice plan unless such drug cov-  
22 erage is at least qualified prescription drug coverage  
23 and unless the requirements of this subsection with re-  
24 spect to such coverage are met.

25 “(B) CONSTRUCTION.—Nothing in this subsection  
26 shall be construed as—

27 “(i) requiring a Medicare+ Choice plan to in-  
28 clude coverage of qualified prescription drug cov-  
29 erage; or

30 “(ii) permitting a Medicare+ Choice organiza-  
31 tion from providing such coverage to an individual  
32 who has not elected such coverage under section  
33 1860A(b).

34 For purposes of this part, an individual who has not  
35 elected qualified prescription drug coverage under sec-  
36 tion 1860A(b) shall be treated as being ineligible to en-



1 roll in a Medicare+ Choice plan under this part that of-  
2 fers such coverage.

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

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

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

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

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

34 “(5) QUALIFIED PRESCRIPTION DRUG COVERAGE;  
35 STANDARD COVERAGE.—For purposes of this part, the  
36 terms ‘qualified prescription drug coverage’ and ‘standard



1 coverage' have the meanings given such terms in section  
2 1860B.'".

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

5 (1) in subsection (a)(1)—

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

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

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

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

14 (2) in subsection (g)(1), by inserting “and section  
15 1860A(c)(2)(B)” after “in this subsection”.

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

18 **SEC. 103. MEDICAID AMENDMENTS.**

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

21 (1) REQUIREMENT.—Section 1902(a) (42 U.S.C.  
22 1396a(a)) is amended—

23 (A) by striking “and” at the end of paragraph  
24 (64);

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

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

29 “(66) provide for making eligibility determinations  
30 under section 1935(a).”.

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

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

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



1 "SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION  
2 DRUG BENEFIT

3 "SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY  
4 DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condi-  
5 tion of its State plan under this title under section 1902(a)(66)  
6 and receipt of any Federal financial assistance under section  
7 1903(a), a State shall—

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

11 "(2) inform the Administrator of the Medicare Bene-  
12 fits Administration of such determinations in cases in  
13 which such eligibility is established; and

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

17 "(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE  
18 COSTS.—

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

27 "(A) For expenditures attributable to costs in-  
28 curred during 2005, the otherwise applicable Federal  
29 matching rate shall be increased by 10 percent of the  
30 percentage otherwise payable (but for this subsection)  
31 by the State.

32 "(B)(i) For expenditures attributable to costs in-  
33 curred during 2006 and each subsequent year through  
34 2013, the otherwise applicable Federal matching rate  
35 shall be increased by the applicable percent (as defined  
36 in clause (ii)) of the percentage otherwise payable (but  
37 for this subsection) by the State.



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

3           “(I) 2006 is 20 percent; or

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

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

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

15          (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RE-  
16 SPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES  
17 FOR DUALY ELIGIBLE INDIVIDUALS.—

18           (1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C.  
19 1396b(a)(1)) is amended by inserting before the semicolon  
20 the following: “, reduced by the amount computed under  
21 section 1935(c)(1) for the State and the quarter”.

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

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

27           “(1) IN GENERAL.—For purposes of section  
28 1903(a)(1), for a State that is one of the 50 States or the  
29 District of Columbia for a calendar quarter in a year (be-  
30 ginning with 2005) the amount computed under this sub-  
31 section is equal to the product of the following:

32           “(A) MEDICARE SUBSIDIES.—The total amount of  
33 payments made in the quarter under section 1860G  
34 (relating to premium and cost-sharing prescription  
35 drug subsidies for low-income medicare beneficiaries)  
36 that are attributable to individuals who are residents of  
37 the State and are entitled to benefits with respect to





1 prescribed drugs under the State plan under this title  
2 (including such a plan operating under a waiver under  
3 section 1115).

4 “(B) STATE MATCHING RATE.—A proportion com-  
5 puted by subtracting from 100 percent the Federal  
6 medical assistance percentage (as defined in section  
7 1905(b)) applicable to the State and the quarter.

8 “(C) PHASE-OUT PROPORTION.—The phase-out  
9 proportion (as defined in paragraph (2)) for the quar-  
10 ter.

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

14 “(A) 2005 is 90 percent;

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

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

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

22 “(d) ADDITIONAL PROVISIONS.—

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

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



(d) TREATMENT OF TERRITORIES.—

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

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

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

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

“(e) TREATMENT OF TERRITORIES.—

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

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

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

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

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

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

“(3) INCREASED AMOUNT.—

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

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



1 “(ii) the amount specified in section  
2 1108(g)(1) for that State, divided by the sum of  
3 the amounts specified in such section for all such  
4 States.

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

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

8 “(ii) a subsequent year, is equal to the aggre-  
9 gate amount specified in this subparagraph for the  
10 previous year increased by annual percentage in-  
11 crease specified in section 1860B(b)(5) for the year  
12 involved.

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

17 (2) CONFORMING AMENDMENT.—Section 1108(f) (42  
18 U.S.C. 1308(f)) is amended by inserting “and section  
19 1935(e)(1)(B)” after “Subject to subsection (g)”.

20 **SEC. 104. MEDIGAP TRANSITION.**

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

23 “(v) COVERAGE OF PRESCRIPTION DRUGS.—

24 “(1) IN GENERAL.—Notwithstanding any other provi-  
25 sion of law, except as provided in paragraph (3) no new  
26 medicare supplemental policy that provides coverage of ex-  
27 penses for prescription drugs may be issued under this sec-  
28 tion on or after January 1, 2005, to an individual unless  
29 it replaces a medicare supplemental policy that was issued  
30 to that individual and that provided some coverage of ex-  
31 penses for prescription drugs.

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

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

36 “(i) may not deny or condition the issuance or  
37 effectiveness of a medicare supplemental policy that



1 has a benefit package classified as 'A', 'B', 'C', 'D',  
2 'E', 'F', or 'G' (under the standards established  
3 under subsection (p)(2)) and that is offered and is  
4 available for issuance to new enrollees by such  
5 issuer;

6 "(ii) may not discriminate in the pricing of  
7 such policy, because of health status, claims experi-  
8 ence, receipt of health care, or medical condition;  
9 and

10 "(iii) may not impose an exclusion of benefits  
11 based on a pre-existing condition under such policy,  
12 in the case of an individual described in subparagraph  
13 (B) who seeks to enroll under the policy not later than  
14 63 days after the date of the termination of enrollment  
15 described in such paragraph and who submits evidence  
16 of the date of termination or disenrollment along with  
17 the application for such medicare supplemental policy.

18 "(B) INDIVIDUAL COVERED.—An individual de-  
19 scribed in this subparagraph is an individual who—

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

22 "(ii) at the time of such enrollment was en-  
23 rolled and terminates enrollment in a medicare sup-  
24 plemental policy which has a benefit package classi-  
25 fied as 'H', 'I', or 'J' under the standards referred  
26 to in subparagraph (A)(i) or terminates enrollment  
27 in a policy to which such standards do not apply  
28 but which provides benefits for prescription drugs.

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

33 "(3) NEW STANDARDS.—In applying subsection  
34 (p)(1)(E) (including permitting the NAIC to revise its  
35 model regulations in response to changes in law) with re-  
36 spect to the change in benefits resulting from title I of the  
37 Medicare Modernization and Prescription Drug Act of



1 2002, with respect to policies issued to individuals who are  
2 enrolled under part D, the changes in standards shall only  
3 provide for substituting for the benefit packages that in-  
4 cluded coverage for prescription drugs two benefit packages  
5 that may provide for coverage of cost-sharing with respect  
6 to qualified prescription drug coverage under such part, ex-  
7 cept that such coverage may not cover the prescription  
8 drug deductible under such part. The two benefit packages  
9 shall be consistent with the following:

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

14 “(i) Coverage of 50 percent of the cost-sharing  
15 otherwise applicable, except coverage of 100 per-  
16 cent of any cost-sharing otherwise applicable for  
17 preventive benefits.

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

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

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

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

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

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

33 “(4) CONSTRUCTION.—Any provision in this section or  
34 in a medicare supplemental policy relating to guaranteed  
35 renewability of coverage shall be deemed to have been met  
36 through the offering of other coverage under this sub-  
37 section.”.



1     **SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT**  
2             **CARD ENDORSEMENT PROGRAM.**

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

5             “MEDICARE PRESCRIPTION DRUG DISCOUNT CARD  
6                             ENDORSEMENT PROGRAM

7             “SEC. 1807. (a) IN GENERAL.—The Secretary (or the  
8 Medicare Benefits Administrator pursuant to section  
9 1808(c)(3)(C)) shall establish a program—

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

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

14             “(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary  
15 may not endorse a prescription drug discount card program  
16 under this section unless the program meets the following re-  
17 quirements:

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

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

25             “(3) BENEFICIARY SERVICES.—The program provides  
26 pharmaceutical support services, such as education and  
27 counseling, and services to prevent adverse drug inter-  
28 actions.

29             “(4) INFORMATION.—The program makes available to  
30 medicare beneficiaries through the Internet and otherwise  
31 information, including information on enrollment fees,  
32 prices charged to beneficiaries, and services offered under  
33 the program, that the Secretary identifies as being nec-  
34 essary to provide for informed choice by beneficiaries  
35 among endorsed programs.



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

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

7           “(7) ADDITIONAL BENEFICIARY PROTECTIONS.—The  
8           program meets such additional requirements as the Sec-  
9           retary identifies to protect and promote the interest of  
10          medicare beneficiaries, including requirements that ensure  
11          that beneficiaries are not charged more than the lower of  
12          the negotiated retail price or the usual and customary  
13          price.

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

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

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

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

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



1           “(5) ENROLLMENT PRACTICES.—A medicare bene-  
2           fiary may not be enrolled in more than one endorsed pro-  
3           gram at any time.

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

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

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

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

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

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

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

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

35                   “(ii) INCLUSION OF COSTS OF VA AND DOD  
36                   MILITARY FACILITY SERVICES TO MEDICARE-ELIGI-





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

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

14 (b) REVISION OF BLEND.—

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

21 (2) CHANGE IN BUDGET NEUTRALITY.—Section  
22 1853(c) (42 U.S.C. 1395w-23(c)) is amended—

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

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

27 (c) REVISION IN MINIMUM PERCENTAGE INCREASE FOR  
28 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C. 1395w-  
29 23(c)(1)(C)) is amended by striking clause (iv) and inserting  
30 the following:

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

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



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

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

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

11                  (2) by adding at the end the following new subpara-  
12                  graph:

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

26                   (e) ANNOUNCEMENT OF REVISED MEDICARE+ CHOICE  
27                   PAYMENT RATES.—Within 2 weeks after the date of the enact-  
28                   ment of this Act, the Secretary shall determine, and shall an-  
29                   nounce (in a manner intended to provide notice to interested  
30                   parties) Medicare+ Choice capitation rates under section 1853  
31                   of the Social Security Act (42 U.S.C. 1395w-23) for 2003, re-  
32                   vised in accordance with the provisions of this section.

33                   (f) MEDPAC STUDY OF AAPCC.—

34                   (1) STUDY.—The Medicare Payment Advisory Com-  
35                   mission shall conduct a study that assesses the method  
36                   used for determining the adjusted average per capita cost  
37                   (AAPCC) under section 1876(a)(4) of the Social Security



1 Act (42 U.S.C. 1395mm(a)(4)). Such study shall  
2 examine—

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

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

9 (C) the accuracy of risk adjustment methods in re-  
10 flecting differences in costs of providing care to dif-  
11 ferent groups of beneficiaries served under such pro-  
12 gram.

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

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

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

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



1 inserting “2002 and each subsequent year (or July 1 of each  
2 year before 2002)”.

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

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

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

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

26 (a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w-  
27 26(b)(3)) is amended to read as follows:

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

15 (e) EFFECTIVE DATES.—

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

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

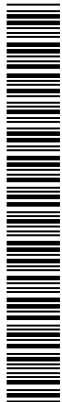
26 **SEC. 205. MEDICARE MSAS.**

27 (a) EXEMPTION FROM REPORTING ENROLLEE ENCOUN-  
28 TER DATA.—

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

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

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



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

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

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

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

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

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

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

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

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

22 (3) by striking clause (iii).

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

25 (a) REASONABLE COST CONTRACTS.—

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

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

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

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



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

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

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

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

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

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

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

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





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

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

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

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

7                           “SUBMISSION OF BID AMOUNTS”;

8                   (2) in subsection (a)(1)(A)—

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

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

15                   (3) by adding at the end of subsection (a) the fol-  
16 lowing:

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

19                           “(A) INFORMATION TO BE SUBMITTED.—The in-  
20 formation described in this subparagraph is as follows:

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

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

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

31   “(II) the provision of statutory prescrip-  
32 tion drug benefits; and

33   “(III) the provision of non-statutory bene-  
34 fits;

35 and the actuarial basis for determining such pro-  
36 portions.



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

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

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

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

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

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

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

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

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

28                   “(C) BENEFICIARY REBATE RULE.—

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



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

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

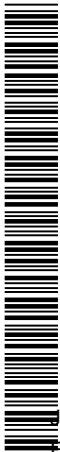
20           (c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

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

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

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

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



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

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

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

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

34 (d) CONFORMING AMENDMENTS.—

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



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

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

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

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

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

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

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

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

35           (4) PERMITTING BENEFICIARY REBATES.—

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



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

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

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

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

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

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

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

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

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

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

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

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





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

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

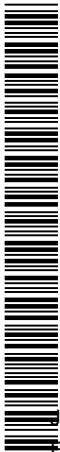
14 “(ii) during March of the previous year at  
15 least 50 percent of the number of Medicare+ Choice  
16 eligible individuals who reside in the area were en-  
17 rolled in a Medicare+ Choice plan.

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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



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

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

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

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

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

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

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

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

35 “(3) The adjustment in the premium under this subsection  
36 shall be effected in such manner as the Medicare Benefits Ad-  
37 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 by inserting “AND BID  
32 AMOUNTS” after “PREMIUMS”;

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

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

37 (b) ADDITIONAL CONFORMING AMENDMENTS.—



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

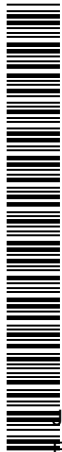
24 (4) PERMITTING GEOGRAPHIC ADJUSTMENT TO CON-  
25 SOLIDATE MULTIPLE MEDICARE+ CHOICE PAYMENT AREAS  
26 IN A STATE INTO A SINGLE STATEWIDE  
27 MEDICARE+ CHOICE PAYMENT AREA.—Section 1853(d)(3)  
28 (42 U.S.C. 1395w-23(e)(3)) is amended—

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

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

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

35 “(B) BUDGET NEUTRALITY ADJUSTMENT.—In the  
36 case of a State requesting an adjustment under this  
37 paragraph, the Medicare Benefits Administrator shall





1 initially (and annually thereafter) adjust the payment  
2 rates otherwise established under this section for  
3 Medicare+ Choice payment areas in the State in a man-  
4 ner so that the aggregate of the payments under this  
5 section in the State shall not exceed the aggregate pay-  
6 ments that would have been made under this section  
7 for Medicare+ Choice payment areas in the State in the  
8 absence of the adjustment under this paragraph.”.

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

## 12 **TITLE III—RURAL HEALTH CARE** 13 **IMPROVEMENTS**

### 14 **SEC. 301. REFERENCE TO FULL MARKET BASKET IN-** 15 **CREASE FOR SOLE COMMUNITY HOSPITALS.**

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

### 19 **SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOS-** 20 **PITAL (DSH) TREATMENT FOR RURAL HOS-** 21 **PITALS AND URBAN HOSPITALS WITH** 22 **FEWER THAN 100 BEDS.**

23 (a) BLENDING OF PAYMENT AMOUNTS.—

24 (1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C.  
25 1395ww(d)(5)(F)) is amended by adding at the end the fol-  
26 lowing new clause:

27 “(xiv)(I) In the case of discharges in a fiscal year begin-  
28 ning on or after October 1, 2002, subject to subclause (II),  
29 there shall be substituted for the disproportionate share adjust-  
30 ment percentage otherwise determined under clause (iv) (other  
31 than subclause (I)) or under clause (viii), (x), (xi), (xii), or  
32 (xiii), the old blend proportion (specified under subclause (III))  
33 of the disproportionate share adjustment percentage otherwise  
34 determined under the respective clause and 100 percent minus  
35 such old blend proportion of the disproportionate share adjust-  
36 ment percentage determined under clause (vii) (relating to  
37 large, urban hospitals).



1 “(II) Under subclause (I), the disproportionate share ad-  
2 justment percentage shall not exceed 10 percent for a hospital  
3 that is not classified as a rural referral center under subpara-  
4 graph (C).

5 “(III) For purposes of subclause (I), the old blend propor-  
6 tion for fiscal year 2003 is 80 percent, for each subsequent  
7 year (through 2006) is the old blend proportion under this sub-  
8 clause for the previous year minus 20 percentage points, and  
9 for each year beginning with 2007 is 0 percent.”.

10 (2) CONFORMING AMENDMENTS.—Section  
11 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

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

15 (B) in clause (viii), by striking “The formula” and  
16 inserting “Subject to clause (xiv), the formula”; and

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

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

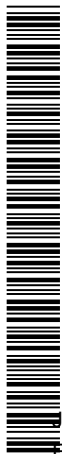
23 **SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STAND-**  
24 **ARDIZED AMOUNT IN RURAL AND SMALL**  
25 **URBAN AREAS TO ACHIEVE A SINGLE, UNI-**  
26 **FORM STANDARDIZED AMOUNT.**

27 Section 1886(d)(3)(A)(iv) (42 U.S.C.  
28 1395ww(d)(3)(A)(iv)) is amended—

29 (1) by striking “(iv) For discharges” and inserting  
30 “(iv)(I) Subject to the succeeding provisions of this clause,  
31 for discharges”; and

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

33 “(II) For discharges occurring during fiscal year  
34 2003, the average standardized amount for hospitals lo-  
35 cated other than in a large urban area shall be increased  
36 by 1/2 of the difference between the average standardized  
37 amount determined under subclause (I) for hospitals lo-



1 cated in large urban areas for such fiscal year and such  
 2 amount determined (without regard to this subclause) for  
 3 other hospitals for such fiscal year.

4 “(III) For discharges occurring in a fiscal year begin-  
 5 ning with fiscal year 2004, the Secretary shall compute an  
 6 average standardized amount for hospitals located in any  
 7 area within the United States and within each region equal  
 8 to the average standardized amount computed for the pre-  
 9 vious fiscal year under this subparagraph for hospitals lo-  
 10 cated in a large urban area (or, beginning with fiscal year  
 11 2005, for hospitals located in any area) increased by the  
 12 applicable percentage increase under subsection  
 13 (b)(3)(B)(i).”.

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

16 (a) MORE FREQUENT UPDATES IN WEIGHTS.—After re-  
 17 vising the weights used in the hospital market basket under  
 18 section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C.  
 19 1395ww(b)(3)(B)(iii)) to reflect the most current data avail-  
 20 able, the Secretary shall establish a frequency for revising such  
 21 weights in such market basket to reflect the most current data  
 22 available more frequently than once every 5 years.

23 (b) REPORT.—Not later than October 1, 2003, the Sec-  
 24 retary shall submit a report to Congress on the frequency es-  
 25 tablished under subsection (a), including an explanation of the  
 26 reasons for, and options considered, in determining such fre-  
 27 quency.

28 **SEC. 305. IMPROVEMENTS TO CRITICAL ACCESS HOS-**  
 29 **PITAL PROGRAM.**

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

33 (1) by striking “and” at the end of subparagraph (C);

34 (2) by adding “and” at the end of subparagraph (D);

35 and

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



1 “(E) inpatient critical access hospital services;”.

2 (b) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN  
3 PAYMENT ADJUSTMENT.—Section 1834(g)(2) (42 U.S.C.  
4 1395m(g)(2)) is amended by adding after and below subpara-  
5 graph (B) the following:

6 “The Secretary may not require, as a condition for apply-  
7 ing subparagraph (B) with respect to a critical access hos-  
8 pital, that each physician providing professional services in  
9 the hospital must assign billing rights with respect to such  
10 services, except that such subparagraph shall not apply to  
11 those physicians who have not assigned such billing  
12 rights.”.

13 (c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS  
14 WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—Section  
15 1820 (42 U.S.C. 1395i-4) is amended—

16 (1) in subsection (c)(2)(B)(iii), by inserting “subject  
17 to paragraph (3)” after “(iii) provides”;

18 (2) by adding at the end of subsection (c) the fol-  
19 lowing new paragraph:

20 “(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR  
21 HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUA-  
22 TIONS.—

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

28 “(B) STANDARDS.—The Secretary shall specify  
29 standards for determining whether a critical access hos-  
30 pital has sufficiently strong seasonal variations in pa-  
31 tient admissions to justify the increase in bed limitation  
32 provided under subparagraph (A).”; and

33 (3) in subsection (f), by adding at the end the fol-  
34 lowing new sentence: “The limitations in numbers of beds  
35 under the first sentence are subject to adjustment under  
36 subsection (c)(3).”.



1 (d) 5-YEAR EXTENSION OF THE AUTHORIZATION FOR AP-  
2 PROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j) (42  
3 U.S.C. 1395i-4(j)) is amended by striking “through 2002” and  
4 inserting “through 2007”.

5 (e) PROHIBITION OF RETROACTIVE RECOUPMENT.—The  
6 Secretary shall not recoup (or otherwise seek to recover) over-  
7 payments made for outpatient critical access hospital services  
8 under part B of title XVIII of the Social Security Act, for serv-  
9 ices furnished in cost reporting periods that began before Octo-  
10 ber 1, 2002, insofar as such overpayments are attributable to  
11 payment being based on 80 percent of reasonable costs (instead  
12 of 100 percent of reasonable costs minus 20 percent of  
13 charges).

14 (f) EFFECTIVE DATES.—

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

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

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

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

31 (a) IN GENERAL.—Section 508(a) BIPA (114 Stat.  
32 2763A-533) is amended—

33 (1) by striking “24-MONTH INCREASE BEGINNING  
34 APRIL 1, 2001” and inserting “IN GENERAL”; and

35 (2) by striking “April 1, 2003” and inserting “Janu-  
36 ary 1, 2005”.



1 (b) CONFORMING AMENDMENT.—Section 547(c)(2) of  
2 BIPA (114 Stat. 2763A–553) is amended by striking “the pe-  
3 riod beginning on April 1, 2001, and ending on September 30,  
4 2002,” and inserting “a period under such section”.

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

9 For—

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

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

15 **SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LO-**  
16 **CATED IN RURAL OR SMALL URBAN AREAS**  
17 **IN REDISTRIBUTION OF UNUSED GRADUATE**  
18 **MEDICAL EDUCATION RESIDENCIES.**

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

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

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

29 (1) an assessment of the validity of the geographic ad-  
30 justment factors used for each component of the fee sched-  
31 ular;

32 (2) an evaluation of the measures used for such ad-  
33 justment, including the frequency of revisions; and

34 (3) an evaluation of the methods used to determine  
35 professional liability insurance costs used in computing the  
36 malpractice component, including a review of increases in  
37 professional liability insurance premiums and variation in  
38 such increases by State and physician specialty and meth-



1 ods used to update the geographic cost of practice index  
2 and relative weights for the malpractice component.

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

10 **SEC. 310. PROVIDING SAFE HARBOR FOR CERTAIN COL-**  
11 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**  
12 **CALLY UNDERSERVED POPULATIONS.**

13 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
14 1320a-7(b)(3)) is amended—

15 (1) in subparagraph (E), by striking “and” after the  
16 semicolon at the end;

17 (2) in subparagraph (F), by striking the period at the  
18 end and inserting “; and”; and

19 (3) by adding at the end the following new subpara-  
20 graph:

21 “(G) any remuneration between a public or non-  
22 profit private health center entity described under  
23 clause (i) or (ii) of section 1905(l)(2)(B) and any indi-  
24 vidual or entity providing goods, items, services, dona-  
25 tions or loans, or a combination thereof, to such health  
26 center entity pursuant to a contract, lease, grant, loan,  
27 or other agreement, if such agreement contributes to  
28 the ability of the health center entity to maintain or in-  
29 crease the availability, or enhance the quality, of serv-  
30 ices provided to a medically underserved population  
31 served by the health center entity.”

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

34 (1) ESTABLISHMENT.—

35 (A) IN GENERAL.—The Secretary of Health and  
36 Human Services (in this subsection referred to as the  
37 “Secretary”) shall establish, on an expedited basis,



1 standards relating to the exception described in section  
2 1128B(b)(3)(G) of the Social Security Act, as added by  
3 subsection (a), for health center entity arrangements to  
4 the antikickback penalties.

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

9 (i) Whether the arrangement between the  
10 health center entity and the other party results in  
11 savings of Federal grant funds or increased reve-  
12 nues to the health center entity.

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

16 (iii) Whether the arrangement between the  
17 health center entity and the other party protects a  
18 health care professional's independent medical  
19 judgment regarding medically appropriate treat-  
20 ment.

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

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





1       **TITLE IV—PROVISIONS RELATING**  
2                   **TO PART A**  
3                   **Subtitle A—Inpatient Hospital**  
4                   **Services**

5       **SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAY-**  
6                   **MENT UPDATES.**

7               Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C.  
8       1395ww(b)(3)(B)(i)) is amended to read as follows:

9               “(XVIII) for fiscal year 2003, the market basket per-  
10              centage increase for sole community hospitals and such in-  
11              crease minus 0.25 percentage points for other hospitals,  
12              and”.

13       **SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT**  
14                   **FOR INDIRECT COSTS OF MEDICAL EDU-**  
15                   **CATION (IME).**

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

18              (1) in subclause (VI) by striking “and” at the end;

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

21              (3) in subclause (VIII) as so redesignated, by striking  
22              “2002” and inserting “2004”; and

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

25              “(VII) during fiscal year 2003, ‘c’ is equal to 1.47;

26              “(VIII) during fiscal year 2004, ‘c’ is equal to  
27              1.45; and”.

28       **SEC. 403. RECOGNITION OF NEW MEDICAL TECH-**  
29                   **NOLOGIES UNDER INPATIENT HOSPITAL**  
30                   **PPS.**

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

34              “(vii) Under the mechanism under this subparagraph, the  
35       Secretary shall provide for the addition of new diagnosis and  
36       procedure codes in April 1 of each year, but the addition of  
37       such codes shall not require the Secretary to adjust the pay-



1 ment (or diagnosis-related group classification) under this sub-  
2 section until the fiscal year that begins after such date.”.

3 (b) ELIGIBILITY STANDARD.—

4 (1) MINIMUM PERIOD FOR RECOGNITION OF NEW  
5 TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C.  
6 1395ww(d)(5)(K)(vi)) is amended—

7 (A) by inserting “(I)” after “(vi)”; and

8 (B) by adding at the end the following new sub-  
9 clause:

10 “(II) Under such criteria, a service or technology shall not  
11 be denied treatment as a new service or technology on the basis  
12 of the period of time in which the service or technology has  
13 been in use if such period ends before the end of the 2-to-3-  
14 year period that begins on the effective date of implementation  
15 of a code under ICD–9–CM (or a successor coding method-  
16 ology) that enables the identification of a significant sample of  
17 specific discharges in which the service or technology has been  
18 used.”.

19 (2) ADJUSTMENT OF THRESHOLD.—Section  
20 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is  
21 amended by inserting “(applying a threshold specified by  
22 the Secretary that is the lesser of 50 percent of the na-  
23 tional average standardized amount for operating costs of  
24 inpatient hospital services for all hospitals and all diag-  
25 nosis-related groups or one standard deviation for the diag-  
26 nosis-related group involved)” after “is inadequate”.

27 (3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—  
28 Section 1886(d)(5)(K)(vi) (42 U.S.C.  
29 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is  
30 further amended by adding at the end the following sub-  
31 clause:

32 “(III) The Secretary shall by regulation provide for fur-  
33 ther clarification of the criteria applied to determine whether  
34 a new service or technology represents an advance in medical  
35 technology that substantially improves the diagnosis or treat-  
36 ment of beneficiaries. Under such criteria, in determining  
37 whether a new service or technology represents an advance in



1 medical technology that substantially improves the diagnosis or  
2 treatment of beneficiaries, the Secretary shall deem a service  
3 or technology as meeting such requirement if the service or  
4 technology is a drug or biological that is designated under sec-  
5 tion 506 or 526 of the Federal Food, Drug, and Cosmetic Act,  
6 approved under section 314.510 or 601.41 of title 21, Code of  
7 Federal Regulations, or designated for priority review when the  
8 marketing application for such drug or biological was filed or  
9 is a medical device for which an exemption has been granted  
10 under section 520(m) of such Act, or for which priority review  
11 has been provided under section 515(d)(5) of such Act.”.

12 (4) PROCESS FOR PUBLIC INPUT.—Section  
13 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended  
14 by paragraph (1), is amended—

15 (A) in clause (i), by adding at the end the fol-  
16 lowing: “Such mechanism shall be modified to meet the  
17 requirements of clause (viii).”; and

18 (B) by adding at the end the following new clause:  
19 “(viii) The mechanism established pursuant to clause (i)  
20 shall be adjusted to provide, before publication of a proposed  
21 rule, for public input regarding whether a new service or tech-  
22 nology not described in the second sentence of clause (vi)(III)  
23 represents an advance in medical technology that substantially  
24 improves the diagnosis or treatment of beneficiaries as follows:

25 “(I) The Secretary shall make public and periodically  
26 update a list of all the services and technologies for which  
27 an application for additional payment under this subpara-  
28 graph is pending.

29 “(II) The Secretary shall accept comments, rec-  
30 ommendations, and data from the public regarding whether  
31 the service or technology represents a substantial improve-  
32 ment.

33 “(III) The Secretary shall provide for a meeting at  
34 which organizations representing hospitals, physicians,  
35 medicare beneficiaries, manufacturers, and any other inter-  
36 ested party may present comments, recommendations, and  
37 data to the clinical staff of the Centers for Medicare &



1 Medicaid Services before publication of a notice of proposed  
2 rulemaking regarding whether service or technology rep-  
3 resents a substantial improvement.”.

4 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Sec-  
5 tion 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further  
6 amended by adding at the end the following new clause:

7 “(ix) Before establishing any add-on payment under this  
8 subparagraph with respect to a new technology, the Secretary  
9 shall seek to identify one or more diagnosis-related groups as-  
10 sociated with such technology, based on similar clinical or ana-  
11 tomical characteristics and the cost of the technology. Within  
12 such groups the Secretary shall assign an eligible new tech-  
13 nology into a diagnosis-related group where the average costs  
14 of care most closely approximate the costs of care of using the  
15 new technology. In such case, no add-on payment under this  
16 subparagraph shall be made with respect to such new tech-  
17 nology and this clause shall not affect the application of para-  
18 graph (4)(C)(iii).”.

19 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-  
20 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.  
21 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after “the  
22 estimated average cost of such service or technology” the fol-  
23 lowing: “(based on the marginal rate applied to costs under  
24 subparagraph (A))”.

25 (e) EFFECTIVE DATE.—

26 (1) IN GENERAL.—The Secretary shall implement the  
27 amendments made by this section so that they apply to  
28 classification for fiscal years beginning with fiscal year  
29 2004.

30 (2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL  
31 YEAR 2003 THAT ARE DENIED.—In the case of an applica-  
32 tion for a classification of a medical service or technology  
33 as a new medical service or technology under section  
34 1886(d)(5)(K) of the Social Security Act (42 U.S.C.  
35 1395ww(d)(5)(K)) that was filed for fiscal year 2003 and  
36 that is denied—



1 (A) the Secretary shall automatically reconsider  
2 the application as an application for fiscal year 2004  
3 under the amendments made by this section; and

4 (B) the maximum time period otherwise permitted  
5 for such classification of the service or technology shall  
6 be extended by 12 months.

7 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS**  
8 **IN PUERTO RICO.**

9 Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is  
10 amended—

11 (1) in subparagraph (A)—

12 (A) in clause (i), by striking “for discharges begin-  
13 ning on or after October 1, 1997, 50 percent (and for  
14 discharges between October 1, 1987, and September  
15 30, 1997, 75 percent)” and inserting “the applicable  
16 Puerto Rico percentage (specified in subparagraph  
17 (E))”; and

18 (B) in clause (ii), by striking “for discharges be-  
19 ginning in a fiscal year beginning on or after October  
20 1, 1997, 50 percent (and for discharges between Octo-  
21 ber 1, 1987, and September 30, 1997, 25 percent)”  
22 and inserting “the applicable Federal percentage (spec-  
23 ified in subparagraph (E))”; and

24 (2) by adding at the end the following new subpara-  
25 graph:

26 “(E) For purposes of subparagraph (A), for discharges  
27 occurring—

28 “(i) between October 1, 1987, and September 30,  
29 1997, the applicable Puerto Rico percentage is 75 percent  
30 and the applicable Federal percentage is 25 percent;

31 “(ii) on or after October 1, 1997, and before October  
32 1, 2003, the applicable Puerto Rico percentage is 50 per-  
33 cent and the applicable Federal percentage is 50 percent;

34 “(iii) during fiscal year 2004, the applicable Puerto  
35 Rico percentage is 45 percent and the applicable Federal  
36 percentage is 55 percent;



1           “(iv) during fiscal year 2005, the applicable Puerto  
2 Rico percentage is 40 percent and the applicable Federal  
3 percentage is 60 percent;

4           “(v) during fiscal year 2006, the applicable Puerto  
5 Rico percentage is 35 percent and the applicable Federal  
6 percentage is 65 percent;

7           “(vi) during fiscal year 2007, the applicable Puerto  
8 Rico percentage is 30 percent and the applicable Federal  
9 percentage is 70 percent; and

10           “(vii) on or after October 1, 2007, the applicable  
11 Puerto Rico percentage is 25 percent and the applicable  
12 Federal percentage is 75 percent.”.

13 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**  
14 **HANCED DISPROPORTIONATE SHARE HOS-**  
15 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**  
16 **PITALS AND URBAN HOSPITALS WITH**  
17 **FEWER THAN 100 BEDS.**

18           For provision enhancing disproportionate share hospital  
19 (DSH) treatment for rural hospitals and urban hospitals with  
20 fewer than 100 beds, see section 302.

21 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-**  
22 **YEAR PHASED-IN INCREASE IN THE STAND-**  
23 **ARDIZED AMOUNT IN RURAL AND SMALL**  
24 **URBAN AREAS TO ACHIEVE A SINGLE, UNI-**  
25 **FORM STANDARDIZED AMOUNT.**

26           For provision phasing in over a 2-year period an increase  
27 in the standardized amount for rural and small urban areas to  
28 achieve a single, uniform, standardized amount, see section  
29 303.

30 **SEC. 407. REFERENCE TO PROVISION FOR MORE FRE-**  
31 **QUENT UPDATES IN THE WEIGHTS USED IN**  
32 **HOSPITAL MARKET BASKET.**

33           For provision providing for more frequent updates in the  
34 weights used in hospital market basket, see section 304.

35 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**  
36 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**  
37 **GRAM.**

38           For provision providing making improvements to critical  
39 access hospital program, see section 305.



1           **Subtitle B—Skilled Nursing Facility**  
2                           **Services**

3           **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING**  
4                           **FACILITY SERVICES.**

5           (a) TEMPORARY INCREASE IN NURSING COMPONENT OF  
6 PPS FEDERAL RATE.—Section 312(a) of BIPA is amended by  
7 adding at the end the following new sentence: “The Secretary  
8 of Health and Human Services shall increase by 12, 10, and  
9 8 percent the nursing component of the case-mix adjusted Fed-  
10 eral prospective payment rate specified in Tables 3 and 4 of  
11 the final rule published in the Federal Register by the Health  
12 Care Financing Administration on July 31, 2000 (65 Fed. Reg.  
13 46770) and as subsequently updated under section  
14 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C.  
15 1395yy(e)(4)(E)(ii)), effective for services furnished during fis-  
16 cal years 2003, 2004, and 2005, respectively.”.

17           (b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

18           (1) IN GENERAL.—Paragraph (12) of section 1888(e)  
19 (42 U.S.C. 1395yy(e)) is amended to read as follows:

20           “(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

21           “(A) IN GENERAL.—Subject to subparagraph (B),  
22 in the case of a resident of a skilled nursing facility  
23 who is afflicted with acquired immune deficiency syn-  
24 drome (AIDS), the per diem amount of payment other-  
25 wise applicable shall be increased by 128 percent to re-  
26 flect increased costs associated with such residents.

27           “(B) SUNSET.—Subparagraph (A) shall not apply  
28 on and after such date as the Secretary certifies that  
29 there is an appropriate adjustment in the case mix  
30 under paragraph (4)(G)(i) to compensate for the in-  
31 creased costs associated with residents described in  
32 such subparagraph.”.

33           (2) EFFECTIVE DATE.—The amendment made by  
34 paragraph (1) shall apply to services furnished on or after  
35 October 1, 2003.



