

108TH CONGRESS  
1ST SESSION

# H. R. 2473

[Report No. 108- ]

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

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 16, 2003

Mr. THOMAS (for himself and Mr. TAUZIN) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, and Ways and Means

JUNE , 2003

Reported from the Committee on Ways and Means with an amendment

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

[For text of introduced bill, see copy of bill as introduced on June 16, 2003]

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## A BILL

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

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



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

4 (a) *SHORT TITLE.*—*This Act may be cited as the*  
5 *“Medicare Prescription Drug and Modernization Act of*  
6 *2003”.*

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

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

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

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

20 (d) *TABLE OF CONTENTS.*—*The table of contents of*  
21 *this Act is as follows:*

*Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.*

**TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT**

*Sec. 101. Establishment of a medicare prescription drug benefit.*

**“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM**

*“Sec. 1860D–1. Benefits; eligibility; enrollment; and coverage period.*

*“Sec. 1860D–2. Requirements for qualified prescription drug coverage.*



*“Sec. 1860D–3. Beneficiary protections for qualified prescription drug coverage.*

*“Sec. 1860D–4. Requirements for and contracts with prescription drug plan (PDP) sponsors.*

*“Sec. 1860D–5. Process for beneficiaries to select qualified prescription drug coverage.*

*“Sec. 1860D–6. Submission of bids and premiums.*

*“Sec. 1860D–7. Premium and cost-sharing subsidies for low-income individuals.*

*“Sec. 1860D–8. Subsidies for all medicare beneficiaries for qualified prescription drug coverage.*

*“Sec. 1860D–9. Medicare Prescription Drug Trust Fund.*

*“Sec. 1860D–10. Definitions; application to medicare advantage and EFFS programs; treatment of references to provisions in part C.*

*Sec. 102. Offering of qualified prescription drug coverage under Medicare Advantage and enhanced fee-for-service (EPPS) program.*

*Sec. 103. Medicaid amendments.*

*“Sec. 1935. Special provisions relating to medicare prescription drug benefit.*

*Sec. 104. Medigap transition.*

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

*Sec. 106. Disclosure of return information for purposes of carrying out medicare catastrophic prescription drug program.*

*Sec. 107. State pharmaceutical assistance transition commission.*

**TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION**

*Sec. 200. Medicare modernization and revitalization.*

**Subtitle A—Medicare Enhanced Fee-for-Service Program**

*Sec. 201. Establishment of enhanced fee-for-service (EPPS) program under medicare.*

**“PART E—ENHANCED FEE-FOR-SERVICE PROGRAM**

*“Sec. 1860E–1. Offering of enhanced fee-for-service plans throughout the United States.*

*“Sec. 1860E–2. Offering of enhanced fee-for-service (EPPS) plans.*

*“Sec. 1860E–3. Submission of bids; beneficiary savings; payment of plans.*

*“Sec. 1860E–4. Premiums; organizational and financial requirements; establishment of standards; contracts with EPPS organizations.*

**Subtitle B—Medicare Advantage Program**

**CHAPTER 1—IMPLEMENTATION OF PROGRAM**

*Sec. 211. Implementation of medicare advantage program.*

*Sec. 212. Medicare advantage improvements.*

**CHAPTER 2—IMPLEMENTATION OF COMPETITION PROGRAM**

*Sec. 221. Competition program beginning in 2006.*

**CHAPTER 3—ADDITIONAL REFORMS**

*Sec. 231. Making permanent change in medicare advantage reporting deadlines and annual, coordinated election period.*



- Sec. 232. Avoiding duplicative State regulation.*
- Sec. 233. Specialized medicare advantage plans for special needs beneficiaries.*
- Sec. 234. Medicare MSAs.*
- Sec. 235. Extension of reasonable cost contracts.*
- Sec. 236. Extension of municipal health service demonstration projects.*

*Subtitle C—Application of FEHBP-Style Competitive Reforms*

- Sec. 241. Application of FEHBP-style competitive reform beginning in 2010.*

*TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE*

- Sec. 301. Medicare secondary payor (MSP) provisions.*
- Sec. 302. Competitive acquisition of certain items and services.*
- Sec. 303. Competitive acquisition of covered outpatient drugs and biologicals.*
- Sec. 304. Demonstration project for use of recovery audit contractors.*

*TITLE IV—RURAL HEALTH CARE IMPROVEMENTS*

- Sec. 401. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.*
- Sec. 402. Immediate establishment of uniform standardized amount in rural and small urban areas.*
- Sec. 403. Establishment of essential rural hospital classification.*
- Sec. 404. More frequent update in weights used in hospital market basket.*
- Sec. 405. Improvements to critical access hospital program.*
- Sec. 406. Redistribution of unused resident positions.*
- Sec. 407. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.*
- Sec. 408. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.*
- Sec. 409. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.*
- Sec. 410. Improvement in payments to retain emergency capacity for ambulance services in rural areas.*
- Sec. 411. Two-year increase for home health services furnished in a rural area.*
- Sec. 412. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.*
- Sec. 413. GAO study of geographic differences in payments for physicians' services.*
- Sec. 414. Treatment of missing cost reporting periods for sole community hospitals.*
- Sec. 415. Extension of telemedicine demonstration project.*
- Sec. 416. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.*
- Sec. 417. Medicare incentive payment program improvements for physician scarcity.*

*TITLE V—PROVISIONS RELATING TO PART A*

*Subtitle A—Inpatient Hospital Services*

- Sec. 501. Revision of acute care hospital payment updates.*
- Sec. 502. Recognition of new medical technologies under inpatient hospital PPS.*
- Sec. 503. Increase in Federal rate for hospitals in Puerto Rico.*



- Sec. 504. Wage index adjustment reclassification reform .*
- Sec. 505. MedPAC report on specialty hospitals.*

*Subtitle B—Other Provisions*

- Sec. 511. Payment for covered skilled nursing facility services.*
- Sec. 512. Coverage of hospice consultation services.*

*TITLE VI—PROVISIONS RELATING TO PART B*

*Subtitle A—Physicians' Services*

- Sec. 601. Revision of updates for physicians' services.*
- Sec. 602. Studies on access to physicians' services.*
- Sec. 603. MedPAC report on payment for physicians' services.*

*SUBTITLE B—PREVENTIVE SERVICES*

- Sec. 611. Coverage of an initial preventive physical examination.*
- Sec. 612. Coverage of cholesterol and blood lipid screening.*
- Sec. 613. Waiver of deductible for colorectal cancer screening tests.*
- Sec. 614. Improved payment for certain mammography services.*

*Subtitle C—Other Services*

- Sec. 621. Hospital outpatient department (HOPD) payment reform.*
- Sec. 622. Payment for ambulance services.*
- Sec. 623. Renal dialysis services.*
- Sec. 624. One-year moratorium on therapy caps; provisions relating to reports.*
- Sec. 625. Adjustment to payments for services furnished in ambulatory surgical centers.*
- Sec. 626. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.*
- Sec. 627. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.*
- Sec. 628. Part B deductible.*
- Sec. 629. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.*

*TITLE VII—PROVISIONS RELATING TO PARTS A AND B*

*Subtitle A—Home Health Services*

- Sec. 701. Update in home health services.*
- Sec. 702. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.*
- Sec. 703. MedPAC study on medicare margins of home health agencies.*

*Subtitle B—Direct Graduate Medical Education*

- Sec. 711. Extension of update limitation on high cost programs.*

*Subtitle C—Chronic Care Improvement*

- Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.*
- Sec. 722. Chronic care improvement under medicare advantage and enhanced fee-for-service programs.*
- Sec. 723. Institute of Medicine report.*
- Sec. 724. MedPAC report.*



*Subtitle D—Other Provisions*

- Sec. 731. Modifications to medicare payment advisory commission (MedPAC).*
- Sec. 732. Demonstration project for medical adult day care services.*
- Sec. 733. Improvements in national and local coverage determination process to respond to changes in technology.*
- Sec. 734. Treatment of certain physician pathology services.*

*TITLE VIII—MEDICARE BENEFITS ADMINISTRATION*

- Sec. 801. Establishment of Medicare Benefits Administration.*

*TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM*

*Subtitle A—Regulatory Reform*

- Sec. 901. Construction; definition of supplier.*

*“Supplier*

- Sec. 902. Issuance of regulations.*
- Sec. 903. Compliance with changes in regulations and policies.*
- Sec. 904. Reports and studies relating to regulatory reform.*

*Subtitle B—Contracting Reform*

- Sec. 911. Increased flexibility in medicare administration.*
- Sec. 912. Requirements for information security for medicare administrative contractors.*

*Subtitle C—Education and Outreach*

- Sec. 921. Provider education and technical assistance.*
- “Sec. 1889. Provider education and technical assistance.*
- Sec. 922. Small provider technical assistance demonstration program.*
- Sec. 923. Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman.*
- Sec. 924. Beneficiary outreach demonstration program.*
- Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.*
- Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.*

*Subtitle D—Appeals and Recovery*

- Sec. 931. Transfer of responsibility for medicare appeals.*
- Sec. 932. Process for expedited access to review.*
- Sec. 933. Revisions to medicare appeals process.*
- Sec. 934. Prepayment review.*
- Sec. 935. Recovery of overpayments.*
- Sec. 936. Provider enrollment process; right of appeal.*
- Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.*
- Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.*

*Subtitle V—Miscellaneous Provisions*

- Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.*





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

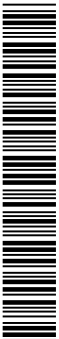
3 “(1) *MEDICARE-RELATED PLANS.*—

4 “(A) *MEDICARE ADVANTAGE.*—*If the indi-*  
5 *vidual is eligible to enroll in a Medicare Advan-*  
6 *tage plan that provides qualified prescription*  
7 *drug coverage under section 1851(j), the indi-*  
8 *vidual may enroll in such plan and obtain cov-*  
9 *erage through such plan.*

10 “(B) *EFFS PLANS.*—*If the individual is el-*  
11 *igible to enroll in an EFFS plan that provides*  
12 *qualified prescription drug coverage under part*  
13 *E under section 1860E–2(d), the individual may*  
14 *enroll in such plan and obtain coverage through*  
15 *such plan.*

16 “(C) *MA-EFFS PLAN; MA-EFFS RX*  
17 *PLAN.*—*For purposes of this part, the term ‘MA-*  
18 *EFFS plan’ means a Medicare Advantage plan*  
19 *under part C and an EFFS plan under part E*  
20 *and the term ‘MA-EFFS Rx plan’ means a MA-*  
21 *EFFS plan insofar as such plan provides quali-*  
22 *fied prescription drug coverage.*

23 “(2) *PRESCRIPTION DRUG PLAN.*—*If the indi-*  
24 *vidual is not enrolled in a MA-EFFS plan , the indi-*





1        *vidual may enroll under this part in a prescription*  
2        *drug plan (as defined in section 1860D-10(a)(5)).*

3        *Such individuals shall have a choice of such plans under*  
4        *section 1860D-5(d).*

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

6            *“(1) IN GENERAL.—An individual eligible to*  
7            *make an election under subsection (a) may elect to*  
8            *enroll in a prescription drug plan under this part, or*  
9            *elect the option of qualified prescription drug cov-*  
10           *erage under a MA-EFFS Rx plan under part C or*  
11           *part E, and to change such election only in such*  
12           *manner and form as may be prescribed by regulations*  
13           *of the Administrator of the Medicare Benefits Admin-*  
14           *istration (appointed under section 1809(b)) (in this*  
15           *part referred to as the ‘Medicare Benefits Adminis-*  
16           *trator’) and only during an election period prescribed*  
17           *in or under this subsection.*

18           *“(2) ELECTION PERIODS.—*

19           *“(A) IN GENERAL.—Except as provided in*  
20           *this paragraph, the election periods under this*  
21           *subsection shall be the same as the coverage elec-*  
22           *tion periods under the Medicare Advantage and*  
23           *EFFS programs under section 1851(e),*  
24           *including—*



1                   “(i) *annual coordinated election peri-*  
2                   *ods; and*

3                   “(ii) *special election periods.*

4                   *In applying the last sentence of section*  
5                   *1851(e)(4) (relating to discontinuance of an elec-*  
6                   *tion during the first year of eligibility) under*  
7                   *this subparagraph, in the case of an election de-*  
8                   *scribed in such section in which the individual*  
9                   *had elected or is provided qualified prescription*  
10                  *drug coverage at the time of such first enroll-*  
11                  *ment, the individual shall be permitted to enroll*  
12                  *in a prescription drug plan under this part at*  
13                  *the time of the election of coverage under the*  
14                  *original fee-for-service plan.*