**Subtitle C—Hospice****SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERVICES.**

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—  
Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking “and” at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4)  
and inserting “; and”; and

(3) by inserting after paragraph (4) the following new  
paragraph:

“(5) for individuals who are terminally ill, have not  
made an election under subsection (d)(1), and have not  
have previously received services under this paragraph,  
services that are furnished by a physician who is the med-  
ical director or an employee of a hospice program and that  
consist of—

“(A) an evaluation of the individual’s need for  
pain and symptom management;

“(B) counseling the individual with respect to end-  
of-life issues and care options; and

“(C) advising the individual regarding advanced  
care planning.”.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is  
amended by adding at the end the following new paragraph:

“(4) The amount paid to a hospice program with respect  
to the services under section 1812(a)(5) for which payment  
may be made under this part shall be equal to an amount  
equivalent to the amount established for an office or other out-  
patient visit for evaluation and management associated with  
presenting problems of moderate severity under the fee sched-  
ule established under section 1848(b), other than the portion  
of such amount attributable to the practice expense compo-  
nent.”.

(c) CONFORMING AMENDMENT.—Section  
1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended  
by inserting before the comma at the end the following: “and  
services described in section 1812(a)(5)”.



1 (d) EFFECTIVE DATE.—The amendments made by this  
2 section shall apply to services provided by a hospice program  
3 on or after January 1, 2004.

4 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**  
5 **PICE CARE FURNISHED IN A FRONTIER**  
6 **AREA.**

7 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.  
8 1395f(i)(1)) is amended by adding at the end the following new  
9 subparagraph:

10 “(D) With respect to hospice care furnished in a frontier  
11 area on or after January 1, 2003, and before January 1, 2008,  
12 the payment rates otherwise established for such care shall be  
13 increased by 10 percent. For purposes of this subparagraph,  
14 the term ‘frontier area’ means a county in which the population  
15 density is less than 7 persons per square mile.”.

16 (b) REPORT ON COSTS.—Not later than January 1, 2007,  
17 the Comptroller General of the United States shall submit to  
18 Congress a report on the costs of furnishing hospice care in  
19 frontier areas. Such report shall include recommendations re-  
20 garding the appropriateness of extending, and modifying, the  
21 payment increase provided under the amendment made by sub-  
22 section (a).

23 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

24 (a) IN GENERAL.—The Secretary shall conduct a dem-  
25 onstration project for the delivery of hospice care to medicare  
26 beneficiaries in rural areas. Under the project medicare bene-  
27 ficiaries who are unable to receive hospice care in the home for  
28 lack of an appropriate caregiver are provided such care in a fa-  
29 cility of 20 or fewer beds which offers, within its walls, the full  
30 range of services provided by hospice programs under section  
31 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

32 (b) SCOPE OF PROJECT.—The Secretary shall conduct the  
33 project under this section with respect to no more than 3 hos-  
34 pice programs over a period of not longer than 5 years each.

35 (c) COMPLIANCE WITH CONDITIONS.—Under the dem-  
36 onstration project—



1 (1) the hospice program shall comply with otherwise  
2 applicable requirements, except that it shall not be required  
3 to offer services outside of the home or to meet the require-  
4 ments of section 1861(dd)(2)(A)(iii) of the Social Security  
5 Act; and

6 (2) payments for hospice care shall be made at the  
7 rates otherwise applicable to such care under title XVIII of  
8 such Act.

9 The Secretary may require the program to comply with such  
10 additional quality assurance standards for its provision of serv-  
11 ices in its facility as the Secretary deems appropriate.

12 (d) REPORT.—Upon completion of the project, the Sec-  
13 retary shall submit a report to Congress on the project and  
14 shall include in the report recommendations regarding exten-  
15 sion of such project to hospice programs serving rural areas.

## 16 **Subtitle D—Other Provisions**

### 17 **SEC. 431. DEMONSTRATION PROJECT FOR USE OF RE-** 18 **COVERY AUDIT CONTRACTORS.**

19 (a) IN GENERAL.—The Secretary of Health and Human  
20 Services shall conduct a demonstration project under this sec-  
21 tion (in this section referred to as the “project”) to dem-  
22 onstrate the use of recovery audit contractors under the Medi-  
23 care Integrity Program in identifying and recouping overpay-  
24 ments under the medicare program for services for which pay-  
25 ment is made under part A of title XVIII of the Social Security  
26 Act. Under the project—

27 (1) payment may be made to such a contractor on a  
28 contingent basis;

29 (2) a percentage of the amount recovered may be re-  
30 tained by the Secretary and shall be available to the pro-  
31 gram management account of the Centers for Medicare &  
32 Medicaid Services; and

33 (3) the Secretary shall examine the efficacy of such  
34 use with respect to duplicative payments, accuracy of cod-  
35 ing, and other payment policies in which inaccurate pay-  
36 ments arise.



1 (b) SCOPE AND DURATION.—The project shall cover at  
2 least 2 States and at least 3 contractors and shall last for not  
3 longer than 3 years.

4 (c) WAIVER.—The Secretary of Health and Human Serv-  
5 ices shall waive such provisions of title XVIII of the Social Se-  
6 curity Act as may be necessary to provide for payment for serv-  
7 ices under the project in accordance with subsection (a).

8 (d) QUALIFICATIONS OF CONTRACTORS.—

9 (1) IN GENERAL.—The Secretary shall enter into a re-  
10 recovery audit contract under this section with an entity only  
11 if the entity has staff that has knowledge of and experience  
12 with the payment rules and regulations under the medicare  
13 program or the entity has or will contract with another en-  
14 tity that has such knowledgeable and experienced staff.

15 (2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The  
16 Secretary may not enter into a recovery audit contract  
17 under this section with an entity to the extent that the en-  
18 tity is a fiscal intermediary under section 1816 of the So-  
19 cial Security Act (42 U.S.C. 1395h), a carrier under sec-  
20 tion 1842 of such Act (42 U.S.C. 1395u), or a Medicare  
21 Administrative Contractor under section 1874A of such  
22 Act.

23 (3) PREFERENCE FOR ENTITIES WITH DEM-  
24 ONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In  
25 awarding contracts to recovery audit contractors under this  
26 section, the Secretary shall give preference to those entities  
27 that the Secretary determines have demonstrated pro-  
28 ficiency in recovery audits with private insurers or under  
29 the medicaid program under title XIX of such Act.

30 (e) REPORT.—The Secretary of Health and Human Serv-  
31 ices shall submit to Congress a report on the project not later  
32 than 6 months after the date of its completion. Such reports  
33 shall include information on the impact of the project on sav-  
34 ings to the medicare program and recommendations on the  
35 cost-effectiveness of extending or expanding the project.



1           **TITLE V—PROVISIONS RELATING**  
2                           **TO PART B**  
3           **Subtitle A—Physicians’ Services**

4   **SEC. 501. REVISION OF UPDATES FOR PHYSICIANS’**  
5           **SERVICES.**

6           (a) UPDATE FOR 2003 THROUGH 2005.—

7               (1) IN GENERAL.—Section 1848(d) (42 U.S.C.  
8           1395w-4(d)) is amended by adding at the end the following  
9           new paragraphs:

10               “(5) UPDATE FOR 2003.—The update to the single  
11           conversion factor established in paragraph (1)(C) for 2003  
12           is 2 percent.

13               “(6) SPECIAL RULES FOR UPDATE FOR 2004 AND  
14           2005.—The following rules apply in determining the update  
15           adjustment factors under paragraph (4)(B) for 2004 and  
16           2005:

17                       “(A) USE OF 2002 DATA IN DETERMINING ALLOW-  
18           ABLE COSTS.—

19                               “(i) The reference in clause (ii)(I) of such  
20           paragraph to April 1, 1996, is deemed to be a refer-  
21           ence to January 1, 2002.

22                               “(ii) The allowed expenditures for 2002 is  
23           deemed to be equal to the actual expenditures for  
24           physicians’ services furnished during 2002, as esti-  
25           mated by the Secretary.

26                       “(B) 1 PERCENTAGE POINT INCREASE IN GDP  
27           UNDER SGR.—The annual average percentage growth  
28           in real gross domestic product per capita under sub-  
29           section (f)(2)(C) for each of 2003, 2004, and 2005 is  
30           deemed to be increased by 1 percentage point.”.

31               (2) CONFORMING AMENDMENT.—Paragraph (4)(B) of  
32           such section is amended, in the matter before clause (i), by  
33           inserting “and paragraph (6)” after “subparagraph (D)”.

34           (b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING  
35           GROSS DOMESTIC PRODUCT.—



1 (1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C.  
2 1395w-4(f)(2)(C)) is amended—

3 (A) by striking “projected” and inserting “annual  
4 average”; and

5 (B) by striking “from the previous applicable pe-  
6 riod to the applicable period involved” and inserting  
7 “during the 10-year period ending with the applicable  
8 period involved”.

9 (2) EFFECTIVE DATE.—The amendment made by  
10 paragraph (1) shall apply to computations of the sustain-  
11 able growth rate for years beginning with 2002.

12 (c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Sec-  
13 tion 1848(d)(4)(F) (42 U.S.C. 1395w-4(d)(4)(F)) is amended  
14 by striking “subparagraph (A)” and all that follows and insert-  
15 ing “subparagraph (A), for each of 2001 and 2002, of –0.2  
16 percent.”

17 **SEC. 502. STUDIES ON ACCESS TO PHYSICIANS’ SERV-**  
18 **ICES.**

19 (a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-  
20 CIANS’ SERVICES.—

21 (1) STUDY.—The Comptroller General of the United  
22 States shall conduct a study on access of medicare bene-  
23 ficiaries to physicians’ services under the medicare pro-  
24 gram. The study shall include—

25 (A) an assessment of the use by beneficiaries of  
26 such services through an analysis of claims submitted  
27 by physicians for such services under part B of the  
28 medicare program;

29 (B) an examination of changes in the use by bene-  
30 ficiaries of physicians’ services over time;

31 (C) an examination of the extent to which physi-  
32 cians are not accepting new medicare beneficiaries as  
33 patients.

34 (2) REPORT.—Not later than 18 months after the  
35 date of the enactment of this Act, the Comptroller General  
36 shall submit to Congress a report on the study conducted



1 under paragraph (1). The report shall include a determina-  
2 tion whether—

3 (A) data from claims submitted by physicians  
4 under part B of the medicare program indicate poten-  
5 tial access problems for medicare beneficiaries in cer-  
6 tain geographic areas; and

7 (B) access by medicare beneficiaries to physicians'  
8 services may have improved, remained constant, or de-  
9 teriorated over time.

10 (b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

11 (1) STUDY.—The Secretary shall request the Institute  
12 of Medicine of the National Academy of Sciences to con-  
13 duct a study on the adequacy of the supply of physicians  
14 (including specialists) in the United States and the factors  
15 that affect such supply.

16 (2) REPORT TO CONGRESS.—Not later than 2 years  
17 after the date of enactment of this section, the Secretary  
18 shall submit to Congress a report on the results of the  
19 study described in paragraph (1), including any rec-  
20 ommendations for legislation.

21 **SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSI-**  
22 **CIAANS' SERVICES.**

23 Not later than 1 year after the date of the enactment of  
24 this Act, the Medicare Payment Advisory Commission shall  
25 submit to Congress a report on the effect of refinements to the  
26 practice expense component of payments for physicians' serv-  
27 ices in the case of services for which there are no physician  
28 work relative value units, after the transition to a full resource-  
29 based payment system in 2002, under section 1848 of the So-  
30 cial Security Act (42 U.S.C. 1395w-4). Such report shall ex-  
31 amine the following matters by physician specialty:

32 (1) The effect of such refinements on payment for  
33 physicians' services.

34 (2) The interaction of the practice expense component  
35 with other components of and adjustments to payment for  
36 physicians' services under such section.



1 (3) The appropriateness of the amount of compensa-  
2 tion by reason of such refinements.

3 (4) The effect of such refinements on access to care  
4 by medicare beneficiaries to physicians' services.

5 (5) The effect of such refinements on physician par-  
6 ticipation under the medicare program.

7 **SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CER-**  
8 **TAIN PHYSICIAN PATHOLOGY SERVICES**  
9 **UNDER MEDICARE.**

10 Section 542(c) of BIPA is amended by striking "2-year  
11 period" and inserting "3-year-period".

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 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.**

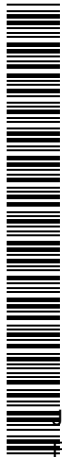
14 (a) 2-YEAR EXTENSION OF MORATORIUM ON THERAPY  
15 CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended  
16 by striking “and 2002” and inserting “2002, 2003, and 2004”.

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 July 1,  
35 2003, the Secretary shall submit to Congress a preliminary  
36 report on the conditions and diseases identified under para-



1 graph (1) and not later than September 1, 2003, a final  
2 report on the conditions and diseases so identified.

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.



1     **SEC. 514. ACCELERATED IMPLEMENTATION OF 20 PER-**  
2                   **CENT COINSURANCE FOR HOSPITAL OUT-**  
3                   **PATIENT DEPARTMENT (OPD) SERVICES;**  
4                   **OTHER OPD PROVISIONS.**

5           (a) ACCELERATED IMPLEMENTATION OF COINSURANCE  
6 REDUCTIONS.—Section 1833(t)(8)(C)(ii) (42 U.S.C.  
7 1395l(t)(8)(C)(ii)) is amended by striking subclauses (III)  
8 through (V) and inserting the following:

9                   “(III) For procedures performed in 2004,  
10                   45 percent.

11                   “(IV) For procedures performed in 2005,  
12                   40 percent.

13                   “(V) For procedures performed in 2006,  
14                   2007, 2008 and 2009, 35 percent.

15                   “(VI) For procedures performed in 2010,  
16                   30 percent.

17                   “(VII) For procedures performed in 2011,  
18                   25 percent.

19                   “(VIII) For procedures performed in 2012  
20                   and thereafter, 20 percent.”.

21           (b) TREATMENT OF TEMPERATURE MONITORED  
22 CRYOABLATION.—

23                   (1) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42  
24 U.S.C. 1395l(t)(6)(A)(ii)) is amended by striking “or tem-  
25 perature monitored cryoablation”.

26                   (2) EFFECTIVE DATE.—The amendment made by  
27 paragraph (1) applies to payment for services furnished on  
28 or after January 1, 2003.

29     **SEC. 515. COVERAGE OF AN INITIAL PREVENTIVE PHYS-**  
30                   **ICAL EXAMINATION.**

31           (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
32 1395x(s)(2)), is amended—

33                   (1) in subparagraph (U), by striking “and” at the  
34                   end;

35                   (2) in subparagraph (V), by inserting “and” at the  
36                   end; and

37                   (3) by adding at the end the following new subpara-  
38                   graph:



1           “(W) an initial preventive physical examination (as  
2           defined in subsection (ww));”.

3           (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
4           1395x) is amended by adding at the end the following new sub-  
5           section:

6                   “Initial Preventive Physical Examination

7           “(ww) The term ‘initial preventive physical examination’  
8           means physicians’ services consisting of a physical examination  
9           with the goal of health promotion and disease detection and in-  
10          cludes items and services specified by the Secretary in regula-  
11          tions.”.

12          (c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

13           (1) DEDUCTIBLE.—The first sentence of section  
14          1833(b) (42 U.S.C. 1395l(b)) is amended—

15                  (A) by striking “and” before “(6)”, and

16                  (B) by inserting before the period at the end the  
17          following: “, and (7) such deductible shall not apply  
18          with respect to an initial preventive physical examina-  
19          tion (as defined in section 1861(ww))”.

20           (2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C.  
21          1395l(a)(1)) is amended—

22                  (A) in clause (N), by inserting “(or 100 percent  
23          in the case of an initial preventive physical examina-  
24          tion, as defined in section 1861(ww))” after “80 per-  
25          cent”; and

26                  (B) in clause (O), by inserting “(or 100 percent  
27          in the case of an initial preventive physical examina-  
28          tion, as defined in section 1861(ww))” after “80 per-  
29          cent”.

30          (d) PAYMENT AS PHYSICIANS’ SERVICES.—Section  
31          1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting  
32          “(2)(W),” after “(2)(S),”.

33          (e) OTHER CONFORMING AMENDMENTS.—Section 1862(a)  
34          (42 U.S.C. 1395y(a)) is amended—

35                  (1) in paragraph (1)—

36                          (A) by striking “and” at the end of subparagraph  
37                          (H);





1 (B) by striking the semicolon at the end of sub-  
2 paragraph (I) and inserting “, and”; and

3 (C) by adding at the end the following new sub-  
4 paragraph:

5 “(J) in the case of an initial preventive physical exam-  
6 ination, which is performed not later than 6 months after  
7 the date the individual’s first coverage period begins under  
8 part B;”; and

9 (2) in paragraph (7), by striking “or (H)” and insert-  
10 ing “(H), or (J)”.

11 (f) EFFECTIVE DATE.—The amendments made by this  
12 section shall apply to services furnished on or after January 1,  
13 2004, but only for individuals whose coverage period begins on  
14 or after such date.

15 **SEC. 516. RENAL DIALYSIS SERVICES.**

16 (a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT  
17 SETTINGS.—Not later than 1 year after the date of the enact-  
18 ment of this Act, the Comptroller General of the United States  
19 shall submit to Congress a report containing—

20 (1) an analysis of the differences in costs of providing  
21 renal dialysis services under the medicare program in home  
22 settings and in facility settings;

23 (2) an assessment of the percentage of overhead costs  
24 in home settings and in facility settings; and

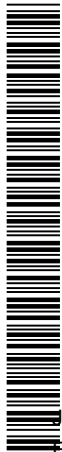
25 (3) an evaluation of whether the charges for home di-  
26 alysis supplies and equipment are reasonable and nec-  
27 essary.

28 (b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDI-  
29 ATRIC FACILITIES.—

30 (1) IN GENERAL.—Section 422(a)(2) of BIPA is  
31 amended—

32 (A) in subparagraph (A), by striking “and (C)”  
33 and inserting “, (C), and (D)”;

34 (B) in subparagraph (B), by striking “In the  
35 case” and inserting “Subject to subparagraph (D), in  
36 the case”; and



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

3 “(D) INAPPLICABILITY TO PEDIATRIC FACILI-  
4 TIES.—Subparagraphs (A) and (B) shall not apply, as  
5 of October 1, 2002, to pediatric facilities that do not  
6 have an exception rate described in subparagraph (C)  
7 in effect on such date. For purposes of this subpara-  
8 graph, the term ‘pediatric facility’ means a renal facil-  
9 ity at least 50 percent of whose patients are individuals  
10 under 18 years of age.”.

11 (2) CONFORMING AMENDMENT.—The fourth sentence  
12 of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended  
13 by striking “The Secretary” and inserting “Subject to sec-  
14 tion 422(a)(2) of the Medicare, Medicaid, and SCHIP Ben-  
15 efits Improvement and Protection Act of 2000, the Sec-  
16 retary”.

17 (c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR  
18 SERVICES FURNISHED IN 2004.—Notwithstanding any other  
19 provision of law, with respect to payment under part B of title  
20 XVIII of the Social Security Act for renal dialysis services fur-  
21 nished in 2004, the composite payment rate otherwise estab-  
22 lished under section 1881(b)(7) of such Act (42 U.S.C.  
23 1395rr(b)(7)) shall be increased by 1.2 percent.

24 **SEC. 517. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**  
25 **RAPHY SERVICES.**

26 (a) EXCLUSION FROM OPD FEE SCHEDULE.—Section  
27 1833(t)(1)(A)(iv) (42 U.S.C. 1395l(t)(1)(A)(iv)) is amended by  
28 inserting before the period at the end the following: “and does  
29 not include screening mammography (as defined in section  
30 1861(jj)) and unilateral and bilateral diagnostic mammog-  
31 raphy”.

32 (b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diag-  
33 nostic mammography performed on or after January 1, 2004,  
34 for which payment is made under the physician fee schedule  
35 under section 1848 of the Social Security Act (42 U.S.C.  
36 1395w-4), the Secretary, based on the most recent cost data  
37 available, shall provide for an appropriate adjustment in the



1 payment amount for the technical component of the diagnostic  
2 mammography.

3 (c) EFFECTIVE DATE.—The amendment made by sub-  
4 section (a) shall apply to mammography performed on or after  
5 January 1, 2004.

6 **TITLE VI—PROVISIONS RELATING**  
7 **TO PARTS A AND B**  
8 **Subtitle A—Home Health Services**

9 **SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN**  
10 **PAYMENT RATES UNDER THE PROSPECTIVE**  
11 **PAYMENT SYSTEM.**

12 (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.  
13 1395fff(b)(3)(A)) is amended to read as follows:

14 “(A) INITIAL BASIS.—Under such system the Sec-  
15 retary shall provide for computation of a standard pro-  
16 spective payment amount (or amounts) as follows:

17 “(i) Such amount (or amounts) shall initially  
18 be based on the most current audited cost report  
19 data available to the Secretary and shall be com-  
20 puted in a manner so that the total amounts pay-  
21 able under the system for fiscal year 2001 shall be  
22 equal to the total amount that would have been  
23 made if the system had not been in effect and if  
24 section 1861(v)(1)(L)(ix) had not been enacted.

25 “(ii) For fiscal year 2002 and for the first  
26 quarter of fiscal year 2003, such amount (or  
27 amounts) shall be equal to the amount (or  
28 amounts) determined under this paragraph for the  
29 previous fiscal year, updated under subparagraph  
30 (B).

31 “(iii) For 2003, such amount (or amounts)  
32 shall be equal to the amount (or amounts) deter-  
33 mined under this paragraph for fiscal year 2002,  
34 updated under subparagraph (B) for 2003.

35 “(iv) For 2004 and each subsequent year,  
36 such amount (or amounts) shall be equal to the  
37 amount (or amounts) determined under this para-



1 graph for the previous year, updated under sub-  
2 paragraph (B).

3 Each such amount shall be standardized in a manner  
4 that eliminates the effect of variations in relative case  
5 mix and area wage adjustments among different home  
6 health agencies in a budget neutral manner consistent  
7 with the case mix and wage level adjustments provided  
8 under paragraph (4)(A). Under the system, the Sec-  
9 retary may recognize regional differences or differences  
10 based upon whether or not the services or agency are  
11 in an urbanized area.”.

12 (b) EFFECTIVE DATE.—The amendment made by sub-  
13 section (a) shall take effect as if included in the amendments  
14 made by section 501 of the Medicare, Medicaid, and SCHIP  
15 Benefits Improvement and Protection Act of 2000 (as enacted  
16 into law by section 1(a)(6) of Public Law 106–554).

17 **SEC. 602. ESTABLISHMENT OF REDUCED COPAYMENT**  
18 **FOR A HOME HEALTH SERVICE EPISODE OF**  
19 **CARE FOR CERTAIN BENEFICIARIES.**

20 (a) PART A.—

21 (1) IN GENERAL.—Section 1813(a) (42 U.S.C.  
22 1395e(a)) is amended by adding at the end the following  
23 new paragraph:

24 “(5)(A)(i) Subject to clause (ii), the amount payable for  
25 home health services furnished to the individual under this title  
26 for each episode of care beginning in a year (beginning with  
27 2003) shall be reduced by a copayment equal to the copayment  
28 amount specified in subparagraph (B)(ii) such year.

29 “(ii) The copayment under clause (i) shall not apply—

30 “(I) in the case of an individual who has been deter-  
31 mined to be a qualified medicare beneficiary (as defined in  
32 section 1905(p)(1)) or otherwise to be entitled to medical  
33 assistance under section 1902(a)(10)(A) or  
34 1902(a)(10)(C); and

35 “(II) in the case of an episode of care which consists  
36 of 4 or fewer visits.



1 “(B)(i) The Secretary shall estimate, before the beginning  
2 of each year (beginning with 2003), the national average pay-  
3 ment under this title per episode for home health services pro-  
4 jected for the year involved.

5 “(ii) For each year the copayment amount under this  
6 clause is equal to 1.5 percent of the national average payment  
7 estimated for the year involved under clause (i). Any amount  
8 determined under the preceding sentence which is not a mul-  
9 tiple of \$5 shall be rounded to the nearest multiple of \$5.

10 “(iii) There shall be no administrative or judicial review  
11 under section 1869, 1878, or otherwise of the estimation of av-  
12 erage payment under clause (i).”.

13 (2) **TIMELY IMPLEMENTATION.**—Unless the Secretary  
14 of Health and Human Services otherwise provides on a  
15 timely basis, the copayment amount specified under section  
16 1813(a)(5)(B)(ii) of the Social Security Act (as added by  
17 paragraph (1)) for 2003 shall be deemed to be \$40.

18 (b) **CONFORMING PROVISIONS.**—

19 (1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A))  
20 is amended by inserting “less the copayment amount appli-  
21 cable under section 1813(a)(5)” after “1895”.

22 (2) Section 1866(a)(2)(A)(i) (42 U.S.C.  
23 1395cc(a)(2)(A)(i)) is amended—

24 (A) by striking “or coinsurance” and inserting “,  
25 coinsurance, or copayment”; and

26 (B) by striking “or (a)(4)” and inserting “(a)(4),  
27 or (a)(5)”.

28 **SEC. 603. UPDATE IN HOME HEALTH SERVICES.**

29 (a) **CHANGE TO CALENDAR YEAR UPDATE.**—

30 (1) **IN GENERAL.**—Section 1895(b) (42 U.S.C.  
31 1395fff(b)(3)) is amended—

32 (A) in paragraph (3)(B)(i)—

33 (i) by striking “each fiscal year (beginning  
34 with fiscal year 2002)” and inserting “fiscal year  
35 2002 and for each subsequent year (beginning with  
36 2003)”; and



1 (ii) by inserting “or year” after “the fiscal  
2 year”;

3 (B) in paragraph (3)(B)(ii)—

4 (i) in subclause (II), by striking “fiscal year”  
5 and inserting “year” and by redesignating such  
6 subclause as subclause (III); and

7 (ii) in subclause (I), by striking “each of fiscal  
8 years 2002 and 2003” and inserting the following:  
9 “fiscal year 2002, the home health market basket  
10 percentage increase (as defined in clause (iii))  
11 minus 1.1 percentage points;

12 “(II) 2003”;

13 (C) in paragraph (3)(B)(iii), by inserting “or  
14 year” after “fiscal year” each place it appears;

15 (D) in paragraph (3)(B)(iv)—

16 (i) by inserting “or year” after “fiscal year”  
17 each place it appears; and

18 (ii) by inserting “or years” after “fiscal  
19 years”; and

20 (E) in paragraph (5), by inserting “or year” after  
21 “fiscal year”.

22 (2) TRANSITION RULE.—The standard prospective  
23 payment amount (or amounts) under section 1895(b)(3) of  
24 the Social Security Act for the calendar quarter beginning  
25 on October 1, 2002, shall be such amount (or amounts) for  
26 the previous calendar quarter.

27 (b) CHANGES IN UPDATES FOR 2003, 2004, AND 2005.—  
28 Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as  
29 amended by subsection (a)(1)(B), is amended—

30 (1) in subclause (II), by striking “the home health  
31 market basket percentage increase (as defined in clause  
32 (iii)) minus 1.1 percentage points” and inserting “2.0 per-  
33 centage points”;

34 (2) by striking “or” at the end of subclause (II);

35 (3) by redesignating subclause (III) as subclause (V);  
36 and



1 (4) by inserting after subclause (II) the following new  
2 subclause:

3 “(III) 2004, 1.1 percentage points;

4 “(IV) 2005, 2.7 percentage points; or”.

5 (c) PAYMENT ADJUSTMENT.—

6 (1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C.  
7 1395fff(b)(5)) is amended “5 percent” and inserting “3  
8 percent”.

9 (2) EFFECTIVE DATE.—The amendment made by  
10 paragraph (1) shall apply to years beginning with 2003.

11 **SEC. 604. OASIS TASK FORCE; SUSPENSION OF CERTAIN**  
12 **OASIS DATA COLLECTION REQUIREMENTS**  
13 **PENDING TASK FORCE SUBMITTAL OF RE-**  
14 **PORT.**

15 (a) ESTABLISHMENT.—The Secretary of Health and  
16 Human Services shall establish and appoint a task force (to be  
17 known as the “OASIS Task Force”) to examine the data col-  
18 lection and reporting requirements under OASIS. For purposes  
19 of this section, the term “OASIS” means the Outcome and As-  
20 sessment Information Set required by reason of section 4602(e)  
21 of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

22 (b) COMPOSITION.—The OASIS Task Force shall be com-  
23 posed of the following:

24 (1) Staff of the Centers for Medicare & Medicaid Serv-  
25 ices with expertise in post-acute care.

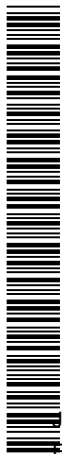
26 (2) Representatives of home health agencies.

27 (3) Health care professionals and research and health  
28 care quality experts outside the Federal Government with  
29 expertise in post-acute care.

30 (4) Advocates for individuals requiring home health  
31 services.

32 (c) DUTIES.—

33 (1) REVIEW AND RECOMMENDATIONS.—The OASIS  
34 Task Force shall review and make recommendations to the  
35 Secretary regarding changes in OASIS to improve and sim-  
36 plify data collection for purposes of—



1 (A) assessing the quality of home health services;  
2 and

3 (B) providing consistency in classification of pa-  
4 tients into home health resource groups (HHRGs) for  
5 payment under section 1895 of the Social Security Act  
6 (42 U.S.C. 1395fff).

7 (2) SPECIFIC ITEMS.—In conducting the review under  
8 paragraph (1), the OASIS Task Force shall specifically  
9 examine—

10 (A) the 41 outcome measures currently in use;

11 (B) the timing and frequency of data collection;  
12 and

13 (C) the collection of information on comorbidities  
14 and clinical indicators.

15 (3) REPORT.—The OASIS Task Force shall submit a  
16 report to the Secretary containing its findings and rec-  
17 ommendations for changes in OASIS by not later than 18  
18 months after the date of the enactment of this Act.

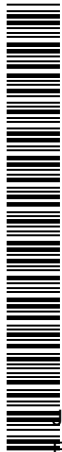
19 (d) SUNSET.—The OASIS Task Force shall terminate 60  
20 days after the date on which the report is submitted under sub-  
21 section (c)(2).

22 (e) NONAPPLICATION OF FACA.—The provisions of the  
23 Federal Advisory Committee Act shall not apply to the OASIS  
24 Task Force.

25 (f) SUSPENSION OF OASIS REQUIREMENT FOR COLLEC-  
26 TION OF DATA ON NON-MEDICARE AND NON-MEDICAID PA-  
27 TIENTS PENDING TASK FORCE REPORT.—

28 (1) IN GENERAL.—During the period described in  
29 paragraph (2), the Secretary of Health and Human Serv-  
30 ices may not require, under section 4602(e) of the Bal-  
31 anced Budget Act of 1997 or otherwise under OASIS, a  
32 home health agency to gather or submit information that  
33 relates to an individual who is not eligible for benefits  
34 under either title XVIII or title XIX of the Social Security  
35 Act.

36 (2) PERIOD OF SUSPENSION.—The period described in  
37 this paragraph—





- 1 (A) begins on January 1, 2003, and  
 2 (B) ends on the last day of the 2nd month begin-  
 3 ning after the date the report is submitted under sub-  
 4 section (c)(2).

5 **SEC. 605. MEDPAC STUDY ON MEDICARE MARGINS OF**  
 6 **HOME HEALTH AGENCIES.**

7 (a) STUDY.—The Medicare Payment Advisory Commission  
 8 shall conduct a study of payment margins of home health agen-  
 9 cies under the home health prospective payment system under  
 10 section 1895 of the Social Security Act (42 U.S.C. 1395fff).  
 11 Such study shall examine whether systematic differences in  
 12 payment margins are related to differences in case mix (as  
 13 measured by home health resource groups (HHRGs)) among  
 14 such agencies. The study shall use the partial or full-year cost  
 15 reports filed by home health agencies.

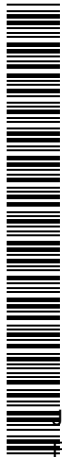
16 (b) REPORT.—Not later than 2 years after the date of the  
 17 enactment of this Act, the Commission shall submit to Con-  
 18 gress a report on the study under subsection (a).

19 **Subtitle B—Direct Graduate Medical**  
 20 **Education**

21 **SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH**  
 22 **COST PROGRAMS.**

23 Section 1886(h)(2)(D)(iv) (42 U.S.C.  
 24 1395ww(h)(2)(D)(iv)) is amended—

- 25 (1) in subclause (I)—  
 26 (A) by striking “AND 2002” and inserting  
 27 “THROUGH 2012”;  
 28 (B) by striking “during fiscal year 2001 or fiscal  
 29 year 2002” and inserting “during the period beginning  
 30 with fiscal year 2001 and ending with fiscal year  
 31 2012”; and  
 32 (C) by striking “subject to subclause (III),”;  
 33 (2) by striking subclause (II); and  
 34 (3) in subclause (III)—  
 35 (A) by redesignating such subclause as subclause  
 36 (II); and  
 37 (B) by striking “or (II)”.



1 **SEC. 612. REDISTRIBUTION OF UNUSED RESIDENT POSI-**  
2 **TIONS.**

3 (a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C.  
4 1395ww(h)(4)) is amended—

5 (1) in subparagraph (F), by inserting “subject to sub-  
6 paragraph (I),” after “October 1, 1997,”;

7 (2) in subparagraph (H), by inserting “subject to sub-  
8 paragraph (I),” after “subparagraphs (F) and (G),”; and

9 (3) by adding at the end the following new subpara-  
10 graph:

11 “(I) REDISTRIBUTION OF UNUSED RESIDENT PO-  
12 SITIONS.—

13 “(i) REDUCTION IN LIMIT BASED ON UNUSED  
14 POSITIONS.—

15 “(I) IN GENERAL.—If a hospital’s resident  
16 level (as defined in clause (iii)(I)) is less than  
17 the otherwise applicable resident limit (as de-  
18 fined in clause (iii)(II)) for each of the ref-  
19 erence periods (as defined in subclause (II)),  
20 effective for cost reporting periods beginning on  
21 or after January 1, 2003, the otherwise appli-  
22 cable resident limit shall be reduced by 75 per-  
23 cent of the difference between such limit and  
24 the reference resident level specified in sub-  
25 clause (III) (or subclause (IV) if applicable).

26 “(II) REFERENCE PERIODS DEFINED.—In  
27 this clause, the term ‘reference periods’ means,  
28 for a hospital, the 3 most recent consecutive  
29 cost reporting periods of the hospital for which  
30 cost reports have been settled (or, if not, sub-  
31 mitted) on or before September 30, 2001.

32 “(III) REFERENCE RESIDENT LEVEL.—  
33 Subject to subclause (IV), the reference resi-  
34 dent level specified in this subclause for a hos-  
35 pital is the highest resident level for the hos-  
36 pital during any of the reference periods.



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1           “(IV) ADJUSTMENT PROCESS.—Upon the  
2 timely request of a hospital, the Secretary may  
3 adjust the reference resident level for a hospital  
4 to be the resident level for the hospital for the  
5 cost reporting period that includes July 1,  
6 2002.

7           “(ii) REDISTRIBUTION.—

8           “(I) IN GENERAL.—The Secretary is au-  
9 thorized to increase the otherwise applicable  
10 resident limits for hospitals by an aggregate  
11 number estimated by the Secretary that does  
12 not exceed the aggregate reduction in such lim-  
13 its attributable to clause (i) (without taking  
14 into account any adjustment under subclause  
15 (IV) of such clause).

16           “(II) EFFECTIVE DATE.—No increase  
17 under subclause (I) shall be permitted or taken  
18 into account for a hospital for any portion of  
19 a cost reporting period that occurs before July  
20 1, 2003, or before the date of the hospital’s ap-  
21 plication for an increase under this clause. No  
22 such increase shall be permitted for a hospital  
23 unless the hospital has applied to the Secretary  
24 for such increase by December 31, 2004.

25           “(III) CONSIDERATIONS IN REDISTRIBU-  
26 TION.—In determining for which hospitals the  
27 increase in the otherwise applicable resident  
28 limit is provided under subclause (I), the Sec-  
29 retary shall take into account the need for such  
30 an increase by specialty and location involved,  
31 consistent with subclause (IV).

32           “(IV) PRIORITY FOR RURAL AND SMALL  
33 URBAN AREAS.—In determining for which hos-  
34 pitals and residency training programs an in-  
35 crease in the otherwise applicable resident limit  
36 is provided under subclause (I), the Secretary  
37 shall first distribute the increase to programs



1 of hospitals located in rural areas or in urban  
2 areas that are not large urban areas (as de-  
3 fined for purposes of subsection (d)) on a first-  
4 come-first-served basis (as determined by the  
5 Secretary) based on a demonstration that the  
6 hospital will fill the positions made available  
7 under this clause and not to exceed an increase  
8 of 25 full-time equivalent positions with respect  
9 to any hospital.