15                  “(B) *INITIAL ELECTION PERIODS.—*

16                  “(i) *INDIVIDUALS CURRENTLY COV-*  
17                  *ERED.—In the case of an individual who is*  
18                  *entitled to benefits under part A or enrolled*  
19                  *under part B as of October 1, 2005, there*  
20                  *shall be an initial election period of 6*  
21                  *months beginning on that date.*

22                  “(ii) *INDIVIDUAL COVERED IN FU-*  
23                  *TURE.—In the case of an individual who is*  
24                  *first entitled to benefits under part A or en-*  
25                  *rolled under part B after such date, there*



1           *shall be an initial election period which is*  
2           *the same as the initial enrollment period*  
3           *under section 1837(d).*

4           “(C) *ADDITIONAL SPECIAL ELECTION PERI-*  
5           *ODS.—The Administrator shall establish special*  
6           *election periods—*

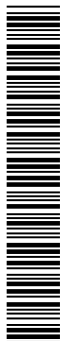
7                   “(i) *in cases of individuals who have*  
8                   *and involuntarily lose prescription drug*  
9                   *coverage described in subsection (c)(2)(C);*

10                   “(ii) *in cases described in section*  
11                   *1837(h) (relating to errors in enrollment),*  
12                   *in the same manner as such section applies*  
13                   *to part B;*

14                   “(iii) *in the case of an individual who*  
15                   *meets such exceptional conditions (including*  
16                   *conditions provided under section*  
17                   *1851(e)(4)(D)) as the Administrator may*  
18                   *provide; and*

19                   “(iv) *in cases of individuals (as deter-*  
20                   *mined by the Administrator) who become el-*  
21                   *igible for prescription drug assistance under*  
22                   *title XIX under section 1935(d).*

23           “(3) *INFORMATION ON PLANS.—Information de-*  
24           *scribed in section 1860D–3(b)(1) on prescription drug*  
25           *plans shall be made available during election periods.*



1           “(c) *GUARANTEED ISSUE; COMMUNITY RATING; AND*  
2 *NONDISCRIMINATION.*—

3                   “(1) *GUARANTEED ISSUE.*—

4                           “(A) *IN GENERAL.*—*An eligible individual*  
5 *who is eligible to elect qualified prescription*  
6 *drug coverage under a prescription drug plan or*  
7 *MA-EFFS Rx plan at a time during which elec-*  
8 *tions are accepted under this part with respect*  
9 *to the plan shall not be denied enrollment based*  
10 *on any health status-related factor (described in*  
11 *section 2702(a)(1) of the Public Health Service*  
12 *Act) or any other factor.*

13                           “(B) *MEDICARE ADVANTAGE LIMITATIONS*  
14 *PERMITTED.*—*The provisions of paragraphs (2)*  
15 *and (3) (other than subparagraph (C)(i), relat-*  
16 *ing to default enrollment) of section 1851(g) (re-*  
17 *lating to priority and limitation on termination*  
18 *of election) shall apply to PDP sponsors under*  
19 *this subsection.*

20                   “(2) *COMMUNITY-RATED PREMIUM.*—

21                           “(A) *IN GENERAL.*—*In the case of an indi-*  
22 *vidual who enrolls under a prescription drug*  
23 *plan or in a MA-EFFS Rx plan during the in-*  
24 *dividual’s initial enrollment period under this*  
25 *part or maintains (as determined under sub-*



1           *paragraph (C)) continuous prescription drug*  
2           *coverage since the date the individual first quali-*  
3           *fies to elect prescription drug coverage under this*  
4           *part, a PDP sponsor or entity offering a pre-*  
5           *scription drug plan or MA-EFFS Rx plan and*  
6           *in which the individual is enrolled may not*  
7           *deny, limit, or condition the coverage or provi-*  
8           *sion of covered prescription drug benefits or vary*  
9           *or increase the premium under the plan based on*  
10          *any health status-related factor described in sec-*  
11          *tion 2702(a)(1) of the Public Health Service Act*  
12          *or any other factor.*

13           “(B) *LATE ENROLLMENT PENALTY.—In the*  
14          *case of an individual who does not maintain*  
15          *such continuous prescription drug coverage (as*  
16          *described in subparagraph (C)), a PDP sponsor*  
17          *or an entity offering a MA-EFFS Rx plan may*  
18          *(notwithstanding any provision in this title) ad-*  
19          *just the premium otherwise applicable or impose*  
20          *a pre-existing condition exclusion with respect to*  
21          *qualified prescription drug coverage in a man-*  
22          *ner that reflects additional actuarial risk in-*  
23          *volved. Such a risk shall be established through*  
24          *an appropriate actuarial opinion of the type de-*



1           *scribed in subparagraphs (A) through (C) of sec-*  
2           *tion 2103(c)(4).*

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

17                   “(i) *COVERAGE UNDER PRESCRIPTION*  
18                   *DRUG PLAN OR MA-EFFS RX PLAN.—Quali-*  
19                   *fied prescription drug coverage under a pre-*  
20                   *scription drug plan or under a MA-EFFS*  
21                   *Rx plan.*

22                   “(ii) *MEDICAID PRESCRIPTION DRUG*  
23                   *COVERAGE.—Prescription drug coverage*  
24                   *under a medicaid plan under title XIX, in-*  
25                   *cluding through the Program of All-inclu-*



1                    *sive Care for the Elderly (PACE) under sec-*  
2                    *tion 1934, through a social health mainte-*  
3                    *nance organization (referred to in section*  
4                    *4104(c) of the Balanced Budget Act of*  
5                    *1997), or through a demonstration project*  
6                    *under part C that demonstrates the applica-*  
7                    *tion of capitation payment rates for frail*  
8                    *elderly medicare beneficiaries through the*  
9                    *use of an interdisciplinary team and*  
10                   *through the provision of primary care serv-*  
11                   *ices to such beneficiaries by means of such*  
12                   *a team at the nursing facility involved.*

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



1                   “(iv) *PRESCRIPTION DRUG COVERAGE*  
2                   *UNDER CERTAIN MEDIGAP POLICIES.*—Cov-  
3                   *erage under a medicare supplemental policy*  
4                   *under section 1882 that provides benefits for*  
5                   *prescription drugs (whether or not such cov-*  
6                   *erage conforms to the standards for pack-*  
7                   *ages of benefits under section 1882(p)(1)),*  
8                   *but only if the policy was in effect on Janu-*  
9                   *ary 1, 2006, and if (subject to subpara-*  
10                   *graph (E)(ii)) the coverage provides benefits*  
11                   *at least equivalent to the benefits under a*  
12                   *qualified prescription drug plan.*

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

20                   “(vi) *VETERANS’ COVERAGE OF PRE-*  
21                   *SCRIPTION DRUGS.*—Coverage of prescrip-  
22                   *tion drugs for veterans under chapter 17 of*  
23                   *title 38, United States Code, but only if*  
24                   *(subject to subparagraph (E)(ii)) the cov-*  
25                   *erage provides benefits at least equivalent to*





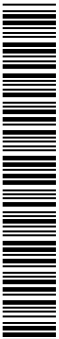
1           *the benefits under a qualified prescription*  
2           *drug plan.*

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

11           “(E) *DISCLOSURE.*—

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

21           “(ii) *WAIVER OF LIMITATIONS.*—*An*  
22           *individual may apply to the Administrator*  
23           *to waive the requirement that coverage of*  
24           *such type provide benefits at least equiva-*  
25           *lent to the benefits under a qualified pre-*



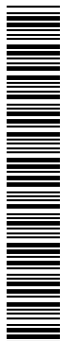
1           *scription drug plan, if the individual estab-*  
2           *lishes that the individual was not ade-*  
3           *quately informed that such coverage did not*  
4           *provide such level of benefits.*

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

14          “(3) NONDISCRIMINATION.—*A PDP sponsor that*  
15          *offers a prescription drug plan in an area designated*  
16          *under section 1860D–4(b)(5) shall make such plan*  
17          *available to all eligible individuals residing in the*  
18          *area without regard to their health or economic status*  
19          *or their place of residence within the area.*

20          “(d) EFFECTIVE DATE OF ELECTIONS.—

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



1       *under section 1851(e) take effect under section*  
2       *1851(f).*

3               “(2) *NO ELECTION EFFECTIVE BEFORE 2006.—In*  
4       *no case shall any election take effect before January*  
5       *1, 2006.*

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

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

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

14       **“SEC. 1860D-2. REQUIREMENTS FOR QUALIFIED PRESCRIP-**  
15                       **TION DRUG COVERAGE.**

16               “(a) *REQUIREMENTS.—*

17                      “(1) *IN GENERAL.—For purposes of this part*  
18       *and part C and part E, the term ‘qualified prescrip-*  
19       *tion drug coverage’ means either of the following:*

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

24                      “(B) *ACTUARIALLY EQUIVALENT COVERAGE*  
25       *WITH ACCESS TO NEGOTIATED PRICES.—Cov-*



1            *erage of covered outpatient drugs which meets the*  
2            *alternative coverage requirements of subsection*  
3            *(c) and access to negotiated prices under sub-*  
4            *section (d), but only if it is approved by the Ad-*  
5            *ministrator, as provided under subsection (c).*

6            *“(2) PERMITTING ADDITIONAL OUTPATIENT PRE-*  
7            *SCRIPTION DRUG COVERAGE.—*

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

16           *“(B) DISAPPROVAL AUTHORITY.—The Ad-*  
17           *ministrator shall review the offering of qualified*  
18           *prescription drug coverage under this part or*  
19           *part C or E. If the Administrator finds, in the*  
20           *case of a qualified prescription drug coverage*  
21           *under a prescription drug plan or a MA-EFFS*  
22           *Rx plan, that the organization or sponsor offer-*  
23           *ing the coverage is engaged in activities intended*  
24           *to discourage enrollment of classes of eligible*  
25           *medicare beneficiaries obtaining coverage*



1           *through the plan on the basis of their higher like-*  
2           *lihood of utilizing prescription drug coverage, the*  
3           *Administrator may terminate the contract with*  
4           *the sponsor or organization under this part or*  
5           *part C or E.*

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

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

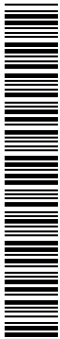
14                 “(1) *DEDUCTIBLE.—The coverage has an annual*  
15                 *deductible—*

16                         “(A) *for 2006, that is equal to \$250; or*

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

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

24                 “(2) *80:20 BENEFIT STRUCTURE.—*



1           “(A) 20 PERCENT COINSURANCE.—The cov-  
2           erage has cost-sharing (for costs above the annual  
3           deductible specified in paragraph (1) and up to  
4           the initial coverage limit under paragraph (3))  
5           that is—

6                   “(i) equal to 20 percent; or

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

11           “(B) USE OF TIERS.—Nothing in this part  
12           shall be construed as preventing a PDP sponsor  
13           from applying tiered copayments, so long as such  
14           tiered copayments are consistent with subpara-  
15           graph (A).

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

20                   “(A) for 2006, that is equal to \$2,000; or

21                   “(B) for a subsequent year, that is equal to  
22                   the amount specified in this paragraph for the  
23                   previous year, increased by the annual percent-  
24                   age increase described in paragraph (5) for the  
25                   year involved.