10 “(V) APPLICATION OF LOCALITY AD-  
11 JUSTED NATIONAL AVERAGE PER RESIDENT  
12 AMOUNT.—With respect to additional residency  
13 positions in a hospital attributable to the in-  
14 crease provided under this clause, notwith-  
15 standing any other provision of this subsection,  
16 the approved FTE resident amount is deemed  
17 to be equal to the locality adjusted national av-  
18 erage per resident amount computed under  
19 subparagraph (E) for that hospital.

20 “(VI) CONSTRUCTION.—Nothing in this  
21 clause shall be construed as permitting the re-  
22 distribution of reductions in residency positions  
23 attributable to voluntary reduction programs  
24 under paragraph (6) or as affecting the ability  
25 of a hospital to establish new medical residency  
26 training programs under subparagraph (H).

27 “(iii) RESIDENT LEVEL AND LIMIT DE-  
28 FINED.—In this subparagraph:

29 “(I) RESIDENT LEVEL.—The term ‘resi-  
30 dent level’ means, with respect to a hospital,  
31 the total number of full-time equivalent resi-  
32 dents, before the application of weighting fac-  
33 tors (as determined under this paragraph), in  
34 the fields of allopathic and osteopathic medi-  
35 cine for the hospital.

36 “(II) OTHERWISE APPLICABLE RESIDENT  
37 LIMIT.—The term ‘otherwise applicable resi-



1 dent limit' means, with respect to a hospital,  
2 the limit otherwise applicable under subpara-  
3 graphs (F)(i) and (H) on the resident level for  
4 the hospital determined without regard to this  
5 subparagraph.”.

6 (b) NO APPLICATION OF INCREASE TO IME.—Section  
7 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended  
8 by adding at the end the following: “The provisions of clause  
9 (i) of subparagraph (I) of subsection (h)(4) shall apply with re-  
10 spect to the first sentence of this clause in the same manner  
11 as it applies with respect to subparagraph (F) of such sub-  
12 section, but the provisions of clause (ii) of such subparagraph  
13 shall not apply.”.

14 (c) REPORT ON EXTENSION OF APPLICATIONS UNDER  
15 REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the  
16 Secretary shall submit to Congress a report containing rec-  
17 ommendations regarding whether to extend the deadline for ap-  
18 plications for an increase in resident limits under section  
19 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by  
20 subsection (a)).

## 21 **Subtitle C—Other Provisions**

### 22 **SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT AD-** 23 **VISORY COMMISSION (MEDPAC).**

24 (a) EXAMINATION OF BUDGET CONSEQUENCES.—Section  
25 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the  
26 end the following new paragraph:

27 “(8) EXAMINATION OF BUDGET CONSEQUENCES.—Be-  
28 fore making any recommendations, the Commission shall  
29 examine the budget consequences of such recommendations,  
30 directly or through consultation with appropriate expert en-  
31 tities.”.

32 (b) CONSIDERATION OF EFFICIENT PROVISION OF SERV-  
33 ICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–  
34 6(b)(2)(B)(i)) is amended by inserting “the efficient provision  
35 of” after “expenditures for”.

36 (c) ADDITIONAL REPORTS.—



1 (1) DATA NEEDS AND SOURCES.—The Medicare Pay-  
2 ment Advisory Commission shall conduct a study, and sub-  
3 mit a report to Congress by not later than June 1, 2003,  
4 on the need for current data, and sources of current data  
5 available, to determine the solvency and financial cir-  
6 cumstances of hospitals and other medicare providers of  
7 services. The Commission shall examine data on uncompen-  
8 sated care, as well as the sahere of uncompensated care ac-  
9 counted for by the expenses for treating illegal aliens.

10 (2) USE OF TAX-RELATED RETURNS.—Using return  
11 information provided under Form 990 of the Internal Rev-  
12 enue Service, the Commission shall submit to Congress, by  
13 not later than June 1, 2003, a report on the following:

14 (A) Investments and capital financing of hospitals  
15 participating under the medicare program and related  
16 foundations.

17 (B) Access to capital financing for private and for  
18 not-for-profit hospitals.

19 **SEC. 622. DEMONSTRATION PROJECT FOR DISEASE**  
20 **MANAGEMENT FOR CERTAIN MEDICARE**  
21 **BENEFICIARIES WITH DIABETES.**

22 (a) IN GENERAL.—The Secretary of Health and Human  
23 Services shall conduct a demonstration project under this sec-  
24 tion (in this section referred to as the “project”) to dem-  
25 onstrate the impact on costs and health outcomes of applying  
26 disease management to certain medicare beneficiaries with di-  
27 agnosed diabetes. In no case may the number of participants  
28 in the project exceed 30,000 at any time.

29 (b) VOLUNTARY PARTICIPATION.—

30 (1) ELIGIBILITY.—Medicare beneficiaries are eligible  
31 to participate in the project only if—

32 (a) they are Hispanic, as determined by the Sec-  
33 retary;

34 (A) they meet specific medical criteria dem-  
35 onstrating the appropriate diagnosis and the advanced  
36 nature of their disease;



1 (B) their physicians approve of participation in the  
2 project; and

3 (C) they are not enrolled in a Medicare+ Choice  
4 plan.

5 (2) BENEFITS.—A medicare beneficiary who is en-  
6 rolled in the project shall be eligible—

7 (A) for disease management services related to  
8 their diabetes; and

9 (B) for payment for all costs for prescription  
10 drugs without regard to whether or not they relate to  
11 the diabetes, except that the project may provide for  
12 modest cost-sharing with respect to prescription drug  
13 coverage.

14 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZA-  
15 TIONS.—

16 (1) IN GENERAL.—The Secretary of Health and  
17 Human Services shall carry out the project through con-  
18 tracts with up to three disease management organizations.  
19 The Secretary shall not enter into such a contract with an  
20 organization unless the organization demonstrates that it  
21 can produce improved health outcomes and reduce aggre-  
22 gate medicare expenditures consistent with paragraph (2).

23 (2) CONTRACT PROVISIONS.—Under such contracts—

24 (A) such an organization shall be required to pro-  
25 vide for prescription drug coverage described in sub-  
26 section (b)(2)(B);

27 (B) such an organization shall be paid a fee nego-  
28 tiated and established by the Secretary in a manner so  
29 that (taking into account savings in expenditures under  
30 parts A and B of the medicare program under title  
31 XVIII of the Social Security Act) there will be no net  
32 increase, and to the extent practicable, there will be a  
33 net reduction in expenditures under the medicare pro-  
34 gram as a result of the project; and

35 (C) such an organization shall guarantee, through  
36 an appropriate arrangement with a reinsurance com-



1           pany or otherwise, the prohibition on net increases in  
2           expenditures described in subparagraph (B).

3           (3) PAYMENTS.—Payments to such organizations shall  
4           be made in appropriate proportion from the Trust Funds  
5           established under title XVIII of the Social Security Act.

6           (4) WORKING GROUP.—The Secretary shall establish  
7           within the Department of Health and Human Services a  
8           working group consisting of employees of the Department  
9           to carry out the following:

10           (A) To oversee the project.

11           (B) To establish policy and criteria for medicare  
12           disease management programs within the Department,  
13           including the establishment of policy and criteria for  
14           such programs.

15           (C) To identify targeted medical conditions and  
16           targeted individuals.

17           (D) To select areas in which such programs are  
18           carried out.

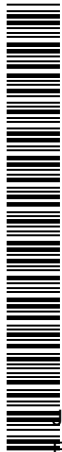
19           (E) To monitor health outcomes under such pro-  
20           grams.

21           (F) To measure the effectiveness of such programs  
22           in meeting any budget neutrality requirements.

23           (G) Otherwise to serve as a central focal point  
24           within the Department for dissemination of information  
25           on medicare disease management programs.

26           (d) APPLICATION OF MEDIGAP PROTECTIONS TO DEM-  
27           ONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph  
28           (2), the provisions of section 1882(s)(3) (other than clauses (i)  
29           through (iv) of subparagraph (B)) and 1882(s)(4) of the Social  
30           Security Act shall apply to enrollment (and termination of en-  
31           rollment) in the demonstration project under this section, in  
32           the same manner as they apply to enrollment (and termination  
33           of enrollment) with a Medicare+ Choice organization in a  
34           Medicare+ Choice plan.

35           (2) In applying paragraph (1)—





1 (A) any reference in clause (v) or (vi) of section  
2 1882(s)(3)(B) of such Act to 12 months is deemed a ref-  
3 erence to the period of the demonstration project; and

4 (B) the notification required under section  
5 1882(s)(3)(D) of such Act shall be provided in a manner  
6 specified by the Secretary of Health and Human Services.

7 (e) DURATION.—The project shall last for not longer than  
8 3 years.

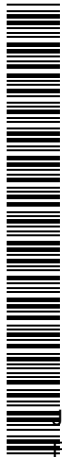
9 (f) WAIVER.—The Secretary of Health and Human Serv-  
10 ices shall waive such provisions of title XVIII of the Social Se-  
11 curity Act as may be necessary to provide for payment for serv-  
12 ices under the project in accordance with subsection (c)(3).

13 (g) REPORT.—The Secretary of Health and Human Serv-  
14 ices shall submit to Congress an interim report on the project  
15 not later than 2 years after the date it is first implemented and  
16 a final report on the project not later than 6 months after the  
17 date of its completion. Such reports shall include information  
18 on the impact of the project on costs and health outcomes and  
19 recommendations on the cost-effectiveness of extending or ex-  
20 panding the project.

21 (h) GAO STUDY ON DISEASE MANAGEMENT PRO-  
22 GRAMS.—The Comptroller General of the United States shall  
23 conduct a study that compares disease management programs  
24 under title XVIII of the Social Security Act with such pro-  
25 grams conducted in the private sector, including the prevalence  
26 of such programs and programs for case management. The  
27 study shall identify the cost-effectiveness of such programs and  
28 any savings achieved by such programs. The Comptroller Gen-  
29 eral shall submit a report on such study to Congress by not  
30 later than 18 months after the date of the enactment of this  
31 Act.

32 **SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL**  
33 **ADULT DAY CARE SERVICES.**

34 (a) ESTABLISHMENT.—Subject to the succeeding provi-  
35 sions of this section, the Secretary of Health and Human Serv-  
36 ices shall establish a demonstration project (in this section re-  
37 ferred to as the “demonstration project”) under which the Sec-



1     retary shall, as part of a plan of an episode of care for home  
2     health services established for a medicare beneficiary, permit a  
3     home health agency, directly or under arrangements with a  
4     medical adult day care facility, to provide medical adult day  
5     care services as a substitute for a portion of home health serv-  
6     ices that would otherwise be provided in the beneficiary's home.

7           (b) PAYMENT.—

8           (1) IN GENERAL.—The amount of payment for an epi-  
9     isode of care for home health services, a portion of which  
10    consists of substitute medical adult day care services, under  
11    the demonstration project shall be made at a rate equal to  
12    95 percent of the amount that would otherwise apply for  
13    such home health services under section 1895 of the Social  
14    Security Act (42 u.s.c. 1395fff). In no case may a home  
15    health agency, or a medical adult day care facility under  
16    arrangements with a home health agency, separately charge  
17    a beneficiary for medical adult day care services furnished  
18    under the plan of care.

19          (2) BUDGET NEUTRALITY FOR DEMONSTRATION  
20    PROJECT.—Notwithstanding any other provision of law, the  
21    Secretary shall provide for an appropriate reduction in the  
22    aggregate amount of additional payments made under sec-  
23    tion 1895 of the Social Security Act (42 U.S.C. 1395fff)  
24    to reflect any increase in amounts expended from the Trust  
25    Funds as a result of the demonstration project conducted  
26    under this section.

27          (c) DEMONSTRATION PROJECT SITES.—The project estab-  
28    lished under this section shall be conducted in not more than  
29    5 sites in States selected by the Secretary that license or certify  
30    providers of services that furnish medical adult day care serv-  
31    ices.

32          (d) DURATION.—The Secretary shall conduct the dem-  
33    onstration project for a period of 3 years.

34          (e) VOLUNTARY PARTICIPATION.—Participation of medi-  
35    care beneficiaries in the demonstration project shall be vol-  
36    untary. The total number of such beneficiaries that may par-



1 participate in the project at any given time may not exceed  
2 15,000.

3 (f) PREFERENCE IN SELECTING AGENCIES.—In selecting  
4 home health agencies to participate under the demonstration  
5 project, the Secretary shall give preference to those agencies  
6 that—

7 (1) are currently licensed or certified to furnish med-  
8 ical adult day care services; and

9 (2) have furnished medical adult day care services to  
10 medicare beneficiaries for a continuous 2-year period before  
11 the beginning of the demonstration project.

12 (g) WAIVER AUTHORITY.—The Secretary may waive such  
13 requirements of title XVIII of the Social Security Act as may  
14 be necessary for the purposes of carrying out the demonstra-  
15 tion project, other than waiving the requirement that an indi-  
16 vidual be homebound in order to be eligible for benefits for  
17 home health services.

18 (h) EVALUATION AND REPORT.—The Secretary shall con-  
19 duct an evaluation of the clinical and cost effectiveness of the  
20 demonstration project. Not later 30 months after the com-  
21 mencement of the project, the Secretary shall submit to Con-  
22 gress a report on the evaluation, and shall include in the report  
23 the following:

24 (1) An analysis of the patient outcomes and costs of  
25 furnishing care to the medicare beneficiaries participating  
26 in the project as compared to such outcomes and costs to  
27 beneficiaries receiving only home health services for the  
28 same health conditions.

29 (2) Such recommendations regarding the extension,  
30 expansion, or termination of the project as the Secretary  
31 determines appropriate.

32 (i) DEFINITIONS.—In this section:

33 (1) HOME HEALTH AGENCY.—The term “home health  
34 agency” has the meaning given such term in section  
35 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

36 (2) MEDICAL ADULT DAY CARE FACILITY.—The term  
37 “medical adult day care facility” means a facility that—



1 (A) has been licensed or certified by a State to  
2 furnish medical adult day care services in the State for  
3 a continuous 2-year period;

4 (B) is engaged in providing skilled nursing serv-  
5 ices and other therapeutic services directly or under ar-  
6 rangement with a home health agency;

7 (C) meets such standards established by the Sec-  
8 retary to assure quality of care and such other require-  
9 ments as the Secretary finds necessary in the interest  
10 of the health and safety of individuals who are fur-  
11 nished services in the facility; and

12 (D) provides medical adult day care services.

13 (3) MEDICAL ADULT DAY CARE SERVICES.—The term  
14 “medical adult day care services” means—

15 (A) home health service items and services de-  
16 scribed in paragraphs (1) through (7) of section  
17 1861(m) furnished in a medical adult day care facility;

18 (B) a program of supervised activities furnished in  
19 a group setting in the facility that—

20 (i) meet such criteria as the Secretary deter-  
21 mines appropriate; and

22 (ii) is designed to promote physical and mental  
23 health of the individuals; and

24 (C) such other services as the Secretary may  
25 specify.

26 (4) MEDICARE BENEFICIARY.—The term “medicare  
27 beneficiary” means an individual entitled to benefits under  
28 part A of this title, enrolled under part B of this title, or  
29 both.

30 **TITLE VII—MEDICARE BENEFITS**  
31 **ADMINISTRATION**

32 **SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS AD-**  
33 **MINISTRATION.**

34 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.),  
35 as amended by section 105, is amended by inserting after 1806  
36 the following new section:



1 "MEDICARE BENEFITS ADMINISTRATION

2 "SEC. 1808. (a) ESTABLISHMENT.—There is established  
3 within the Department of Health and Human Services an agen-  
4 cy to be known as the Medicare Benefits Administration.

5 "(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF  
6 ACTUARY.—

7 "(1) ADMINISTRATOR.—

8 "(A) IN GENERAL.—The Medicare Benefits Ad-  
9 ministration shall be headed by an administrator to be  
10 known as the 'Medicare Benefits Administrator' (in  
11 this section referred to as the 'Administrator') who  
12 shall be appointed by the President, by and with the  
13 advice and consent of the Senate. The Administrator  
14 shall be in direct line of authority to the Secretary.

15 "(B) COMPENSATION.—The Administrator shall  
16 be paid at the rate of basic pay payable for level III  
17 of the Executive Schedule under section 5314 of title  
18 5, United States Code.

19 "(C) TERM OF OFFICE.—The Administrator shall  
20 be appointed for a term of 5 years. In any case in  
21 which a successor does not take office at the end of an  
22 Administrator's term of office, that Administrator may  
23 continue in office until the entry upon office of such a  
24 successor. An Administrator appointed to a term of of-  
25 fice after the commencement of such term may serve  
26 under such appointment only for the remainder of such  
27 term.

28 "(D) GENERAL AUTHORITY.—The Administrator  
29 shall be responsible for the exercise of all powers and  
30 the discharge of all duties of the Administration, and  
31 shall have authority and control over all personnel and  
32 activities thereof.

33 "(E) RULEMAKING AUTHORITY.—The Adminis-  
34 trator may prescribe such rules and regulations as the  
35 Administrator determines necessary or appropriate to  
36 carry out the functions of the Administration. The reg-  
37 ulations prescribed by the Administrator shall be sub-



1           ject to the rulemaking procedures established under  
2           section 553 of title 5, United States Code.

3           “(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL  
4           UNITS.—The Administrator may establish, alter, con-  
5           solidate, or discontinue such organizational units or  
6           components within the Administration as the Adminis-  
7           trator considers necessary or appropriate, except as  
8           specified in this section.

9           “(G) AUTHORITY TO DELEGATE.—The Adminis-  
10          trator may assign duties, and delegate, or authorize  
11          successive redelegations of, authority to act and to  
12          render decisions, to such officers and employees of the  
13          Administration as the Administrator may find nec-  
14          essary. Within the limitations of such delegations, re-  
15          delegations, or assignments, all official acts and deci-  
16          sions of such officers and employees shall have the  
17          same force and effect as though performed or rendered  
18          by the Administrator.

19          “(2) DEPUTY ADMINISTRATOR.—

20          “(A) IN GENERAL.—There shall be a Deputy Ad-  
21          ministrator of the Medicare Benefits Administration  
22          who shall be appointed by the President, by and with  
23          the advice and consent of the Senate.

24          “(B) COMPENSATION.—The Deputy Administrator  
25          shall be paid at the rate of basic pay payable for level  
26          IV of the Executive Schedule under section 5315 of  
27          title 5, United States Code.

28          “(C) TERM OF OFFICE.—The Deputy Adminis-  
29          trator shall be appointed for a term of 5 years. In any  
30          case in which a successor does not take office at the  
31          end of a Deputy Administrator’s term of office, such  
32          Deputy Administrator may continue in office until the  
33          entry upon office of such a successor. A Deputy Ad-  
34          ministrator appointed to a term of office after the com-  
35          mencement of such term may serve under such ap-  
36          pointment only for the remainder of such term.



1           “(D) DUTIES.—The Deputy Administrator shall  
2 perform such duties and exercise such powers as the  
3 Administrator shall from time to time assign or dele-  
4 gate. The Deputy Administrator shall be Acting Ad-  
5 ministrator of the Administration during the absence or  
6 disability of the Administrator and, unless the Presi-  
7 dent designates another officer of the Government as  
8 Acting Administrator, in the event of a vacancy in the  
9 office of the Administrator.

10           “(3) CHIEF ACTUARY.—

11           “(A) IN GENERAL.—There is established in the  
12 Administration the position of Chief Actuary. The  
13 Chief Actuary shall be appointed by, and in direct line  
14 of authority to, the Administrator of such Administra-  
15 tion. The Chief Actuary shall be appointed from among  
16 individuals who have demonstrated, by their education  
17 and experience, superior expertise in the actuarial  
18 sciences. The Chief Actuary may be removed only for  
19 cause.

20           “(B) COMPENSATION.—The Chief Actuary shall  
21 be compensated at the highest rate of basic pay for the  
22 Senior Executive Service under section 5382(b) of title  
23 5, United States Code.

24           “(C) DUTIES.—The Chief Actuary shall exercise  
25 such duties as are appropriate for the office of the  
26 Chief Actuary and in accordance with professional  
27 standards of actuarial independence.

28           “(4) SECRETARIAL COORDINATION OF PROGRAM AD-  
29 MINISTRATION.—The Secretary shall ensure appropriate  
30 coordination between the Administrator and the Adminis-  
31 trator of the Centers for Medicare & Medicaid Services in  
32 carrying out the programs under this title.

33           “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

34           “(1) DUTIES.—

35           “(A) GENERAL DUTIES.—The Administrator shall  
36 carry out parts C and D, including—



1                   “(i) negotiating, entering into, and enforcing,  
 2                   contracts with plans for the offering of  
 3                   Medicare+ Choice plans under part C, including the  
 4                   offering of qualified prescription drug coverage  
 5                   under such plans; and

6                   “(ii) negotiating, entering into, and enforcing,  
 7                   contracts with PDP sponsors for the offering of  
 8                   prescription drug plans under part D.

9                   “(B) OTHER DUTIES.—The Administrator shall  
 10                  carry out any duty provided for under part C or part  
 11                  D, including demonstration projects carried out in part  
 12                  or in whole under such parts, the programs of all-inclu-  
 13                  sive care for the elderly (PACE program) under section  
 14                  1894, the social health maintenance organization  
 15                  (SHMO) demonstration projects (referred to in section  
 16                  4104(c) of the Balanced Budget Act of 1997), and  
 17                  through a Medicare+ Choice project that demonstrates  
 18                  the application of capitation payment rates for frail el-  
 19                  derly medicare beneficiaries through the use of a inter-  
 20                  disciplinary team and through the provision of primary  
 21                  care services to such beneficiaries by means of such a  
 22                  team at the nursing facility involved).

23                  “(C) PRESCRIPTION DRUG CARD.—The Adminis-  
 24                  trator shall carry out section 1807 (relating to the  
 25                  medicare prescription drug discount card endorsement  
 26                  program).

27                  “(D) NONINTERFERENCE.—In carrying out its  
 28                  duties with respect to the provision of qualified pre-  
 29                  scription drug coverage to beneficiaries under this title,  
 30                  the Administrator may not—

31                         “(i) require a particular formulary or institute  
 32                         a price structure for the reimbursement of covered  
 33                         outpatient drugs;

34                         “(ii) interfere in any way with negotiations be-  
 35                         tween PDP sponsors and Medicare+ Choice organi-  
 36                         zations and drug manufacturers, wholesalers, or  
 37                         other suppliers of covered outpatient drugs; and





1           “(iii) otherwise interfere with the competitive  
2           nature of providing such coverage through such  
3           sponsors and organizations.

4           “(E) ANNUAL REPORTS.—Not later March 31 of  
5           each year, the Administrator shall submit to Congress  
6           and the President a report on the administration of  
7           parts C and D during the previous fiscal year.

8           “(2) STAFF.—

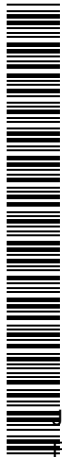
9           “(A) IN GENERAL.—The Administrator, with the  
10          approval of the Secretary, may employ, without regard  
11          to chapter 31 of title 5, United States Code, other than  
12          sections 3110 and 3112, such officers and employees as  
13          are necessary to administer the activities to be carried  
14          out through the Medicare Benefits Administration. The  
15          Administrator shall employ staff with appropriate and  
16          necessary expertise in negotiating contracts in the pri-  
17          vate sector.

18          “(B) FLEXIBILITY WITH RESPECT TO COMPENSA-  
19          TION.—

20          “(i) IN GENERAL.—The staff of the Medicare  
21          Benefits Administration shall, subject to clause (ii),  
22          be paid without regard to the provisions of chapter  
23          51 (other than section 5101) and chapter 53 (other  
24          than section 5301) of such title (relating to classi-  
25          fication and schedule pay rates).

26          “(ii) MAXIMUM RATE.—In no case may the  
27          rate of compensation determined under clause (i)  
28          exceed the rate of basic pay payable for level IV of  
29          the Executive Schedule under section 5315 of title  
30          5, United States Code.

31          “(C) LIMITATION ON FULL-TIME EQUIVALENT  
32          STAFFING FOR CURRENT CMS FUNCTIONS BEING  
33          TRANSFERRED.—The Administrator may not employ  
34          under this paragraph a number of full-time equivalent  
35          employees, to carry out functions that were previously  
36          conducted by the Centers for Medicare & Medicaid  
37          Services and that are conducted by the Administrator



1 by reason of this section, that exceeds the number of  
2 such full-time equivalent employees authorized to be  
3 employed by the Centers for Medicare & Medicaid Serv-  
4 ices to conduct such functions as of the date of the en-  
5 actment of this Act.

6 “(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE  
7 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

8 “(A) IN GENERAL.—The Secretary, the Adminis-  
9 trator, and the Administrator of the Centers for Medi-  
10 care & Medicaid Services shall establish an appropriate  
11 transition of responsibility in order to redelegate the  
12 administration of part C from the Secretary and the  
13 Administrator of the Centers for Medicare & Medicaid  
14 Services to the Administrator as is appropriate to carry  
15 out the purposes of this section.

16 “(B) TRANSFER OF DATA AND INFORMATION.—  
17 The Secretary shall ensure that the Administrator of  
18 the Centers for Medicare & Medicaid Services transfers  
19 to the Administrator of the Medicare Benefits Adminis-  
20 tration such information and data in the possession of  
21 the Administrator of the Centers for Medicare & Med-  
22 icaid Services as the Administrator of the Medicare  
23 Benefits Administration requires to carry out the du-  
24 ties described in paragraph (1).

25 “(C) CONSTRUCTION.—Insofar as a responsibility  
26 of the Secretary or the Administrator of the Centers  
27 for Medicare & Medicaid Services is redelegated to the  
28 Administrator under this section, any reference to the  
29 Secretary or the Administrator of the Centers for Medi-  
30 care & Medicaid Services in this title or title XI with  
31 respect to such responsibility is deemed to be a ref-  
32 erence to the Administrator.

33 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

34 “(1) ESTABLISHMENT.—The Secretary shall establish  
35 within the Medicare Benefits Administration an Office of  
36 Beneficiary Assistance to coordinate functions relating to  
37 outreach and education of medicare beneficiaries under this



1 title, including the functions described in paragraph (2).  
2 The Office shall be separate operating division within the  
3 Administration.

4 “(2) DISSEMINATION OF INFORMATION ON BENEFITS  
5 AND APPEALS RIGHTS.—

6 “(A) DISSEMINATION OF BENEFITS INFORMA-  
7 TION.—The Office of Beneficiary Assistance shall dis-  
8 seminate, directly or through contract, to medicare  
9 beneficiaries, by mail, by posting on the Internet site  
10 of the Medicare Benefits Administration and through a  
11 toll-free telephone number, information with respect to  
12 the following:

13 “(i) Benefits, and limitations on payment (in-  
14 cluding cost-sharing, stop-loss provisions, and for-  
15 mulary restrictions) under parts C and D.

16 “(ii) Benefits, and limitations on payment  
17 under parts A and B, including information on  
18 medicare supplemental policies under section 1882.  
19 Such information shall be presented in a manner so  
20 that medicare beneficiaries may compare benefits under  
21 parts A, B, D, and medicare supplemental policies with  
22 benefits under Medicare+ Choice plans under part C.

23 “(B) DISSEMINATION OF APPEALS RIGHTS INFOR-  
24 MATION.—The Office of Beneficiary Assistance shall  
25 disseminate to medicare beneficiaries in the manner  
26 provided under subparagraph (A) a description of pro-  
27 cedural rights (including grievance and appeals proce-  
28 dures) of beneficiaries under the original medicare fee-  
29 for-service program under parts A and B, the  
30 Medicare+ Choice program under part C, and the Vol-  
31 untary Prescription Drug Benefit Program under part  
32 D.

33 “(e) MEDICARE POLICY ADVISORY BOARD.—

34 “(1) ESTABLISHMENT.—There is established within  
35 the Medicare Benefits Administration the Medicare Policy  
36 Advisory Board (in this section referred to the ‘Board’).  
37 The Board shall advise, consult with, and make rec-



1           ommendations to the Administrator of the Medicare Bene-  
2           fits Administration with respect to the administration of  
3           parts C and D, including the review of payment policies  
4           under such parts.

5           “(2) REPORTS.—

6           “(A) IN GENERAL.—With respect to matters of  
7           the administration of parts C and D, the Board shall  
8           submit to Congress and to the Administrator of the  
9           Medicare Benefits Administration such reports as the  
10          Board determines appropriate. Each such report may  
11          contain such recommendations as the Board determines  
12          appropriate for legislative or administrative changes to  
13          improve the administration of such parts, including the  
14          topics described in subparagraph (B). Each such report  
15          shall be published in the Federal Register.

16          “(B) TOPICS DESCRIBED.—Reports required  
17          under subparagraph (A) may include the following top-  
18          ics:

19               “(i) FOSTERING COMPETITION.—Rec-  
20               ommendations or proposals to increase competition  
21               under parts C and D for services furnished to  
22               medicare beneficiaries.

23               “(ii) EDUCATION AND ENROLLMENT.—Rec-  
24               ommendations for the improvement to efforts to  
25               provide medicare beneficiaries information and edu-  
26               cation on the program under this title, and specifi-  
27               cally parts C and D, and the program for enroll-  
28               ment under the title.

29               “(iii) IMPLEMENTATION OF RISK-ADJUST-  
30               MENT.—Evaluation of the implementation under  
31               section 1853(a)(3)(C) of the risk adjustment meth-  
32               odology to payment rates under that section to  
33               Medicare+ Choice organizations offering  
34               Medicare+ Choice plans that accounts for variations  
35               in per capita costs based on health status and other  
36               demographic factors.



1                   “(iv) DISEASE MANAGEMENT PROGRAMS.—  
 2                   Recommendations on the incorporation of disease  
 3                   management programs under parts C and D.

4                   “(v) RURAL ACCESS.—Recommendations to  
 5                   improve competition and access to plans under  
 6                   parts C and D in rural areas.

7                   “(C) MAINTAINING INDEPENDENCE OF BOARD.—  
 8                   The Board shall directly submit to Congress reports re-  
 9                   quired under subparagraph (A). No officer or agency of  
 10                  the United States may require the Board to submit to  
 11                  any officer or agency of the United States for approval,  
 12                  comments, or review, prior to the submission to Con-  
 13                  gress of such reports.

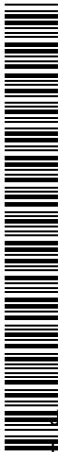
14                  “(3) DUTY OF ADMINISTRATOR OF MEDICARE BENE-  
 15                  FITS ADMINISTRATION.—With respect to any report sub-  
 16                  mitted by the Board under paragraph (2)(A), not later  
 17                  than 90 days after the report is submitted, the Adminis-  
 18                  trator of the Medicare Benefits Administration shall submit  
 19                  to Congress and the President an analysis of recommenda-  
 20                  tions made by the Board in such report. Each such analysis  
 21                  shall be published in the Federal Register.

22                  “(4) MEMBERSHIP.—  
 23                  “(A) APPOINTMENT.—Subject to the succeeding  
 24                  provisions of this paragraph, the Board shall consist of  
 25                  seven members to be appointed as follows:

26                         “(i) Three members shall be appointed by the  
 27                         President.

28                         “(ii) Two members shall be appointed by the  
 29                         Speaker of the House of Representatives, with the  
 30                         advice of the chairmen and the ranking minority  
 31                         members of the Committees on Ways and Means  
 32                         and on Energy and Commerce of the House of  
 33                         Representatives.

34                         “(iii) Two members shall be appointed by the  
 35                         President pro tempore of the Senate with the ad-  
 36                         vice of the chairman and the ranking minority  
 37                         member of the Senate Committee on Finance.



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1           “(B) QUALIFICATIONS.—The members shall be  
2 chosen on the basis of their integrity, impartiality, and  
3 good judgment, and shall be individuals who are, by  
4 reason of their education and experience in health care  
5 benefits management, exceptionally qualified to perform  
6 the duties of members of the Board.

7           “(C) PROHIBITION ON INCLUSION OF FEDERAL  
8 EMPLOYEES.—No officer or employee of the United  
9 States may serve as a member of the Board.

10          “(5) COMPENSATION.—Members of the Board shall  
11 receive, for each day (including travel time) they are en-  
12 gaged in the performance of the functions of the board,  
13 compensation at rates not to exceed the daily equivalent to  
14 the annual rate in effect for level IV of the Executive  
15 Schedule under section 5315 of title 5, United States Code.

16          “(6) TERMS OF OFFICE.—

17           “(A) IN GENERAL.—The term of office of mem-  
18 bers of the Board shall be 3 years.

19           “(B) TERMS OF INITIAL APPOINTEES.—As des-  
20 ignated by the President at the time of appointment,  
21 of the members first appointed—

22           “(i) one shall be appointed for a term of 1  
23 year;

24           “(ii) three shall be appointed for terms of 2  
25 years; and

26           “(iii) three shall be appointed for terms of 3  
27 years.

28           “(C) REAPPOINTMENTS.—Any person appointed  
29 as a member of the Board may not serve for more than  
30 8 years.

31           “(D) VACANCY.—Any member appointed to fill a  
32 vacancy occurring before the expiration of the term for  
33 which the member’s predecessor was appointed shall be  
34 appointed only for the remainder of that term. A mem-  
35 ber may serve after the expiration of that member’s  
36 term until a successor has taken office. A vacancy in



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1 the Board shall be filled in the manner in which the  
2 original appointment was made.

3 “(7) CHAIR.—The Chair of the Board shall be elected  
4 by the members. The term of office of the Chair shall be  
5 3 years.

6 “(8) MEETINGS.—The Board shall meet at the call of  
7 the Chair, but in no event less than three times during  
8 each fiscal year.

9 “(9) DIRECTOR AND STAFF.—

10 “(A) APPOINTMENT OF DIRECTOR.—The Board  
11 shall have a Director who shall be appointed by the  
12 Chair.

13 “(B) IN GENERAL.—With the approval of the  
14 Board, the Director may appoint, without regard to  
15 chapter 31 of title 5, United States Code, such addi-  
16 tional personnel as the Director considers appropriate.

17 “(C) FLEXIBILITY WITH RESPECT TO COMPENSA-  
18 TION.—

19 “(i) IN GENERAL.—The Director and staff of  
20 the Board shall, subject to clause (ii), be paid with-  
21 out regard to the provisions of chapter 51 and  
22 chapter 53 of such title (relating to classification  
23 and schedule pay rates).

24 “(ii) MAXIMUM RATE.—In no case may the  
25 rate of compensation determined under clause (i)  
26 exceed the rate of basic pay payable for level IV of  
27 the Executive Schedule under section 5315 of title  
28 5, United States Code.

29 “(D) ASSISTANCE FROM THE ADMINISTRATOR OF  
30 THE MEDICARE BENEFITS ADMINISTRATION.—The Ad-  
31 ministrator of the Medicare Benefits Administration  
32 shall make available to the Board such information and  
33 other assistance as it may require to carry out its func-  
34 tions.

35 “(10) CONTRACT AUTHORITY.—The Board may con-  
36 tract with and compensate government and private agencies  
37 or persons to carry out its duties under this subsection,



1 without regard to section 3709 of the Revised Statutes (41  
2 U.S.C. 5).

3 “(f) FUNDING.—There is authorized to be appropriated, in  
4 appropriate part from the Federal Hospital Insurance Trust  
5 Fund and from the Federal Supplementary Medical Insurance  
6 Trust Fund (including the Medicare Prescription Drug Ac-  
7 count), such sums as are necessary to carry out this section.”.

8 (b) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The amendment made by sub-  
10 section (a) shall take effect on the date of the enactment  
11 of this Act.

12 (2) TIMING OF INITIAL APPOINTMENTS.—The Admin-  
13 istrator and Deputy Administrator of the Medicare Bene-  
14 fits Administration may not be appointed before March 1,  
15 2003.

16 (3) DUTIES WITH RESPECT TO ELIGIBILITY DETER-  
17 MINATIONS AND ENROLLMENT.—The Administrator of the  
18 Medicare Benefits Administration shall carry out enroll-  
19 ment under title XVIII of the Social Security Act, make  
20 eligibility determinations under such title, and carry out  
21 part C of such title for years beginning or after January  
22 1, 2005.

23 (4) TRANSITION.—Before the date the Administrator  
24 of the Medicare Benefits Administration is appointed and  
25 assumes responsibilities under this section and section  
26 1807 of the Social Security Act, the Secretary of Health  
27 and Human Services shall provide for the conduct of any  
28 responsibilities of such Administrator that are otherwise  
29 provided under law.