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

4             “(4) *CATASTROPHIC PROTECTION.*—

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

12                    “(B) *ANNUAL OUT-OF-POCKET THRESH-*  
13                    *OLD.*—

14                             “(i) *IN GENERAL.*—*For purposes of*  
15                             *this part, the ‘annual out-of-pocket thresh-*  
16                             *old’ specified in this subparagraph is equal*  
17                             *to \$3,500 (subject to adjustment under*  
18                             *clause (i) and subparagraph (D)).*

19                             “(ii) *INFLATION INCREASE.*—*For a*  
20                             *year after 2006, the dollar amount specified*  
21                             *in clause (i) shall be increased by the an-*  
22                             *annual percentage increase described in para-*  
23                             *graph (5) for the year involved. Any*  
24                             *amount determined under the previous sen-*



1                    *tence that is not a multiple of \$100 shall be*  
2                    *rounded to the nearest multiple of \$100.*

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

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

12                   *“(ii) such costs shall be treated as in-*  
13                   *curring only if they are paid by the indi-*  
14                   *vidual (or by another individual, such as a*  
15                   *family member, on behalf of the individual),*  
16                   *under section 1860D-7, under title XIX, or*  
17                   *under a State pharmaceutical assistance*  
18                   *program and the individual (or other indi-*  
19                   *vidual) is not reimbursed through insurance*  
20                   *or otherwise, a group health plan, or other*  
21                   *third-party payment arrangement (other*  
22                   *than under such title or such program) for*  
23                   *such costs.*

24                   *“(D) ADJUSTMENT OF ANNUAL OUT-OF-*  
25                   *POCKET THRESHOLDS.—*





1                   “(i) *IN GENERAL.*—For each enrollee  
2                   in a prescription drug plan or in a MA-  
3                   *EFFS Rx* plan whose adjusted gross income  
4                   exceeds the income threshold as defined in  
5                   clause (ii) for a year, the annual out-of-  
6                   pocket threshold otherwise determined under  
7                   subparagraph (B) for such year shall be in-  
8                   creased by an amount equal to the percent-  
9                   age specified in clause (iii), multiplied by  
10                  the lesser of—

11                               “(I) the amount of such excess; or

12                               “(II) the amount by which the in-  
13                               come threshold limit exceeds the income  
14                               threshold.

15                  Any amount determined under the previous  
16                  sentence that is not a multiple of \$100 shall  
17                  be rounded to the nearest multiple of \$100.

18                   “(ii) *INCOME THRESHOLD.*—For pur-  
19                   poses of clause (i)—

20                               “(I) *IN GENERAL.*—Subject to  
21                               subclause (II), the term ‘income thresh-  
22                               old’ means \$60,000 and the term ‘in-  
23                               come threshold limit’ means \$200,000.

24                               “(II) *INCOME INFLATION ADJUST-*  
25                               *MENT.*—In the case of a year begin-



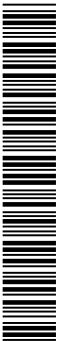
1            *ning after 2006, each of the dollar*  
2            *amounts in subclause (I) shall be in-*  
3            *creased by an amount equal to such*  
4            *dollar amount multiplied by the cost-*  
5            *of-living adjustment determined under*  
6            *section 1(f)(3) of the Internal Revenue*  
7            *Code of 1986 for such year, determined*  
8            *by substituting ‘calendar year 2005’*  
9            *for ‘calendar year 1992’. If any*  
10           *amount increased under the previous*  
11           *sentence is not a multiple of \$100, such*  
12           *amount shall be rounded to the nearest*  
13           *multiple of \$100.*

14           *“(iii) PERCENTAGE.—The percentage*  
15           *specified in this clause for a year is a frac-*  
16           *tion (expressed as a percentage) equal to—*

17                    *“(I) the annual out-of-pocket*  
18                    *threshold for a year under subpara-*  
19                    *graph (B) (determined without regard*  
20                    *to this subparagraph), divided by*

21                    *“(II) the income threshold under*  
22                    *clause (ii) for that year.*

23           *If any percentage determined under the pre-*  
24           *vious sentence that is not a multiple of*  
25           *1/10th of 1 percentage point, such percentage*



1           *shall be rounded to the nearest multiple of*  
2           *1/10th of 1 percentage point.*

3           “(iv) *USE OF MOST RECENT RETURN*  
4           *INFORMATION.—For purposes of clause (i)*  
5           *for an enrollee for a year, except as pro-*  
6           *vided in clause (v), the adjusted gross in-*  
7           *come of an individual shall be based on the*  
8           *most recent information disclosed to the*  
9           *Secretary under section 6109(l)(19) of the*  
10           *Internal Revenue Code of 1986 before the be-*  
11           *ginning of that year.*

12           “(v) *INDIVIDUAL ELECTION TO*  
13           *PRESENT MOST RECENT INFORMATION RE-*  
14           *GARDING INCOME.—The Secretary shall pro-*  
15           *vide, in coordination with the Secretary of*  
16           *the Treasury, a procedure under which, for*  
17           *purposes of applying this subparagraph for*  
18           *a calendar year, instead of using the infor-*  
19           *mation described in clause (iv), an enrollee*  
20           *may elect to use more recent information,*  
21           *including information with respect to a tax-*  
22           *able year ending in such calendar year.*  
23           *Such process shall—*

24                           “(I) *require the enrollee to provide*  
25                           *the Secretary with a copy of the rel-*



1                    *evant portion of the more recent return*  
2                    *to be used under this clause;*

3                    *“(II) provide for the Medicare*  
4                    *Beneficiary Ombudsman (under sec-*  
5                    *tion 1810) offering assistance to such*  
6                    *enrollees in presenting such informa-*  
7                    *tion and the toll-free number under*  
8                    *such section being a point of contact*  
9                    *for beneficiaries to inquire as to how to*  
10                   *present such information;*

11                   *“(III) provide for the verification*  
12                   *of the information in such return by*  
13                   *the Secretary of the Treasury under*  
14                   *section 6103(l)(19) of the Internal Rev-*  
15                   *enue Code of 1986; and*

16                   *“(IV) provide for the payment by*  
17                   *the Secretary (in a manner specified*  
18                   *by the Secretary) to the enrollee of an*  
19                   *amount equal to the excess of the ben-*  
20                   *efit payments that would have been*  
21                   *payable under the plan if the more re-*  
22                   *cent return information were used,*  
23                   *over the benefit payments that were*  
24                   *made under the plan.*



1                    *In the case of a payment under subclause*  
2                    *(III) for an enrollee under a prescription*  
3                    *drug plan, the PDP sponsor of the plan*  
4                    *shall pay to the Secretary the amount so*  
5                    *paid, less the applicable reinsurance*  
6                    *amount that would have applied under sec-*  
7                    *tion 1860D–8(c)(1)(B) if such payment had*  
8                    *been treated as an allowable cost under such*  
9                    *section. Such plan payment shall be depos-*  
10                   *ited in the Treasury to the credit of the*  
11                   *Medicare Prescription Drug Account in the*  
12                   *Federal Supplementary Medical Insurance*  
13                   *Trust Fund (under section 1841).*

14                   *“(vi) DISSEMINATION OF INFORMATION*  
15                   *ON PROCESS.—The Secretary shall provide,*  
16                   *through the annual medicare handbook*  
17                   *under section 1804(a), for a general descrip-*  
18                   *tion of the adjustment of annual out-of-*  
19                   *pocket thresholds provided under this sub-*  
20                   *paragraph, including the process for adjust-*  
21                   *ment based upon more recent information*  
22                   *and the confidentiality provisions of sub-*  
23                   *paragraph (F), and shall provide for dis-*  
24                   *semination of a table for each year that sets*  
25                   *forth the amount of the adjustment that is*



1                   *made under clause (i) based on the amount*  
2                   *of an enrollee's adjusted gross income.*

3                   “(E) *REQUESTING INFORMATION ON EN-*  
4                   *ROLLEES.—*

5                   “(i) *IN GENERAL.—The Secretary*  
6                   *shall, periodically as required to carry out*  
7                   *subparagraph (D), transmit to the Sec-*  
8                   *retary of the Treasury a list of the names*  
9                   *and TINs of enrollees in prescription drug*  
10                  *plans (or in MA-EFFS Rx plans) and re-*  
11                  *quest that such Secretary disclose to the*  
12                  *Secretary information under subparagraph*  
13                  *(A) of section 6103(l)(19) of the Internal*  
14                  *Revenue Code of 1986 with respect to those*  
15                  *enrollees for a specified taxable year for ap-*  
16                  *plication in a particular calendar year.*

17                  “(ii) *DISCLOSURE TO PLAN SPON-*  
18                  *SORS.—In the case of a specified taxpayer*  
19                  *(as defined in section 6103(l)(19)(B) of the*  
20                  *Internal Revenue Code of 1986) who is en-*  
21                  *rolled in a prescription drug plan or in an*  
22                  *MA-EFFS Rx plan, the Secretary shall dis-*  
23                  *close to the entity that offers the plan the*  
24                  *annual out-of-pocket threshold applicable to*  
25                  *such individual under subparagraph (D).*



1                   “(F) *MAINTAINING CONFIDENTIALITY OF IN-*  
2                   *FORMATION.—*

3                   “(i) *IN GENERAL.—The amount of any*  
4                   *increase in an annual out-of-pocket thresh-*  
5                   *old under subparagraph (D) may not be*  
6                   *disclosed by the Secretary except to a PDP*  
7                   *sponsor or entity that offers a MA-EFFS*  
8                   *Rx plan to the extent necessary to carry out*  
9                   *this part.*

10                   “(ii) *CRIMINAL AND CIVIL PENALTIES*  
11                   *FOR UNAUTHORIZED DISCLOSURE.—A per-*  
12                   *son who makes an unauthorized disclosure*  
13                   *of information disclosed under section*  
14                   *6103(l)(19) of the Internal Revenue Code of*  
15                   *1986 (including disclosure of any increase*  
16                   *in an annual out-of-pocket threshold under*  
17                   *subparagraph (D)) shall be subject to pen-*  
18                   *alty to the extent provided under—*

19                   “(I) *section 7213 of such Code (re-*  
20                   *lating to criminal penalty for unau-*  
21                   *thorized disclosure of information);*

22                   “(II) *section 7213A of such Code*  
23                   *(relating to criminal penalty for unau-*  
24                   *thorized inspection of returns or return*  
25                   *information);*



1                   “(III) section 7431 of such Code  
2                   (relying to civil damages for unau-  
3                   thorized inspection or disclosure of re-  
4                   turns and return information);

5                   “(IV) any other provision of the  
6                   Internal Revenue Code of 1986; or

7                   “(V) any other provision of law.

8                   “(iii) APPLICATION OF ADDITIONAL  
9                   CIVIL MONETARY PENALTY FOR UNAUTHOR-  
10                  IZED DISCLOSURES.—In addition to any  
11                  penalty otherwise provided under law, any  
12                  person who makes an unauthorized disclo-  
13                  sure of such information shall be subject to  
14                  a civil monetary penalty of not to exceed  
15                  \$10,000 for each such unauthorized disclo-  
16                  sure. The provisions of section 1128A (other  
17                  than subsections (a) and (b)) shall apply to  
18                  civil money penalties under this subpara-  
19                  graph in the same manner as they apply to  
20                  a penalty or proceeding under section  
21                  1128A(a).

22                  “(5) ANNUAL PERCENTAGE INCREASE.—For pur-  
23                  poses of this part, the annual percentage increase  
24                  specified in this paragraph for a year is equal to the  
25                  annual percentage increase in average per capita ag-





1 *gregate expenditures for covered outpatient drugs in*  
2 *the United States for medicare beneficiaries, as deter-*  
3 *mined by the Administrator for the 12-month period*  
4 *ending in July of the previous year.*

5 *“(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A*  
6 *prescription drug plan or MA-EFFS Rx plan may provide*  
7 *a different prescription drug benefit design from the stand-*  
8 *ard coverage described in subsection (b) so long as the Ad-*  
9 *ministrator determines (based on an actuarial analysis by*  
10 *the Administrator) that the following requirements are met*  
11 *and the plan applies for, and receives, the approval of the*  
12 *Administrator for such benefit design:*

13 *“(1) ASSURING AT LEAST ACTUARIALLY EQUIVA-*  
14 *LENT COVERAGE.—*

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

20 *“(B) ASSURING EQUIVALENT UNSUBSIDIZED*  
21 *VALUE OF COVERAGE.—The unsubsidized value*  
22 *of the coverage is at least equal to the unsub-*  
23 *sidized value of standard coverage. For purposes*  
24 *of this subparagraph, the unsubsidized value of*  
25 *coverage is the amount by which the actuarial*



1           *value of the coverage (as determined under sub-*  
2           *section (e)) exceeds the actuarial value of the sub-*  
3           *sidy payments under section 1860D–8 with re-*  
4           *spect to such coverage.*

5           “(C) *ASSURING STANDARD PAYMENT FOR*  
6           *COSTS AT INITIAL COVERAGE LIMIT.—The cov-*  
7           *erage is designed, based upon an actuarially rep-*  
8           *resentative pattern of utilization (as determined*  
9           *under subsection (e)), to provide for the pay-*  
10           *ment, with respect to costs incurred that are*  
11           *equal to the initial coverage limit under sub-*  
12           *section (b)(3), of an amount equal to at least the*  
13           *product of—*

14           *“(i) the amount by which the initial*  
15           *coverage limit described in subsection (b)(3)*  
16           *exceeds the deductible described in sub-*  
17           *section (b)(1); and*