30 (c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

31 (1) ADMINISTRATOR AS MEMBER OF THE BOARD OF  
32 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section  
33 1817(b) and section 1841(b) (42 U.S.C. 1395i(b),  
34 1395t(b)) are each amended by striking “and the Secretary  
35 of Health and Human Services, all ex officio,” and insert-  
36 ing “the Secretary of Health and Human Services, and the





1 Administrator of the Medicare Benefits Administration, all  
2 ex officio.”.

3 (2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR  
4 THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE &  
5 MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS AD-  
6 MINISTRATOR.—

7 (A) IN GENERAL.—Section 5314 of title 5, United  
8 States Code, by adding at the end the following:

9 “Administrator of the Centers for Medicare &  
10 Medicaid Services .

11 “Administrator of the Medicare Benefits Adminis-  
12 tration.”.

13 (B) CONFORMING AMENDMENT.—Section 5315 of  
14 such title is amended by striking “Administrator of the  
15 Health Care Financing Administration.”.

16 (C) EFFECTIVE DATE.—The amendments made by  
17 this paragraph take effect on January 1, 2003.

18 **TITLE VIII—REGULATORY REDUC-**  
19 **TION AND CONTRACTING RE-**  
20 **FORM**

21 **Subtitle A—Regulatory Reform**

22 **SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.**

23 (a) CONSTRUCTION.—Nothing in this title shall be  
24 construed—

25 (1) to compromise or affect existing legal remedies for  
26 addressing fraud or abuse, whether it be criminal prosecu-  
27 tion, civil enforcement, or administrative remedies, includ-  
28 ing under sections 3729 through 3733 of title 31, United  
29 States Code (known as the False Claims Act); or

30 (2) to prevent or impede the Department of Health  
31 and Human Services in any way from its ongoing efforts  
32 to eliminate waste, fraud, and abuse in the medicare pro-  
33 gram.

34 Furthermore, the consolidation of medicare administrative con-  
35 tracting set forth in this Act does not constitute consolidation  
36 of the Federal Hospital Insurance Trust Fund and the Federal



1 Supplementary Medical Insurance Trust Fund or reflect any  
2 position on that issue.

3 (b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C.  
4 1395x) is amended by inserting after subsection (c) the fol-  
5 lowing new subsection:

6 “Supplier

7 “(d) The term ‘supplier’ means, unless the context other-  
8 wise requires, a physician or other practitioner, a facility, or  
9 other entity (other than a provider of services) that furnishes  
10 items or services under this title.”.

11 **SEC. 802. ISSUANCE OF REGULATIONS.**

12 (a) CONSOLIDATION OF PROMULGATION TO ONCE A  
13 MONTH.—

14 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh)  
15 is amended by adding at the end the following new sub-  
16 section:

17 “(d)(1) Subject to paragraph (2), the Secretary shall issue  
18 proposed or final (including interim final) regulations to carry  
19 out this title only on one business day of every month.

20 “(2) The Secretary may issue a proposed or final regula-  
21 tion described in paragraph (1) on any other day than the day  
22 described in paragraph (1) if the Secretary—

23 “(A) finds that issuance of such regulation on another  
24 day is necessary to comply with requirements under law; or

25 “(B) finds that with respect to that regulation the lim-  
26 itation of issuance on the date described in paragraph (1)  
27 is contrary to the public interest.

28 If the Secretary makes a finding under this paragraph, the  
29 Secretary shall include such finding, and brief statement of the  
30 reasons for such finding, in the issuance of such regulation.

31 “(3) The Secretary shall coordinate issuance of new regu-  
32 lations described in paragraph (1) relating to a category of pro-  
33 vider of services or suppliers based on an analysis of the collec-  
34 tive impact of regulatory changes on that category of providers  
35 or suppliers.”.

36 (2) GAO REPORT ON PUBLICATION OF REGULATIONS  
37 ON A QUARTERLY BASIS.—Not later than 3 years after the



1 date of the enactment of this Act, the Comptroller General  
2 of the United States shall submit to Congress a report on  
3 the feasibility of requiring that regulations described in sec-  
4 tion 1871(d) of the Social Security Act be promulgated on  
5 a quarterly basis rather than on a monthly basis.

6 (3) EFFECTIVE DATE.—The amendment made by  
7 paragraph (1) shall apply to regulations promulgated on or  
8 after the date that is 30 days after the date of the enact-  
9 ment of this Act.

10 (b) REGULAR TIMELINE FOR PUBLICATION OF FINAL  
11 RULES.—

12 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
13 1395hh(a)) is amended by adding at the end the following  
14 new paragraph:

15 “(3)(A) The Secretary, in consultation with the Director  
16 of the Office of Management and Budget, shall establish and  
17 publish a regular timeline for the publication of final regula-  
18 tions based on the previous publication of a proposed regulation  
19 or an interim final regulation.

20 “(B) Such timeline may vary among different regulations  
21 based on differences in the complexity of the regulation, the  
22 number and scope of comments received, and other relevant  
23 factors, but shall not be longer than 3 years except under ex-  
24 ceptional circumstances. If the Secretary intends to vary such  
25 timeline with respect to the publication of a final regulation,  
26 the Secretary shall cause to have published in the Federal Reg-  
27 ister notice of the different timeline by not later than the  
28 timeline previously established with respect to such regulation.  
29 Such notice shall include a brief explanation of the justification  
30 for such variation.

31 “(C) In the case of interim final regulations, upon the ex-  
32 piration of the regular timeline established under this para-  
33 graph for the publication of a final regulation after opportunity  
34 for public comment, the interim final regulation shall not con-  
35 tinue in effect unless the Secretary publishes (at the end of the  
36 regular timeline and, if applicable, at the end of each suc-  
37 ceeding 1-year period) a notice of continuation of the regulation



1 that includes an explanation of why the regular timeline (and  
2 any subsequent 1-year extension) was not complied with. If  
3 such a notice is published, the regular timeline (or such  
4 timeline as previously extended under this paragraph) for publi-  
5 cation of the final regulation shall be treated as having been  
6 extended for 1 additional year.

7 “(D) The Secretary shall annually submit to Congress a  
8 report that describes the instances in which the Secretary failed  
9 to publish a final regulation within the applicable regular  
10 timeline under this paragraph and that provides an explanation  
11 for such failures.”.

12 (2) EFFECTIVE DATE.—The amendment made by  
13 paragraph (1) shall take effect on the date of the enact-  
14 ment of this Act. The Secretary shall provide for an appro-  
15 priate transition to take into account the backlog of pre-  
16 viously published interim final regulations.

17 (c) LIMITATIONS ON NEW MATTER IN FINAL REGULA-  
18 TIONS.—

19 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
20 1395hh(a)), as amended by subsection (b), is further  
21 amended by adding at the end the following new para-  
22 graph:

23 “(4) If the Secretary publishes notice of proposed rule-  
24 making relating to a regulation (including an interim final reg-  
25 ulation), insofar as such final regulation includes a provision  
26 that is not a logical outgrowth of such notice of proposed rule-  
27 making, that provision shall be treated as a proposed regulation  
28 and shall not take effect until there is the further opportunity  
29 for public comment and a publication of the provision again as  
30 a final regulation.”.

31 (2) EFFECTIVE DATE.—The amendment made by  
32 paragraph (1) shall apply to final regulations published on  
33 or after the date of the enactment of this Act.

34 **SEC. 803. COMPLIANCE WITH CHANGES IN REGULA-**  
35 **TIONS AND POLICIES.**

36 (a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE  
37 CHANGES.—



1 (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh),  
2 as amended by section 802(a), is amended by adding at the  
3 end the following new subsection:

4 “(e)(1)(A) A substantive change in regulations, manual in-  
5 structions, interpretative rules, statements of policy, or guide-  
6 lines of general applicability under this title shall not be applied  
7 (by extrapolation or otherwise) retroactively to items and serv-  
8 ices furnished before the effective date of the change, unless  
9 the Secretary determines that—

10 “(i) such retroactive application is necessary to comply  
11 with statutory requirements; or

12 “(ii) failure to apply the change retroactively would be  
13 contrary to the public interest.”.

14 (2) EFFECTIVE DATE.—The amendment made by  
15 paragraph (1) shall apply to substantive changes issued on  
16 or after the date of the enactment of this Act.

17 (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE  
18 CHANGES AFTER NOTICE.—

19 (1) IN GENERAL.—Section 1871(e)(1), as added by  
20 subsection (a), is amended by adding at the end the fol-  
21 lowing:

22 “(B)(i) Except as provided in clause (ii), a substantive  
23 change referred to in subparagraph (A) shall not become effec-  
24 tive before the end of the 30-day period that begins on the date  
25 that the Secretary has issued or published, as the case may be,  
26 the substantive change.

27 “(ii) The Secretary may provide for such a substantive  
28 change to take effect on a date that precedes the end of the  
29 30-day period under clause (i) if the Secretary finds that waiv-  
30 er of such 30-day period is necessary to comply with statutory  
31 requirements or that the application of such 30-day period is  
32 contrary to the public interest. If the Secretary provides for an  
33 earlier effective date pursuant to this clause, the Secretary  
34 shall include in the issuance or publication of the substantive  
35 change a finding described in the first sentence, and a brief  
36 statement of the reasons for such finding.



1 “(C) No action shall be taken against a provider of serv-  
2 ices or supplier with respect to noncompliance with such a sub-  
3 stantive change for items and services furnished before the ef-  
4 fective date of such a change.”.

5 (2) EFFECTIVE DATE.—The amendment made by  
6 paragraph (1) shall apply to compliance actions undertaken  
7 on or after the date of the enactment of this Act.

8 (c) RELIANCE ON GUIDANCE.—

9 (1) IN GENERAL.—Section 1871(e), as added by sub-  
10 section (a), is further amended by adding at the end the  
11 following new paragraph:

12 “(2)(A) If—

13 “(i) a provider of services or supplier follows the writ-  
14 ten guidance (which may be transmitted electronically) pro-  
15 vided by the Secretary or by a medicare contractor (as de-  
16 fined in section 1889(g)) acting within the scope of the  
17 contractor’s contract authority, with respect to the fur-  
18 nishing of items or services and submission of a claim for  
19 benefits for such items or services with respect to such pro-  
20 vider or supplier;

21 “(ii) the Secretary determines that the provider of  
22 services or supplier has accurately presented the cir-  
23 cumstances relating to such items, services, and claim to  
24 the contractor in writing; and

25 “(iii) the guidance was in error;  
26 the provider of services or supplier shall not be subject to any  
27 sanction (including any penalty or requirement for repayment  
28 of any amount) if the provider of services or supplier reason-  
29 ably relied on such guidance.

30 “(B) Subparagraph (A) shall not be construed as pre-  
31 venting the recoupment or repayment (without any additional  
32 penalty) relating to an overpayment insofar as the overpayment  
33 was solely the result of a clerical or technical operational  
34 error.”.

35 (2) EFFECTIVE DATE.—The amendment made by  
36 paragraph (1) shall take effect on the date of the enact-  
37 ment of this Act but shall not apply to any sanction for



1 which notice was provided on or before the date of the en-  
2 actment of this Act.

3 **SEC. 804. REPORTS AND STUDIES RELATING TO REGU-**  
4 **LATORY REFORM.**

5 (a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

6 (1) STUDY.—The Comptroller General of the United  
7 States shall conduct a study to determine the feasibility  
8 and appropriateness of establishing in the Secretary au-  
9 thority to provide legally binding advisory opinions on ap-  
10 propriate interpretation and application of regulations to  
11 carry out the medicare program under title XVIII of the  
12 Social Security Act. Such study shall examine the appro-  
13 priate timeframe for issuing such advisory opinions, as well  
14 as the need for additional staff and funding to provide such  
15 opinions.

16 (2) REPORT.—The Comptroller General shall submit  
17 to Congress a report on the study conducted under para-  
18 graph (1) by not later than January 1, 2004.

19 (b) REPORT ON LEGAL AND REGULATORY INCONSIST-  
20 ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by  
21 section 803(a), is amended by adding at the end the following  
22 new subsection:

23 “(f)(1) Not later than 2 years after the date of the enact-  
24 ment of this subsection, and every 2 years thereafter, the Sec-  
25 retary shall submit to Congress a report with respect to the ad-  
26 ministration of this title and areas of inconsistency or conflict  
27 among the various provisions under law and regulation.

28 “(2) In preparing a report under paragraph (1), the Sec-  
29 retary shall collect—

30 “(A) information from individuals entitled to benefits  
31 under part A or enrolled under part B, or both, providers  
32 of services, and suppliers and from the Medicare Bene-  
33 ficiary Ombudsman and the Medicare Provider Ombuds-  
34 man with respect to such areas of inconsistency and con-  
35 flict; and

36 “(B) information from medicare contractors that  
37 tracks the nature of written and telephone inquiries.



1 “(3) A report under paragraph (1) shall include a descrip-  
2 tion of efforts by the Secretary to reduce such inconsistency or  
3 conflicts, and recommendations for legislation or administrative  
4 action that the Secretary determines appropriate to further re-  
5 duce such inconsistency or conflicts.”.

## 6 **Subtitle B—Contracting Reform**

### 7 **SEC. 811. INCREASED FLEXIBILITY IN MEDICARE AD-** 8 **MINISTRATION.**

9 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE AD-  
10 MINISTRATION.—

11 (1) IN GENERAL.—Title XVIII is amended by insert-  
12 ing after section 1874 the following new section:

13 “CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

14 “SEC. 1874A. (a) AUTHORITY.—

15 “(1) AUTHORITY TO ENTER INTO CONTRACTS.—The  
16 Secretary may enter into contracts with any eligible entity  
17 to serve as a medicare administrative contractor with re-  
18 spect to the performance of any or all of the functions de-  
19 scribed in paragraph (4) or parts of those functions (or, to  
20 the extent provided in a contract, to secure performance  
21 thereof by other entities).

22 “(2) ELIGIBILITY OF ENTITIES.—An entity is eligible  
23 to enter into a contract with respect to the performance of  
24 a particular function described in paragraph (4) only if—

25 “(A) the entity has demonstrated capability to  
26 carry out such function;

27 “(B) the entity complies with such conflict of in-  
28 terest standards as are generally applicable to Federal  
29 acquisition and procurement;

30 “(C) the entity has sufficient assets to financially  
31 support the performance of such function; and

32 “(D) the entity meets such other requirements as  
33 the Secretary may impose.

34 “(3) MEDICARE ADMINISTRATIVE CONTRACTOR DE-  
35 FINED.—For purposes of this title and title XI—





1           “(A) IN GENERAL.—The term ‘medicare adminis-  
2           trative contractor’ means an agency, organization, or  
3           other person with a contract under this section.

4           “(B) APPROPRIATE MEDICARE ADMINISTRATIVE  
5           CONTRACTOR.—With respect to the performance of a  
6           particular function in relation to an individual entitled  
7           to benefits under part A or enrolled under part B, or  
8           both, a specific provider of services or supplier (or class  
9           of such providers of services or suppliers), the ‘appro-  
10          priate’ medicare administrative contractor is the medi-  
11          care administrative contractor that has a contract  
12          under this section with respect to the performance of  
13          that function in relation to that individual, provider of  
14          services or supplier or class of provider of services or  
15          supplier.

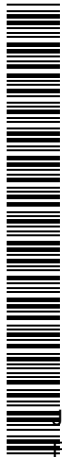
16          “(4) FUNCTIONS DESCRIBED.—The functions referred  
17          to in paragraphs (1) and (2) are payment functions, pro-  
18          vider services functions, and functions relating to services  
19          furnished to individuals entitled to benefits under part A  
20          or enrolled under part B, or both, as follows:

21               “(A) DETERMINATION OF PAYMENT AMOUNTS.—  
22               Determining (subject to the provisions of section 1878  
23               and to such review by the Secretary as may be provided  
24               for by the contracts) the amount of the payments re-  
25               quired pursuant to this title to be made to providers of  
26               services, suppliers and individuals.

27               “(B) MAKING PAYMENTS.—Making payments de-  
28               scribed in subparagraph (A) (including receipt, dis-  
29               bursement, and accounting for funds in making such  
30               payments).

31               “(C) BENEFICIARY EDUCATION AND ASSIST-  
32               ANCE.—Providing education and outreach to individ-  
33               uals entitled to benefits under part A or enrolled under  
34               part B, or both, and providing assistance to those indi-  
35               viduals with specific issues, concerns or problems.

36               “(D) PROVIDER CONSULTATIVE SERVICES.—Pro-  
37               viding consultative services to institutions, agencies,



1 and other persons to enable them to establish and  
2 maintain fiscal records necessary for purposes of this  
3 title and otherwise to qualify as providers of services or  
4 suppliers.

5 “(E) COMMUNICATION WITH PROVIDERS.—Com-  
6 municating to providers of services and suppliers any  
7 information or instructions furnished to the medicare  
8 administrative contractor by the Secretary, and facili-  
9 tating communication between such providers and sup-  
10 pliers and the Secretary.

11 “(F) PROVIDER EDUCATION AND TECHNICAL AS-  
12 SISTANCE.—Performing the functions relating to pro-  
13 vider education, training, and technical assistance.

14 “(G) ADDITIONAL FUNCTIONS.—Performing such  
15 other functions as are necessary to carry out the pur-  
16 poses of this title.

17 “(5) RELATIONSHIP TO MIP CONTRACTS.—

18 “(A) NONDUPLICATION OF DUTIES.—In entering  
19 into contracts under this section, the Secretary shall  
20 assure that functions of medicare administrative con-  
21 tractors in carrying out activities under parts A and B  
22 do not duplicate activities carried out under the Medi-  
23 care Integrity Program under section 1893. The pre-  
24 vious sentence shall not apply with respect to the activ-  
25 ity described in section 1893(b)(5) (relating to prior  
26 authorization of certain items of durable medical equip-  
27 ment under section 1834(a)(15)).

28 “(B) CONSTRUCTION.—An entity shall not be  
29 treated as a medicare administrative contractor merely  
30 by reason of having entered into a contract with the  
31 Secretary under section 1893.

32 “(6) APPLICATION OF FEDERAL ACQUISITION REGULA-  
33 TION.—Except to the extent inconsistent with a specific re-  
34 quirement of this title, the Federal Acquisition Regulation  
35 applies to contracts under this title.

36 “(b) CONTRACTING REQUIREMENTS.—

37 “(1) USE OF COMPETITIVE PROCEDURES.—



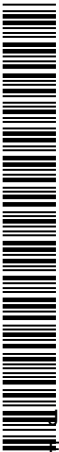
1           “(A) IN GENERAL.—Except as provided in laws  
2 with general applicability to Federal acquisition and  
3 procurement or in subparagraph (B), the Secretary  
4 shall use competitive procedures when entering into  
5 contracts with medicare administrative contractors  
6 under this section, taking into account performance  
7 quality as well as price and other factors.

8           “(B) RENEWAL OF CONTRACTS.—The Secretary  
9 may renew a contract with a medicare administrative  
10 contractor under this section from term to term with-  
11 out regard to section 5 of title 41, United States Code,  
12 or any other provision of law requiring competition, if  
13 the medicare administrative contractor has met or ex-  
14 ceeded the performance requirements applicable with  
15 respect to the contract and contractor, except that the  
16 Secretary shall provide for the application of competi-  
17 tive procedures under such a contract not less fre-  
18 quently than once every five years.

19           “(C) TRANSFER OF FUNCTIONS.—The Secretary  
20 may transfer functions among medicare administrative  
21 contractors consistent with the provisions of this para-  
22 graph. The Secretary shall ensure that performance  
23 quality is considered in such transfers. The Secretary  
24 shall provide public notice (whether in the Federal Reg-  
25 ister or otherwise) of any such transfer (including a de-  
26 scription of the functions so transferred, a description  
27 of the providers of services and suppliers affected by  
28 such transfer, and contact information for the contrac-  
29 tors involved).

30           “(D) INCENTIVES FOR QUALITY.—The Secretary  
31 shall provide incentives for medicare administrative  
32 contractors to provide quality service and to promote  
33 efficiency.

34           “(2) COMPLIANCE WITH REQUIREMENTS.—No con-  
35 tract under this section shall be entered into with any  
36 medicare administrative contractor unless the Secretary  
37 finds that such medicare administrative contractor will per-



1 form its obligations under the contract efficiently and effec-  
2 tively and will meet such requirements as to financial re-  
3 sponsibility, legal authority, quality of services provided,  
4 and other matters as the Secretary finds pertinent.

5 “(3) PERFORMANCE REQUIREMENTS.—

6 “(A) DEVELOPMENT OF SPECIFIC PERFORMANCE  
7 REQUIREMENTS.—In developing contract performance  
8 requirements, the Secretary shall develop performance  
9 requirements applicable to functions described in sub-  
10 section (a)(4).

11 “(B) CONSULTATION.— In developing such re-  
12 quirements, the Secretary may consult with providers  
13 of services and suppliers, organizations representing in-  
14 dividuals entitled to benefits under part A or enrolled  
15 under part B, or both, and organizations and agencies  
16 performing functions necessary to carry out the pur-  
17 poses of this section with respect to such performance  
18 requirements.

19 “(C) INCLUSION IN CONTRACTS.—All contractor  
20 performance requirements shall be set forth in the con-  
21 tract between the Secretary and the appropriate medi-  
22 care administrative contractor. Such performance  
23 requirements—

24 “(i) shall reflect the performance requirements  
25 developed under subparagraph (A), but may in-  
26 clude additional performance requirements;

27 “(ii) shall be used for evaluating contractor  
28 performance under the contract; and

29 “(iii) shall be consistent with the written state-  
30 ment of work provided under the contract.

31 “(4) INFORMATION REQUIREMENTS.—The Secretary  
32 shall not enter into a contract with a medicare administra-  
33 tive contractor under this section unless the contractor  
34 agrees—

35 “(A) to furnish to the Secretary such timely infor-  
36 mation and reports as the Secretary may find nec-  
37 essary in performing his functions under this title; and



1           “(B) to maintain such records and afford such ac-  
2           cess thereto as the Secretary finds necessary to assure  
3           the correctness and verification of the information and  
4           reports under subparagraph (A) and otherwise to carry  
5           out the purposes of this title.

6           “(5) SURETY BOND.—A contract with a medicare ad-  
7           ministrative contractor under this section may require the  
8           medicare administrative contractor, and any of its officers  
9           or employees certifying payments or disbursing funds pur-  
10          suant to the contract, or otherwise participating in carrying  
11          out the contract, to give surety bond to the United States  
12          in such amount as the Secretary may deem appropriate.

13          “(c) TERMS AND CONDITIONS.—

14          “(1) IN GENERAL.—A contract with any medicare ad-  
15          ministrative contractor under this section may contain such  
16          terms and conditions as the Secretary finds necessary or  
17          appropriate and may provide for advances of funds to the  
18          medicare administrative contractor for the making of pay-  
19          ments by it under subsection (a)(4)(B).

20          “(2) PROHIBITION ON MANDATES FOR CERTAIN DATA  
21          COLLECTION.—The Secretary may not require, as a condi-  
22          tion of entering into, or renewing, a contract under this  
23          section, that the medicare administrative contractor match  
24          data obtained other than in its activities under this title  
25          with data used in the administration of this title for pur-  
26          poses of identifying situations in which the provisions of  
27          section 1862(b) may apply.

28          “(d) LIMITATION ON LIABILITY OF MEDICARE ADMINIS-  
29          TRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

30          “(1) CERTIFYING OFFICER.—No individual designated  
31          pursuant to a contract under this section as a certifying of-  
32          ficer shall, in the absence of gross negligence or intent to  
33          defraud the United States, be liable with respect to any  
34          payments certified by the individual under this section.

35          “(2) DISBURSING OFFICER.—No disbursing officer  
36          shall, in the absence of gross negligence or intent to de-  
37          fraud the United States, be liable with respect to any pay-



1 ment by such officer under this section if it was based upon  
2 an authorization (which meets the applicable requirements  
3 for such internal controls established by the Comptroller  
4 General) of a certifying officer designated as provided in  
5 paragraph (1) of this subsection.

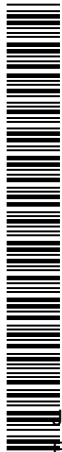
6 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE CON-  
7 TRACTOR.—No medicare administrative contractor shall be  
8 liable to the United States for a payment by a certifying  
9 or disbursing officer unless in connection with such pay-  
10 ment or in the supervision of or selection of such officer  
11 the medicare administrative contractor acted with gross  
12 negligence.

13 “(4) INDEMNIFICATION BY SECRETARY.—

14 “(A) IN GENERAL.—Subject to subparagraphs (B)  
15 and (D), in the case of a medicare administrative con-  
16 tractor (or a person who is a director, officer, or em-  
17 ployee of such a contractor or who is engaged by the  
18 contractor to participate directly in the claims adminis-  
19 tration process) who is made a party to any judicial or  
20 administrative proceeding arising from or relating di-  
21 rectly to the claims administration process under this  
22 title, the Secretary may, to the extent the Secretary de-  
23 termines to be appropriate and as specified in the con-  
24 tract with the contractor, indemnify the contractor and  
25 such persons.

26 “(B) CONDITIONS.—The Secretary may not pro-  
27 vide indemnification under subparagraph (A) insofar as  
28 the liability for such costs arises directly from conduct  
29 that is determined by the judicial proceeding or by the  
30 Secretary to be criminal in nature, fraudulent, or  
31 grossly negligent. If indemnification is provided by the  
32 Secretary with respect to a contractor before a deter-  
33 mination that such costs arose directly from such con-  
34 duct, the contractor shall reimburse the Secretary for  
35 costs of indemnification.

36 “(C) SCOPE OF INDEMNIFICATION.—Indemnifica-  
37 tion by the Secretary under subparagraph (A) may in-



1           clude payment of judgments, settlements (subject to  
2           subparagraph (D)), awards, and costs (including rea-  
3           sonable legal expenses).

4           “(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A  
5           contractor or other person described in subparagraph  
6           (A) may not propose to negotiate a settlement or com-  
7           promise of a proceeding described in such subpara-  
8           graph without the prior written approval of the Sec-  
9           retary to negotiate such settlement or compromise. Any  
10          indemnification under subparagraph (A) with respect to  
11          amounts paid under a settlement or compromise of a  
12          proceeding described in such subparagraph are condi-  
13          tioned upon prior written approval by the Secretary of  
14          the final settlement or compromise.

15          “(E) CONSTRUCTION.—Nothing in this paragraph  
16          shall be construed—

17                 “(i) to change any common law immunity that  
18                 may be available to a medicare administrative con-  
19                 tractor or person described in subparagraph (A); or

20                 “(ii) to permit the payment of costs not other-  
21                 wise allowable, reasonable, or allocable under the  
22                 Federal Acquisition Regulations.”.

23          (2) CONSIDERATION OF INCORPORATION OF CURRENT  
24          LAW STANDARDS.—In developing contract performance re-  
25          quirements under section 1874A(b) of the Social Security  
26          Act, as inserted by paragraph (1), the Secretary shall con-  
27          sider inclusion of the performance standards described in  
28          sections 1816(f)(2) of such Act (relating to timely proc-  
29          essing of reconsiderations and applications for exemptions)  
30          and section 1842(b)(2)(B) of such Act (relating to timely  
31          review of determinations and fair hearing requests), as  
32          such sections were in effect before the date of the enact-  
33          ment of this Act.

34          (b) CONFORMING AMENDMENTS TO SECTION 1816 (RE-  
35          LATING TO FISCAL INTERMEDIARIES).—Section 1816 (42  
36          U.S.C. 1395h) is amended as follows:

37                 (1) The heading is amended to read as follows:

1 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

2 (2) Subsection (a) is amended to read as follows:

3 “(a) The administration of this part shall be conducted  
4 through contracts with medicare administrative contractors  
5 under section 1874A.”.

6 (3) Subsection (b) is repealed.

7 (4) Subsection (c) is amended—

8 (A) by striking paragraph (1); and

9 (B) in each of paragraphs (2)(A) and (3)(A), by  
10 striking “agreement under this section” and inserting  
11 “contract under section 1874A that provides for mak-  
12 ing payments under this part”.

13 (5) Subsections (d) through (i) are repealed.

14 (6) Subsections (j) and (k) are each amended—

15 (A) by striking “An agreement with an agency or  
16 organization under this section” and inserting “A con-  
17 tract with a medicare administrative contractor under  
18 section 1874A with respect to the administration of  
19 this part”; and

20 (B) by striking “such agency or organization” and  
21 inserting “such medicare administrative contractor”  
22 each place it appears.

23 (7) Subsection (l) is repealed.

24 (c) CONFORMING AMENDMENTS TO SECTION 1842 (RE-  
25 LATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is  
26 amended as follows:

27 (1) The heading is amended to read as follows:

28 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

29 (2) Subsection (a) is amended to read as follows:

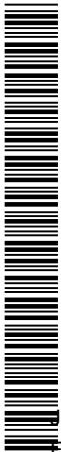
30 “(a) The administration of this part shall be conducted  
31 through contracts with medicare administrative contractors  
32 under section 1874A.”.

33 (3) Subsection (b) is amended—

34 (A) by striking paragraph (1);

35 (B) in paragraph (2)—

36 (i) by striking subparagraphs (A) and (B);





1 (ii) in subparagraph (C), by striking “car-  
2 riers” and inserting “medicare administrative con-  
3 tractors”; and

4 (iii) by striking subparagraphs (D) and (E);  
5 (C) in paragraph (3)—

6 (i) in the matter before subparagraph (A), by  
7 striking “Each such contract shall provide that the  
8 carrier” and inserting “The Secretary”;

9 (ii) by striking “will” the first place it appears  
10 in each of subparagraphs (A), (B), (F), (G), (H),  
11 and (L) and inserting “shall”;

12 (iii) in subparagraph (B), in the matter before  
13 clause (i), by striking “to the policyholders and  
14 subscribers of the carrier” and inserting “to the  
15 policyholders and subscribers of the medicare ad-  
16 ministrative contractor”;

17 (iv) by striking subparagraphs (C), (D), and  
18 (E);

19 (v) in subparagraph (H)—

20 (I) by striking “if it makes determinations  
21 or payments with respect to physicians’ serv-  
22 ices,”; and

23 (II) by striking “carrier” and inserting  
24 “medicare administrative contractor”;

25 (vi) by striking subparagraph (I);

26 (vii) in subparagraph (L), by striking the  
27 semicolon and inserting a period;

28 (viii) in the first sentence, after subparagraph  
29 (L), by striking “and shall contain” and all that  
30 follows through the period; and

31 (ix) in the seventh sentence, by inserting  
32 “medicare administrative contractor,” after “car-  
33 rier,”; and

34 (D) by striking paragraph (5);

35 (E) in paragraph (6)(D)(iv), by striking “carrier”  
36 and inserting “medicare administrative contractor”;  
37 and



1 (F) in paragraph (7), by striking “the carrier”  
2 and inserting “the Secretary” each place it appears.

3 (4) Subsection (c) is amended—

4 (A) by striking paragraph (1);

5 (B) in paragraph (2), by striking “contract under  
6 this section which provides for the disbursement of  
7 funds, as described in subsection (a)(1)(B),” and in-  
8 serting “contract under section 1874A that provides for  
9 making payments under this part”;

10 (C) in paragraph (3)(A), by striking “subsection  
11 (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;

12 (D) in paragraph (4), by striking “carrier” and in-  
13 serting “medicare administrative contractor”; and

14 (E) by striking paragraphs (5) and (6).

15 (5) Subsections (d), (e), and (f) are repealed.

16 (6) Subsection (g) is amended by striking “carrier or  
17 carriers” and inserting “medicare administrative contractor  
18 or contractors”.

19 (7) Subsection (h) is amended—

20 (A) in paragraph (2)—

21 (i) by striking “Each carrier having an agree-  
22 ment with the Secretary under subsection (a)” and  
23 inserting “The Secretary”; and

24 (ii) by striking “Each such carrier” and in-  
25 serting “The Secretary”;

26 (B) in paragraph (3)(A)—

27 (i) by striking “a carrier having an agreement  
28 with the Secretary under subsection (a)” and in-  
29 serting “medicare administrative contractor having  
30 a contract under section 1874A that provides for  
31 making payments under this part”; and

32 (ii) by striking “such carrier” and inserting  
33 “such contractor”;

34 (C) in paragraph (3)(B)—

35 (i) by striking “a carrier” and inserting “a  
36 medicare administrative contractor” each place it  
37 appears; and



1 (ii) by striking “the carrier” and inserting  
2 “the contractor” each place it appears; and

3 (D) in paragraphs (5)(A) and (5)(B)(iii), by strik-  
4 ing “carriers” and inserting “medicare administrative  
5 contractors” each place it appears.

6 (8) Subsection (l) is amended—

7 (A) in paragraph (1)(A)(iii), by striking “carrier”  
8 and inserting “medicare administrative contractor”;  
9 and

10 (B) in paragraph (2), by striking “carrier” and in-  
11 serting “medicare administrative contractor”.

12 (9) Subsection (p)(3)(A) is amended by striking “car-  
13 rier” and inserting “medicare administrative contractor”.

14 (10) Subsection (q)(1)(A) is amended by striking “car-  
15 rier”.

16 (d) EFFECTIVE DATE; TRANSITION RULE.—

17 (1) EFFECTIVE DATE.—

18 (A) IN GENERAL.—Except as otherwise provided  
19 in this subsection, the amendments made by this sec-  
20 tion shall take effect on October 1, 2004, and the Sec-  
21 retary is authorized to take such steps before such date  
22 as may be necessary to implement such amendments on  
23 a timely basis.

24 (B) CONSTRUCTION FOR CURRENT CONTRACTS.—  
25 Such amendments shall not apply to contracts in effect  
26 before the date specified under subparagraph (A) that  
27 continue to retain the terms and conditions in effect on  
28 such date (except as otherwise provided under this Act,  
29 other than under this section) until such date as the  
30 contract is let out for competitive bidding under such  
31 amendments.

32 (C) DEADLINE FOR COMPETITIVE BIDDING.—The  
33 Secretary shall provide for the letting by competitive  
34 bidding of all contracts for functions of medicare ad-  
35 ministrative contractors for annual contract periods  
36 that begin on or after October 1, 2009.



1 (D) WAIVER OF PROVIDER NOMINATION PROVI-  
2 SIONS DURING TRANSITION.—During the period begin-  
3 ning on the date of the enactment of this Act and be-  
4 fore the date specified under subparagraph (A), the  
5 Secretary may enter into new agreements under section  
6 1816 of the Social Security Act (42 U.S.C. 1395h)  
7 without regard to any of the provider nomination provi-  
8 sions of such section.

9 (2) GENERAL TRANSITION RULES.—The Secretary  
10 shall take such steps, consistent with paragraph (1)(B) and  
11 (1)(C), as are necessary to provide for an appropriate tran-  
12 sition from contracts under section 1816 and section 1842  
13 of the Social Security Act (42 U.S.C. 1395h, 1395u) to  
14 contracts under section 1874A, as added by subsection  
15 (a)(1).

16 (3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS  
17 UNDER CURRENT CONTRACTS AND AGREEMENTS AND  
18 UNDER ROLLOVER CONTRACTS.—The provisions contained  
19 in the exception in section 1893(d)(2) of the Social Secu-  
20 rity Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply  
21 notwithstanding the amendments made by this section, and  
22 any reference in such provisions to an agreement or con-  
23 tract shall be deemed to include a contract under section  
24 1874A of such Act, as inserted by subsection (a)(1), that  
25 continues the activities referred to in such provisions.

26 (e) REFERENCES.—On and after the effective date pro-  
27 vided under subsection (d)(1), any reference to a fiscal inter-  
28 mediary or carrier under title XI or XVIII of the Social Secu-  
29 rity Act (or any regulation, manual instruction, interpretative  
30 rule, statement of policy, or guideline issued to carry out such  
31 titles) shall be deemed a reference to an appropriate medicare  
32 administrative contractor (as provided under section 1874A of  
33 the Social Security Act).

34 (f) REPORTS ON IMPLEMENTATION.—

35 (1) PLAN FOR IMPLEMENTATION.—By not later than  
36 October 1, 2003, the Secretary shall submit a report to  
37 Congress and the Comptroller General of the United States



1 that describes the plan for implementation of the amend-  
2 ments made by this section. The Comptroller General shall  
3 conduct an evaluation of such plan and shall submit to  
4 Congress, not later than 6 months after the date the report  
5 is received, a report on such evaluation and shall include  
6 in such report such recommendations as the Comptroller  
7 General deems appropriate.

8 (2) STATUS OF IMPLEMENTATION.—The Secretary  
9 shall submit a report to Congress not later than October  
10 1, 2007, that describes the status of implementation of  
11 such amendments and that includes a description of the  
12 following:

13 (A) The number of contracts that have been com-  
14 petitively bid as of such date.

15 (B) The distribution of functions among contracts  
16 and contractors.

17 (C) A timeline for complete transition to full com-  
18 petition.

19 (D) A detailed description of how the Secretary  
20 has modified oversight and management of medicare  
21 contractors to adapt to full competition.

22 **SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY**  
23 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**  
24 **TORS.**

25 (a) IN GENERAL.—Section 1874A, as added by section  
26 811(a)(1), is amended by adding at the end the following new  
27 subsection:

28 “(e) REQUIREMENTS FOR INFORMATION SECURITY.—

29 “(1) DEVELOPMENT OF INFORMATION SECURITY PRO-  
30 GRAM.—A medicare administrative contractor that per-  
31 forms the functions referred to in subparagraphs (A) and  
32 (B) of subsection (a)(4) (relating to determining and mak-  
33 ing payments) shall implement a contractor-wide informa-  
34 tion security program to provide information security for  
35 the operation and assets of the contractor with respect to  
36 such functions under this title. An information security  
37 program under this paragraph shall meet the requirements



1 for information security programs imposed on Federal  
 2 agencies under section 3534(b)(2) of title 44, United States  
 3 Code (other than requirements under subparagraphs  
 4 (B)(ii), (F)(iii), and (F)(iv) of such section).

5 “(2) INDEPENDENT AUDITS.—

6 “(A) PERFORMANCE OF ANNUAL EVALUATIONS.—

7 Each year a medicare administrative contractor that  
 8 performs the functions referred to in subparagraphs  
 9 (A) and (B) of subsection (a)(4) (relating to deter-  
 10 mining and making payments) shall undergo an evalua-  
 11 tion of the information security of the contractor with  
 12 respect to such functions under this title. The evalua-  
 13 tion shall—

14 “(i) be performed by an entity that meets such  
 15 requirements for independence as the Inspector  
 16 General of the Department of Health and Human  
 17 Services may establish; and

18 “(ii) test the effectiveness of information secu-  
 19 rity control techniques for an appropriate subset of  
 20 the contractor’s information systems (as defined in  
 21 section 3502(8) of title 44, United States Code) re-  
 22 lating to such functions under this title and an as-  
 23 sessment of compliance with the requirements of  
 24 this subsection and related information security  
 25 policies, procedures, standards and guidelines.

26 “(B) DEADLINE FOR INITIAL EVALUATION.—

27 “(i) NEW CONTRACTORS.—In the case of a  
 28 medicare administrative contractor covered by this  
 29 subsection that has not previously performed the  
 30 functions referred to in subparagraphs (A) and (B)  
 31 of subsection (a)(4) (relating to determining and  
 32 making payments) as a fiscal intermediary or car-  
 33 rier under section 1816 or 1842, the first inde-  
 34 pendent evaluation conducted pursuant subpara-  
 35 graph (A) shall be completed prior to commencing  
 36 such functions.



1                   “(ii) OTHER CONTRACTORS.—In the case of a  
 2                   medicare administrative contractor covered by this  
 3                   subsection that is not described in clause (i), the  
 4                   first independent evaluation conducted pursuant  
 5                   subparagraph (A) shall be completed within 1 year  
 6                   after the date the contractor commences functions  
 7                   referred to in clause (i) under this section.

8                   “(C) REPORTS ON EVALUATIONS.—

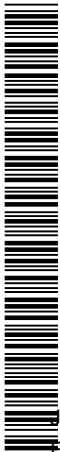
9                   “(i) TO THE INSPECTOR GENERAL.—The re-  
 10                   sults of independent evaluations under subpara-  
 11                   graph (A) shall be submitted promptly to the In-  
 12                   spector General of the Department of Health and  
 13                   Human Services.

14                   “(ii) TO CONGRESS.—The Inspector General  
 15                   of Department of Health and Human Services shall  
 16                   submit to Congress annual reports on the results of  
 17                   such evaluations.”.

18                   (b) APPLICATION OF REQUIREMENTS TO FISCAL INTER-  
 19                   MEDIARIES AND CARRIERS.—

20                   (1) IN GENERAL.—The provisions of section  
 21                   1874A(e)(2) of the Social Security Act (other than sub-  
 22                   paragraph (B)), as added by subsection (a), shall apply to  
 23                   each fiscal intermediary under section 1816 of the Social  
 24                   Security Act (42 U.S.C. 1395h) and each carrier under  
 25                   section 1842 of such Act (42 U.S.C. 1395u) in the same  
 26                   manner as they apply to medicare administrative contrac-  
 27                   tors under such provisions.

28                   (2) DEADLINE FOR INITIAL EVALUATION.—In the case  
 29                   of such a fiscal intermediary or carrier with an agreement  
 30                   or contract under such respective section in effect as of the  
 31                   date of the enactment of this Act, the first evaluation  
 32                   under section 1874A(e)(2)(A) of the Social Security Act  
 33                   (as added by subsection (a)), pursuant to paragraph (1),  
 34                   shall be completed (and a report on the evaluation sub-  
 35                   mitted to the Secretary) by not later than 1 year after such  
 36                   date.



**Subtitle C—Education and Outreach****SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.****(a) COORDINATION OF EDUCATION FUNDING.—**

**(1) IN GENERAL.—**The Social Security Act is amended by inserting after section 1888 the following new section:

“PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

“SEC. 1889. **(a) COORDINATION OF EDUCATION FUNDING.—**The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.”.

**(2) EFFECTIVE DATE.—**The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

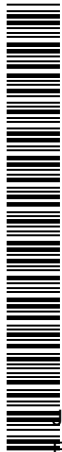
**(3) REPORT.—**Not later than October 1, 2003, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

**(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—**

**(1) IN GENERAL.—**Section 1874A, as added by section 811(a)(1) and as amended by section 812(a), is amended by adding at the end the following new subsection:

“(f) **INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—**In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.”.

**(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—**The provisions of section 1874A(f) of the So-





1           cial Security Act, as added by paragraph (1), shall apply  
2           to each fiscal intermediary under section 1816 of the Social  
3           Security Act (42 U.S.C. 1395h) and each carrier under  
4           section 1842 of such Act (42 U.S.C. 1395u) in the same  
5           manner as they apply to medicare administrative contrac-  
6           tors under such provisions.

7           (3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—  
8           Not later than October 1, 2003, the Comptroller General  
9           of the United States shall submit to Congress and to the  
10          Secretary a report on the adequacy of the methodology  
11          under section 1874A(f) of the Social Security Act, as added  
12          by paragraph (1), and shall include in the report such rec-  
13          ommendations as the Comptroller General determines ap-  
14          propriate with respect to the methodology.

15          (4) REPORT ON USE OF METHODOLOGY IN ASSESSING  
16          CONTRACTOR PERFORMANCE.—Not later than October 1,  
17          2003, the Secretary shall submit to Congress a report that  
18          describes how the Secretary intends to use such method-  
19          ology in assessing medicare contractor performance in im-  
20          plementing effective education and outreach programs, in-  
21          cluding whether to use such methodology as a basis for per-  
22          formance bonuses. The report shall include an analysis of  
23          the sources of identified errors and potential changes in  
24          systems of contractors and rules of the Secretary that could  
25          reduce claims error rates.

26          (c) PROVISION OF ACCESS TO AND PROMPT RESPONSES  
27          FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

28          (1) IN GENERAL.—Section 1874A, as added by section  
29          811(a)(1) and as amended by section 812(a) and sub-  
30          section (b), is further amended by adding at the end the  
31          following new subsection:

32          “(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS  
33          OF SERVICES AND SUPPLIERS.—

34          “(1) COMMUNICATION STRATEGY.—The Secretary  
35          shall develop a strategy for communications with individ-  
36          uals entitled to benefits under part A or enrolled under



1 part B, or both, and with providers of services and sup-  
2 pliers under this title.

3 “(2) RESPONSE TO WRITTEN INQUIRIES.—Each medi-  
4 care administrative contractor shall, for those providers of  
5 services and suppliers which submit claims to the con-  
6 tractor for claims processing and for those individuals enti-  
7 tled to benefits under part A or enrolled under part B, or  
8 both, with respect to whom claims are submitted for claims  
9 processing, provide general written responses (which may  
10 be through electronic transmission) in a clear, concise, and  
11 accurate manner to inquiries of providers of services, sup-  
12 pliers and individuals entitled to benefits under part A or  
13 enrolled under part B, or both, concerning the programs  
14 under this title within 45 business days of the date of re-  
15 ceipt of such inquiries.

16 “(3) RESPONSE TO TOLL-FREE LINES.—The Secretary  
17 shall ensure that each medicare administrative contractor  
18 shall provide, for those providers of services and suppliers  
19 which submit claims to the contractor for claims processing  
20 and for those individuals entitled to benefits under part A  
21 or enrolled under part B, or both, with respect to whom  
22 claims are submitted for claims processing, a toll-free tele-  
23 phone number at which such individuals, providers of serv-  
24 ices and suppliers may obtain information regarding billing,  
25 coding, claims, coverage, and other appropriate information  
26 under this title.

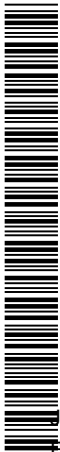
27 “(4) MONITORING OF CONTRACTOR RESPONSES.—

28 “(A) IN GENERAL.—Each medicare administrative  
29 contractor shall, consistent with standards developed by  
30 the Secretary under subparagraph (B)—

31 “(i) maintain a system for identifying who  
32 provides the information referred to in paragraphs  
33 (2) and (3); and

34 “(ii) monitor the accuracy, consistency, and  
35 timeliness of the information so provided.

36 “(B) DEVELOPMENT OF STANDARDS.—



1           “(i) IN GENERAL.—The Secretary shall estab-  
2           lish and make public standards to monitor the ac-  
3           curacy, consistency, and timeliness of the informa-  
4           tion provided in response to written and telephone  
5           inquiries under this subsection. Such standards  
6           shall be consistent with the performance require-  
7           ments established under subsection (b)(3).

8           “(ii) EVALUATION.—In conducting evaluations  
9           of individual medicare administrative contractors,  
10          the Secretary shall take into account the results of  
11          the monitoring conducted under subparagraph (A)  
12          taking into account as performance requirements  
13          the standards established under clause (i). The  
14          Secretary shall, in consultation with organizations  
15          representing providers of services, suppliers, and  
16          individuals entitled to benefits under part A or en-  
17          rolled under part B, or both, establish standards  
18          relating to the accuracy, consistency, and timeliness  
19          of the information so provided.

20          “(C) DIRECT MONITORING.—Nothing in this para-  
21          graph shall be construed as preventing the Secretary  
22          from directly monitoring the accuracy, consistency, and  
23          timeliness of the information so provided.”.

24          (2) EFFECTIVE DATE.—The amendment made by  
25          paragraph (1) shall take effect October 1, 2003.

26          (3) APPLICATION TO FISCAL INTERMEDIARIES AND  
27          CARRIERS.—The provisions of section 1874A(g) of the So-  
28          cial Security Act, as added by paragraph (1), shall apply  
29          to each fiscal intermediary under section 1816 of the Social  
30          Security Act (42 U.S.C. 1395h) and each carrier under  
31          section 1842 of such Act (42 U.S.C. 1395u) in the same  
32          manner as they apply to medicare administrative contrac-  
33          tors under such provisions.

34          (d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

35                  (1) IN GENERAL.—Section 1889, as added by sub-  
36                  section (a), is amended by adding at the end the following  
37                  new subsections:



1 “(b) ENHANCED EDUCATION AND TRAINING.—

2 “(1) ADDITIONAL RESOURCES.—There are authorized  
3 to be appropriated to the Secretary (in appropriate part  
4 from the Federal Hospital Insurance Trust Fund and the  
5 Federal Supplementary Medical Insurance Trust Fund)  
6 \$25,000,000 for each of fiscal years 2004 and 2005 and  
7 such sums as may be necessary for succeeding fiscal years.

8 “(2) USE.—The funds made available under para-  
9 graph (1) shall be used to increase the conduct by medicare  
10 contractors of education and training of providers of serv-  
11 ices and suppliers regarding billing, coding, and other ap-  
12 propriate items and may also be used to improve the accu-  
13 racy, consistency, and timeliness of contractor responses.

14 “(c) TAILORING EDUCATION AND TRAINING ACTIVITIES  
15 FOR SMALL PROVIDERS OR SUPPLIERS.—

16 “(1) IN GENERAL.—Insofar as a medicare contractor  
17 conducts education and training activities, it shall tailor  
18 such activities to meet the special needs of small providers  
19 of services or suppliers (as defined in paragraph (2)).

20 “(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—  
21 In this subsection, the term ‘small provider of services or  
22 supplier’ means—

23 “(A) a provider of services with fewer than 25 full-  
24 time-equivalent employees; or

25 “(B) a supplier with fewer than 10 full-time-equiv-  
26 alent employees.”.

27 (2) EFFECTIVE DATE.—The amendment made by  
28 paragraph (1) shall take effect on October 1, 2003.

29 (e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

30 (1) IN GENERAL.—Section 1889, as added by sub-  
31 section (a) and as amended by subsection (d), is further  
32 amended by adding at the end the following new sub-  
33 section:

34 “(d) INTERNET SITES; FAQs.—The Secretary, and each  
35 medicare contractor insofar as it provides services (including  
36 claims processing) for providers of services or suppliers, shall  
37 maintain an Internet site which—



1           “(1) provides answers in an easily accessible format to  
2 frequently asked questions, and

3           “(2) includes other published materials of the con-  
4 tractor,

5 that relate to providers of services and suppliers under the pro-  
6 grams under this title (and title XI insofar as it relates to such  
7 programs).”.

8           (2) EFFECTIVE DATE.—The amendment made by  
9 paragraph (1) shall take effect on October 1, 2003.

10          (f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

11           (1) IN GENERAL.—Section 1889, as added by sub-  
12 section (a) and as amended by subsections (d) and (e), is  
13 further amended by adding at the end the following new  
14 subsections:

15           “(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION  
16 PROGRAM ACTIVITIES.—A medicare contractor may not use a  
17 record of attendance at (or failure to attend) educational activi-  
18 ties or other information gathered during an educational pro-  
19 gram conducted under this section or otherwise by the Sec-  
20 retary to select or track providers of services or suppliers for  
21 the purpose of conducting any type of audit or prepayment re-  
22 view.

23           “(f) CONSTRUCTION.—Nothing in this section or section  
24 1893(g) shall be construed as providing for disclosure by a  
25 medicare contractor of information that would compromise  
26 pending law enforcement activities or reveal findings of law en-  
27 forcement-related audits.

28           “(g) DEFINITIONS.—For purposes of this section, the  
29 term ‘medicare contractor’ includes the following:

30           “(1) A medicare administrative contractor with a con-  
31 tract under section 1874A, including a fiscal intermediary  
32 with a contract under section 1816 and a carrier with a  
33 contract under section 1842.

34           “(2) An eligible entity with a contract under section  
35 1893.

36 Such term does not include, with respect to activities of a spe-  
37 cific provider of services or supplier an entity that has no au-



1     thority under this title or title IX with respect to such activities  
2     and such provider of services or supplier.”.

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     **SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE**  
7     **DEMONSTRATION PROGRAM.**

8             (a) ESTABLISHMENT.—

9             (1) IN GENERAL.—The Secretary shall establish a  
10     demonstration program (in this section referred to as the  
11     “demonstration program”) under which technical assist-  
12     ance described in paragraph (2) is made available, upon re-  
13     quest and on a voluntary basis, to small providers of serv-  
14     ices or suppliers in order to improve compliance with the  
15     applicable requirements of the programs under medicare  
16     program under title XVIII of the Social Security Act (in-  
17     cluding provisions of title XI of such Act insofar as they  
18     relate to such title and are not administered by the Office  
19     of the Inspector General of the Department of Health and  
20     Human Services).

21             (2) FORMS OF TECHNICAL ASSISTANCE.—The tech-  
22     nical assistance described in this paragraph is—

23             (A) evaluation and recommendations regarding  
24     billing and related systems; and

25             (B) information and assistance regarding policies  
26     and procedures under the medicare program, including  
27     coding and reimbursement.

28             (3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—  
29     In this section, the term “small providers of services or  
30     suppliers” means—

31             (A) a provider of services with fewer than 25 full-  
32     time-equivalent employees; or

33             (B) a supplier with fewer than 10 full-time-equa-  
34     lent employees.

35             (b) QUALIFICATION OF CONTRACTORS.—In conducting the  
36     demonstration program, the Secretary shall enter into contracts  
37     with qualified organizations (such as peer review organizations



1 or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

9 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

15 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

23 (1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

27 (2) such problem remains corrected for such period as is appropriate.

29 The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

33 (e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program.



1 The evaluation shall include a determination of whether claims  
2 error rates are reduced for small providers of services or sup-  
3 pliers who participated in the program and the extent of im-  
4 proper payments made as a result of the demonstration pro-  
5 gram. The Comptroller General shall submit a report to the  
6 Secretary and the Congress on such evaluation and shall in-  
7 clude in such report recommendations regarding the continu-  
8 ation or extension of the demonstration program.

9 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The pro-  
10 vision of technical assistance to a small provider of services or  
11 supplier under the demonstration program is conditioned upon  
12 the small provider of services or supplier paying an amount es-  
13 timated (and disclosed in advance of a provider's or supplier's  
14 participation in the program) to be equal to 25 percent of the  
15 cost of the technical assistance.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—There are au-  
17 thorized to be appropriated to the Secretary (in appropriate  
18 part from the Federal Hospital Insurance Trust Fund and the  
19 Federal Supplementary Medical Insurance Trust Fund) to  
20 carry out the demonstration program—

21 (1) for fiscal year 2004, \$1,000,000, and

22 (2) for fiscal year 2005, \$6,000,000.

23 **SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDI-**  
24 **CARE BENEFICIARY OMBUDSMAN.**

25 (a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868  
26 (42 U.S.C. 1395ee) is amended—

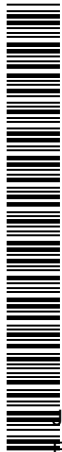
27 (1) by adding at the end of the heading the following:  
28 “; MEDICARE PROVIDER OMBUDSMAN”;

29 (2) by inserting “PRACTICING PHYSICIANS ADVISORY  
30 COUNCIL.—(1)” after “(a)”;

31 (3) in paragraph (1), as so redesignated under para-  
32 graph (2), by striking “in this section” and inserting “in  
33 this subsection”;

34 (4) by redesignating subsections (b) and (c) as para-  
35 graphs (2) and (3), respectively; and

36 (5) by adding at the end the following new subsection:





1           “(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary  
2 shall appoint within the Department of Health and Human  
3 Services a Medicare Provider Ombudsman. The Ombudsman  
4 shall—

5           “(1) provide assistance, on a confidential basis, to pro-  
6 viders of services and suppliers with respect to complaints,  
7 grievances, and requests for information concerning the  
8 programs under this title (including provisions of title XI  
9 insofar as they relate to this title and are not administered  
10 by the Office of the Inspector General of the Department  
11 of Health and Human Services) and in the resolution of  
12 unclear or conflicting guidance given by the Secretary and  
13 medicare contractors to such providers of services and sup-  
14 pliers regarding such programs and provisions and require-  
15 ments under this title and such provisions; and

16           “(2) submit recommendations to the Secretary for im-  
17 provement in the administration of this title and such pro-  
18 visions, including—

19           “(A) recommendations to respond to recurring  
20 patterns of confusion in this title and such provisions  
21 (including recommendations regarding suspending im-  
22 position of sanctions where there is widespread confu-  
23 sion in program administration), and

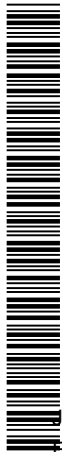
24           “(B) recommendations to provide for an appro-  
25 priate and consistent response (including not providing  
26 for audits) in cases of self-identified overpayments by  
27 providers of services and suppliers.

28 The Ombudsman shall not serve as an advocate for any in-  
29 creases in payments or new coverage of services, but may iden-  
30 tify issues and problems in payment or coverage policies.”.

31           (b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII,  
32 as amended by sections 105 and 701, is amended by inserting  
33 after section 1808 the following new section:

34           “MEDICARE BENEFICIARY OMBUDSMAN

35           “SEC. 1809. (a) IN GENERAL.—The Secretary shall ap-  
36 point within the Department of Health and Human Services a  
37 Medicare Beneficiary Ombudsman who shall have expertise and



1 experience in the fields of health care and education of (and  
2 assistance to) individuals entitled to benefits under this title.

3 “(b) DUTIES.—The Medicare Beneficiary Ombudsman  
4 shall—

5 “(1) receive complaints, grievances, and requests for  
6 information submitted by individuals entitled to benefits  
7 under part A or enrolled under part B, or both, with re-  
8 spect to any aspect of the medicare program;

9 “(2) provide assistance with respect to complaints,  
10 grievances, and requests referred to in paragraph (1),  
11 including—

12 “(A) assistance in collecting relevant information  
13 for such individuals, to seek an appeal of a decision or  
14 determination made by a fiscal intermediary, carrier,  
15 Medicare+ Choice organization, or the Secretary; and

16 “(B) assistance to such individuals with any prob-  
17 lems arising from disenrollment from a  
18 Medicare+ Choice plan under part C; and

19 “(3) submit annual reports to Congress and the Sec-  
20 retary that describe the activities of the Office and that in-  
21 clude such recommendations for improvement in the admin-  
22 istration of this title as the Ombudsman determines appro-  
23 priate.

24 The Ombudsman shall not serve as an advocate for any in-  
25 creases in payments or new coverage of services, but may iden-  
26 tify issues and problems in payment or coverage policies.

27 “(c) WORKING WITH HEALTH INSURANCE COUNSELING  
28 PROGRAMS.—To the extent possible, the Ombudsman shall  
29 work with health insurance counseling programs (receiving  
30 funding under section 4360 of Omnibus Budget Reconciliation  
31 Act of 1990) to facilitate the provision of information to indi-  
32 viduals entitled to benefits under part A or enrolled under part  
33 B, or both regarding Medicare+ Choice plans and changes to  
34 those plans. Nothing in this subsection shall preclude further  
35 collaboration between the Ombudsman and such programs.”.

36 (c) DEADLINE FOR APPOINTMENT.—The Secretary shall  
37 appoint the Medicare Provider Ombudsman and the Medicare



1 Beneficiary Ombudsman, under the amendments made by sub-  
2 sections (a) and (b), respectively, by not later than 1 year after  
3 the date of the enactment of this Act.

4 (d) FUNDING.—There are authorized to be appropriated to  
5 the Secretary (in appropriate part from the Federal Hospital  
6 Insurance Trust Fund and the Federal Supplementary Medical  
7 Insurance Trust Fund) to carry out the provisions of sub-  
8 section (b) of section 1868 of the Social Security Act (relating  
9 to the Medicare Provider Ombudsman), as added by subsection  
10 (a)(5) and section 1809 of such Act (relating to the Medicare  
11 Beneficiary Ombudsman), as added by subsection (b), such  
12 sums as are necessary for fiscal year 2003 and each succeeding  
13 fiscal year.

14 (e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-  
15 MEDICARE).—

16 (1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE  
17 HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—  
18 Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by  
19 adding at the end the following: “The Secretary shall pro-  
20 vide, through the toll-free number 1-800-MEDICARE, for  
21 a means by which individuals seeking information about, or  
22 assistance with, such programs who phone such toll-free  
23 number are transferred (without charge) to appropriate en-  
24 tities for the provision of such information or assistance.  
25 Such toll-free number shall be the toll-free number listed  
26 for general information and assistance in the annual notice  
27 under subsection (a) instead of the listing of numbers of  
28 individual contractors.”.

29 (2) MONITORING ACCURACY.—

30 (A) STUDY.—The Comptroller General of the  
31 United States shall conduct a study to monitor the ac-  
32 curacy and consistency of information provided to indi-  
33 viduals entitled to benefits under part A or enrolled  
34 under part B, or both, through the toll-free number 1-  
35 800-MEDICARE, including an assessment of whether  
36 the information provided is sufficient to answer ques-  
37 tions of such individuals. In conducting the study, the



1 Comptroller General shall examine the education and  
2 training of the individuals providing information  
3 through such number.

4 (B) REPORT.—Not later than 1 year after the  
5 date of the enactment of this Act, the Comptroller Gen-  
6 eral shall submit to Congress a report on the study  
7 conducted under subparagraph (A).

8 **SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION**  
9 **PROGRAM.**

10 (a) IN GENERAL.—The Secretary shall establish a dem-  
11 onstration program (in this section referred to as the “dem-  
12 onstration program”) under which medicare specialists em-  
13 ployed by the Department of Health and Human Services pro-  
14 vide advice and assistance to individuals entitled to benefits  
15 under part A of title XVIII of the Social Security Act, or en-  
16 rolled under part B of such title, or both, regarding the medi-  
17 care program at the location of existing local offices of the So-  
18 cial Security Administration.

19 (b) LOCATIONS.—

20 (1) IN GENERAL.—The demonstration program shall  
21 be conducted in at least 6 offices or areas. Subject to para-  
22 graph (2), in selecting such offices and areas, the Secretary  
23 shall provide preference for offices with a high volume of  
24 visits by individuals referred to in subsection (a).

25 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—The  
26 Secretary shall provide for the selection of at least 2 rural  
27 areas to participate in the demonstration program. In con-  
28 ducting the demonstration program in such rural areas, the  
29 Secretary shall provide for medicare specialists to travel  
30 among local offices in a rural area on a scheduled basis.

31 (c) DURATION.—The demonstration program shall be con-  
32 ducted over a 3-year period.

33 (d) EVALUATION AND REPORT.—

34 (1) EVALUATION.—The Secretary shall provide for an  
35 evaluation of the demonstration program. Such evaluation  
36 shall include an analysis of—



1 (A) utilization of, and satisfaction of those individ-  
2 uals referred to in subsection (a) with, the assistance  
3 provided under the program; and

4 (B) the cost-effectiveness of providing beneficiary  
5 assistance through out-stationing medicare specialists  
6 at local offices of the Social Security Administration.

7 (2) REPORT.—The Secretary shall submit to Congress  
8 a report on such evaluation and shall include in such report  
9 recommendations regarding the feasibility of permanently  
10 out-stationing medicare specialists at local offices of the So-  
11 cial Security Administration.

## 12 **Subtitle D—Appeals and Recovery**

### 13 **SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDI-** 14 **CARE APPEALS.**

#### 15 (a) TRANSITION PLAN.—

16 (1) IN GENERAL.—Not later than October 1, 2003,  
17 the Commissioner of Social Security and the Secretary  
18 shall develop and transmit to Congress and the Comptroller  
19 General of the United States a plan under which the func-  
20 tions of administrative law judges responsible for hearing  
21 cases under title XVIII of the Social Security Act (and re-  
22 lated provisions in title XI of such Act) are transferred  
23 from the responsibility of the Commissioner and the Social  
24 Security Administration to the Secretary and the Depart-  
25 ment of Health and Human Services.

26 (2) GAO EVALUATION.—The Comptroller General of  
27 the United States shall evaluate the plan and, not later  
28 than the date that is 6 months after the date on which the  
29 plan is received by the Comptroller General, shall submit  
30 to Congress a report on such evaluation.

#### 31 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

32 (1) IN GENERAL.—Not earlier than July 1, 2004, and  
33 not later than October 1, 2004, the Commissioner of Social  
34 Security and the Secretary shall implement the transition  
35 plan under subsection (a) and transfer the administrative  
36 law judge functions described in such subsection from the  
37 Social Security Administration to the Secretary.



1 (2) ASSURING INDEPENDENCE OF JUDGES.—The Sec-  
2 retary shall assure the independence of administrative law  
3 judges performing the administrative law judge functions  
4 transferred under paragraph (1) from the Centers for  
5 Medicare & Medicaid Services and its contractors.

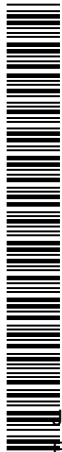
6 (3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall  
7 provide for an appropriate geographic distribution of ad-  
8 ministrative law judges performing the administrative law  
9 judge functions transferred under paragraph (1) through-  
10 out the United States to ensure timely access to such  
11 judges.

12 (4) HIRING AUTHORITY.—Subject to the amounts pro-  
13 vided in advance in appropriations Act, the Secretary shall  
14 have authority to hire administrative law judges to hear  
15 such cases, giving priority to those judges with prior experi-  
16 ence in handling medicare appeals and in a manner con-  
17 sistent with paragraph (3), and to hire support staff for  
18 such judges.

19 (5) FINANCING.—Amounts payable under law to the  
20 Commissioner for administrative law judges performing the  
21 administrative law judge functions transferred under para-  
22 graph (1) from the Federal Hospital Insurance Trust Fund  
23 and the Federal Supplementary Medical Insurance Trust  
24 Fund shall become payable to the Secretary for the func-  
25 tions so transferred.

26 (6) SHARED RESOURCES.—The Secretary shall enter  
27 into such arrangements with the Commissioner as may be  
28 appropriate with respect to transferred functions of admin-  
29 istrative law judges to share office space, support staff, and  
30 other resources, with appropriate reimbursement from the  
31 Trust Funds described in paragraph (5).

32 (c) INCREASED FINANCIAL SUPPORT.—In addition to any  
33 amounts otherwise appropriated, to ensure timely action on ap-  
34 peals before administrative law judges and the Departmental  
35 Appeals Board consistent with section 1869 of the Social Secu-  
36 rity Act (as amended by section 521 of BIPA, 114 Stat.  
37 2763A-534), there are authorized to be appropriated (in appro-



1 puate part from the Federal Hospital Insurance Trust Fund  
2 and the Federal Supplementary Medical Insurance Trust  
3 Fund) to the Secretary such sums as are necessary for fiscal  
4 year 2004 and each subsequent fiscal year to—

5 (1) increase the number of administrative law judges  
6 (and their staffs) under subsection (b)(4);

7 (2) improve education and training opportunities for  
8 administrative law judges (and their staffs); and

9 (3) increase the staff of the Departmental Appeals  
10 Board.

11 (d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i)  
12 (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of  
13 BIPA (114 Stat. 2763A–543), is amended by striking “of the  
14 Social Security Administration”.

15 **SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

16 (a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section  
17 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is  
18 amended—

19 (1) in paragraph (1)(A), by inserting “, subject to  
20 paragraph (2),” before “to judicial review of the Sec-  
21 retary’s final decision”;

22 (2) in paragraph (1)(F)—

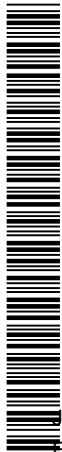
23 (A) by striking clause (ii);

24 (B) by striking “PROCEEDING” and all that follows  
25 through “DETERMINATION” and inserting “DETER-  
26 MINATIONS AND RECONSIDERATIONS”; and

27 (C) by redesignating subclauses (I) and (II) as  
28 clauses (i) and (ii) and by moving the indentation of  
29 such subclauses (and the matter that follows) 2 ems to  
30 the left; and

31 (3) by adding at the end the following new paragraph:  
32 “(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

33 “(A) IN GENERAL.—The Secretary shall establish  
34 a process under which a provider of services or supplier  
35 that furnishes an item or service or an individual enti-  
36 tled to benefits under part A or enrolled under part B,  
37 or both, who has filed an appeal under paragraph (1)



1 may obtain access to judicial review when a review  
2 panel (described in subparagraph (D)), on its own mo-  
3 tion or at the request of the appellant, determines that  
4 no entity in the administrative appeals process has the  
5 authority to decide the question of law or regulation  
6 relevant to the matters in controversy and that there  
7 is no material issue of fact in dispute. The appellant  
8 may make such request only once with respect to a  
9 question of law or regulation in a case of an appeal.

10 “(B) PROMPT DETERMINATIONS.—If, after or co-  
11 incident with appropriately filing a request for an ad-  
12 ministrative hearing, the appellant requests a deter-  
13 mination by the appropriate review panel that no re-  
14 view panel has the authority to decide the question of  
15 law or regulations relevant to the matters in con-  
16 troversy and that there is no material issue of fact in  
17 dispute and if such request is accompanied by the doc-  
18 uments and materials as the appropriate review panel  
19 shall require for purposes of making such determina-  
20 tion, such review panel shall make a determination on  
21 the request in writing within 60 days after the date  
22 such review panel receives the request and such accom-  
23 panying documents and materials. Such a determina-  
24 tion by such review panel shall be considered a final de-  
25 cision and not subject to review by the Secretary.

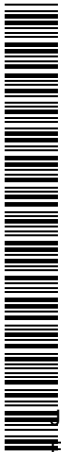
26 “(C) ACCESS TO JUDICIAL REVIEW.—

27 “(i) IN GENERAL.—If the appropriate review  
28 panel—

29 “(I) determines that there are no material  
30 issues of fact in dispute and that the only issue  
31 is one of law or regulation that no review panel  
32 has the authority to decide; or

33 “(II) fails to make such determination  
34 within the period provided under subparagraph  
35 (B);

36 then the appellant may bring a civil action as de-  
37 scribed in this subparagraph.





1           “(ii) DEADLINE FOR FILING.—Such action  
2 shall be filed, in the case described in—

3           “(I) clause (i)(I), within 60 days of date  
4 of the determination described in such subpara-  
5 graph; or

6           “(II) clause (i)(II), within 60 days of the  
7 end of the period provided under subparagraph  
8 (B) for the determination.

9           “(iii) VENUE.—Such action shall be brought  
10 in the district court of the United States for the ju-  
11 dicial district in which the appellant is located (or,  
12 in the case of an action brought jointly by more  
13 than one applicant, the judicial district in which  
14 the greatest number of applicants are located) or in  
15 the district court for the District of Columbia.

16           “(iv) INTEREST ON AMOUNTS IN CON-  
17 TROVERSY.—Where a provider of services or sup-  
18 plier seeks judicial review pursuant to this para-  
19 graph, the amount in controversy shall be subject  
20 to annual interest beginning on the first day of the  
21 first month beginning after the 60-day period as  
22 determined pursuant to clause (ii) and equal to the  
23 rate of interest on obligations issued for purchase  
24 by the Federal Hospital Insurance Trust Fund and  
25 by the Federal Supplementary Medical Insurance  
26 Trust Fund for the month in which the civil action  
27 authorized under this paragraph is commenced, to  
28 be awarded by the reviewing court in favor of the  
29 prevailing party. No interest awarded pursuant to  
30 the preceding sentence shall be deemed income or  
31 cost for the purposes of determining reimbursement  
32 due providers of services or suppliers under this  
33 Act.

34           “(D) REVIEW PANELS.—For purposes of this sub-  
35 section, a ‘review panel’ is a panel consisting of 3 mem-  
36 bers (who shall be administrative law judges, members  
37 of the Departmental Appeals Board, or qualified indi-



1           viduals associated with a qualified independent con-  
2           tractor (as defined in subsection (c)(2)) or with another  
3           independent entity) designated by the Secretary for  
4           purposes of making determinations under this para-  
5           graph.”.

6           (b) APPLICATION TO PROVIDER AGREEMENT DETERMINA-  
7           TIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is  
8           amended—

9           (1) by inserting “(A)” after “(h)(1)”; and

10          (2) by adding at the end the following new subpara-  
11          graph:

12          “(B) An institution or agency described in subparagraph  
13          (A) that has filed for a hearing under subparagraph (A) shall  
14          have expedited access to judicial review under this subpara-  
15          graph in the same manner as providers of services, suppliers,  
16          and individuals entitled to benefits under part A or enrolled  
17          under part B, or both, may obtain expedited access to judicial  
18          review under the process established under section 1869(b)(2).  
19          Nothing in this subparagraph shall be construed to affect the  
20          application of any remedy imposed under section 1819 during  
21          the pendency of an appeal under this subparagraph.”.

22          (c) EFFECTIVE DATE.—The amendments made by this  
23          section shall apply to appeals filed on or after October 1, 2003.

24          (d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREE-  
25          MENT DETERMINATIONS.—

26          (1) TERMINATION AND CERTAIN OTHER IMMEDIATE  
27          REMEDIES.—The Secretary shall develop and implement a  
28          process to expedite proceedings under sections 1866(h) of  
29          the Social Security Act (42 U.S.C. 1395cc(h)) in which the  
30          remedy of termination of participation, or a remedy de-  
31          scribed in clause (i) or (iii) of section 1819(h)(2)(B) of  
32          such Act (42 U.S.C. 1395i-3(h)(2)(B)) which is applied on  
33          an immediate basis, has been imposed. Under such process  
34          priority shall be provided in cases of termination.

35          (2) INCREASED FINANCIAL SUPPORT.—In addition to  
36          any amounts otherwise appropriated, to reduce by 50 per-  
37          cent the average time for administrative determinations on



1 appeals under section 1866(h) of the Social Security Act  
2 (42 U.S.C. 1395cc(h)), there are authorized to be appro-  
3 priated (in appropriate part from the Federal Hospital In-  
4 surance Trust Fund and the Federal Supplementary Med-  
5 ical Insurance Trust Fund) to the Secretary such addi-  
6 tional sums for fiscal year 2004 and each subsequent fiscal  
7 year as may be necessary. The purposes for which such  
8 amounts are available include increasing the number of ad-  
9 ministrative law judges (and their staffs) and the appellate  
10 level staff at the Departmental Appeals Board of the De-  
11 partment of Health and Human Services and educating  
12 such judges and staffs on long-term care issues.