18           *“(ii) 100 percent minus the cost-shar-*  
19           *ing percentage specified in subsection*  
20           *(b)(2)(A)(i).*

21           “(2) *CATASTROPHIC PROTECTION.—The coverage*  
22           *provides for beneficiaries the catastrophic protection*  
23           *described in subsection (b)(4).*

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



1           “(1) *IN GENERAL.*—Under qualified prescription  
2           *drug coverage offered by a PDP sponsor or an entity*  
3           *offering a MA-EFFS Rx plan, the sponsor or entity*  
4           *shall provide beneficiaries with access to negotiated*  
5           *prices (including applicable discounts) used for pay-*  
6           *ment for covered outpatient drugs, regardless of the*  
7           *fact that no benefits may be payable under the cov-*  
8           *erage with respect to such drugs because of the appli-*  
9           *cation of cost-sharing or an initial coverage limit (de-*  
10           *scribed in subsection (b)(3)). Insofar as a State elects*  
11           *to provide medical assistance under title XIX to a*  
12           *beneficiary enrolled under such title and under a pre-*  
13           *scription drug plan or MA-EFFS Rx plan for a drug*  
14           *based on the prices negotiated by a prescription drug*  
15           *plan or MA-EFFS Rx plan under this part, the re-*  
16           *quirements of section 1927 shall not apply to such*  
17           *drugs. The prices negotiated by a prescription drug*  
18           *plan under this part, by a MA-EFFS Rx plan with*  
19           *respect to covered outpatient drugs, or by a qualified*  
20           *retiree prescription drug plan (as defined in section*  
21           *1860D–8(f)(1)) with respect to such drugs on behalf*  
22           *of individuals entitled to benefits under part A or en-*  
23           *rolled under part B, shall (notwithstanding any other*  
24           *provision of law) not be taken into account for the*



1        *purposes of establishing the best price under section*  
2        *1927(c)(1)(C).*

3            *“(2) DISCLOSURE.—The PDP sponsor or entity*  
4        *offering a MA-EFFS Rx plan shall disclose to the Ad-*  
5        *ministrator (in a manner specified by the Adminis-*  
6        *trator) the extent to which discounts or rebates or*  
7        *other remuneration or price concessions made avail-*  
8        *able to the sponsor or organization by a manufacturer*  
9        *are passed through to enrollees through pharmacies*  
10       *and other dispensers or otherwise. The provisions of*  
11       *section 1927(b)(3)(D) shall apply to information dis-*  
12       *closed to the Administrator under this paragraph in*  
13       *the same manner as such provisions apply to infor-*  
14       *mation disclosed under such section.*

15           *“(3) AUDITS AND REPORTS.—To protect against*  
16        *fraud and abuse and to ensure proper disclosures and*  
17        *accounting under this part, in addition to any pro-*  
18        *tections against fraud and abuse provided under sec-*  
19        *tion 1860D-4(b)(3)(C), the Administrator may peri-*  
20        *odically audit the financial statements and records of*  
21        *PDP sponsor or entities offering a MA-EFFS Rx*  
22        *plan.*

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



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

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

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

9                           “(ii) *the use of generally accepted actu-*  
10                           *arial principles and methodologies; and*

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

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

18           “(2) *USE OF OUTSIDE ACTUARIES.*—*Under the*  
19           *processes under paragraph (1)(A), PDP sponsors and*  
20           *entities offering MA-EFFS Rx plans may use actu-*  
21           *arial opinions certified by independent, qualified ac-*  
22           *tuaries to establish actuarial values, but the Adminis-*  
23           *trator shall determine whether such actuarial values*  
24           *meet the requirements under subsection (c)(1).*

25           “(f) *COVERED OUTPATIENT DRUGS DEFINED.*—



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

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

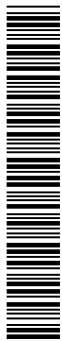
8                   “(B) *a biological product described in*  
9                   *clauses (i) through (iii) of subparagraph (B) of*  
10                   *such section or insulin described in subpara-*  
11                   *graph (C) of such section,*

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

16           “(2) *EXCLUSIONS.*—

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

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



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

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

13           “(4) *APPLICATION OF GENERAL EXCLUSION PRO-*  
14           *VISIONS.—A prescription drug plan or MA-EFFS Rx*  
15           *plan may exclude from qualified prescription drug*  
16           *coverage any covered outpatient drug—*

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

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

21           *Such exclusions are determinations subject to recon-*  
22           *sideration and appeal pursuant to section 1860D–*  
23           *3(f).*



1 **“SEC. 1860D–3. BENEFICIARY PROTECTIONS FOR QUALIFIED**  
2 **PRESCRIPTION DRUG COVERAGE.**

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

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

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

17 *“(A) Access to specific covered outpatient*  
18 *drugs, including access through pharmacy net-*  
19 *works.*

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

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





1                   “(D) *Grievance and appeals procedures.*  
2                   *Such information shall also be made available upon*  
3                   *request to prospective enrollees.*

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

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

18                   “(4) *CLAIMS INFORMATION.—Each PDP sponsor*  
19                   *offering a prescription drug plan must furnish to*  
20                   *each enrollee in a form easily understandable to such*  
21                   *enrollees an explanation of benefits (in accordance*  
22                   *with section 1806(a) or in a comparable manner) and*  
23                   *a notice of the benefits in relation to initial coverage*  
24                   *limit and the annual out-of-pocket threshold applica-*  
25                   *ble to such enrollee for the current year, whenever pre-*



1       *scription drug benefits are provided under this part*  
2       *(except that such notice need not be provided more*  
3       *often than monthly).*

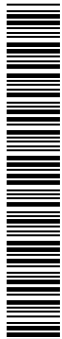
4       “(c) *ACCESS TO COVERED BENEFITS.*—

5               “(1) *ASSURING PHARMACY ACCESS.*—

6                       “(A) *PARTICIPATION OF ANY WILLING*  
7                       *PHARMACY.*—*A PDP sponsor and an entity of-*  
8                       *fering a MA-EFFS Rx plan shall permit the*  
9                       *participation of any pharmacy that meets terms*  
10                      *and conditions that the plan has established.*

11                     “(B) *DISCOUNTS ALLOWED FOR NETWORK*  
12                     *PHARMACIES.*—*A prescription drug plan and a*  
13                     *MA-EFFS Rx plan may, notwithstanding sub-*  
14                     *paragraph (A), reduce coinsurance or copay-*  
15                     *ments for its enrolled beneficiaries below the level*  
16                     *otherwise provided for covered outpatient drugs*  
17                     *dispensed through in-network pharmacies, but in*  
18                     *no case shall such a reduction result in an in-*  
19                     *crease in payments made by the Administrator*  
20                     *under section 1860D–8 to a plan.*

21                     “(C) *CONVENIENT ACCESS FOR NETWORK*  
22                     *PHARMACIES.*—*The PDP sponsor of the prescrip-*  
23                     *tion drug plan and the entity offering a MA-*  
24                     *EFFS Rx plan shall secure the participation in*  
25                     *its network of a sufficient number of pharmacies*



1           *that dispense (other than by mail order) drugs*  
2           *directly to patients to ensure convenient access*  
3           *(consistent with rules of the Administrator). The*  
4           *Administrator shall establish convenient access*  
5           *rules under this subparagraph that are no less*  
6           *favorable to enrollees than the rules for conven-*  
7           *ient access to pharmacies of the Secretary of De-*  
8           *fense established as of June 1, 2003, for purposes*  
9           *of the TRICARE Retail Pharmacy (TRRx) pro-*  
10           *gram. Such rules shall include adequate emer-*  
11           *gency access for enrolled beneficiaries.*

12           “(D) *LEVEL PLAYING FIELD.*—Such a spon-  
13           *sor shall permit enrollees to receive benefits*  
14           *(which may include a 90-day supply of drugs or*  
15           *biologicals) through a community pharmacy,*  
16           *rather than through mail order, with any dif-*  
17           *ferential in cost paid by such enrollees.*

18           “(E) *NOT REQUIRED TO ACCEPT INSURANCE*  
19           *RISK.*—The terms and conditions under subpara-  
20           *graph (A) may not require participating phar-*  
21           *macies to accept insurance risk as a condition of*  
22           *participation.*

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

24           “(A) *IN GENERAL.*—The PDP sponsor of a  
25           *prescription drug plan and an entity offering a*



1           *MA-EFFS Rx plan shall issue (and reissue, as*  
2           *appropriate) such a card (or other technology)*  
3           *that may be used by an enrollee to assure access*  
4           *to negotiated prices under section 1860D-2(d)*  
5           *for the purchase of prescription drugs for which*  
6           *coverage is not otherwise provided under the*  
7           *plan.*

8           “(B) *STANDARDS.—*

9                   “(i) *DEVELOPMENT.—The Adminis-*  
10                   *trator shall provide for the development or*  
11                   *utilization of uniform standards relating to*  
12                   *a standardized format for the card or other*  
13                   *technology referred to in subparagraph (A).*  
14                   *Such standards shall be compatible with*  
15                   *standards established under part C of title*  
16                   *XI.*

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

23                   “(3) *REQUIREMENTS ON DEVELOPMENT AND AP-*  
24                   *PLICATION OF FORMULARIES.—If a PDP sponsor of a*  
25                   *prescription drug plan or an entity offering a MA-*



1        *EFFS Rx plan uses a formulary, the following re-*  
2        *quirements must be met:*

3                *“(A) PHARMACY AND THERAPEUTIC (P&T)*  
4                *COMMITTEE.—The sponsor or entity must estab-*  
5                *lish a pharmacy and therapeutic committee that*  
6                *develops and reviews the formulary. Such com-*  
7                *mittee shall include at least one practicing phy-*  
8                *sician and at least one practicing pharmacist*  
9                *independent and free of conflict with respect to*  
10               *the committee both with expertise in the care of*  
11               *elderly or disabled persons and a majority of its*  
12               *members shall consist of individuals who are*  
13               *practicing physicians or practicing pharmacists*  
14               *(or both).*

15               *“(B) FORMULARY DEVELOPMENT.—In de-*  
16               *veloping and reviewing the formulary, the com-*  
17               *mittee shall—*

18                        *“(i) base clinical decisions on the*  
19                        *strength of scientific evidence and standards*  
20                        *of practice, including assessing peer-re-*  
21                        *viewed medical literature, such as random-*  
22                        *ized clinical trials, pharmacoeconomic stud-*  
23                        *ies, outcomes research data, and such other*  
24                        *information as the committee determines to*  
25                        *be appropriate; and*

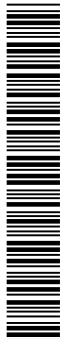


1                   “(ii) shall take into account whether  
2                   including in the formulary particular cov-  
3                   ered outpatient drugs has therapeutic ad-  
4                   vantages in terms of safety and efficacy.

5                   “(C) INCLUSION OF DRUGS IN ALL THERA-  
6                   PEUTIC CATEGORIES.—The formulary must in-  
7                   clude drugs within each therapeutic category and  
8                   class of covered outpatient drugs (although not  
9                   necessarily for all drugs within such categories  
10                  and classes). In establishing such classes, the  
11                  committee shall take into account the standards  
12                  published in the United States Pharmacopeia-  
13                  Drug Information. The committee shall make  
14                  available to the enrollees under the plan through  
15                  the Internet or otherwise the bases for the exclu-  
16                  sion of coverage of any drug from the formulary.

17                  “(D) PROVIDER AND PATIENT EDU-  
18                  CATION.—The committee shall establish policies  
19                  and procedures to educate and inform health  
20                  care providers and enrollees concerning the for-  
21                  mulary.

22                  “(E) NOTICE BEFORE REMOVING DRUG  
23                  FROM FORMULARY FOR CHANGING PREFERRED  
24                  OR TIER STATUS OF DRUG.—Any removal of a  
25                  covered outpatient drug from a formulary and



1           *any change in the preferred or tier cost-sharing*  
2           *status of such a drug shall take effect only after*  
3           *appropriate notice is made available to bene-*  
4           *ficiaries and physicians.*

5           “(F) *PERIODIC EVALUATION OF PROTO-*  
6           *COLS.—In connection with the formulary, a pre-*  
7           *scription drug plan shall provide for the periodic*  
8           *evaluation and analysis of treatment protocols*  
9           *and procedures.*

10          “(G) *GRIEVANCES AND APPEALS RELATING*  
11          *TO APPLICATION OF FORMULARIES.—For provi-*  
12          *sions relating to grievances and appeals of cov-*  
13          *erage, see subsections (e) and (f).*

14          “(d) *COST AND UTILIZATION MANAGEMENT; QUALITY*  
15          *ASSURANCE; MEDICATION THERAPY MANAGEMENT PRO-*  
16          *GRAM.—*

17                 “(1) *IN GENERAL.—The PDP sponsor or entity*  
18                 *offering a MA-EFFS Rx plan shall have in place, di-*  
19                 *rectly or through appropriate arrangements, with re-*  
20                 *spect to covered outpatient drugs—*

21                         “(A) *an effective cost and drug utilization*  
22                         *management program, including medically ap-*  
23                         *propriate incentives to use generic drugs and*  
24                         *therapeutic interchange, when appropriate;*



1           “(B) *quality assurance measures and sys-*  
2           *tems to reduce medical errors and adverse drug*  
3           *interactions, including side-effects, and improve*  
4           *medication use, including a medication therapy*  
5           *management program described in paragraph*  
6           *(2) and for years beginning with 2007, an elec-*  
7           *tronic prescription program described in para-*  
8           *graph (3); and*

9           “(C) *a program to control fraud, abuse, and*  
10          *waste.*

11          *Nothing in this section shall be construed as impair-*  
12          *ing a PDP sponsor or entity from utilizing cost man-*  
13          *agement tools (including differential payments) under*  
14          *all methods of operation.*

15          “(2) *MEDICATION THERAPY MANAGEMENT PRO-*  
16          *GRAM.—*

17                 “(A) *IN GENERAL.—A medication therapy*  
18                 *management program described in this para-*  
19                 *graph is a program of drug therapy management*  
20                 *and medication administration that may be fur-*  
21                 *nished by a pharmacy provider and that is de-*  
22                 *signed to assure, with respect to beneficiaries at*  
23                 *risk for potential medication problems, such as*  
24                 *beneficiaries with complex or chronic diseases*  
25                 *(such as diabetes, asthma, hypertension, and*





1           *congestive heart failure) or multiple prescrip-*  
2           *tions, that covered outpatient drugs under the*  
3           *prescription drug plan are appropriately used to*  
4           *optimize therapeutic outcomes through improved*  
5           *medication use and reduce the risk of adverse*  
6           *events, including adverse drug interactions. Such*  
7           *programs may distinguish between services in*  
8           *ambulatory and institutional settings.*

9           “(B) *ELEMENTS.—Such program may*  
10          *include—*

11           “(i) *enhanced beneficiary under-*  
12          *standing to promote the appropriate use of*  
13          *medications by beneficiaries and to reduce*  
14          *the risk of potential adverse events associ-*  
15          *ated with medications, through beneficiary*  
16          *education, counseling, case management,*  
17          *disease state management programs, and*  
18          *other appropriate means;*

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

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



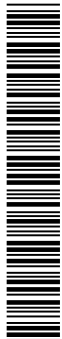
1                   “(C) *DEVELOPMENT OF PROGRAM IN CO-*  
2                   *OPERATION WITH LICENSED PHARMACISTS.—The*  
3                   *program shall be developed in cooperation with*  
4                   *licensed and practicing pharmacists and physi-*  
5                   *cians.*

6                   “(D) *CONSIDERATIONS IN PHARMACY*  
7                   *FEES.—The PDP sponsor of a prescription drug*  
8                   *program and an entity offering a MA-EFFS Rx*  
9                   *plan shall take into account, in establishing fees*  
10                  *for pharmacists and others providing services*  
11                  *under the medication therapy management pro-*  
12                  *gram, the resources and time used in imple-*  
13                  *menting the program. Each such sponsor or enti-*  
14                  *ty shall disclose to the Administrator upon re-*  
15                  *quest the amount of any such management or*  
16                  *dispensing fees.*

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

18                  “(A) *IN GENERAL.—An electronic prescrip-*  
19                  *tion drug program described in this paragraph*  
20                  *is a program that includes at least the following*  
21                  *components, consistent with uniform standards*  
22                  *established under subparagraph (B):*

23                  “(i) *ELECTRONIC TRANSMITTAL OF*  
24                  *PRESCRIPTIONS.—Prescriptions must be*  
25                  *written and transmitted electronically*



1                   *(other than by facsimile), except in emer-*  
2                   *gency cases and other exceptional cir-*  
3                   *cumstances recognized by the Adminis-*  
4                   *trator.*

5                   “(ii) *PROVISION OF INFORMATION TO*  
6                   *PRESCRIBING HEALTH CARE PROFES-*  
7                   *SIONAL.—The program provides for the elec-*  
8                   *tronic transmittal to the prescribing health*  
9                   *care professional of information that*  
10                   *includes—*

11                   “(I) *information (to the extent*  
12                   *available and feasible) on the drug or*  
13                   *drugs being prescribed for that patient*  
14                   *and other information relating to the*  
15                   *medical history or condition of the pa-*  
16                   *tient that may be relevant to the ap-*  
17                   *propriate prescription for that patient;*

18                   “(II) *cost-effective alternatives (if*  
19                   *any) for the use of the drug prescribed;*  
20                   *and*

21                   “(III) *information on the drugs*  
22                   *included in the applicable formulary.*

23                   *To the extent feasible, such program shall*  
24                   *permit the prescribing health care profes-*  
25                   *sional to provide (and be provided) related*

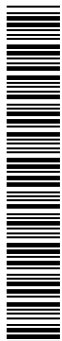


1                    *information on an interactive, real-time*  
2                    *basis.*

3                    “(B) *STANDARDS.—*

4                                       “(i) *DEVELOPMENT.—The Adminis-*  
5                    *trator shall provide for the development of*  
6                    *uniform standards relating to the electronic*  
7                    *prescription drug program described in sub-*  
8                    *paragraph (A). Such standards shall be*  
9                    *compatible with standards established under*  
10                    *part C of title XI.*

11                                       “(ii) *ADVISORY TASK FORCE.—In de-*  
12                    *veloping such standards and the standards*  
13                    *described in subsection (c)(2)(B)(i) the Ad-*  
14                    *ministrator shall establish a task force that*  
15                    *includes representatives of physicians, hos-*  
16                    *pitals, pharmacies, beneficiaries, pharmacy*  
17                    *benefit managers, individuals with expertise*  
18                    *in information technology, and pharmacy*  
19                    *benefit experts of the Departments of Vet-*  
20                    *erans Affairs and Defense and other appro-*  
21                    *priate Federal agencies to provide rec-*  
22                    *ommendations to the Administrator on such*  
23                    *standards, including recommendations re-*  
24                    *lating to the following:*



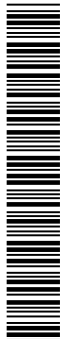
1                   “(I) *The range of available com-*  
2                   *puterized prescribing software and*  
3                   *hardware and their costs to develop*  
4                   *and implement.*

5                   “(II) *The extent to which such*  
6                   *standards and systems reduce medica-*  
7                   *tion errors and can be readily imple-*  
8                   *mented by physicians, pharmacies, and*  
9                   *hospitals.*

10                  “(III) *Efforts to develop uniform*  
11                  *standards and a common software*  
12                  *platform for the secure electronic com-*  
13                  *munication of medication history, eli-*  
14                  *gibility, benefit, and prescription in-*  
15                  *formation.*

16                  “(IV) *Efforts to develop and pro-*  
17                  *mote universal connectivity and inter-*  
18                  *operability for the secure electronic ex-*  
19                  *change of such information.*

20                  “(V) *The cost of implementing*  
21                  *such systems in the range of hospital*  
22                  *and physician office settings and phar-*  
23                  *macies, including hardware, software,*  
24                  *and training costs.*



1                   “(VI) *Implementation issues as*  
2                   *they relate to part C of title XI, and*  
3                   *current Federal and State prescribing*  
4                   *laws and regulations and their impact*  
5                   *on implementation of computerized*  
6                   *prescribing.*

7                   “(iii) *DEADLINES.—*

8                   “(I) *The Administrator shall con-*  
9                   *stitute the task force under clause (ii)*  
10                  *by not later than April 1, 2004.*

11                  “(II) *Such task force shall submit*  
12                  *recommendations to Administrator by*  
13                  *not later than January 1, 2005.*

14                  “(III) *The Administrator shall*  
15                  *provide for the development and pro-*  
16                  *mulgation, by not later than January*  
17                  *1, 2006, of national standards relating*  
18                  *to the electronic prescription drug pro-*  
19                  *gram described in clause (ii). Such*  
20                  *standards shall be issued by a stand-*  
21                  *ards organization accredited by the*  
22                  *American National Standards Insti-*  
23                  *tute (ANSI) and shall be compatible*  
24                  *with standards established under part*  
25                  *C of title XI.*



1           “(4) *TREATMENT OF ACCREDITATION.*—Section  
2           1852(e)(4) (relating to treatment of accreditation)  
3           shall apply to prescription drug plans under this part  
4           with respect to the following requirements, in the  
5           same manner as they apply to plans under part C  
6           with respect to the requirements described in a clause  
7           of section 1852(e)(4)(B):

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

11                  “(B) Subsection (c)(1) (relating to access to  
12                  covered benefits).

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

15           “(5) *PUBLIC DISCLOSURE OF PHARMACEUTICAL*  
16           *PRICES FOR EQUIVALENT DRUGS.*—Each PDP spon-  
17           sor and each entity offering a MA-EFFS Rx plan  
18           shall provide that each pharmacy or other dispenser  
19           that arranges for the dispensing of a covered out-  
20           patient drug shall inform the beneficiary at the time  
21           of purchase of the drug of any differential between the  
22           price of the prescribed drug to the enrollee and the  
23           price of the lowest cost available generic drug covered  
24           under the plan that is therapeutically equivalent and  
25           bioequivalent.

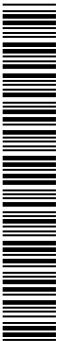


1       “(e) *GRIEVANCE MECHANISM, COVERAGE DETERMINA-*  
2 *TIONS, AND RECONSIDERATIONS.*—

3               “(1) *IN GENERAL.*—*Each PDP sponsor shall*  
4 *provide meaningful procedures for hearing and resolv-*  
5 *ing grievances between the organization (including*  
6 *any entity or individual through which the sponsor*  
7 *provides covered benefits) and enrollees with prescrip-*  
8 *tion drug plans of the sponsor under this part in ac-*  
9 *cordance with section 1852(f).*

10              “(2) *APPLICATION OF COVERAGE DETERMINA-*  
11 *TION AND RECONSIDERATION PROVISIONS.*—*A PDP*  
12 *sponsor shall meet the requirements of paragraphs (1)*  
13 *through (3) of section 1852(g) with respect to covered*  
14 *benefits under the prescription drug plan it offers*  
15 *under this part in the same manner as such require-*  
16 *ments apply to an organization with respect to bene-*  
17 *fits it offers under a plan under part C.*

18              “(3) *REQUEST FOR REVIEW OF TIERED FOR-*  
19 *MULARY DETERMINATIONS.*—*In the case of a prescrip-*  
20 *tion drug plan offered by a PDP sponsor or a MA-*  
21 *EFFS Rx plan that provides for tiered cost-sharing*  
22 *for drugs included within a formulary and provides*  
23 *lower cost-sharing for preferred drugs included within*  
24 *the formulary, an individual who is enrolled in the*  
25 *plan may request coverage of a nonpreferred drug*





1        *under the terms applicable for preferred drugs if the*  
2        *prescribing physician determines that the preferred*  
3        *drug for treatment of the same condition either would*  
4        *not be as effective for the individual or would have*  
5        *adverse effects for the individual or both.*

6        “(f) *APPEALS.—*

7                “(1) *IN GENERAL.—Subject to paragraph (2), a*  
8        *PDP sponsor shall meet the requirements of para-*  
9        *graphs (4) and (5) of section 1852(g) with respect to*  
10        *drugs (including a determination related to the appli-*  
11        *cation of tiered cost-sharing described in subsection*  
12        *(e)(3)) in the same manner as such requirements*  
13        *apply to an organization with respect to benefits it*  
14        *offers under a plan under part C.*

15                “(2) *FORMULARY DETERMINATIONS.—An indi-*  
16        *vidual who is enrolled in a prescription drug plan of-*  
17        *fered by a PDP sponsor or in a MA-EFFS Rx plan*  
18        *may appeal to obtain coverage for a covered out-*  
19        *patient drug that is not on a formulary of the sponsor*  
20        *or entity offering the plan if the prescribing physi-*  
21        *cian determines that the formulary drug for treat-*  
22        *ment of the same condition either would not be as ef-*  
23        *fective for the individual or would have adverse effects*  
24        *for the individual or both.*



1           “(g) *CONFIDENTIALITY AND ACCURACY OF ENROLLEE*  
2 *RECORDS.*—A PDP sponsor that offers a prescription drug  
3 plan shall meet the requirements of section 1852(h) with  
4 respect to enrollees under the plan in the same manner as  
5 such requirements apply to an organization with respect  
6 to enrollees under part C. A PDP sponsor shall be treated  
7 as a business associate for purposes of the provisions of sub-  
8 part E of part 164 of title 45, Code of Federal Regulations,  
9 adopted pursuant to the authority of the Secretary under  
10 section 264(c) of the Health Insurance Portability and Ac-  
11 countability Act of 1996 (42 U.S. C. 1320d-2 note).