13 **SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.**

14 (a) **REQUIRING FULL AND EARLY PRESENTATION OF EVI-**  
15 **DENCE.—**

16 (1) **IN GENERAL.—**Section 1869(b) (42 U.S.C.  
17 1395ff(b)), as amended by BIPA and as amended by sec-  
18 tion 832(a), is further amended by adding at the end the  
19 following new paragraph:

20 “(3) **REQUIRING FULL AND EARLY PRESENTATION OF**  
21 **EVIDENCE BY PROVIDERS.—**A provider of services or sup-  
22 plier may not introduce evidence in any appeal under this  
23 section that was not presented at the reconsideration con-  
24 ducted by the qualified independent contractor under sub-  
25 section (c), unless there is good cause which precluded the  
26 introduction of such evidence at or before that reconsider-  
27 ation.”.

28 (2) **EFFECTIVE DATE.—**The amendment made by  
29 paragraph (1) shall take effect on October 1, 2003.

30 (b) **USE OF PATIENTS’ MEDICAL RECORDS.—**Section  
31 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended  
32 by BIPA, is amended by inserting “(including the medical  
33 records of the individual involved)” after “clinical experience”.

34 (c) **NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—**

35 (1) **INITIAL DETERMINATIONS AND REDETERMINA-**  
36 **TIONS.—**Section 1869(a) (42 U.S.C. 1395ff(a)), as amend-



1 ed by BIPA, is amended by adding at the end the following  
2 new paragraph:

3 “(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS  
4 AND REDETERMINATIONS.—A written notice of a deter-  
5 mination on an initial determination or on a redetermina-  
6 tion, insofar as such determination or redetermination re-  
7 sults in a denial of a claim for benefits, shall include—

8 “(A) the specific reasons for the determination,  
9 including—

10 “(i) upon request, the provision of the policy,  
11 manual, or regulation used in making the deter-  
12 mination; and

13 “(ii) as appropriate in the case of a redeter-  
14 mination, a summary of the clinical or scientific  
15 evidence used in making the determination;

16 “(B) the procedures for obtaining additional infor-  
17 mation concerning the determination or redetermina-  
18 tion; and

19 “(C) notification of the right to seek a redeter-  
20 mination or otherwise appeal the determination and in-  
21 structions on how to initiate such a redetermination or  
22 appeal under this section.

23 The written notice on a redetermination shall be provided  
24 in printed form and written in a manner calculated to be  
25 understood by the individual entitled to benefits under part  
26 A or enrolled under part B, or both.”.

27 (2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42  
28 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is  
29 amended—

30 (A) by inserting “be written in a manner cal-  
31 culated to be understood by the individual entitled to  
32 benefits under part A or enrolled under part B, or  
33 both, and shall include (to the extent appropriate)”  
34 after “in writing, ”; and

35 (B) by inserting “and a notification of the right to  
36 appeal such determination and instructions on how to



1 initiate such appeal under this section” after “such de-  
2 cision, ”.

3 (3) APPEALS.—Section 1869(d) (42 U.S.C.  
4 1395ff(d)), as amended by BIPA, is amended—

5 (A) in the heading, by inserting “; NOTICE” after  
6 “SECRETARY”; and

7 (B) by adding at the end the following new para-  
8 graph:

9 “(4) NOTICE.—Notice of the decision of an adminis-  
10 trative law judge shall be in writing in a manner calculated  
11 to be understood by the individual entitled to benefits  
12 under part A or enrolled under part B, or both, and shall  
13 include—

14 “(A) the specific reasons for the determination (in-  
15 cluding, to the extent appropriate, a summary of the  
16 clinical or scientific evidence used in making the deter-  
17 mination);

18 “(B) the procedures for obtaining additional infor-  
19 mation concerning the decision; and

20 “(C) notification of the right to appeal the deci-  
21 sion and instructions on how to initiate such an appeal  
22 under this section.”.

23 (4) SUBMISSION OF RECORD FOR APPEAL.—Section  
24 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking  
25 “prepare” and inserting “submit” and by striking “with re-  
26 spect to” and all that follows through “and relevant poli-  
27 cies”.

28 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

29 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDE-  
30 PENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C.  
31 1395ff(c)(3)), as amended by BIPA, is amended—

32 (A) in subparagraph (A), by striking “sufficient  
33 training and expertise in medical science and legal mat-  
34 ters” and inserting “sufficient medical, legal, and other  
35 expertise (including knowledge of the program under  
36 this title) and sufficient staffing”; and



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

3 “(K) INDEPENDENCE REQUIREMENTS.—

4 “(i) IN GENERAL.—Subject to clause (ii), a  
5 qualified independent contractor shall not conduct  
6 any activities in a case unless the entity—

7 “(I) is not a related party (as defined in  
8 subsection (g)(5));

9 “(II) does not have a material familial, fi-  
10 nancial, or professional relationship with such a  
11 party in relation to such case; and

12 “(III) does not otherwise have a conflict of  
13 interest with such a party.

14 “(ii) EXCEPTION FOR REASONABLE COM-  
15 PENSATION.—Nothing in clause (i) shall be con-  
16 strued to prohibit receipt by a qualified inde-  
17 pendent contractor of compensation from the Sec-  
18 retary for the conduct of activities under this sec-  
19 tion if the compensation is provided consistent with  
20 clause (iii).

21 “(iii) LIMITATIONS ON ENTITY COMPENSA-  
22 TION.—Compensation provided by the Secretary to  
23 a qualified independent contractor in connection  
24 with reviews under this section shall not be contin-  
25 gent on any decision rendered by the contractor or  
26 by any reviewing professional.”.

27 (2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—  
28 Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is  
29 amended—

30 (A) by amending subsection (c)(3)(D) to read as  
31 follows:

32 “(D) QUALIFICATIONS FOR REVIEWERS.—The re-  
33 quirements of subsection (g) shall be met (relating to  
34 qualifications of reviewing professionals).”; and

35 (B) by adding at the end the following new sub-  
36 section:

37 “(g) QUALIFICATIONS OF REVIEWERS.—



1           “(1) IN GENERAL.—In reviewing determinations under  
2 this section, a qualified independent contractor shall assure  
3 that—

4           “(A) each individual conducting a review shall  
5 meet the qualifications of paragraph (2);

6           “(B) compensation provided by the contractor to  
7 each such reviewer is consistent with paragraph (3);  
8 and

9           “(C) in the case of a review by a panel described  
10 in subsection (c)(3)(B) composed of physicians or other  
11 health care professionals (each in this subsection re-  
12 ferred to as a ‘reviewing professional’), each reviewing  
13 professional meets the qualifications described in para-  
14 graph (4) and, where a claim is regarding the fur-  
15 nishing of treatment by a physician (allopathic or os-  
16 teopathic) or the provision of items or services by a  
17 physician (allopathic or osteopathic), each reviewing  
18 professional shall be a physician (allopathic or osteo-  
19 pathic).

20           “(2) INDEPENDENCE.—

21           “(A) IN GENERAL.—Subject to subparagraph (B),  
22 each individual conducting a review in a case shall—

23           “(i) not be a related party (as defined in para-  
24 graph (5));

25           “(ii) not have a material familial, financial, or  
26 professional relationship with such a party in the  
27 case under review; and

28           “(iii) not otherwise have a conflict of interest  
29 with such a party.

30           “(B) EXCEPTION.—Nothing in subparagraph (A)  
31 shall be construed to—

32           “(i) prohibit an individual, solely on the basis  
33 of a participation agreement with a fiscal inter-  
34 mediary, carrier, or other contractor, from serving  
35 as a reviewing professional if—



1                   “(I) the individual is not involved in the  
2                   provision of items or services in the case under  
3                   review;

4                   “(II) the fact of such an agreement is dis-  
5                   closed to the Secretary and the individual enti-  
6                   tled to benefits under part A or enrolled under  
7                   part B, or both, (or authorized representative)  
8                   and neither party objects; and

9                   “(III) the individual is not an employee of  
10                  the intermediary, carrier, or contractor and  
11                  does not provide services exclusively or pri-  
12                  marily to or on behalf of such intermediary,  
13                  carrier, or contractor;

14                  “(ii) prohibit an individual who has staff privi-  
15                  leges at the institution where the treatment in-  
16                  volved takes place from serving as a reviewer mere-  
17                  ly on the basis of having such staff privileges if the  
18                  existence of such privileges is disclosed to the Sec-  
19                  retary and such individual (or authorized represent-  
20                  ative), and neither party objects; or

21                  “(iii) prohibit receipt of compensation by a re-  
22                  viewing professional from a contractor if the com-  
23                  pensation is provided consistent with paragraph  
24                  (3).

25                  For purposes of this paragraph, the term ‘participation  
26                  agreement’ means an agreement relating to the provi-  
27                  sion of health care services by the individual and does  
28                  not include the provision of services as a reviewer  
29                  under this subsection.

30                  “(3) LIMITATIONS ON REVIEWER COMPENSATION.—  
31                  Compensation provided by a qualified independent con-  
32                  tractor to a reviewer in connection with a review under this  
33                  section shall not be contingent on the decision rendered by  
34                  the reviewer.

35                  “(4) LICENSURE AND EXPERTISE.—Each reviewing  
36                  professional shall be—





1           “(A) a physician (allopathic or osteopathic) who is  
2 appropriately credentialed or licensed in one or more  
3 States to deliver health care services and has medical  
4 expertise in the field of practice that is appropriate for  
5 the items or services at issue; or

6           “(B) a health care professional who is legally au-  
7 thorized in one or more States (in accordance with  
8 State law or the State regulatory mechanism provided  
9 by State law) to furnish the health care items or serv-  
10 ices at issue and has medical expertise in the field of  
11 practice that is appropriate for such items or services.

12           “(5) RELATED PARTY DEFINED.—For purposes of this  
13 section, the term ‘related party’ means, with respect to a  
14 case under this title involving a specific individual entitled  
15 to benefits under part A or enrolled under part B, or both,  
16 any of the following:

17           “(A) The Secretary, the medicare administrative  
18 contractor involved, or any fiduciary, officer, director,  
19 or employee of the Department of Health and Human  
20 Services, or of such contractor.

21           “(B) The individual (or authorized representative).

22           “(C) The health care professional that provides  
23 the items or services involved in the case.

24           “(D) The institution at which the items or services  
25 (or treatment) involved in the case are provided.

26           “(E) The manufacturer of any drug or other item  
27 that is included in the items or services involved in the  
28 case.

29           “(F) Any other party determined under any regu-  
30 lations to have a substantial interest in the case in-  
31 volved.”.

32           “(3) EFFECTIVE DATE.—The amendments made by  
33 paragraphs (1) and (2) shall be effective as if included in  
34 the enactment of the respective provisions of subtitle C of  
35 title V of BIPA, (114 Stat. 2763A-534).

36           “(4) TRANSITION.—In applying section 1869(g) of the  
37 Social Security Act (as added by paragraph (2)), any ref-



1           erence to a medicare administrative contractor shall be  
2           deemed to include a reference to a fiscal intermediary  
3           under section 1816 of the Social Security Act (42 U.S.C.  
4           1395h) and a carrier under section 1842 of such Act (42  
5           U.S.C. 1395u).

6           **SEC. 834. PREPAYMENT REVIEW.**

7           (a) IN GENERAL.—Section 1874A, as added by section  
8           811(a)(1) and as amended by sections 812(b), 821(b)(1), and  
9           821(c)(1), is further amended by adding at the end the fol-  
10          lowing new subsection:

11          “(h) CONDUCT OF PREPAYMENT REVIEW.—

12           “(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

13           “(A) IN GENERAL.—A medicare administrative  
14           contractor may conduct random prepayment review  
15           only to develop a contractor-wide or program-wide  
16           claims payment error rates or under such additional  
17           circumstances as may be provided under regulations,  
18           developed in consultation with providers of services and  
19           suppliers.

20           “(B) USE OF STANDARD PROTOCOLS WHEN CON-  
21           DUCTING PREPAYMENT REVIEWS.—When a medicare  
22           administrative contractor conducts a random prepay-  
23           ment review, the contractor may conduct such review  
24           only in accordance with a standard protocol for random  
25           prepayment audits developed by the Secretary.

26           “(C) CONSTRUCTION.—Nothing in this paragraph  
27           shall be construed as preventing the denial of payments  
28           for claims actually reviewed under a random prepay-  
29           ment review.

30           “(D) RANDOM PREPAYMENT REVIEW.—For pur-  
31           poses of this subsection, the term ‘random prepayment  
32           review’ means a demand for the production of records  
33           or documentation absent cause with respect to a claim.

34           “(2) LIMITATIONS ON NON-RANDOM PREPAYMENT RE-  
35           VIEW.—

36           “(A) LIMITATIONS ON INITIATION OF NON-RAN-  
37           DOM PREPAYMENT REVIEW.—A medicare administra-



1           tive contractor may not initiate non-random prepay-  
2           ment review of a provider of services or supplier based  
3           on the initial identification by that provider of services  
4           or supplier of an improper billing practice unless there  
5           is a likelihood of sustained or high level of payment  
6           error (as defined in subsection (i)(3)(A)).

7           “(B) TERMINATION OF NON-RANDOM PREPAY-  
8           MENT REVIEW.—The Secretary shall issue regulations  
9           relating to the termination, including termination  
10          dates, of non-random prepayment review. Such regula-  
11          tions may vary such a termination date based upon the  
12          differences in the circumstances triggering prepayment  
13          review.”.

14          (b) EFFECTIVE DATE.—

15           (1) IN GENERAL.—Except as provided in this sub-  
16           section, the amendment made by subsection (a) shall take  
17           effect 1 year after the date of the enactment of this Act.

18           (2) DEADLINE FOR PROMULGATION OF CERTAIN REG-  
19           ULATIONS.—The Secretary shall first issue regulations  
20           under section 1874A(h) of the Social Security Act, as  
21           added by subsection (a), by not later than 1 year after the  
22           date of the enactment of this Act.

23           (3) APPLICATION OF STANDARD PROTOCOLS FOR RAN-  
24           DOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of  
25           the Social Security Act, as added by subsection (a), shall  
26           apply to random prepayment reviews conducted on or after  
27           such date (not later than 1 year after the date of the enact-  
28           ment of this Act) as the Secretary shall specify.

29           (c) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-  
30           RIERS.—The provisions of section 1874A(h) of the Social Secu-  
31           rity Act, as added by subsection (a), shall apply to each fiscal  
32           intermediary under section 1816 of the Social Security Act (42  
33           U.S.C. 1395h) and each carrier under section 1842 of such Act  
34           (42 U.S.C. 1395u) in the same manner as they apply to medi-  
35           care administrative contractors under such provisions.



1 **SEC. 835. RECOVERY OF OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is  
3 amended by adding at the end the following new subsection:

4 “(f) RECOVERY OF OVERPAYMENTS.—

5 “(1) USE OF REPAYMENT PLANS.—

6 “(A) IN GENERAL.—If the repayment, within 30  
7 days by a provider of services or supplier, of an over-  
8 payment under this title would constitute a hardship  
9 (as defined in subparagraph (B)), subject to subpara-  
10 graph (C), upon request of the provider of services or  
11 supplier the Secretary shall enter into a plan with the  
12 provider of services or supplier for the repayment  
13 (through offset or otherwise) of such overpayment over  
14 a period of at least 6 months but not longer than 3  
15 years (or not longer than 5 years in the case of extreme  
16 hardship, as determined by the Secretary). Interest  
17 shall accrue on the balance through the period of re-  
18 payment. Such plan shall meet terms and conditions  
19 determined to be appropriate by the Secretary.

20 “(B) HARDSHIP.—

21 “(i) IN GENERAL.—For purposes of subpara-  
22 graph (A), the repayment of an overpayment (or  
23 overpayments) within 30 days is deemed to con-  
24 stitute a hardship if—

25 “(I) in the case of a provider of services  
26 that files cost reports, the aggregate amount of  
27 the overpayments exceeds 10 percent of the  
28 amount paid under this title to the provider of  
29 services for the cost reporting period covered by  
30 the most recently submitted cost report; or

31 “(II) in the case of another provider of  
32 services or supplier, the aggregate amount of  
33 the overpayments exceeds 10 percent of the  
34 amount paid under this title to the provider of  
35 services or supplier for the previous calendar  
36 year.



1           “(ii) RULE OF APPLICATION.—The Secretary  
2 shall establish rules for the application of this sub-  
3 paragraph in the case of a provider of services or  
4 supplier that was not paid under this title during  
5 the previous year or was paid under this title only  
6 during a portion of that year.

7           “(iii) TREATMENT OF PREVIOUS OVERPAY-  
8 MENTS.—If a provider of services or supplier has  
9 entered into a repayment plan under subparagraph  
10 (A) with respect to a specific overpayment amount,  
11 such payment amount under the repayment plan  
12 shall not be taken into account under clause (i)  
13 with respect to subsequent overpayment amounts.

14           “(C) EXCEPTIONS.—Subparagraph (A) shall not  
15 apply if—

16           “(i) the Secretary has reason to suspect that  
17 the provider of services or supplier may file for  
18 bankruptcy or otherwise cease to do business or  
19 discontinue participation in the program under this  
20 title; or

21           “(ii) there is an indication of fraud or abuse  
22 committed against the program.

23           “(D) IMMEDIATE COLLECTION IF VIOLATION OF  
24 REPAYMENT PLAN.—If a provider of services or sup-  
25 plier fails to make a payment in accordance with a re-  
26 payment plan under this paragraph, the Secretary may  
27 immediately seek to offset or otherwise recover the  
28 total balance outstanding (including applicable interest)  
29 under the repayment plan.

30           “(E) RELATION TO NO FAULT PROVISION.—Noth-  
31 ing in this paragraph shall be construed as affecting  
32 the application of section 1870(c) (relating to no ad-  
33 justment in the cases of certain overpayments).

34           “(2) LIMITATION ON RECOUPMENT.—

35           “(A) IN GENERAL.—In the case of a provider of  
36 services or supplier that is determined to have received  
37 an overpayment under this title and that seeks a recon-



1           sideration by a qualified independent contractor on  
2 such determination under section 1869(b)(1), the Sec-  
3 retary may not take any action (or authorize any other  
4 person, including any medicare contractor, as defined  
5 in subparagraph (C)) to recoup the overpayment until  
6 the date the decision on the reconsideration has been  
7 rendered. If the provisions of section 1869(b)(1) (pro-  
8 viding for such a reconsideration by a qualified inde-  
9 pendent contractor) are not in effect, in applying the  
10 previous sentence any reference to such a reconsider-  
11 ation shall be treated as a reference to a redetermina-  
12 tion by the fiscal intermediary or carrier involved.

13           “(B) COLLECTION WITH INTEREST.—Insofar as  
14 the determination on such appeal is against the pro-  
15 vider of services or supplier, interest on the overpay-  
16 ment shall accrue on and after the date of the original  
17 notice of overpayment. Insofar as such determination  
18 against the provider of services or supplier is later re-  
19 versed, the Secretary shall provide for repayment of the  
20 amount recouped plus interest at the same rate as  
21 would apply under the previous sentence for the period  
22 in which the amount was recouped.

23           “(C) MEDICARE CONTRACTOR DEFINED.—For  
24 purposes of this subsection, the term ‘medicare con-  
25 tractor’ has the meaning given such term in section  
26 1889(g).

27           “(3) LIMITATION ON USE OF EXTRAPOLATION.—A  
28 medicare contractor may not use extrapolation to determine  
29 overpayment amounts to be recovered by recoupment, off-  
30 set, or otherwise unless—

31           “(A) there is a sustained or high level of payment  
32 error (as defined by the Secretary by regulation); or

33           “(B) documented educational intervention has  
34 failed to correct the payment error (as determined by  
35 the Secretary).

36           “(4) PROVISION OF SUPPORTING DOCUMENTATION.—  
37 In the case of a provider of services or supplier with respect



1 to which amounts were previously overpaid, a medicare con-  
2 tractor may request the periodic production of records or  
3 supporting documentation for a limited sample of sub-  
4 mitted claims to ensure that the previous practice is not  
5 continuing.

6 “(5) CONSENT SETTLEMENT REFORMS.—

7 “(A) IN GENERAL.—The Secretary may use a con-  
8 sent settlement (as defined in subparagraph (D)) to  
9 settle a projected overpayment.

10 “(B) OPPORTUNITY TO SUBMIT ADDITIONAL IN-  
11 FORMATION BEFORE CONSENT SETTLEMENT OFFER.—  
12 Before offering a provider of services or supplier a con-  
13 sent settlement, the Secretary shall—

14 “(i) communicate to the provider of services or  
15 supplier—

16 “(I) that, based on a review of the medical  
17 records requested by the Secretary, a prelimi-  
18 nary evaluation of those records indicates that  
19 there would be an overpayment;

20 “(II) the nature of the problems identified  
21 in such evaluation; and

22 “(III) the steps that the provider of serv-  
23 ices or supplier should take to address the  
24 problems; and

25 “(ii) provide for a 45-day period during which  
26 the provider of services or supplier may furnish ad-  
27 ditional information concerning the medical records  
28 for the claims that had been reviewed.

29 “(C) CONSENT SETTLEMENT OFFER.—The Sec-  
30 retary shall review any additional information furnished  
31 by the provider of services or supplier under subpara-  
32 graph (B)(ii). Taking into consideration such informa-  
33 tion, the Secretary shall determine if there still appears  
34 to be an overpayment. If so, the Secretary—

35 “(i) shall provide notice of such determination  
36 to the provider of services or supplier, including an



1 explanation of the reason for such determination;  
2 and

3 “(ii) in order to resolve the overpayment, may  
4 offer the provider of services or supplier—

5 “(I) the opportunity for a statistically  
6 valid random sample; or

7 “(II) a consent settlement.

8 The opportunity provided under clause (ii)(I) does not  
9 waive any appeal rights with respect to the alleged  
10 overpayment involved.

11 “(D) CONSENT SETTLEMENT DEFINED.—For pur-  
12 poses of this paragraph, the term ‘consent settlement’  
13 means an agreement between the Secretary and a pro-  
14 vider of services or supplier whereby both parties agree  
15 to settle a projected overpayment based on less than a  
16 statistically valid sample of claims and the provider of  
17 services or supplier agrees not to appeal the claims in-  
18 volved.

19 “(6) NOTICE OF OVER-UTILIZATION OF CODES.—The  
20 Secretary shall establish, in consultation with organizations  
21 representing the classes of providers of services and sup-  
22 pliers, a process under which the Secretary provides for no-  
23 tice to classes of providers of services and suppliers served  
24 by the contractor in cases in which the contractor has iden-  
25 tified that particular billing codes may be overutilized by  
26 that class of providers of services or suppliers under the  
27 programs under this title (or provisions of title XI insofar  
28 as they relate to such programs).

29 “(7) PAYMENT AUDITS.—

30 “(A) WRITTEN NOTICE FOR POST-PAYMENT AU-  
31 DITS.—Subject to subparagraph (C), if a medicare con-  
32 tractor decides to conduct a post-payment audit of a  
33 provider of services or supplier under this title, the con-  
34 tractor shall provide the provider of services or supplier  
35 with written notice (which may be in electronic form)  
36 of the intent to conduct such an audit.





1           “(B) EXPLANATION OF FINDINGS FOR ALL AU-  
2           DITS.—Subject to subparagraph (C), if a medicare con-  
3           tractor audits a provider of services or supplier under  
4           this title, the contractor shall—

5           “(i) give the provider of services or supplier a  
6           full review and explanation of the findings of the  
7           audit in a manner that is understandable to the  
8           provider of services or supplier and permits the de-  
9           velopment of an appropriate corrective action plan;

10          “(ii) inform the provider of services or supplier  
11          of the appeal rights under this title as well as con-  
12          sent settlement options (which are at the discretion  
13          of the Secretary);

14          “(iii) give the provider of services or supplier  
15          an opportunity to provide additional information to  
16          the contractor; and

17          “(iv) take into account information provided,  
18          on a timely basis, by the provider of services or  
19          supplier under clause (iii).

20          “(C) EXCEPTION.—Subparagraphs (A) and (B)  
21          shall not apply if the provision of notice or findings  
22          would compromise pending law enforcement activities,  
23          whether civil or criminal, or reveal findings of law en-  
24          forcement-related audits.

25          “(8) STANDARD METHODOLOGY FOR PROBE SAM-  
26          PLING.—The Secretary shall establish a standard method-  
27          ology for medicare contractors to use in selecting a sample  
28          of claims for review in the case of an abnormal billing pat-  
29          tern.”.

30          (b) EFFECTIVE DATES AND DEADLINES.—

31                (1) USE OF REPAYMENT PLANS.—Section 1893(f)(1)  
32                of the Social Security Act, as added by subsection (a), shall  
33                apply to requests for repayment plans made after the date  
34                of the enactment of this Act.

35                (2) LIMITATION ON RECOUPMENT.—Section  
36                1893(f)(2) of the Social Security Act, as added by sub-



1 section (a), shall apply to actions taken after the date of  
2 the enactment of this Act.

3 (3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of  
4 the Social Security Act, as added by subsection (a), shall  
5 apply to statistically valid random samples initiated after  
6 the date that is 1 year after the date of the enactment of  
7 this Act.

8 (4) PROVISION OF SUPPORTING DOCUMENTATION.—  
9 Section 1893(f)(4) of the Social Security Act, as added by  
10 subsection (a), shall take effect on the date of the enact-  
11 ment of this Act.

12 (5) CONSENT SETTLEMENT.—Section 1893(f)(5) of  
13 the Social Security Act, as added by subsection (a), shall  
14 apply to consent settlements entered into after the date of  
15 the enactment of this Act.

16 (6) NOTICE OF OVERUTILIZATION.—Not later than 1  
17 year after the date of the enactment of this Act, the Sec-  
18 retary shall first establish the process for notice of over-  
19 utilization of billing codes under section 1893A(f)(6) of the  
20 Social Security Act, as added by subsection (a).

21 (7) PAYMENT AUDITS.—Section 1893A(f)(7) of the  
22 Social Security Act, as added by subsection (a), shall apply  
23 to audits initiated after the date of the enactment of this  
24 Act.

25 (8) STANDARD FOR ABNORMAL BILLING PATTERNS.—  
26 Not later than 1 year after the date of the enactment of  
27 this Act, the Secretary shall first establish a standard  
28 methodology for selection of sample claims for abnormal  
29 billing patterns under section 1893(f)(8) of the Social Se-  
30 curity Act, as added by subsection (a).

31 **SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF**  
32 **APPEAL.**

33 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is  
34 amended—

- 35 (1) by adding at the end of the heading the following:  
36 “; ENROLLMENT PROCESSES”; and  
37 (2) by adding at the end the following new subsection:



1           “(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERV-  
2 ICES AND SUPPLIERS.—

3           “(1) ENROLLMENT PROCESS.—

4           “(A) IN GENERAL.—The Secretary shall establish  
5 by regulation a process for the enrollment of providers  
6 of services and suppliers under this title.

7           “(B) DEADLINES.—The Secretary shall establish  
8 by regulation procedures under which there are dead-  
9 lines for actions on applications for enrollment (and, if  
10 applicable, renewal of enrollment). The Secretary shall  
11 monitor the performance of medicare administrative  
12 contractors in meeting the deadlines established under  
13 this subparagraph.

14           “(C) CONSULTATION BEFORE CHANGING PRO-  
15 VIDER ENROLLMENT FORMS.—The Secretary shall con-  
16 sult with providers of services and suppliers before  
17 making changes in the provider enrollment forms re-  
18 quired of such providers and suppliers to be eligible to  
19 submit claims for which payment may be made under  
20 this title.

21           “(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-  
22 RENEWAL.—A provider of services or supplier whose appli-  
23 cation to enroll (or, if applicable, to renew enrollment)  
24 under this title is denied may have a hearing and judicial  
25 review of such denial under the procedures that apply  
26 under subsection (h)(1)(A) to a provider of services that is  
27 dissatisfied with a determination by the Secretary.”.

28           (b) EFFECTIVE DATES.—

29           (1) ENROLLMENT PROCESS.—The Secretary shall pro-  
30 vide for the establishment of the enrollment process under  
31 section 1866(j)(1) of the Social Security Act, as added by  
32 subsection (a)(2), within 6 months after the date of the en-  
33 actment of this Act.

34           (2) CONSULTATION.—Section 1866(j)(1)(C) of the So-  
35 cial Security Act, as added by subsection (a)(2), shall apply  
36 with respect to changes in provider enrollment forms made  
37 on or after January 1, 2003.

1           (3) HEARING RIGHTS.—Section 1866(j)(2) of the So-  
2           cial Security Act, as added by subsection (a)(2), shall apply  
3           to denials occurring on or after such date (not later than  
4           1 year after the date of the enactment of this Act) as the  
5           Secretary specifies.

6           **SEC. 837. PROCESS FOR CORRECTION OF MINOR ER-**  
7           **RORS AND OMISSIONS ON CLAIMS WITHOUT**  
8           **PURSUING APPEALS PROCESS.**

9           The Secretary shall develop, in consultation with appro-  
10          priate medicare contractors (as defined in section 1889(g) of  
11          the Social Security Act, as inserted by section 821(a)(1)) and  
12          representatives of providers of services and suppliers, a process  
13          whereby, in the case of minor errors or omissions (as defined  
14          by the Secretary) that are detected in the submission of claims  
15          under the programs under title XVIII of such Act, a provider  
16          of services or supplier is given an opportunity to correct such  
17          an error or omission without the need to initiate an appeal.  
18          Such process shall include the ability to resubmit corrected  
19          claims.

20          **SEC. 838. PRIOR DETERMINATION PROCESS FOR CER-**  
21          **TAIN ITEMS AND SERVICES; ADVANCE BENE-**  
22          **FICIARY NOTICES.**

23          (a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as  
24          amended by sections 521 and 522 of BIPA and section  
25          833(d)(2)(B), is further amended by adding at the end the fol-  
26          lowing new subsection:

27               “(h) PRIOR DETERMINATION PROCESS FOR CERTAIN  
28               ITEMS AND SERVICES.—

29                       “(1) ESTABLISHMENT OF PROCESS.—

30                               “(A) IN GENERAL.—With respect to a medicare  
31                               administrative contractor that has a contract under  
32                               section 1874A that provides for making payments  
33                               under this title with respect to eligible items and serv-  
34                               ices described in subparagraph (C), the Secretary shall  
35                               establish a prior determination process that meets the  
36                               requirements of this subsection and that shall be ap-  
37                               plied by such contractor in the case of eligible request-  
38                               ers.



1           “(B) ELIGIBLE REQUESTER.—For purposes of  
2 this subsection, each of the following shall be an eligi-  
3 ble requester:

4           “(i) A physician, but only with respect to eligi-  
5 ble items and services for which the physician may  
6 be paid directly.

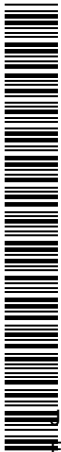
7           “(ii) An individual entitled to benefits under  
8 this title, but only with respect to an item or serv-  
9 ice for which the individual receives, from the phy-  
10 sician who may be paid directly for the item or  
11 service, an advance beneficiary notice under section  
12 1879(a) that payment may not be made (or may no  
13 longer be made) for the item or service under this  
14 title.

15           “(C) ELIGIBLE ITEMS AND SERVICES.—For pur-  
16 poses of this subsection and subject to paragraph (2),  
17 eligible items and services are items and services which  
18 are physicians’ services (as defined in paragraph (4)(A)  
19 of section 1848(f) for purposes of calculating the sus-  
20 tainable growth rate under such section).

21           “(2) SECRETARIAL FLEXIBILITY.—The Secretary shall  
22 establish by regulation reasonable limits on the categories  
23 of eligible items and services for which a prior determina-  
24 tion of coverage may be requested under this subsection. In  
25 establishing such limits, the Secretary may consider the  
26 dollar amount involved with respect to the item or service,  
27 administrative costs and burdens, and other relevant fac-  
28 tors.

29           “(3) REQUEST FOR PRIOR DETERMINATION.—

30           “(A) IN GENERAL.—Subject to paragraph (2),  
31 under the process established under this subsection an  
32 eligible requester may submit to the contractor a re-  
33 quest for a determination, before the furnishing of an  
34 eligible item or service involved as to whether the item  
35 or service is covered under this title consistent with the  
36 applicable requirements of section 1862(a)(1)(A) (relat-  
37 ing to medical necessity).



1           “(B) ACCOMPANYING DOCUMENTATION.—The Sec-  
2           retary may require that the request be accompanied by  
3           a description of the item or service, supporting docu-  
4           mentation relating to the medical necessity for the item  
5           or service, and any other appropriate documentation.  
6           In the case of a request submitted by an eligible re-  
7           quester who is described in paragraph (1)(B)(ii), the  
8           Secretary may require that the request also be accom-  
9           panied by a copy of the advance beneficiary notice in-  
10          volved.

11          “(4) RESPONSE TO REQUEST.—

12           “(A) IN GENERAL.—Under such process, the con-  
13           tractor shall provide the eligible requester with written  
14           notice of a determination as to whether—

15                   “(i) the item or service is so covered;

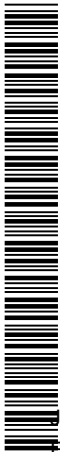
16                   “(ii) the item or service is not so covered; or

17                   “(iii) the contractor lacks sufficient informa-  
18                  tion to make a coverage determination.

19          If the contractor makes the determination described in  
20          clause (iii), the contractor shall include in the notice a  
21          description of the additional information required to  
22          make the coverage determination.

23           “(B) DEADLINE TO RESPOND.—Such notice shall  
24           be provided within the same time period as the time pe-  
25           riod applicable to the contractor providing notice of ini-  
26           tial determinations on a claim for benefits under sub-  
27           section (a)(2)(A).

28           “(C) INFORMING BENEFICIARY IN CASE OF PHYSI-  
29           CIAN REQUEST.—In the case of a request in which an  
30           eligible requester is not the individual described in  
31           paragraph (1)(B)(ii), the process shall provide that the  
32           individual to whom the item or service is proposed to  
33           be furnished shall be informed of any determination de-  
34           scribed in clause (ii) (relating to a determination of  
35           non-coverage) and the right (referred to in paragraph  
36           (6)(B)) to obtain the item or service and have a claim  
37           submitted for the item or service.



1 “(5) EFFECT OF DETERMINATIONS.—

2 “(A) BINDING NATURE OF POSITIVE DETERMINA-  
3 TION.—If the contractor makes the determination de-  
4 scribed in paragraph (4)(A)(i), such determination  
5 shall be binding on the contractor in the absence of  
6 fraud or evidence of misrepresentation of facts pre-  
7 sented to the contractor.

8 “(B) NOTICE AND RIGHT TO REDETERMINATION  
9 IN CASE OF A DENIAL.—

10 “(i) IN GENERAL.—If the contractor makes  
11 the determination described in paragraph  
12 (4)(A)(ii)—

13 “(I) the eligible requester has the right to  
14 a redetermination by the contractor on the de-  
15 termination that the item or service is not so  
16 covered; and

17 “(II) the contractor shall include in notice  
18 under paragraph (4)(A) a brief explanation of  
19 the basis for the determination, including on  
20 what national or local coverage or noncoverage  
21 determination (if any) the determination is  
22 based, and the right to such a redetermination.

23 “(ii) DEADLINE FOR REDETERMINATIONS.—  
24 The contractor shall complete and provide notice of  
25 such redetermination within the same time period  
26 as the time period applicable to the contractor pro-  
27 viding notice of redeterminations relating to a  
28 claim for benefits under subsection (a)(3)(C)(ii).

29 “(6) LIMITATION ON FURTHER REVIEW.—

30 “(A) IN GENERAL.—Contractor determinations de-  
31 scribed in paragraph (4)(A)(ii) or (4)(A)(iii) (and rede-  
32 terminations made under paragraph (5)(B)), relating  
33 to pre-service claims are not subject to further adminis-  
34 trative appeal or judicial review under this section or  
35 otherwise.

36 “(B) DECISION NOT TO SEEK PRIOR DETERMINA-  
37 TION OR NEGATIVE DETERMINATION DOES NOT IMPACT



1 RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT,  
2 OR APPEAL RIGHTS.—Nothing in this subsection shall  
3 be construed as affecting the right of an individual  
4 who—

5 “(i) decides not to seek a prior determination  
6 under this subsection with respect to items or serv-  
7 ices; or

8 “(ii) seeks such a determination and has re-  
9 ceived a determination described in paragraph  
10 (4)(A)(ii),

11 from receiving (and submitting a claim for) such items  
12 services and from obtaining administrative or judicial  
13 review respecting such claim under the other applicable  
14 provisions of this section. Failure to seek a prior deter-  
15 mination under this subsection with respect to items  
16 and services shall not be taken into account in such ad-  
17 ministrative or judicial review.

18 “(C) NO PRIOR DETERMINATION AFTER RECEIPT  
19 OF SERVICES.—Once an individual is provided items  
20 and services, there shall be no prior determination  
21 under this subsection with respect to such items or  
22 services.”.