12           **“SEC. 1860D-4. REQUIREMENTS FOR AND CONTRACTS WITH**  
13                                   **PRESCRIPTION DRUG PLAN (PDP) SPONSORS.**

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

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

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

24                                   “(A) *IN GENERAL.*—Subject to subpara-  
25 graph (B) and section 1860D-5(d)(2), the entity



1           *assumes full financial risk on a prospective basis*  
2           *for qualified prescription drug coverage that it*  
3           *offers under a prescription drug plan and that*  
4           *is not covered under section 1860D–8.*

5           “(B) *REINSURANCE PERMITTED.*—*The enti-*  
6           *ty may obtain insurance or make other arrange-*  
7           *ments for the cost of coverage provided to any*  
8           *enrollee.*

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

13          “(b) *CONTRACT REQUIREMENTS.*—

14               “(1) *IN GENERAL.*—*The Administrator shall not*  
15               *permit the election under section 1860D–1 of a pre-*  
16               *scription drug plan offered by a PDP sponsor under*  
17               *this part, and the sponsor shall not be eligible for*  
18               *payments under section 1860D–7 or 1860D–8, unless*  
19               *the Administrator has entered into a contract under*  
20               *this subsection with the sponsor with respect to the of-*  
21               *fering of such plan. Such a contract with a sponsor*  
22               *may cover more than one prescription drug plan.*  
23               *Such contract shall provide that the sponsor agrees to*  
24               *comply with the applicable requirements and stand-*



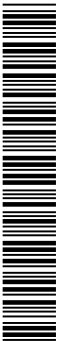
1        *ards of this part and the terms and conditions of*  
2        *payment as provided for in this part.*

3            *“(2) NEGOTIATION REGARDING TERMS AND CON-*  
4        *DITIONS.—The Administrator shall have the same au-*  
5        *thority to negotiate the terms and conditions of pre-*  
6        *scription drug plans under this part as the Director*  
7        *of the Office of Personnel Management has with re-*  
8        *spect to health benefits plans under chapter 89 of title*  
9        *5, United States Code. In negotiating the terms and*  
10       *conditions regarding premiums for which information*  
11       *is submitted under section 1860D–6(a)(2), the Ad-*  
12       *ministrator shall take into account the subsidy pay-*  
13       *ments under section 1860D–8.*

14           *“(3) INCORPORATION OF CERTAIN MEDICARE AD-*  
15        *VANTAGE CONTRACT REQUIREMENTS.—The following*  
16        *provisions of section 1857 shall apply, subject to sub-*  
17        *section (c)(5), to contracts under this section in the*  
18        *same manner as they apply to contracts under section*  
19        *1857(a):*

20           *“(A) MINIMUM ENROLLMENT.—Paragraphs*  
21        *(1) and (3) of section 1857(b).*

22           *“(B) CONTRACT PERIOD AND EFFECTIVE-*  
23        *NESS.—Paragraphs (1) through (3) and (5) of*  
24        *section 1857(c).*



1                   “(C) *PROTECTIONS AGAINST FRAUD AND*  
2                   *BENEFICIARY PROTECTIONS.—Section 1857(d).*

3                   “(D) *ADDITIONAL CONTRACT TERMS.—Sec-*  
4                   *tion 1857(e); except that in applying section*  
5                   *1857(e)(2) under this part—*

6                   “*(i) such section shall be applied sepa-*  
7                   *rately to costs relating to this part (from*  
8                   *costs under part C and part E);*

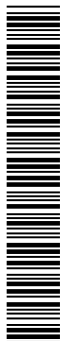
9                   “*(ii) in no case shall the amount of the*  
10                  *fee established under this subparagraph for*  
11                  *a plan exceed 20 percent of the maximum*  
12                  *amount of the fee that may be established*  
13                  *under subparagraph (B) of such section;*  
14                  *and*

15                  “*(iii) no fees shall be applied under*  
16                  *this subparagraph with respect to MA-*  
17                  *EFFS Rx plans.*

18                  “(E) *INTERMEDIATE SANCTIONS.—Section*  
19                  *1857(g).*

20                  “(F) *PROCEDURES FOR TERMINATION.—*  
21                  *Section 1857(h).*

22                  “(4) *RULES OF APPLICATION FOR INTERMEDIATE*  
23                  *SANCTIONS.—In applying paragraph (3)(E)—*



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

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

6           “(5) SERVICE AREA REQUIREMENT.—For pur-  
7           poses of this part, the Administrator shall designate  
8           at least 10 areas covering the entire United States  
9           and shall be consistent with EFFS regions established  
10          under section 1860E-1(a)(2).

11          “(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND  
12          CHOICE.—

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

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



1        *cation by a State of any grounds other than those re-*  
2        *quired under Federal law.*

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

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

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

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

21            *“(B) any reference to solvency standards*  
22            *shall be treated as a reference to solvency stand-*  
23            *ards established under subsection (d).*

24            *“(d) SOLVENCY STANDARDS FOR NON-LICENSED*  
25       *SPONSORS.—*



1           “(1) *ESTABLISHMENT.*—*The Administrator shall*  
2           *establish, by not later than October 1, 2004, financial*  
3           *solvency and capital adequacy standards that an en-*  
4           *tity that does not meet the requirements of subsection*  
5           *(a)(1) must meet to qualify as a PDP sponsor under*  
6           *this part.*

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

16           “(e) *RELATION TO STATE LAWS.*—

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

23           “(2) *PROHIBITION OF STATE IMPOSITION OF*  
24           *PREMIUM TAXES.*—*No State may impose a premium*  
25           *tax or similar tax with respect to premiums paid to*





1       *PDP sponsors for prescription drug plans under this*  
2       *part, or with respect to any payments made to such*  
3       *a sponsor by the Administrator under this part.*

4       **“SEC. 1860D-5. PROCESS FOR BENEFICIARIES TO SELECT**  
5                               **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

6       “(a) *IN GENERAL.—The Administrator shall establish*  
7       *a process for the selection of the prescription drug plan or*  
8       *MA-EFFS Rx plan through which eligible individuals elect*  
9       *qualified prescription drug coverage under this part.*

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

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

16               “(2) *Active dissemination of information to pro-*  
17       *mote an informed selection among qualifying plans*  
18       *based upon price, quality, and other features, in the*  
19       *manner described in (and in coordination with) sec-*  
20       *tion 1851(d), including the provision of annual com-*  
21       *parative information, maintenance of a toll-free hot-*  
22       *line, and the use of non-Federal entities.*

23               “(3) *Coordination of elections through filing*  
24       *with the entity offering a MA-EFFS Rx plan or a*



1 *PDP sponsor, in the manner described in (and in co-*  
2 *ordination with) section 1851(c)(2).*

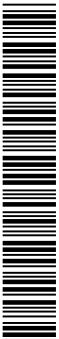
3 *“(4) Informing each enrollee before the beginning*  
4 *of each year of the annual out-of-pocket threshold ap-*  
5 *plicable to the enrollee for that year under section*  
6 *1860D-2(b)(4) at such time.*

7 *“(c) MA-EFFS RX ENROLLEE MAY ONLY OBTAIN*  
8 *BENEFITS THROUGH THE PLAN.—An individual who is*  
9 *enrolled under a MA-EFFS Rx plan may only elect to re-*  
10 *ceive qualified prescription drug coverage under this part*  
11 *through such plan.*

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

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

16 *“(A) IN GENERAL.—The Administrator*  
17 *shall assure that each individual who is entitled*  
18 *to benefits under part A or enrolled under part*  
19 *B and who is residing in an area in the United*  
20 *States has available, consistent with subpara-*  
21 *graph (B), a choice of enrollment in at least two*  
22 *qualifying plans (as defined in paragraph (5))*  
23 *in the area in which the individual resides, at*  
24 *least one of which is a prescription drug plan.*



1                   “(B) *REQUIREMENT FOR DIFFERENT PLAN*  
2                   *SPONSORS.—The requirement in subparagraph*  
3                   *(A) is not satisfied with respect to an area if*  
4                   *only one PDP sponsor or one entity that offers*  
5                   *a MA-EFFS Rx plan offers all the qualifying*  
6                   *plans in the area.*

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

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

19                         “(A) *shall not provide for the full under-*  
20                         *writing of financial risk for any PDP sponsor;*  
21                         *and*

22                         “(B) *shall seek to maximize the assumption*  
23                         *of financial risk by PDP sponsors or entities of-*  
24                         *fering a MA-EFFS Rx plan.*



1           “(4) *REPORTS.*—*The Administrator shall, in*  
2           *each annual report to Congress under section 1809(f),*  
3           *include information on the exercise of authority under*  
4           *this subsection. The Administrator also shall include*  
5           *such recommendations as may be appropriate to min-*  
6           *imize the exercise of such authority, including mini-*  
7           *mizing the assumption of financial risk.*

8           “(5) *QUALIFYING PLAN DEFINED.*—*For purposes*  
9           *of this subsection, the term ‘qualifying plan’ means a*  
10          *prescription drug plan or a MA-EFFS Rx plan.*

11          **“SEC. 1860D-6. SUBMISSION OF BIDS AND PREMIUMS.**

12          “(a) *SUBMISSION OF BIDS, PREMIUMS, AND RELATED*  
13          *INFORMATION.*—

14                 “(1) *IN GENERAL.*—*Each PDP sponsor shall*  
15                 *submit to the Administrator the information de-*  
16                 *scribed in paragraph (2) in the same manner as in-*  
17                 *formation is submitted by an organization under sec-*  
18                 *tion 1854(a)(1).*

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

21                         “(A) *COVERAGE PROVIDED.*—*Information*  
22                         *on the qualified prescription drug coverage to be*  
23                         *provided.*

24                         “(B) *ACTUARIAL VALUE.*—*Information on*  
25                         *the actuarial value of the coverage.*



1                   “(C) *BID AND PREMIUM.*—*Information on*  
2                   *the bid and the premium for the coverage, in-*  
3                   *cluding an actuarial certification of—*

4                   “*(i) the actuarial basis for such bid*  
5                   *and premium;*

6                   “*(ii) the portion of such bid and pre-*  
7                   *mium attributable to benefits in excess of*  
8                   *standard coverage;*

9                   “*(iii) the reduction in such bid result-*  
10                  *ing from the reinsurance subsidy payments*  
11                  *provided under section 1860D–8(a)(2); and*

12                  “*(iv) the reduction in such premium*  
13                  *resulting from the direct and reinsurance*  
14                  *subsidy payments provided under section*  
15                  *1860D–8.*

16                  “(D) *ADDITIONAL INFORMATION.*—*Such*  
17                  *other information as the Administrator may re-*  
18                  *quire to carry out this part.*

19                  “(3) *REVIEW OF INFORMATION; NEGOTIATION*  
20                  *AND APPROVAL OF PREMIUMS.—*

21                  “(A) *IN GENERAL.*—*Subject to subpara-*  
22                  *graph (B), the Administrator shall review the in-*  
23                  *formation filed under paragraph (2) for the pur-*  
24                  *pose of conducting negotiations under section*  
25                  *1860D–4(b)(2) (relating to using OPM-like au-*



1            *thority under the FEHBP). The Administrator,*  
2            *using the information provided (including the*  
3            *actuarial certification under paragraph (2)(C))*  
4            *shall approve the premium submitted under this*  
5            *subsection only if the premium accurately re-*  
6            *fects both (i) the actuarial value of the benefits*  
7            *provided, and (ii) the 73 percent average subsidy*  
8            *provided under section 1860D–8 for the standard*  
9            *benefit. The Administrator shall apply actuarial*  
10           *principles to approval of a premium under this*  
11           *part in a manner similar to the manner in*  
12           *which those principles are applied in estab-*  
13           *lishing the monthly part B premium under sec-*  
14           *tion 1839.*