23 (b) EFFECTIVE DATE; TRANSITION.—

24 (1) EFFECTIVE DATE.—The Secretary shall establish  
25 the prior determination process under the amendment  
26 made by subsection (a) in such a manner as to provide for  
27 the acceptance of requests for determinations under such  
28 process filed not later than 18 months after the date of the  
29 enactment of this Act.

30 (2) TRANSITION.—During the period in which the  
31 amendment made by subsection (a) has become effective  
32 but contracts are not provided under section 1874A of the  
33 Social Security Act with medicare administrative contrac-  
34 tors, any reference in section 1869(g) of such Act (as  
35 added by such amendment) to such a contractor is deemed  
36 a reference to a fiscal intermediary or carrier with an





1 agreement under section 1816, or contract under section  
2 1842, respectively, of such Act.

3 (3) LIMITATION ON APPLICATION TO SGR.—For pur-  
4 poses of applying section 1848(f)(2)(D) of the Social Secu-  
5 rity Act (42 U.S.C. 1395w-4(f)(2)(D)), the amendment  
6 made by subsection (a) shall not be considered to be a  
7 change in law or regulation.

8 (c) PROVISIONS RELATING TO ADVANCE BENEFICIARY  
9 NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

10 (1) DATA COLLECTION.—The Secretary shall establish  
11 a process for the collection of information on the instances  
12 in which an advance beneficiary notice (as defined in para-  
13 graph (4)) has been provided and on instances in which a  
14 beneficiary indicates on such a notice that the beneficiary  
15 does not intend to seek to have the item or service that is  
16 the subject of the notice furnished.

17 (2) OUTREACH AND EDUCATION.—The Secretary shall  
18 establish a program of outreach and education for bene-  
19 ficiaries and providers of services and other persons on the  
20 appropriate use of advance beneficiary notices and coverage  
21 policies under the medicare program.

22 (3) GAO REPORT REPORT ON USE OF ADVANCE BENE-  
23 FICIARY NOTICES.—Not later than 18 months after the  
24 date on which section 1869(g) of the Social Security Act  
25 (as added by subsection (a)) takes effect, the Comptroller  
26 General of the United States shall submit to Congress a re-  
27 port on the use of advance beneficiary notices under title  
28 XVIII of such Act. Such report shall include information  
29 concerning the providers of services and other persons that  
30 have provided such notices and the response of beneficiaries  
31 to such notices.

32 (4) GAO REPORT ON USE OF PRIOR DETERMINATION  
33 PROCESS.—Not later than 18 months after the date on  
34 which section 1869(g) of the Social Security Act (as added  
35 by subsection (a)) takes effect, the Comptroller General of  
36 the United States shall submit to Congress a report on the



1 use of the prior determination process under such section.  
2 Such report shall include—

3 (A) information concerning the types of proce-  
4 dures for which a prior determination has been sought,  
5 determinations made under the process, and changes in  
6 receipt of services resulting from the application of  
7 such process; and

8 (B) an evaluation of whether the process was use-  
9 ful for physicians (and other suppliers) and bene-  
10 ficiaries, whether it was timely, and whether the  
11 amount of information required was burdensome to  
12 physicians and beneficiaries.

13 (5) ADVANCE BENEFICIARY NOTICE DEFINED.—In  
14 this subsection, the term “advance beneficiary notice”  
15 means a written notice provided under section 1879(a) of  
16 the Social Security Act (42 U.S.C. 1395pp(a)) to an indi-  
17 vidual entitled to benefits under part A or B of title XVIII  
18 of such Act before items or services are furnished under  
19 such part in cases where a provider of services or other  
20 person that would furnish the item or service believes that  
21 payment will not be made for some or all of such items or  
22 services under such title.

## 23 **Subtitle E—Miscellaneous Provisions**

### 24 **SEC. 841. POLICY DEVELOPMENT REGARDING EVALUA-** 25 **TION AND MANAGEMENT (E & M) DOCU-** 26 **MENTATION GUIDELINES.**

27 (a) IN GENERAL.—The Secretary may not implement any  
28 new documentation guidelines for evaluation and management  
29 physician services under the title XVIII of the Social Security  
30 Act on or after the date of the enactment of this Act unless  
31 the Secretary—

32 (1) has developed the guidelines in collaboration with  
33 practicing physicians (including both generalists and spe-  
34 cialists) and provided for an assessment of the proposed  
35 guidelines by the physician community;



1 (2) has established a plan that contains specific goals,  
2 including a schedule, for improving the use of such guide-  
3 lines;

4 (3) has conducted appropriate and representative pilot  
5 projects under subsection (b) to test modifications to the  
6 evaluation and management documentation guidelines;

7 (4) finds that the objectives described in subsection (c)  
8 will be met in the implementation of such guidelines; and

9 (5) has established, and is implementing, a program to  
10 educate physicians on the use of such guidelines and that  
11 includes appropriate outreach.

12 The Secretary shall make changes to the manner in which ex-  
13 isting evaluation and management documentation guidelines  
14 are implemented to reduce paperwork burdens on physicians.

15 (b) PILOT PROJECTS TO TEST EVALUATION AND MAN-  
16 AGEMENT DOCUMENTATION GUIDELINES.—

17 (1) IN GENERAL.—The Secretary shall conduct under  
18 this subsection appropriate and representative pilot projects  
19 to test new evaluation and management documentation  
20 guidelines referred to in subsection (a).

21 (2) LENGTH AND CONSULTATION.—Each pilot project  
22 under this subsection shall—

23 (A) be voluntary;

24 (B) be of sufficient length as determined by the  
25 Secretary to allow for preparatory physician and medi-  
26 care contractor education, analysis, and use and assess-  
27 ment of potential evaluation and management guide-  
28 lines; and

29 (C) be conducted, in development and throughout  
30 the planning and operational stages of the project, in  
31 consultation with practicing physicians (including both  
32 generalists and specialists).

33 (3) RANGE OF PILOT PROJECTS.—Of the pilot projects  
34 conducted under this subsection—

35 (A) at least one shall focus on a peer review meth-  
36 od by physicians (not employed by a medicare con-  
37 tractor) which evaluates medical record information for



1 claims submitted by physicians identified as statistical  
2 outliers relative to definitions published in the Current  
3 Procedures Terminology (CPT) code book of the Amer-  
4 ican Medical Association;

5 (B) at least one shall focus on an alternative  
6 method to detailed guidelines based on physician docu-  
7 mentation of face to face encounter time with a patient;

8 (C) at least one shall be conducted for services  
9 furnished in a rural area and at least one for services  
10 furnished outside such an area; and

11 (D) at least one shall be conducted in a setting  
12 where physicians bill under physicians' services in  
13 teaching settings and at least one shall be conducted in  
14 a setting other than a teaching setting.

15 (4) BANNING OF TARGETING OF PILOT PROJECT PAR-  
16 TICIPANTS.—Data collected under this subsection shall not  
17 be used as the basis for overpayment demands or post-pay-  
18 ment audits. Such limitation applies only to claims filed as  
19 part of the pilot project and lasts only for the duration of  
20 the pilot project and only as long as the provider is a par-  
21 ticipant in the pilot project.

22 (5) STUDY OF IMPACT.—Each pilot project shall ex-  
23 amine the effect of the new evaluation and management  
24 documentation guidelines on—

25 (A) different types of physician practices, includ-  
26 ing those with fewer than 10 full-time-equivalent em-  
27 ployees (including physicians); and

28 (B) the costs of physician compliance, including  
29 education, implementation, auditing, and monitoring.

30 (6) PERIODIC REPORTS.—The Secretary shall submit  
31 to Congress periodic reports on the pilot projects under this  
32 subsection.

33 (c) OBJECTIVES FOR EVALUATION AND MANAGEMENT  
34 GUIDELINES.—The objectives for modified evaluation and man-  
35 agement documentation guidelines developed by the Secretary  
36 shall be to—



1 (1) identify clinically relevant documentation needed to  
2 code accurately and assess coding levels accurately;

3 (2) decrease the level of non-clinically pertinent and  
4 burdensome documentation time and content in the physi-  
5 cian's medical record;

6 (3) increase accuracy by reviewers; and

7 (4) educate both physicians and reviewers.

8 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOC-  
9 UMENTATION FOR PHYSICIAN CLAIMS.—

10 (1) STUDY.—The Secretary shall carry out a study of  
11 the matters described in paragraph (2).

12 (2) MATTERS DESCRIBED.—The matters referred to in  
13 paragraph (1) are—

14 (A) the development of a simpler, alternative sys-  
15 tem of requirements for documentation accompanying  
16 claims for evaluation and management physician serv-  
17 ices for which payment is made under title XVIII of  
18 the Social Security Act; and

19 (B) consideration of systems other than current  
20 coding and documentation requirements for payment  
21 for such physician services.

22 (3) CONSULTATION WITH PRACTICING PHYSICIANS.—  
23 In designing and carrying out the study under paragraph  
24 (1), the Secretary shall consult with practicing physicians,  
25 including physicians who are part of group practices and  
26 including both generalists and specialists.

27 (4) APPLICATION OF HIPAA UNIFORM CODING RE-  
28 QUIREMENTS.—In developing an alternative system under  
29 paragraph (2), the Secretary shall consider requirements of  
30 administrative simplification under part C of title XI of the  
31 Social Security Act.

32 (5) REPORT TO CONGRESS.—(A) Not later than Octo-  
33 ber 1, 2004, the Secretary shall submit to Congress a re-  
34 port on the results of the study conducted under paragraph  
35 (1).

36 (B) The Medicare Payment Advisory Commission shall  
37 conduct an analysis of the results of the study included in



1 the report under subparagraph (A) and shall submit a re-  
2 port on such analysis to Congress.

3 (e) STUDY ON APPROPRIATE CODING OF CERTAIN EX-  
4 TENDED OFFICE VISITS.—The Secretary shall conduct a study  
5 of the appropriateness of coding in cases of extended office vis-  
6 its in which there is no diagnosis made. Not later than October  
7 1, 2004, the Secretary shall submit a report to Congress on  
8 such study and shall include recommendations on how to code  
9 appropriately for such visits in a manner that takes into ac-  
10 count the amount of time the physician spent with the patient.

11 (f) DEFINITIONS.—In this section—

12 (1) the term “rural area” has the meaning given that  
13 term in section 1886(d)(2)(D) of the Social Security Act,  
14 42 U.S.C. 1395ww(d)(2)(D); and

15 (2) the term “teaching settings” are those settings de-  
16 scribed in section 415.150 of title 42, Code of Federal Reg-  
17 ulations.

18 **SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECH-**  
19 **NOLOGY AND COVERAGE.**

20 (a) IMPROVED COORDINATION BETWEEN FDA AND CMS  
21 ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

22 (1) IN GENERAL.—Upon request by an applicant and  
23 to the extent feasible (as determined by the Secretary), the  
24 Secretary shall, in the case of a class III medical device  
25 that is subject to premarket approval under section 515 of  
26 the Federal Food, Drug, and Cosmetic Act, ensure the  
27 sharing of appropriate information from the review for ap-  
28 plication for premarket approval conducted by the Food  
29 and Drug Administration for coverage decisions under title  
30 XVIII of the Social Security Act.

31 (2) PUBLICATION OF PLAN.—Not later than 6 months  
32 after the date of the enactment of this Act, the Secretary  
33 shall submit to appropriate Committees of Congress a re-  
34 port that contains the plan for improving such coordination  
35 and for shortening the time lag between the premarket ap-  
36 proval by the Food and Drug Administration and coding



1 and coverage decisions by the Centers for Medicare & Med-  
2 icaid Services.

3 (3) CONSTRUCTION.—Nothing in this subsection shall  
4 be construed as changing the criteria for coverage of a  
5 medical device under title XVIII of the Social Security Act  
6 nor premarket approval by the Food and Drug Administra-  
7 tion and nothing in this subsection shall be construed to in-  
8 crease premarket approval application requirements under  
9 the Federal Food, Drug, and Cosmetic Act.

10 (b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Sec-  
11 tion 1868 (42 U.S.C. 1395ee), as amended by section 823(a),  
12 is amended by adding at the end the following new subsection:

13 “(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

14 “(1) ESTABLISHMENT.—The Secretary shall establish  
15 a Council for Technology and Innovation within the Cen-  
16 ters for Medicare & Medicaid Services (in this section re-  
17 ferred to as ‘CMS’).

18 “(2) COMPOSITION.—The Council shall be composed  
19 of senior CMS staff and clinicians and shall be chaired by  
20 the Executive Coordinator for Technology and Innovation  
21 (appointed or designated under paragraph (4)).

22 “(3) DUTIES.—The Council shall coordinate the activi-  
23 ties of coverage, coding, and payment processes under this  
24 title with respect to new technologies and procedures, in-  
25 cluding new drug therapies, and shall coordinate the ex-  
26 change of information on new technologies between CMS  
27 and other entities that make similar decisions.

28 “(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY  
29 AND INNOVATION.—The Secretary shall appoint (or des-  
30 ignate) a noncareer appointee (as defined in section  
31 3132(a)(7) of title 5, United States Code) who shall serve  
32 as the Executive Coordinator for Technology and Innova-  
33 tion. Such executive coordinator shall report to the Admin-  
34 istrator of CMS, shall chair the Council, shall oversee the  
35 execution of its duties, and shall serve as a single point of  
36 contact for outside groups and entities regarding the cov-  
37 erage, coding, and payment processes under this title.”.



1 (c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA  
2 COLLECTION FOR USE IN THE MEDICARE INPATIENT PAY-  
3 MENT SYSTEM.—

4 (1) STUDY.—The Comptroller General of the United  
5 States shall conduct a study that analyzes which external  
6 data can be collected in a shorter time frame by the Cen-  
7 ters for Medicare & Medicaid Services for use in computing  
8 payments for inpatient hospital services. The study may in-  
9 clude an evaluation of the feasibility and appropriateness of  
10 using of quarterly samples or special surveys or any other  
11 methods. The study shall include an analysis of whether  
12 other executive agencies, such as the Bureau of Labor Sta-  
13 tistics in the Department of Commerce, are best suited to  
14 collect this information.

15 (2) REPORT.—By not later than October 1, 2003, the  
16 Comptroller General shall submit a report to Congress on  
17 the study under paragraph (1).

18 (d) IOM STUDY ON LOCAL COVERAGE DETERMINA-  
19 TIONS.—

20 (1) STUDY.—The Secretary shall enter into an ar-  
21 rangement with the Institute of Medicine of the National  
22 Academy of Sciences under which the Institute shall con-  
23 duct a study on local coverage determinations (including  
24 the application of local medical review policies) under the  
25 medicare program under title XVIII of the Social Security  
26 Act. Such study shall examine—

27 (A) the consistency of the definitions used in such  
28 determinations;

29 (B) the types of evidence on which such deter-  
30 minations are based, including medical and scientific  
31 evidence;

32 (C) the advantages and disadvantages of local cov-  
33 erage decisionmaking, including the flexibility it offers  
34 for ensuring timely patient access to new medical tech-  
35 nology for which data are still be collected;

36 (D) the manner in which the local coverage deter-  
37 mination process is used to develop data needed for a





1 national coverage determination, including the need for  
2 collection of such data within a protocol and informed  
3 consent by individuals entitled to benefits under part A  
4 of title XVIII of the Social Security Act, or enrolled  
5 under part B of such title, or both; and

6 (E) the advantages and disadvantages of main-  
7 taining local medicare contractor advisory committees  
8 that can advise on local coverage decisions based on an  
9 open, collaborative public process.

10 (2) REPORT.—Such arrangement shall provide that  
11 the Institute shall submit to the Secretary a report on such  
12 study by not later than 3 years after the date of the enact-  
13 ment of this Act. The Secretary shall promptly transmit a  
14 copy of such report to Congress.

15 (e) METHODS FOR DETERMINING PAYMENT BASIS FOR  
16 NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is  
17 amended by adding at the end the following:

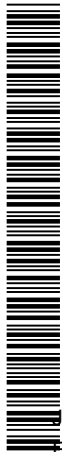
18 “(8)(A) The Secretary shall establish by regulation proce-  
19 dures for determining the basis for, and amount of, payment  
20 under this subsection for any clinical diagnostic laboratory test  
21 with respect to which a new or substantially revised HCPCS  
22 code is assigned on or after January 1, 2004 (in this para-  
23 graph referred to as ‘new tests’).

24 “(B) Determinations under subparagraph (A) shall be  
25 made only after the Secretary—

26 “(i) makes available to the public (through an Internet  
27 site and other appropriate mechanisms) a list that includes  
28 any such test for which establishment of a payment amount  
29 under this subsection is being considered for a year;

30 “(ii) on the same day such list is made available,  
31 causes to have published in the Federal Register notice of  
32 a meeting to receive comments and recommendations (and  
33 data on which recommendations are based) from the public  
34 on the appropriate basis under this subsection for estab-  
35 lishing payment amounts for the tests on such list;

36 “(iii) not less than 30 days after publication of such  
37 notice convenes a meeting, that includes representatives of



1 officials of the Centers for Medicare & Medicaid Services  
2 involved in determining payment amounts, to receive such  
3 comments and recommendations (and data on which the  
4 recommendations are based);

5 “(iv) taking into account the comments and rec-  
6 ommendations (and accompanying data) received at such  
7 meeting, develops and makes available to the public  
8 (through an Internet site and other appropriate mecha-  
9 nisms) a list of proposed determinations with respect to the  
10 appropriate basis for establishing a payment amount under  
11 this subsection for each such code, together with an expla-  
12 nation of the reasons for each such determination, the data  
13 on which the determinations are based, and a request for  
14 public written comments on the proposed determination;  
15 and

16 “(v) taking into account the comments received during  
17 the public comment period, develops and makes available to  
18 the public (through an Internet site and other appropriate  
19 mechanisms) a list of final determinations of the payment  
20 amounts for such tests under this subsection, together with  
21 the rationale for each such determination, the data on  
22 which the determinations are based, and responses to com-  
23 ments and suggestions received from the public.

24 “(C) Under the procedures established pursuant to sub-  
25 paragraph (A), the Secretary shall—

26 “(i) set forth the criteria for making determinations  
27 under subparagraph (A); and

28 “(ii) make available to the public the data (other than  
29 proprietary data) considered in making such determina-  
30 tions.

31 “(D) The Secretary may convene such further public meet-  
32 ings to receive public comments on payment amounts for new  
33 tests under this subsection as the Secretary deems appropriate.

34 “(E) For purposes of this paragraph:

35 “(i) The term ‘HCPCS’ refers to the Health Care Pro-  
36 cedure Coding System.



1           “(ii) A code shall be considered to be ‘substantially re-  
2           vised’ if there is a substantive change to the definition of  
3           the test or procedure to which the code applies (such as a  
4           new analyte or a new methodology for measuring an exist-  
5           ing analyte-specific test).”.

6           **SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN**  
7           **SERVICES UNDER MEDICARE SECONDARY**  
8           **PAYOR (MSP) PROVISIONS.**

9           (a) **IN GENERAL.**—The Secretary shall not require a hos-  
10          pital (including a critical access hospital) to ask questions (or  
11          obtain information) relating to the application of section  
12          1862(b) of the Social Security Act (relating to medicare sec-  
13          ondary payor provisions) in the case of reference laboratory  
14          services described in subsection (b), if the Secretary does not  
15          impose such requirement in the case of such services furnished  
16          by an independent laboratory.

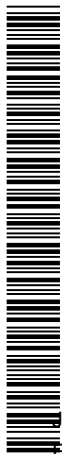
17          (b) **REFERENCE LABORATORY SERVICES DESCRIBED.**—  
18          Reference laboratory services described in this subsection are  
19          clinical laboratory diagnostic tests (or the interpretation of  
20          such tests, or both) furnished without a face-to-face encounter  
21          between the individual entitled to benefits under part A or en-  
22          rolled under part B, or both, and the hospital involved and in  
23          which the hospital submits a claim only for such test or inter-  
24          pretation.

25          **SEC. 844. EMTALA IMPROVEMENTS.**

26          (a) **PAYMENT FOR EMTALA-MANDATED SCREENING AND**  
27          **STABILIZATION SERVICES.**—

28                 (1) **IN GENERAL.**—Section 1862 (42 U.S.C. 1395y) is  
29                 amended by inserting after subsection (c) the following new  
30                 subsection:

31                 “(d) For purposes of subsection (a)(1)(A), in the case of  
32                 any item or service that is required to be provided pursuant to  
33                 section 1867 to an individual who is entitled to benefits under  
34                 this title, determinations as to whether the item or service is  
35                 reasonable and necessary shall be made on the basis of the in-  
36                 formation available to the treating physician or practitioner (in-  
37                 cluding the patient’s presenting symptoms or complaint) at the



1 time the item or service was ordered or furnished by the physi-  
2 cian or practitioner (and not on the patient's principal diag-  
3 nosis). When making such determinations with respect to such  
4 an item or service, the Secretary shall not consider the fre-  
5 quency with which the item or service was provided to the pa-  
6 tient before or after the time of the admission or visit.”.

7 (2) EFFECTIVE DATE.—The amendment made by  
8 paragraph (1) shall apply to items and services furnished  
9 on or after January 1, 2003.

10 (b) NOTIFICATION OF PROVIDERS WHEN EMTALA IN-  
11 VESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C.  
12 1395dd(d)) is amended by adding at the end the following new  
13 paragraph:

14 “(4) NOTICE UPON CLOSING AN INVESTIGATION.—The  
15 Secretary shall establish a procedure to notify hospitals and  
16 physicians when an investigation under this section is  
17 closed.”.

18 (c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN  
19 EMTALA CASES INVOLVING TERMINATION OF PARTICIPA-  
20 TION.—

21 (1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C.  
22 1395dd(d)(3)) is amended—

23 (A) in the first sentence, by inserting “or in termi-  
24 nating a hospital's participation under this title” after  
25 “in imposing sanctions under paragraph (1)”; and

26 (B) by adding at the end the following new sen-  
27 tences: “Except in the case in which a delay would  
28 jeopardize the health or safety of individuals, the Sec-  
29 retary shall also request such a review before making  
30 a compliance determination as part of the process of  
31 terminating a hospital's participation under this title  
32 for violations related to the appropriateness of a med-  
33 ical screening examination, stabilizing treatment, or an  
34 appropriate transfer as required by this section, and  
35 shall provide a period of 5 days for such review. The  
36 Secretary shall provide a copy of the report on the or-  
37 ganization's report to the hospital or physician con-



1           sistent with confidentiality requirements imposed on  
2           the organization under such part B.”.

3           (2) EFFECTIVE DATE.—The amendments made by  
4           paragraph (1) shall apply to terminations of participation  
5           initiated on or after the date of the enactment of this Act.

6           **SEC. 845. EMERGENCY MEDICAL TREATMENT AND AC-**  
7           **TIVE LABOR ACT (EMTALA) TECHNICAL AD-**  
8           **VISORY GROUP.**

9           (a) ESTABLISHMENT.—The Secretary shall establish a  
10          Technical Advisory Group (in this section referred to as the  
11          “Advisory Group”) to review issues related to the Emergency  
12          Medical Treatment and Active Labor Act (EMTALA) and its  
13          implementation. In this section, the term “EMTALA” refers to  
14          the provisions of section 1867 of the Social Security Act (42  
15          U.S.C. 1395dd).

16          (b) MEMBERSHIP.—The Advisory Group shall be com-  
17          posed of 19 members, including the Administrator of the Cen-  
18          ters for Medicare & Medicaid Services and the Inspector Gen-  
19          eral of the Department of Health and Human Services and of  
20          which—

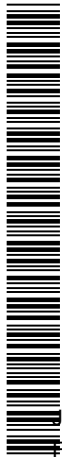
21               (1) 4 shall be representatives of hospitals, including at  
22               least one public hospital, that have experience with the ap-  
23               plication of EMTALA and at least 2 of which have not  
24               been cited for EMTALA violations;

25               (2) 7 shall be practicing physicians drawn from the  
26               fields of emergency medicine, cardiology or cardiothoracic  
27               surgery, orthopedic surgery, neurosurgery, obstetrics-gyne-  
28               cology, and psychiatry, with not more than one physician  
29               from any particular field;

30               (3) 2 shall represent patients;

31               (4) 2 shall be staff involved in EMTALA investiga-  
32               tions from different regional offices of the Centers for  
33               Medicare & Medicaid Services; and

34               (5) 1 shall be from a State survey office involved in  
35               EMTALA investigations and 1 shall be from a peer review  
36               organization, both of whom shall be from areas other than  
37               the regions represented under paragraph (4).



1 In selecting members described in paragraphs (1) through (3),  
2 the Secretary shall consider qualified individuals nominated by  
3 organizations representing providers and patients.

4 (c) GENERAL RESPONSIBILITIES.—The Advisory Group—

5 (1) shall review EMTALA regulations;

6 (2) may provide advice and recommendations to the  
7 Secretary with respect to those regulations and their appli-  
8 cation to hospitals and physicians;

9 (3) shall solicit comments and recommendations from  
10 hospitals, physicians, and the public regarding the imple-  
11 mentation of such regulations; and

12 (4) may disseminate information on the application of  
13 such regulations to hospitals, physicians, and the public.

14 (d) ADMINISTRATIVE MATTERS.—

15 (1) CHAIRPERSON.—The members of the Advisory  
16 Group shall elect a member to serve as chairperson of the  
17 Advisory Group for the life of the Advisory Group.

18 (2) MEETINGS.—The Advisory Group shall first meet  
19 at the direction of the Secretary. The Advisory Group shall  
20 then meet twice per year and at such other times as the  
21 Advisory Group may provide.

22 (e) TERMINATION.—The Advisory Group shall terminate  
23 30 months after the date of its first meeting.

24 (f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Sec-  
25 retary shall establish the Advisory Group notwithstanding any  
26 limitation that may apply to the number of advisory committees  
27 that may be established (within the Department of Health and  
28 Human Services or otherwise).

29 **SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH**  
30 **OTHER HOSPICE PROGRAMS TO PROVIDE**  
31 **CORE HOSPICE SERVICES IN CERTAIN CIR-**  
32 **CUMSTANCES.**

33 (a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C.  
34 1395x(dd)(5)) is amended by adding at the end the following  
35 new subparagraph:

36 “(D) In extraordinary, exigent, or other non-routine cir-  
37 cumstances, such as unanticipated periods of high patient



1 loads, staffing shortages due to illness or other events, or tem-  
 2 porary travel of a patient outside a hospice program's service  
 3 area, a hospice program may enter into arrangements with an-  
 4 other hospice program for the provision by that other program  
 5 of services described in paragraph (2)(A)(ii)(I). The provisions  
 6 of paragraph (2)(A)(ii)(II) shall apply with respect to the serv-  
 7 ices provided under such arrangements.”.

8 (b) CONFORMING PAYMENT PROVISION.—Section 1814(i)  
 9 (42 U.S.C. 1395f(i)), as amended by section 421(b), is amend-  
 10 ed by adding at the end the following new paragraph:

11 “(5) In the case of hospice care provided by a hospice pro-  
 12 gram under arrangements under section 1861(dd)(5)(D) made  
 13 by another hospice program, the hospice program that made  
 14 the arrangements shall bill and be paid for the hospice care.”.

15 (c) EFFECTIVE DATE.—The amendments made by this  
 16 section shall apply to hospice care provided on or after the date  
 17 of the enactment of this Act.

18 **SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHO-**  
 19 **GENS STANDARD TO CERTAIN HOSPITALS.**

20 (a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is  
 21 amended—

22 (1) in subsection (a)(1)—

23 (A) in subparagraph (R), by striking “and” at the  
 24 end;

25 (B) in subparagraph (S), by striking the period at  
 26 the end and inserting “, and”; and

27 (C) by inserting after subparagraph (S) the fol-  
 28 lowing new subparagraph:

29 “(T) in the case of hospitals that are not otherwise  
 30 subject to the Occupational Safety and Health Act of 1970,  
 31 to comply with the Bloodborne Pathogens standard under  
 32 section 1910.1030 of title 29 of the Code of Federal Regu-  
 33 lations (or as subsequently redesignated).”; and

34 (2) by adding at the end of subsection (b) the fol-  
 35 lowing new paragraph:

36 “(4)(A) A hospital that fails to comply with the require-  
 37 ment of subsection (a)(1)(T) (relating to the Bloodborne



1 Pathogens standard) is subject to a civil money penalty in an  
2 amount described in subparagraph (B), but is not subject to  
3 termination of an agreement under this section.

4 “(B) The amount referred to in subparagraph (A) is an  
5 amount that is similar to the amount of civil penalties that may  
6 be imposed under section 17 of the Occupational Safety and  
7 Health Act of 1970 for a violation of the Bloodborne Pathogens  
8 standard referred to in subsection (a)(1)(T) by a hospital that  
9 is subject to the provisions of such Act.

10 “(C) A civil money penalty under this paragraph shall be  
11 imposed and collected in the same manner as civil money pen-  
12 alties under subsection (a) of section 1128A are imposed and  
13 collected under that section.”.

14 (b) EFFECTIVE DATE.—The amendments made by this  
15 subsection (a) shall apply to hospitals as of July 1, 2003.

16 **SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND**  
17 **CORRECTIONS.**

18 (a) TECHNICAL AMENDMENTS RELATING TO ADVISORY  
19 COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of  
20 section 1114 (42 U.S.C. 1314)—

21 (A) is transferred to section 1862 and added at the  
22 end of such section; and

23 (B) is redesignated as subsection (j).

24 (2) Section 1862 (42 U.S.C. 1395y) is amended—

25 (A) in the last sentence of subsection (a), by striking  
26 “established under section 1114(f)”; and

27 (B) in subsection (j), as so transferred and  
28 redesignated—

29 (i) by striking “under subsection (f)”; and

30 (ii) by striking “section 1862(a)(1)” and inserting  
31 “subsection (a)(1)”.

32 (b) TERMINOLOGY CORRECTIONS.—(1) Section  
33 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by  
34 section 521 of BIPA, is amended—

35 (A) in subclause (III), by striking “policy” and insert-  
36 ing “determination”; and





1 (B) in subclause (IV), by striking “medical review  
2 policies” and inserting “coverage determinations”.

3 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C))  
4 is amended by striking “policy” and “POLICY” and inserting  
5 “determination” each place it appears and “DETERMINATION”,  
6 respectively.

7 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42  
8 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is  
9 amended—

10 (1) in subparagraph (A)(iv), by striking “subclause  
11 (I), (II), or (III)” and inserting “clause (i), (ii), or (iii)”;

12 (2) in subparagraph (B), by striking “clause (i)(IV)”  
13 and “clause (i)(III)” and inserting “subparagraph (A)(iv)”  
14 and “subparagraph (A)(iii)”, respectively; and

15 (3) in subparagraph (C), by striking “clause (i)”,  
16 “subclause (IV)” and “subparagraph (A)” and inserting  
17 “subparagraph (A)”, “clause (iv)” and “paragraph  
18 (1)(A)”, respectively each place it appears.

19 (d) OTHER CORRECTIONS.—Effective as if included in the  
20 enactment of section 521(c) of BIPA, section 1154(e) (42  
21 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

22 (e) EFFECTIVE DATE.—Except as otherwise provided, the  
23 amendments made by this section shall be effective as if in-  
24 cluded in the enactment of BIPA.

25 **SEC. 849. CONFORMING AUTHORITY TO WAIVE A PRO-**  
26 **GRAM EXCLUSION.**

27 The first sentence of section 1128(c)(3)(B) (42 U.S.C.  
28 1320a-7(c)(3)(B)) is amended to read as follows: “Subject to  
29 subparagraph (G), in the case of an exclusion under subsection  
30 (a), the minimum period of exclusion shall be not less than five  
31 years, except that, upon the request of the administrator of a  
32 Federal health care program (as defined in section 1128B(f))  
33 who determines that the exclusion would impose a hardship on  
34 individuals entitled to benefits under part A of title XVIII or  
35 enrolled under part B of such title, or both, the Secretary may  
36 waive the exclusion under subsection (a)(1), (a)(3), or (a)(4)  
37 with respect to that program in the case of an individual or en-



1 tity that is the sole community physician or sole source of es-  
2 sential specialized services in a community.”.

3 **SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.**

4 (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y), as  
5 amended by section 844(a)(1), is amended by adding at the end  
6 the following new subsection:

7 “(e)(1) Subject to paragraph (2), a group health plan (as  
8 defined in subsection (a)(1)(A)(v)) providing supplemental or  
9 secondary coverage to individuals also entitled to services under  
10 this title shall not require a medicare claims determination  
11 under this title for dental benefits specifically excluded under  
12 subsection (a)(12) as a condition of making a claims deter-  
13 mination for such benefits under the group health plan.

14 “(2) A group health plan may require a claims determina-  
15 tion under this title in cases involving or appearing to involve  
16 inpatient dental hospital services or dental services expressly  
17 covered under this title pursuant to actions taken by the Sec-  
18 retary.”.

19 (b) EFFECTIVE DATE.—The amendment made by sub-  
20 section (a) shall take effect on the date that is 60 days after  
21 the date of the enactment of this Act.

22 **SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL**  
23 **COVERAGE DETERMINATIONS.**

24 The Secretary shall provide, in an appropriate annual pub-  
25 lication available to the public, a list of national coverage deter-  
26 minations made under title XVIII of the Social Security Act in  
27 the previous year and information on how to get more informa-  
28 tion with respect to such determinations.

29 **TITLE IX—MEDICAID, PUBLIC**  
30 **HEALTH, AND OTHER HEALTH**  
31 **PROVISIONS**

32 **Subtitle A—Medicaid Provisions**

33 **SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE**  
34 **FUTURE OF MEDICAID.**

35 (a) ESTABLISHMENT.—There is established a commission  
36 to be known as the National Bipartisan Commission on the Fu-



1     ture of Medicaid (in this section referred to as the “Commis-  
2     sion”).

3           (b) DUTIES OF THE COMMISSION.—The Commission  
4     shall—

5           (1) review and analyze the long-term financial condi-  
6           tion of the medicaid program under title XIX of the Social  
7           Security Act (42 U.S.C. 1396 et seq.);

8           (2) identify the factors that are causing, and the con-  
9           sequences of, increases in costs under the medicaid pro-  
10          gram, including—

11           (A) the impact of these cost increases upon State  
12           budgets, funding for other State programs, and levels  
13           of State taxes necessary to fund growing expenditures  
14           under the medicaid program;

15           (B) the financial obligations of the Federal gov-  
16           ernment arising from the Federal matching require-  
17           ment for expenditures under the medicaid program;  
18           and

19           (C) the size and scope of the current program and  
20           how the program has evolved over time;

21           (3) analyze potential policies that will ensure both the  
22           financial integrity of the medicaid program and the provi-  
23           sion of appropriate benefits under such program;

24           (4) make recommendations for establishing incentives  
25           and structures to promote enhanced efficiencies and ways  
26           of encouraging innovative State policies under the medicaid  
27           program;

28           (5) make recommendations for establishing the appro-  
29           priate balance between benefits covered, payments to pro-  
30           viders, State and Federal contributions and, where appro-  
31           priate, recipient cost-sharing obligations;

32           (6) make recommendations on the impact of pro-  
33           moting increased utilization of competitive, private enter-  
34           prise models to contain program cost growth, through en-  
35           hanced utilization of private plans, pharmacy benefit man-  
36           agers, and other methods currently being used to contain  
37           private sector health-care costs;



1 (7) make recommendations on the financing of pre-  
 2 scription drug benefits currently covered under medicaid  
 3 programs, including analysis of the current Federal manu-  
 4 facturer rebate program, its impact upon both private mar-  
 5 ket prices as well as those paid by other government pur-  
 6 chasers, recent State efforts to negotiate additional supple-  
 7 mental manufacturer rebates and the ability of pharmacy  
 8 benefit managers to lower drug costs;

9 (8) review and analyze such other matters relating to  
 10 the medicaid program as the Commission deems appro-  
 11 priate; and

12 (9) analyze the impact of impending demographic  
 13 changes upon medicaid benefits, including long term care  
 14 services, and make recommendations for how best to appro-  
 15 priately divide State and Federal responsibilities for fund-  
 16 ing these benefits.

17 (c) MEMBERSHIP.—

18 (1) NUMBER AND APPOINTMENT.—The Commission  
 19 shall be composed of 17 members, of whom—

20 (A) four shall be appointed by the President;

21 (B) six shall be appointed by the Majority Leader  
 22 of the Senate, in consultation with the Minority Leader  
 23 of the Senate, of whom not more than 4 shall be of the  
 24 same political party;

25 (C) six shall be appointed by the Speaker of the  
 26 House of Representatives, in consultation with the Mi-  
 27 nority Leader of the House of Representatives, of  
 28 whom not more than 4 shall be of the same political  
 29 party; and

30 (D) one, who shall serve as Chairman of the Com-  
 31 mission, appointed jointly by the President, Majority  
 32 Leader of the Senate, and the Speaker of the House  
 33 of Representatives.

34 (2) DEADLINE FOR APPOINTMENT.—Members of the  
 35 Commission shall be appointed by not later than December  
 36 1, 2002.



1 (3) TERMS OF APPOINTMENT.—The term of any ap-  
2 pointment under paragraph (1) to the Commission shall be  
3 for the life of the Commission.

4 (4) MEETINGS.—The Commission shall meet at the  
5 call of its Chairman or a majority of its members.

6 (5) QUORUM.—A quorum shall consist of 8 members  
7 of the Commission, except that 4 members may conduct a  
8 hearing under subsection (e).

9 (6) VACANCIES.—A vacancy on the Commission shall  
10 be filled in the same manner in which the original appoint-  
11 ment was made not later than 30 days after the Commis-  
12 sion is given notice of the vacancy and shall not affect the  
13 power of the remaining members to execute the duties of  
14 the Commission.

15 (7) COMPENSATION.—Members of the Commission  
16 shall receive no additional pay, allowances, or benefits by  
17 reason of their service on the Commission.

18 (8) EXPENSES.—Each member of the Commission  
19 shall receive travel expenses and per diem in lieu of subsist-  
20 ence in accordance with sections 5702 and 5703 of title 5,  
21 United States Code.

22 (d) STAFF AND SUPPORT SERVICES.—

23 (1) EXECUTIVE DIRECTOR.—

24 (A) APPOINTMENT.—The Chairman shall appoint  
25 an executive director of the Commission.

26 (B) COMPENSATION.—The executive director shall  
27 be paid the rate of basic pay for level V of the Execu-  
28 tive Schedule.

29 (2) STAFF.—With the approval of the Commission,  
30 the executive director may appoint such personnel as the  
31 executive director considers appropriate.

32 (3) APPLICABILITY OF CIVIL SERVICE LAWS.—The  
33 staff of the Commission shall be appointed without regard  
34 to the provisions of title 5, United States Code, governing  
35 appointments in the competitive service, and shall be paid  
36 without regard to the provisions of chapter 51 and sub-



1 chapter III of chapter 53 of such title (relating to classi-  
2 fication and General Schedule pay rates).

3 (4) EXPERTS AND CONSULTANTS.—With the approval  
4 of the Commission, the executive director may procure tem-  
5 porary and intermittent services under section 3109(b) of  
6 title 5, United States Code.

7 (5) PHYSICAL FACILITIES.—The Administrator of the  
8 General Services Administration shall locate suitable office  
9 space for the operation of the Commission. The facilities  
10 shall serve as the headquarters of the Commission and  
11 shall include all necessary equipment and incidentals re-  
12 quired for the proper functioning of the Commission.

13 (e) POWERS OF COMMISSION.—

14 (1) HEARINGS AND OTHER ACTIVITIES.—For the pur-  
15 pose of carrying out its duties, the Commission may hold  
16 such hearings and undertake such other activities as the  
17 Commission determines to be necessary to carry out its du-  
18 ties.

19 (2) STUDIES BY GAO.—Upon the request of the Com-  
20 mission, the Comptroller General shall conduct such studies  
21 or investigations as the Commission determines to be nec-  
22 essary to carry out its duties.

23 (3) COST ESTIMATES BY CONGRESSIONAL BUDGET OF-  
24 FICE AND OFFICE OF THE CHIEF ACTUARY OF HCFA.—

25 (A) The Director of the Congressional Budget Of-  
26 fice or the Chief Actuary of the Centers for Medicare  
27 & Medicaid Services, or both, shall provide to the Com-  
28 mission, upon the request of the Commission, such cost  
29 estimates as the Commission determines to be nec-  
30 essary to carry out its duties.

31 (B) The Commission shall reimburse the Director  
32 of the Congressional Budget Office for expenses relat-  
33 ing to the employment in the office of the Director of  
34 such additional staff as may be necessary for the Direc-  
35 tor to comply with requests by the Commission under  
36 subparagraph (A).



1 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon the re-  
2 quest of the Commission, the head of any Federal agency  
3 is authorized to detail, without reimbursement, any of the  
4 personnel of such agency to the Commission to assist the  
5 Commission in carrying out its duties. Any such detail shall  
6 not interrupt or otherwise affect the civil service status or  
7 privileges of the Federal employee.

8 (5) TECHNICAL ASSISTANCE.—Upon the request of the  
9 Commission, the head of a Federal agency shall provide  
10 such technical assistance to the Commission as the Com-  
11 mission determines to be necessary to carry out its duties.

12 (6) USE OF MAILS.—The Commission may use the  
13 United States mails in the same manner and under the  
14 same conditions as Federal agencies and shall, for purposes  
15 of the frank, be considered a commission of Congress as  
16 described in section 3215 of title 39, United States Code.

17 (7) OBTAINING INFORMATION.—The Commission may  
18 secure directly from any Federal agency information nec-  
19 essary to enable it to carry out its duties, if the information  
20 may be disclosed under section 552 of title 5, United States  
21 Code. Upon request of the Chairman of the Commission,  
22 the head of such agency shall furnish such information to  
23 the Commission.

24 (8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the  
25 request of the Commission, the Administrator of General  
26 Services shall provide to the Commission on a reimbursable  
27 basis such administrative support services as the Commis-  
28 sion may request.

29 (9) PRINTING.—For purposes of costs relating to  
30 printing and binding, including the cost of personnel de-  
31 tailed from the Government Printing Office, the Commis-  
32 sion shall be deemed to be a committee of the Congress.

33 (f) REPORT.—Not later than March 1, 2004, the Commis-  
34 sion shall submit a report to the President and Congress which  
35 shall contain a detailed statement of only those the rec-  
36 ommendations, findings, and conclusions of the Commission.



1 (g) TERMINATION.—The Commission shall terminate 30  
2 days after the date of submission of the report required in sub-  
3 section (f).

4 (h) AUTHORIZATION OF APPROPRIATIONS.—There are au-  
5 thorized to be appropriated \$1,500,000 to carry out this sec-  
6 tion.

7 **SEC. 902. GAO STUDY ON MEDICAID DRUG PAYMENT**  
8 **SYSTEM.**

9 (a) STUDY.—The Comptroller General of the United  
10 States shall conduct a study on the reimbursement under the  
11 medicaid program for covered outpatient drugs. Such study  
12 shall examine—

13 (1) the extent to which such reimbursements for a  
14 drug exceed the acquisition costs for that drug;

15 (2) the services and resources associated with dis-  
16 pensing a prescription and any additional payments avail-  
17 able to compensate for expenses for these services and re-  
18 sources; and

19 (3) efforts undertaken by States to change the levels  
20 of such reimbursement and the price data they use in ef-  
21 fecting such change.

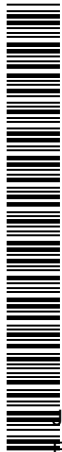
22 (b) REPORT.—Not later than 1 year after the date of the  
23 enactment of this Act, the Comptroller General shall submit to  
24 Congress a report on the study conducted under subsection (a)  
25 and shall include in such report such recommendations for  
26 changes for legislative or administrative action regarding med-  
27 icaid reimbursement methodologies for outpatient prescription  
28 drugs, and their application to the medicare program, as the  
29 Comptroller General deems appropriate.

30 **Subtitle B—Internet Pharmacies**

31 **SEC. 911. FINDINGS.**

32 The Congress finds as follows:

33 (1) Legitimate Internet sellers of prescription drugs  
34 can offer substantial benefits to consumers. These potential  
35 benefits include convenience, privacy, valuable information,  
36 competitive prices, and personalized services.





1 (2) Unlawful Internet sellers of prescription drugs  
2 may dispense inappropriate, contaminated, counterfeit, or  
3 subpotent prescription drugs that could put at risk the  
4 health and safety of consumers.

5 (3) Unlawful Internet sellers have exposed consumers  
6 to significant health risks by knowingly filling invalid pre-  
7 scriptions, such as prescriptions based solely on an online  
8 questionnaire, or by dispensing prescription drugs without  
9 any prescription.

10 (4) Consumers may have difficulty distinguishing le-  
11 gitimate from unlawful Internet sellers, as well as foreign  
12 from domestic Internet sellers, of prescription drugs.

13 **SEC. 912. AMENDMENT TO FEDERAL FOOD, DRUG, AND**  
14 **COSMETIC ACT.**

15 (a) IN GENERAL.—Chapter V of the Federal Food, Drug,  
16 and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by in-  
17 sserting after section 503A the following:

18 **“SEC. 503B. INTERNET PRESCRIPTION DRUG SALES.**

19 “(a) DEFINITIONS.—For purposes of this section:

20 “(1) CONSUMER.—The term ‘consumer’ means a per-  
21 son (other than an entity licensed or otherwise authorized  
22 under Federal or State law as a pharmacy or to dispense  
23 or distribute prescription drugs) that purchases or seeks to  
24 purchase prescription drugs through the Internet.

25 “(2) HOME PAGE.—The term ‘home page’ means the  
26 entry point or main web page for an Internet site.

27 “(3) INTERNET.—The term ‘Internet’ means collec-  
28 tively the myriad of computer and telecommunications fa-  
29 cilities, including equipment and operating software, which  
30 comprise the interconnected worldwide network of networks  
31 that employ the Transmission Control Protocol/Internet  
32 Protocol, or any predecessor or successor protocols to such  
33 protocol, to communicate information of all kinds by wire  
34 or radio, including electronic mail.

35 “(4) INTERSTATE INTERNET SELLER.—

36 “(A) IN GENERAL.—The term ‘interstate Internet  
37 seller’ means a person whether in the United States or



1           abroad, that engages in, offers to engage in, or causes  
2           the delivery or sale of a prescription drug through the  
3           Internet and has such drug delivered directly to the  
4           consumer via the Postal Service, or any private or com-  
5           mercial interstate carrier to a consumer in the United  
6           States who is residing in a State other than the State  
7           in which the seller's place of business is located. This  
8           definition excludes a person who only delivers a pre-  
9           scription drug to a consumer, such as an interstate car-  
10          rier service.

11           “(B) EXEMPTION.—With respect to the consumer  
12          involved, the term ‘interstate Internet seller’ does not  
13          include a person described in subparagraph (A) whose  
14          place of business is located within 75 miles of the con-  
15          sumer.

16           “(5) LINK.—The term ‘link’ means either a textual or  
17          graphical marker on a web page that, when clicked on,  
18          takes the consumer to another part of the Internet, such  
19          as to another web page or a different area on the same web  
20          page, or from an electronic message to a web page.

21           “(6) PHARMACY.—The term ‘pharmacy’ means any  
22          place licensed or otherwise authorized as a pharmacy under  
23          State law.

24           “(7) PRESCRIBER.—The term ‘prescriber’ means an  
25          individual, licensed or otherwise authorized under applica-  
26          ble Federal and State law to issue prescriptions for pre-  
27          scription drugs.

28           “(8) PRESCRIPTION DRUG.—The term ‘prescription  
29          drug’ means a drug under section 503(b)(1).

30           “(9) VALID PRESCRIPTION.—The term ‘valid prescrip-  
31          tion’ means a prescription that meets the requirements of  
32          section 503(b)(1) and other applicable Federal and State  
33          law.

34           “(10) WEB SITE; SITE.—The terms ‘web site’ and  
35          ‘site’ mean a specific location on the Internet that is deter-  
36          mined by Internet protocol numbers or by a domain name.



1           “(b) REQUIREMENTS FOR INTERSTATE INTERNET SELL-  
2   ERS.—

3           “(1) IN GENERAL.—Each interstate Internet seller  
4   shall comply with the requirements of this subsection with  
5   respect to the sale of, or the offer to sell, prescription drugs  
6   through the Internet and shall at all times display on its  
7   web site information in accordance with paragraph (2).

8           “(2) WEB SITE DISCLOSURE INFORMATION.—An inter-  
9   state Internet seller shall post in a visible and clear manner  
10   (as determined by regulation) on the home page of its web  
11   site, or on a page directly linked to such home page—

12           “(A) the street address of the interstate Internet  
13   seller’s place of business, and the telephone number of  
14   such place of business;

15           “(B) each State in which the interstate Internet  
16   seller is licensed or otherwise authorized as a phar-  
17   macy, or if the interstate Internet seller is not licensed  
18   or otherwise authorized by a State as a pharmacy, each  
19   State in which the interstate Internet seller is licensed  
20   or otherwise authorized to dispense prescription drugs,  
21   and the type of State license or authorization;

22           “(C) in the case of an interstate Internet seller  
23   that makes referrals to or solicits on behalf of a pre-  
24   scriber, the name of each prescriber, the street address  
25   of each such prescriber’s place of business, the tele-  
26   phone number of such place of business, each State in  
27   which each such prescriber is licensed or otherwise au-  
28   thorized to prescribe prescription drugs, and the type  
29   of such license or authorization; and

30           “(D) a statement that the interstate Internet sell-  
31   er will dispense prescription drugs only upon a valid  
32   prescription.

33           “(3) DATE OF POSTING.—Information required to be  
34   posted under paragraph (2) shall be posted by an interstate  
35   Internet seller—



1           “(A) not later than 90 days after the effective date  
2 of this section if the web site of such seller is in oper-  
3 ation as of such date; or

4           “(B) on the date of the first day of operation of  
5 such seller’s web site if such site goes into operation  
6 after such date.

7           “(4) QUALIFYING STATEMENTS.—An interstate Inter-  
8 net seller shall not indicate in any manner that posting dis-  
9 closure information on its web site signifies that the Fed-  
10 eral Government has made any determination on the legit-  
11 imacy of the interstate Internet seller or its business.

12           “(5) DISCLOSURE TO STATE LICENSING BOARDS.—An  
13 interstate Internet seller licensed or otherwise authorized to  
14 dispense prescription drugs in accordance with applicable  
15 State law shall notify each State entity that granted such  
16 licensure or authorization that it is an interstate Internet  
17 seller, the name of its business, the Internet address of its  
18 business, the street address of its place of business, and the  
19 telephone number of such place of business.

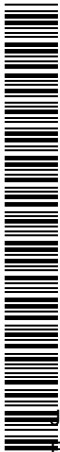
20           “(6) REGULATIONS.—The Secretary is authorized to  
21 promulgate such regulations as are necessary to carry out  
22 the provisions of this subsection. In issuing such regula-  
23 tions, the Secretary—

24           “(A) shall take into consideration disclosure for-  
25 mats used by existing interstate Internet seller certifi-  
26 cation programs; and

27           “(B) shall in defining the term ‘place of business’  
28 include provisions providing that such place is a single  
29 location at which employees of the business perform job  
30 functions, and not a post office box or similar locale.”.

31           “(b) PROHIBITED ACTS.—Section 301 of the Federal Food,  
32 Drug, and Cosmetic Act (21 U.S.C. 331) is amended by adding  
33 at the end the following:

34           “(bb) The failure to post information required under sec-  
35 tion 503B(b)(2) or for knowingly making a materially false  
36 statement when posting such information as required under  
37 such section or violating section 503B(b)(4).”.



1     **SEC. 913. PUBLIC EDUCATION.**

2           The Secretary of Health and Human Services shall engage  
3     in activities to educate the public about the dangers of pur-  
4     chasing prescription drugs from unlawful Internet sources. The  
5     Secretary should educate the public about effective public and  
6     private sector consumer protection efforts, as appropriate, with  
7     input from the public and private sectors, as appropriate.

8     **SEC. 914. STUDY REGARDING COORDINATION OF REGU-**  
9           **LATORY ACTIVITIES.**

10           Not later than 180 days after the date of enactment of  
11     this Act, the Secretary of Health and Human Services, after  
12     consultation with the Attorney General, shall submit to Con-  
13     gress a report providing recommendations for coordinating the  
14     activities of Federal agencies regarding interstate Internet sell-  
15     ers that operate from foreign countries and for coordinating the  
16     activities of the Federal Government with the activities of gov-  
17     ernments of foreign countries regarding such interstate Inter-  
18     net sellers.

19     **SEC. 915. EFFECTIVE DATE.**

20           The amendments made by this subtitle shall take effect 1  
21     year after the date of enactment of this Act, except that the  
22     authority of the Secretary of Health and Human Services to  
23     commence the process of rulemaking is effective on the date of  
24     enactment of this Act.

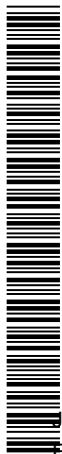
25           **Subtitle C—Promotion of Electronic**  
26           **Prescription**

27     **SEC. 921. PROGRAM OF GRANTS TO HEALTH CARE PRO-**  
28           **VIDERS TO IMPLEMENT ELECTRONIC PRE-**  
29           **SCRIPTION DRUG PROGRAMS.**

30           Part P of title III of the Public Health Service Act is  
31     amended by inserting after section 399N the following new sec-  
32     tion:

33     **“SEC. 3990. GRANTS TO HEALTH CARE PROVIDERS TO**  
34           **IMPLEMENT ELECTRONIC PRESCRIPTION**  
35           **DRUG PROGRAMS.**

36           “(a) IN GENERAL.—The Secretary is authorized to make  
37     grants for the purpose of assisting health care providers who  
38     prescribe drugs and biologicals in implementing electronic pre-



1    scription programs described in section 1860C(d)(3) of the So-  
2    cial Security Act.

3           “(b) APPLICATION.—No grant may be made under this  
4    section except pursuant to a grant application that is submitted  
5    in a time, manner, and form approved by the Secretary.

6           “(c) AUTHORIZATION OF APPROPRIATIONS.—There are  
7    authorized to be appropriated for fiscal year 2004, such sums  
8    as may be appropriate to carry out this section.”.

## 9                   **Subtitle D—Treatment of Rare** 10                   **Diseases**

### 11    **SEC. 931. NIH OFFICE OF RARE DISEASES AT NATIONAL** 12                   **INSTITUTES OF HEALTH.**

13           Title IV of the Public Health Service Act (42 U.S.C. 281  
14    et seq.), as amended by Public Law 107–84, is amended by in-  
15    serting after section 404E the following:

16                   “OFFICE OF RARE DISEASES

17           “SEC. 404F. (a) ESTABLISHMENT.—There is established  
18    within the Office of the Director of NIH an office to be known  
19    as the Office of Rare Diseases (in this section referred to as  
20    the ‘Office’), which shall be headed by a Director (in this sec-  
21    tion referred to as the ‘Director’), appointed by the Director of  
22    NIH.

23           “(b) DUTIES.—

24                   “(1) IN GENERAL.—The Director of the Office shall  
25    carry out the following:

26                           “(A) The Director shall recommend an agenda for  
27    conducting and supporting research on rare diseases  
28    through the national research institutes and centers.  
29    The agenda shall provide for a broad range of research  
30    and education activities, including scientific workshops  
31    and symposia to identify research opportunities for rare  
32    diseases.

33                           “(B) The Director shall, with respect to rare dis-  
34    eases, promote coordination and cooperation among the  
35    national research institutes and centers and entities  
36    whose research is supported by such institutes.



1           “(C) The Director, in collaboration with the direc-  
2           tors of the other relevant institutes and centers of the  
3           National Institutes of Health, may enter into coopera-  
4           tive agreements with and make grants for regional cen-  
5           ters of excellence on rare diseases in accordance with  
6           section 404G.

7           “(D) The Director shall promote the sufficient al-  
8           location of the resources of the National Institutes of  
9           Health for conducting and supporting research on rare  
10          diseases.

11          “(E) The Director shall promote and encourage  
12          the establishment of a centralized clearinghouse for  
13          rare and genetic disease information that will provide  
14          understandable information about these diseases to the  
15          public, medical professionals, patients and families.

16          “(F) The Director shall biennially prepare a re-  
17          port that describes the research and education activities  
18          on rare diseases being conducted or supported through  
19          the national research institutes and centers, and that  
20          identifies particular projects or types of projects that  
21          should in the future be conducted or supported by the  
22          national research institutes and centers or other enti-  
23          ties in the field of research on rare diseases.

24          “(G) The Director shall prepare the NIH Direc-  
25          tor’s annual report to Congress on rare disease re-  
26          search conducted by or supported through the national  
27          research institutes and centers.

28          “(2) PRINCIPAL ADVISOR REGARDING ORPHAN DIS-  
29          EASES.—With respect to rare diseases, the Director shall  
30          serve as the principal advisor to the Director of NIH and  
31          shall provide advice to other relevant agencies. The Direc-  
32          tor shall provide liaison with national and international pa-  
33          tient, health and scientific organizations concerned with  
34          rare diseases.

35          “(c) DEFINITION.—For purposes of this section, the term  
36          ‘rare disease’ means any disease or condition that affects less  
37          than 200,000 persons in the United States.



1           “(d) AUTHORIZATION OF APPROPRIATIONS.—For the pur-  
2     pose of carrying out this section, there are authorized to be ap-  
3     propriated such sums as already have been appropriated for fis-  
4     cal year 2002, and \$4,000,000 for each of the fiscal years 2003  
5     through 2006.”.

6     **SEC. 932. RARE DISEASE REGIONAL CENTERS OF EXCEL-**  
7           **LENCE.**

8           Title IV of the Public Health Service Act (42 U.S.C. 281  
9     et seq.), as amended by section 1021, is further amended by  
10    inserting after section 404F the following:

11           “RARE DISEASE REGIONAL CENTERS OF EXCELLENCE

12           “SEC. 404G. (a) COOPERATIVE AGREEMENTS AND  
13    GRANTS.—

14           “(1) IN GENERAL.—The Director of the Office of Rare  
15    Diseases (in this section referred to as the ‘Director’), in  
16    collaboration with the directors of the other relevant insti-  
17    tutes and centers of the National Institutes of Health, may  
18    enter into cooperative agreements with and make grants to  
19    public or private nonprofit entities to pay all or part of the  
20    cost of planning, establishing, or strengthening, and pro-  
21    viding basic operating support for regional centers of excel-  
22    lence for clinical research into, training in, and demonstra-  
23    tion of diagnostic, prevention, control, and treatment meth-  
24    ods for rare diseases.

25           “(2) POLICIES.—A cooperative agreement or grant  
26    under paragraph (1) shall be entered into in accordance  
27    with policies established by the Director of NIH.

28           “(b) COORDINATION WITH OTHER INSTITUTES.—The Di-  
29    rector shall coordinate the activities under this section with  
30    similar activities conducted by other national research insti-  
31    tutes, centers and agencies of the National Institutes of Health  
32    and by the Food and Drug Administration to the extent that  
33    such institutes, centers and agencies have responsibilities that  
34    are related to rare diseases.

35           “(c) USES FOR FEDERAL PAYMENTS UNDER COOPERA-  
36    TIVE AGREEMENTS OR GRANTS.—Federal payments made





1 under a cooperative agreement or grant under subsection (a)  
2 may be used for—

3 “(1) staffing, administrative, and other basic operating  
4 costs, including such patient care costs as are required for  
5 research;

6 “(2) clinical training, including training for allied  
7 health professionals, continuing education for health profes-  
8 sionals and allied health professions personnel, and infor-  
9 mation programs for the public with respect to rare dis-  
10 eases; and

11 “(3) clinical research and demonstration programs.

12 “(d) PERIOD OF SUPPORT; ADDITIONAL PERIODS.—Sup-  
13 port of a center under subsection (a) may be for a period of  
14 not to exceed 5 years. Such period may be extended by the Di-  
15 rector for additional periods of not more than 5 years if the  
16 operations of such center have been reviewed by an appropriate  
17 technical and scientific peer review group established by the Di-  
18 rector and if such group has recommended to the Director that  
19 such period should be extended.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the pur-  
21 pose of carrying out this section, there are authorized to be ap-  
22 propriated such sums as already have been appropriated for fis-  
23 cal year 2002, and \$20,000,000 for each of the fiscal years  
24 2003 through 2006.”.

## 25 **Subtitle E—Other Provisions** 26 **Relating to Drugs**

### 27 **SEC. 941. GAO STUDY REGARDING DIRECT-TO-CON-** 28 **SUMER ADVERTISING OF PRESCRIPTION** 29 **DRUGS.**

30 (a) IN GENERAL.—The Comptroller General of the United  
31 States shall conduct a study for the purpose of determining—

32 (1) whether and to what extent there have been in-  
33 creases in utilization rates of prescription drugs that are  
34 attributable to guidance regarding direct-to-consumer ad-  
35 vertising of such drugs that has been issued by the Food  
36 and Drug Administration under section 502(n) of the Fed-  
37 eral Food, Drug, and Cosmetic Act; and



1 (2) if so, whether and to what extent such increased  
2 utilization rates have resulted in increases in the costs of  
3 public or private health plans, health insurance, or other  
4 health programs.

5 (b) CERTAIN DETERMINATIONS.—The study under sub-  
6 section (a) shall include determinations of the following:

7 (1) The extent to which advertisements referred to in  
8 such subsection have resulted in effective consumer edu-  
9 cation about the prescription drugs involved, including an  
10 understanding of the risks of the drugs relative to the bene-  
11 fits.

12 (2) The extent of consumer satisfaction with such ad-  
13 vertisements.

14 (3) The extent of physician satisfaction with the ad-  
15 vertisements, including determining whether physicians be-  
16 lieve that the advertisements interfere with the exercise of  
17 their medical judgment by influencing consumers to prefer  
18 advertised drugs over alternative therapies.

19 (4) The extent to which the advertisements have re-  
20 sulted in increases in health care costs for taxpayers, for  
21 employers, or for consumers due to consumer decisions to  
22 seek advertised drugs rather than lower-costs alternative  
23 therapies.

24 (5) The extent to which the advertisements have re-  
25 sulted in decreases in health care costs for taxpayers, for  
26 employers, or for consumers due to decreased hospitaliza-  
27 tion rates, fewer physician visits (not related to hospitaliza-  
28 tion), lower treatment costs, or reduced instances of em-  
29 ployee absences to care for family members with diseases  
30 or disorders.

31 (c) REPORT.—Not later than two years after the date of  
32 the enactment of this Act, the Comptroller General of the  
33 United States shall submit to the Congress a report providing  
34 the findings of the study under subsection (a).



1     **SEC. 942. CERTAIN HEALTH PROFESSIONS PROGRAMS**  
2             **REGARDING PRACTICE OF PHARMACY.**

3             Part E of title VII of the Public Health Service Act (42  
4     U.S.C. 294n et seq.) is amended by adding at the end the fol-  
5     lowing subpart:

6             **“Subpart 3—Pharmacist Workforce Programs**

7     **“SEC. 771. PUBLIC SERVICE ANNOUNCEMENTS.**

8             “(a) PUBLIC SERVICE ANNOUNCEMENTS.—

9                 “(1) IN GENERAL.—The Secretary shall develop and  
10             issue public service announcements that advertise and pro-  
11             mote the pharmacist profession, highlight the advantages  
12             and rewards of being a pharmacist, and encourage individ-  
13             uals to enter the pharmacist profession.

14                 “(2) METHOD.—The public service announcements de-  
15             scribed in subsection (a) shall be broadcast through appro-  
16             priate media outlets, including television or radio, in a  
17             manner intended to reach as wide and diverse an audience  
18             as possible.

19             “(b) STATE AND LOCAL PUBLIC SERVICE ANNOUNCE-  
20     MENTS.—

21                 “(1) IN GENERAL.—The Secretary shall award grants  
22             to entities to support State and local advertising campaigns  
23             through appropriate media outlets to promote the phar-  
24             macist profession, highlight the advantages and rewards of  
25             being a pharmacist, and encourage individuals to enter the  
26             pharmacist profession.

27                 “(2) USE OF FUNDS.—An entity that receives a grant  
28             under subsection (a) shall use funds received through such  
29             grant to acquire local television and radio time, place ad-  
30             vertisements in local newspapers, and post information on  
31             billboards or on the Internet, in order to—

32                         “(A) advertise and promote the pharmacist profes-  
33                         sion;

34                         “(B) promote pharmacist education programs;

35                         “(C) inform the public of public assistance regard-  
36                         ing such education programs;



1           “(D) highlight individuals in the community that  
2           are presently practicing as pharmacists to recruit new  
3           pharmacists; and

4           “(E) provide any other information to recruit indi-  
5           viduals for the pharmacist profession.

6           “(3) METHOD.—The campaigns described in sub-  
7           section (a) shall be broadcast on television or radio, placed  
8           in newspapers as advertisements, or posted on billboards or  
9           the Internet, in a manner intended to reach as wide and  
10          diverse an audience as possible.

11          **“SEC. 772. DEMONSTRATION PROJECT.**

12          “(a) IN GENERAL.—The Secretary shall establish a dem-  
13          onstration project to enhance the participation of individuals  
14          who are pharmacists in the National Health Service Corps  
15          Loan Repayment Program described in section 338B.

16          “(b) SERVICES.—Services that may be provided by phar-  
17          macists pursuant to the demonstration project established  
18          under this section include medication therapy management  
19          services to assure that medications are used appropriately by  
20          patients, to enhance patients’ understanding of the appropriate  
21          use of medications, to increase patients’ adherence to prescrip-  
22          tion medication regimens, to reduce the risk of adverse events  
23          associated with medications, and to reduce the need for other  
24          costly medical services through better management of medica-  
25          tion therapy. Such services may include case management, dis-  
26          ease management, drug therapy management, patient training  
27          and education, counseling, drug therapy problem resolution,  
28          medication administration, the provision of special packaging,  
29          or other services that enhance the use of prescription medica-  
30          tions.

31          “(c) PROCEDURE.—The Secretary may not provide assist-  
32          ance to an individual under this section unless the individual  
33          agrees to comply with all requirements described in sections  
34          338B and 338D.

35          “(d) LIMITATIONS.—The demonstration project described  
36          in this section shall provide for the participation of—



1           “(1) individuals to provide services in rural and urban  
2           areas; and

3           “(2) enough individuals to allow the Secretary to prop-  
4           erly analyze the effectiveness of such project.

5           “(e) DESIGNATIONS.—The demonstration project de-  
6           scribed in this section, and any pharmacists who are selected  
7           to participate in such project, shall not be considered by the  
8           Secretary in the designation of a health professional shortage  
9           area under section 332 during fiscal years 2003 through 2005.

10          “(f) RULE OF CONSTRUCTION.—This section shall not be  
11          construed to require any State to participate in the project de-  
12          scribed in this section.

13          “(g) REPORT.—The Secretary shall prepare and submit a  
14          report on the project to—

15                 “(A) the Committee on Health, Education, Labor,  
16                 and Pensions of the Senate;

17                 “(B) the Subcommittee on Labor, Health and  
18                 Human Services, and Education of the Committee on  
19                 Appropriations of the Senate;

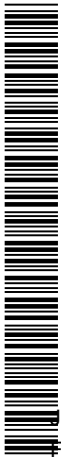
20                 “(C) the Committee on Energy and Commerce of  
21                 the House of Representatives; and

22                 “(D) the Subcommittee on Labor, Health and  
23                 Human Services, and Education of the Committee on  
24                 Appropriations of the House of Representatives.

25          **“SEC. 773. INFORMATION TECHNOLOGY.**

26                 “(a) GRANTS AND CONTRACTS.—The Secretary may make  
27                 awards of grants or contracts to qualifying schools of pharmacy  
28                 for the purpose of assisting such schools in acquiring and in-  
29                 stalling computer-based systems to provide pharmaceutical edu-  
30                 cation. Education provided through such systems may be grad-  
31                 uate education, professional education, or continuing education.  
32                 The computer-based systems may be designed to provide on-site  
33                 education, or education at remote sites (commonly referred to  
34                 as distance learning), or both.

35                 “(b) QUALIFYING SCHOOL OF PHARMACY.—For purposes  
36                 of this section, the term ‘qualifying school of pharmacy’ means  
37                 a school of pharmacy (as defined in section 799B) that requires



1 students to serve in a clinical rotation in which pharmacist  
2 services are part of the curriculum.

3 **“SEC. 774. AUTHORIZATION OF APPROPRIATIONS.**

4 “For the purpose of carrying out this subpart, there are  
5 authorized to be appropriated such sums as may be necessary  
6 for each of the fiscal years 2003 through 2006.”.

7 **TITLE X—HEALTH-CARE RELATED**  
8 **TAX PROVISIONS**

9 **SEC. 1001. ELIGIBILITY FOR ARCHER MSA’S EXTENDED**  
10 **TO ACCOUNT HOLDERS OF**  
11 **MEDICARE+CHOICE MSA’S.**

12 (a) IN GENERAL.—Subparagraph (B) of section 220(c)(2)  
13 of the Internal Revenue Code of 1986 is amended by adding  
14 at the end the following new clause:

15 “(iii) MEDICARE+ CHOICE MSA’S.—In the case  
16 of an individual who is covered under an MSA plan  
17 (as defined in section 1859(b)(3) of the Social Se-  
18 curity Act) which such individual elected under sec-  
19 tion 1851(a)(2)(B) of such Act—

20 “(I) such plan shall be treated as a high  
21 deductible health plan for purposes of this sec-  
22 tion,

23 “(II) subsection (b)(2)(A) shall be applied  
24 by substituting ‘100 percent’ for ‘65 percent’  
25 with respect to such individual,

26 “(III) with respect to such individual, the  
27 limitation under subsection (d)(1)(A)(ii) shall  
28 be 100 percent of the highest annual deductible  
29 limitation under section 1859(b)(3)(B) of the  
30 Social Security Act,

31 “(IV) paragraphs (4), (5), and (7) of sub-  
32 section (b) and paragraph (1)(A)(iii) of this  
33 subsection shall not apply with respect to such  
34 individual, and

35 “(V) the limitation which would (but for  
36 this subclause) apply under subsection (b)(1)  
37 with respect to such individual for any taxable



1 year shall be reduced (but not below zero) by  
2 the amount which would (but for subsection  
3 106(b)) be includible in such individual's gross  
4 income for the taxable year.”.

5 (b) ACCOUNTS NOT COUNTED AGAINST NUMERICAL LIM-  
6 ITS.—

7 (1) IN GENERAL.—Paragraph (3) of section 220(j) of  
8 such Code is amended—

9 (A) in the heading, by striking “PREVIOUSLY UN-  
10 INSURED” and inserting “CERTAIN”,

11 (B) in subparagraph (A), by striking “by not  
12 counting the Archer MSA of any previously uninsured  
13 individual.” and inserting “by not counting—

14 “(i) the Archer MSA of any previously unin-  
15 sured individual, and

16 “(ii) the Archer MSA of any eligible individual  
17 who qualifies as such an individual by reason of  
18 subsection (c)(2)(B)(iii).”.

19 (2) REPORTING REQUIREMENT.—Subparagraph (A) of  
20 section 220(j)(4) of such Code is amended in clause (ii) by  
21 striking “and” at the end, in clause (iii) by striking the pe-  
22 riod and inserting “, and”, and by adding at the end the  
23 following new clause:

24 “(iv) the number of such accounts which are  
25 accounts of eligible individuals who qualify as such  
26 individuals by reason of subsection (c)(2)(B)(iii).”.

27 (c) EFFECTIVE DATE.—The amendments made by this  
28 section shall apply to taxable years beginning after December  
29 31, 2002.

30 **SEC. 1002. ADJUSTMENT OF EMPLOYER CONTRIBU-**  
31 **TIONS TO COMBINED BENEFIT FUND TO RE-**  
32 **FLECT MEDICARE PRESCRIPTION DRUG**  
33 **SUBSIDY PAYMENTS.**

34 Section 9704(b) of the Internal Revenue Code of 1986 (re-  
35 lating to health benefit premium) is amended by adding at the  
36 end the following new paragraph:



1           “(4) ADJUSTMENTS FOR MEDICARE PRESCRIPTION  
2 DRUG SUBSIDIES.—The trustees of the Combined Fund  
3 shall decrease the per beneficiary premium for each plan  
4 year in which a subsidy payment is provided to it under  
5 section 1860H of the Social Security Act by the amount  
6 which would place the Combined Fund in the same finan-  
7 cial position as if such subsidy payment had not been re-  
8 ceived.”.

9       **SEC. 1003. EXPANSION OF HUMAN CLINICAL TRIALS**  
10           **QUALIFYING FOR ORPHAN DRUG CREDIT.**

11           (a) IN GENERAL.—Paragraph (2) of section 45C(b) of the  
12 Internal Revenue Code of 1986 is amended by adding at the  
13 end the following new subparagraph:

14                   “(C) TREATMENT OF CERTAIN EXPENSES IN-  
15                   CURRED BEFORE DESIGNATION.—For purposes of sub-  
16                   paragraph (A)(ii)(I), if a drug is designated under sec-  
17                   tion 526 of the Federal Food, Drug, and Cosmetic Act  
18                   not later than the due date (including extensions) for  
19                   filing the return of tax under this subtitle for the tax-  
20                   able year in which the application for such designation  
21                   of such drug was filed, such drug shall be treated as  
22                   having been designated on the date that such applica-  
23                   tion was filed.”.

24           (b) EFFECTIVE DATE.—The amendment made by sub-  
25           section (a) shall apply to expenses incurred after the date of  
26           the enactment of this Act.