15           “(B) *EXCEPTION.*—*In the case of a plan de-*  
16           *scribed in section 1851(a)(2)(C), the provisions*  
17           *of subparagraph (A) shall not apply and the*  
18           *provisions of paragraph (5)(B) of section*  
19           *1854(a), prohibiting the review, approval, or dis-*  
20           *approval of amounts described in such para-*  
21           *graph, shall apply to the negotiation and rejec-*  
22           *tion of the monthly bid amounts and proportion*  
23           *referred to in subparagraph (A).*

24           “(b) *UNIFORM BID AND PREMIUM.*—



1           “(1) *IN GENERAL.*—*The bid and premium for a*  
2           *prescription drug plan under this section may not*  
3           *vary among enrollees in the plan in the same service*  
4           *area.*

5           “(2) *CONSTRUCTION.*—*Nothing in paragraph (1)*  
6           *shall be construed as preventing the imposition of a*  
7           *late enrollment penalty under section 1860D-*  
8           *1(c)(2)(B).*

9           “(c) *COLLECTION.*—

10           “(1) *BENEFICIARY’S OPTION OF PAYMENT*  
11           *THROUGH WITHHOLDING FROM SOCIAL SECURITY*  
12           *PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER*  
13           *MECHANISM.*—*In accordance with regulations, a PDP*  
14           *sponsor shall permit each enrollee, at the enrollee’s*  
15           *option, to make payment of premiums under this*  
16           *part to the sponsor through withholding from benefit*  
17           *payments in the manner provided under section 1840*  
18           *with respect to monthly premiums under section 1839*  
19           *or through an electronic funds transfer mechanism*  
20           *(such as automatic charges of an account at a finan-*  
21           *cial institution or a credit or debit card account) or*  
22           *otherwise. All premium payments that are withheld*  
23           *under this paragraph shall be credited to the Medi-*  
24           *care Prescription Drug Trust Fund and shall be paid*  
25           *to the PDP sponsor involved.*



1           “(2) *OFFSETTING.*—*Reductions in premiums for*  
2           *coverage under parts A and B as a result of a selec-*  
3           *tion of a MA-EFFS Rx plan may be used to reduce*  
4           *the premium otherwise imposed under paragraph (1).*

5           “(d) *ACCEPTANCE OF REFERENCE PREMIUM AMOUNT*  
6           *AS FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDI-*  
7           *VIDUALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN*  
8           *AN AREA.*—

9           “(1) *IN GENERAL.*—*If there is no standard pre-*  
10           *scription drug coverage (as defined in paragraph (2))*  
11           *offered in an area, in the case of an individual who*  
12           *is eligible for a premium subsidy under section*  
13           *1860D–7 and resides in the area, the PDP sponsor of*  
14           *any prescription drug plan offered in the area (and*  
15           *any entity offering a MA-EFFS Rx plan in the area)*  
16           *shall accept the reference premium amount (under*  
17           *paragraph (3)) as payment in full for the premium*  
18           *charge for qualified prescription drug coverage.*

19           “(2) *STANDARD PRESCRIPTION DRUG COVERAGE*  
20           *DEFINED.*—*For purposes of this subsection, the term*  
21           *‘standard prescription drug coverage’ means qualified*  
22           *prescription drug coverage that is standard coverage*  
23           *or that has an actuarial value equivalent to the actu-*  
24           *arial value for standard coverage.*





1           “(3) *REFERENCE PREMIUM AMOUNT DEFINED.*—

2           *For purposes of this subsection, the term ‘reference*  
3           *premium amount’ means, with respect to qualified*  
4           *prescription drug coverage offered under—*

5                   “(A) *a prescription drug plan that—*

6                           “(i) *provides standard coverage (or al-*  
7                           *ternative prescription drug coverage the ac-*  
8                           *tuarial value is equivalent to that of stand-*  
9                           *ard coverage), the plan’s PDP premium; or*

10                           “(ii) *provides alternative prescription*  
11                           *drug coverage the actuarial value of which*  
12                           *is greater than that of standard coverage,*  
13                           *the plan’s PDP premium multiplied by the*  
14                           *ratio of (I) the actuarial value of standard*  
15                           *coverage, to (II) the actuarial value of the*  
16                           *alternative coverage;*

17                           “(B) *an EFFS plan, the EFFS monthly*  
18                           *prescription drug beneficiary premium (as de-*  
19                           *finied in section 1860E–4(a)(3)(B)); or*

20                           “(C) *a Medicare Advantage, the Medicare*  
21                           *Advantage monthly prescription drug beneficiary*  
22                           *premium (as defined in section 1854(b)(2)(B)).*

23           *For purposes of subparagraph (A), the term ‘PDP*  
24           *premium’ means, with respect to a prescription drug*  
25           *plan, the premium amount for enrollment under the*



1 *plan under this part (determined without regard to*  
2 *any low-income subsidy under section 1860D-7 or*  
3 *any late enrollment penalty under section 1860D-*  
4 *1(c)(2)(B)).*

5 **“SEC. 1860D-7. PREMIUM AND COST-SHARING SUBSIDIES**  
6 **FOR LOW-INCOME INDIVIDUALS.**

7 *“(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS*  
8 *WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY*  
9 *LEVEL.—*

10 *“(1) FULL PREMIUM SUBSIDY AND REDUCTION*  
11 *OF COST-SHARING FOR INDIVIDUALS WITH INCOME*  
12 *BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—*

13 *In the case of a subsidy eligible individual (as defined*  
14 *in paragraph (4)) who is determined to have income*  
15 *that does not exceed 135 percent of the Federal pov-*  
16 *erty level, the individual is entitled under this*  
17 *section—*

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

21 *“(B) subject to subsection (c), to the substi-*  
22 *tution for the beneficiary cost-sharing described*  
23 *in paragraphs (1) and (2) of section 1860D-2(b)*  
24 *(up to the initial coverage limit specified in*  
25 *paragraph (3) of such section) of amounts that*



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

4           “(2) *SLIDING SCALE PREMIUM SUBSIDY FOR IN-*  
5           *DIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150*  
6           *PERCENT, OF FEDERAL POVERTY LEVEL.—In the case*  
7           *of a subsidy eligible individual who is determined to*  
8           *have income that exceeds 135 percent, but does not ex-*  
9           *ceed 150 percent, of the Federal poverty level, the in-*  
10          *dividual is entitled under this section to an income-*  
11          *related premium subsidy determined on a linear slid-*  
12          *ing scale ranging from 100 percent of the amount de-*  
13          *scribed in subsection (b)(1) for individuals with in-*  
14          *comes at 135 percent of such level to 0 percent of such*  
15          *amount for individuals with incomes at 150 percent*  
16          *of such level.*

17          “(3) *CONSTRUCTION.—Nothing in this section*  
18          *shall be construed as preventing a PDP sponsor or*  
19          *entity offering a MA-EFFS Rx plan from reducing to*  
20          *0 the cost-sharing otherwise applicable to generic*  
21          *drugs.*

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

23                  “(A) *SUBSIDY ELIGIBLE INDIVIDUAL DE-*  
24                  *FINED.—For purposes of this section, subject to*



1           *subparagraph (D), the term ‘subsidy eligible in-*  
2           *dividual’ means an individual who—*

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

6                     *“(ii) has income below 150 percent of*  
7                     *the Federal poverty line; and*

8                     *“(iii) meets the resources requirement*  
9                     *described in subparagraph (D) .*

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



1                   “(C) *INCOME DETERMINATIONS.*—*For pur-*  
2                   *poses of applying this section—*

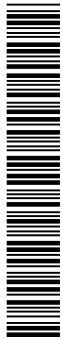
3                   “*(i) income shall be determined in the*  
4                   *manner described in section 1905(p)(1)(B);*  
5                   *and*

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

13                  “(D) *RESOURCE STANDARD APPLIED TO BE*  
14                  *BASED ON TWICE SSI RESOURCE STANDARD.*—  
15                  *The resource requirement of this subparagraph is*  
16                  *that an individual’s resources (as determined*  
17                  *under section 1613 for purposes of the supple-*  
18                  *mental security income program) do not*  
19                  *exceed—*

20                  “*(i) for 2006 twice the maximum*  
21                  *amount of resources that an individual may*  
22                  *have and obtain benefits under that pro-*  
23                  *gram; and*

24                  “*(ii) for a subsequent year the resource*  
25                  *limitation established under this clause for*



1           *the previous year increased by the annual*  
2           *percentage increase in the consumer price*  
3           *index (all items; U.S. city average) as of*  
4           *September of such previous year.*

5           *Any resource limitation established under clause*  
6           *(ii) that is not a multiple of \$10 shall be round-*  
7           *ed to the nearest multiple of \$10.*

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

15           “(F) *TREATMENT OF CONFORMING MEDIGAP*  
16           *POLICIES.—For purposes of this section, the term*  
17           *‘qualified prescription drug coverage’ includes a*  
18           *medicare supplemental policy described in sec-*  
19           *tion 1860D–8(b)(4).*

20           “(5) *INDEXING DOLLAR AMOUNTS.—*

21           “(A) *FOR 2007.—The dollar amounts ap-*  
22           *plied under paragraphs (1)(B) for 2007 shall be*  
23           *the dollar amounts specified in such paragraph*  
24           *increased by the annual percentage increase de-*  
25           *scribed in section 1860D–2(b)(5) for 2007.*



1           “(B) *FOR SUBSEQUENT YEARS.*—*The dollar*  
2           *amounts applied under paragraph (1)(B) for a*  
3           *year after 2007 shall be the amounts (under this*  
4           *paragraph) applied under paragraph (1)(B) for*  
5           *the preceding year increased by the annual per-*  
6           *centage increase described in section 1860D-*  
7           *2(b)(5) (relating to growth in medicare prescrip-*  
8           *tion drug costs per beneficiary) for the year in-*  
9           *olved.*

10          “(b) *PREMIUM SUBSIDY AMOUNT.*—

11           “(1) *IN GENERAL.*—*The premium subsidy*  
12           *amount described in this subsection for an individual*  
13           *residing in an area is the benchmark premium*  
14           *amount (as defined in paragraph (2)) for qualified*  
15           *prescription drug coverage offered by the prescription*  
16           *drug plan or the MA-EFFS Rx plan in which the in-*  
17           *dividual is enrolled.*

18           “(2) *BENCHMARK PREMIUM AMOUNT DEFINED.*—  
19           *For purposes of this subsection, the term ‘benchmark*  
20           *premium amount’ means, with respect to qualified*  
21           *prescription drug coverage offered under—*

22           “(A) *a prescription drug plan that—*

23           “(i) *provides standard coverage (or al-*  
24           *ternative prescription drug coverage the ac-*  
25           *tuarial value of which is equivalent to that*



1           *of standard coverage), the premium amount*  
2           *for enrollment under the plan under this*  
3           *part (determined without regard to any*  
4           *subsidy under this section or any late en-*  
5           *rollment penalty under section 1860D-*  
6           *1(c)(2)(B)); or*

7           *“(ii) provides alternative prescription*  
8           *drug coverage the actuarial value of which*  
9           *is greater than that of standard coverage,*  
10          *the premium amount described in clause (i)*  
11          *multiplied by the ratio of (I) the actuarial*  
12          *value of standard coverage, to (II) the actu-*  
13          *arial value of the alternative coverage; or*

14          *“(B) a MA-EFFS Rx plan, the portion of*  
15          *the premium amount that is attributable to stat-*  
16          *utory drug benefits (described in section*  
17          *1853(a)(1)(A)(ii)(II)).*

18          *“(c) RULES IN APPLYING COST-SHARING SUB-*  
19          *SIDIES.—*

20                 *“(1) IN GENERAL.—In applying subsection*  
21                 *(a)(1)(B), nothing in this part shall be construed as*  
22                 *preventing a plan or provider from waiving or reduc-*  
23                 *ing the amount of cost-sharing otherwise applicable.*

24                 *“(2) LIMITATION ON CHARGES.—In the case of*  
25                 *an individual receiving cost-sharing subsidies under*





1        *subsection (a)(1)(B), the PDP sponsor or entity offer-*  
2        *ing a MA-EFFS Rx plan may not charge more than*  
3        *\$5 per prescription.*

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

9            *“(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The*  
10       *Administrator shall provide a process whereby, in the case*  
11       *of an individual who is determined to be a subsidy eligible*  
12       *individual and who is enrolled in prescription drug plan*  
13       *or is enrolled in a MA-EFFS Rx plan—*

14            *“(1) the Administrator provides for a notifica-*  
15       *tion of the PDP sponsor or the entity offering the*  
16       *MA-EFFS Rx plan involved that the individual is el-*  
17       *igible for a subsidy and the amount of the subsidy*  
18       *under subsection (a);*

19            *“(2) the sponsor or entity involved reduces the*  
20       *premiums or cost-sharing otherwise imposed by the*  
21       *amount of the applicable subsidy and submits to the*  
22       *Administrator information on the amount of such re-*  
23       *duction; and*



1           “(3) *the Administrator periodically and on a*  
2           *timely basis reimburses the sponsor or entity for the*  
3           *amount of such reductions.*

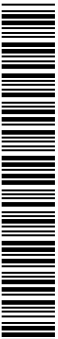
4 *The reimbursement under paragraph (3) with respect to*  
5 *cost-sharing subsidies may be computed on a capitated*  
6 *basis, taking into account the actuarial value of the sub-*  
7 *sidies and with appropriate adjustments to reflect dif-*  
8 *ferences in the risks actually involved.*

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

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

13           “(2) *MEDICAID PROVIDING WRAP AROUND BENE-*  
14 *FITS.—The coverage provided under this part is pri-*  
15 *mary payor to benefits for prescribed drugs provided*  
16 *under the medicaid program under title XIX con-*  
17 *sistent with section 1935(d)(1).*

18           “(3) *COORDINATION.—The Administrator shall*  
19 *develop and implement a plan for the coordination of*  
20 *prescription drug benefits under this part with the*  
21 *benefits provided under the medicaid program under*  
22 *title XIX, with particular attention to insuring co-*  
23 *ordination of payments and prevention of fraud and*  
24 *abuse. In developing and implementing such plan, the*  
25 *Administrator shall involve the Secretary, the States,*



1       *the data processing industry, pharmacists, and phar-*  
2       *maceutical manufacturers, and other experts.*

3       **“SEC. 1860D–8. SUBSIDIES FOR ALL MEDICARE BENE-**  
4                               **FICIARIES FOR QUALIFIED PRESCRIPTION**  
5                               **DRUG COVERAGE.**

6       “(a) *SUBSIDY PAYMENT.*—*In order to reduce premium*  
7       *levels applicable to qualified prescription drug coverage for*  
8       *all medicare beneficiaries consistent with an overall subsidy*  
9       *level of 73 percent, to reduce adverse selection among pre-*  
10       *scription drug plans and MA-EFFS Rx plans, and to pro-*  
11       *mote the participation of PDP sponsors under this part,*  
12       *the Administrator shall provide in accordance with this sec-*  
13       *tion for payment to a qualifying entity (as defined in sub-*  
14       *section (b)) of the following subsidies:*

15               “(1) *DIRECT SUBSIDY.*—*In the case of an en-*  
16       *rollee enrolled for a month in a prescription drug*  
17       *plan or a MA-EFFS Rx plan, a direct subsidy equal*  
18       *to 43 percent of the national average monthly bid*  
19       *amount (computed under subsection (g)) for that*  
20       *month.*

21               “(2) *SUBSIDY THROUGH REINSURANCE.*—*In the*  
22       *case of an enrollee enrolled for a month in a prescrip-*  
23       *tion drug plan or a MA-EFFS Rx plan, the reinsur-*  
24       *ance payment amount (as defined in subsection (c)),*  
25       *which in the aggregate is 30 percent of the total pay-*



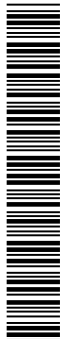
1        *ments made by qualifying entities for standard cov-*  
2        *erage under the respective plan, for excess costs in-*  
3        *curring in providing qualified prescription drug*  
4        *coverage—*

5                *“(A) for enrollees with a prescription drug*  
6                *plan under this part; and*

7                *“(B) for enrollees with a MA-EFFS Rx*  
8                *plan.*

9                *“(3) EMPLOYER AND UNION FLEXIBILITY.—In*  
10        *the case of an individual who is a participant or ben-*  
11        *eficiary in a qualified retiree prescription drug plan*  
12        *(as defined in subsection (f)(1)) and who is not en-*  
13        *rolled in a prescription drug plan or in a MA-EFFS*  
14        *Rx plan, the special subsidy payments under sub-*  
15        *section (f)(3).*

16 *This section constitutes budget authority in advance of ap-*  
17 *propriations Acts and represents the obligation of the Ad-*  
18 *ministrator to provide for the payment of amounts provided*  
19 *under this section. In applying the percentages under para-*  
20 *graphs (1) and (2), there shall be taken into account under*  
21 *the respective paragraphs the portion of the employer and*  
22 *union special subsidy payments under subsection (f)(3) that*  
23 *reflect payments that would have been made under the re-*  
24 *spective paragraphs if such paragraphs had applied to*



1 *qualified retiree prescription drug plans instead of para-*  
2 *graph (3).*

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

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

10              “(2) *An entity that offers a MA-EFFS Rx plan.*

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

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

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

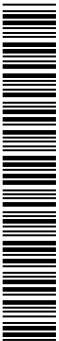
20                      “(A) *REINSURANCE BETWEEN INITIAL REIN-*  
21 *SURANCE THRESHOLD AND THE INITIAL COV-*  
22 *ERAGE LIMIT.*—*For the portion of the individ-*  
23 *ual’s gross covered prescription drug costs (as de-*  
24 *finied in paragraph (3)) for the year that exceeds*  
25 *the initial reinsurance threshold specified in*



1           *paragraph (4), but does not exceed the initial*  
2           *coverage limit specified in section 1860D-*  
3           *2(b)(3), an amount equal to 20 percent of the al-*  
4           *lowable costs (as defined in paragraph (2)) at-*  
5           *tributable to such gross covered prescription drug*  
6           *costs.*

7                   “(B) *REINSURANCE ABOVE ANNUAL OUT-OF-*  
8                   *POCKET THRESHOLD.—For the portion of the in-*  
9                   *dividual’s gross covered prescription drug costs*  
10                  *for the year that exceeds the annual out-of-pocket*  
11                  *threshold specified in 1860D–2(b)(4)(B), an*  
12                  *amount equal to 80 percent of the allowable costs*  
13                  *attributable to such gross covered prescription*  
14                  *drug costs.*

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



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

13           “(4) *INITIAL REINSURANCE THRESHOLD.*—*The*  
14           *initial reinsurance threshold specified in this*  
15           *paragraph—*

16                   “(A) *for 2006, is equal to \$1,000; or*

17                   “(B) *for a subsequent year, is equal to the*  
18                   *payment threshold specified in this paragraph*  
19                   *for the previous year, increased by the annual*  
20                   *percentage increase described in section 1860D-*  
21                   *2(b)(5) for the year involved.*

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



1           “(5) *QUALIFYING COVERED INDIVIDUAL DE-*  
2           *FINED.—For purposes of this subsection, the term*  
3           *‘qualifying covered individual’ means an individual*  
4           *who—*

5                     “(A) *is enrolled with a prescription drug*  
6                     *plan under this part; or*

7                     “(B) *is enrolled with a MA-EFFS Rx plan.*

8           “(d) *ADJUSTMENT OF PAYMENTS.—*

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

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

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

17                            “(ii) *the total payments to be made by*  
18                            *qualifying entities for standard coverage*  
19                            *under plans described in subsection (b) dur-*  
20                            *ing the year.*

21                    “(B) *ADJUSTMENT.—The Administrator*  
22                    *shall proportionally adjust the payments made*  
23                    *under subsections (a)(2) and (c) for a coverage*  
24                    *year in such manner so that the total of the pay-*  
25                    *ments made under such subsections (and under*



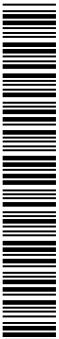


1            *subsection (f)(3) insofar as such payments reflect*  
2            *payments that would have been made under such*  
3            *subsections if such subsections had applied to*  
4            *qualified retiree prescription drug plans instead*  
5            *of subsections (a)(3) and (f)(3)) for the year is*  
6            *equal to 30 percent of the total payments de-*  
7            *scribed in subparagraph (A)(ii).*

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

17           *“(e) PAYMENT METHODS.—*

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



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

4           “(f) *RULES RELATING TO QUALIFIED RETIREE PRE-*  
5           *SCRIPTION DRUG PLAN.*—

6           “(1) *DEFINITION.*—*For purposes of this section,*  
7           *the term ‘qualified retiree prescription drug plan’*  
8           *means employment-based retiree health coverage (as*  
9           *defined in paragraph (4)(A)) if, with respect to an*  
10           *individual who is a participant or beneficiary under*  
11           *such coverage and is eligible to be enrolled in a pre-*  
12           *scription drug plan or a MA-EFFS Rx plan under*  
13           *this part, the following requirements are met:*

14                   “(A) *ACTUARIAL EQUIVALENCE TO STAND-*  
15                   *ARD COVERAGE.*—*The Administrator determines*  
16                   *(based on an actuarial analysis by the Adminis-*  
17                   *trator) that coverage provides at least the same*  
18                   *actuarial value as standard coverage. Such de-*  
19                   *termination may be made on an annual basis.*

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



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

3           “(C) *PROVISION OF CERTIFICATION OF PRE-*  
4           *SCRIPTION DRUG COVERAGE.—The sponsor of the*  
5           *plan shall provide for issuance of certifications*  
6           *of the type described in section 1860D-*  
7           *1(c)(2)(D).*

8           “(2) *LIMITATION ON BENEFIT ELIGIBILITY.—No*  
9           *payment shall be provided under this section with re-*  
10          *spect to a participant or beneficiary in a qualified re-*  
11          *tiree prescription drug plan unless the individual*  
12          *is—*

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

14                   *“(B) is eligible to obtain qualified prescrip-*  
15                   *tion drug coverage under section 1860D-1 but*  
16                   *did not elect such coverage under this part (ei-*  
17                   *ther through a prescription drug plan or through*  
18                   *a MA-EFFS Rx plan).*

19           “(3) *EMPLOYER AND UNION SPECIAL SUBSIDY*  
20          *AMOUNTS.—*

21                   *“(A) IN GENERAL.—For purposes of sub-*  
22                   *section (a), the special subsidy payment amount*  
23                   *under this paragraph for a qualifying covered*  
24                   *retiree(as defined in paragraph (6)) for a cov-*  
25                   *erage year (as defined in subsection (h)) enrolled*



1           *in a qualifying entity described in subsection*  
2           *(b)(3) under a qualified retiree prescription drug*  
3           *plan is, for the portion of the individual's gross*  
4           *covered prescription drug costs for the year that*  
5           *exceeds the deductible amount specified in sub-*  
6           *paragraph (B), an amount equal to, subject to*  
7           *subparagraph (D), 28 percent of the allowable*  
8           *costs attributable to such gross covered prescrip-*  
9           *tion drug costs, but only to the extent such costs*  
10           *exceed the deductible under subparagraph (B)*  
11           *and do not exceed the cost limit under such sub-*  
12           *paragraph in the case of any such individual for*  
13           *the plan year.*

14           “(B) *DEDUCTIBLE AND COST LIMIT APPLI-*  
15           *CABLE.—Subject to subparagraph (C)—*

16                   “(i) *the deductible under this subpara-*  
17                   *graph is equal to \$250 for plan years that*  
18                   *end in 2006; and*

19                   “(ii) *the cost limit under this subpara-*  
20                   *graph is equal to \$5,000 for plan years that*  
21                   *end in 2006.*

22           “(C) *INDEXING.—The deductible and cost*  
23           *limit amounts specified in subparagraphs (B)*  
24           *for a plan year that ends after 2006 shall be ad-*  
25           *justed in the same manner as the annual deduct-*



1            *ible under section 1860D-2(b)(1) is annually ad-*  
2            *justed under such section.*

3            “(D) *ADJUSTMENT CONTINGENCY.—The*  
4            *Secretary may adjust the percentage specified in*  
5            *subparagraph (A) with respect to plan years that*  
6            *end in a year in a manner so that the aggregate*  
7            *expenditures in the year under this section are*  
8            *the same as the aggregate expenditures that*  
9            *would have been made under this section (taking*  
10           *into account the effect of any adjustment under*  
11           *subsection (d)(1)(B)) if paragraphs (1) and (2)*  
12           *of subsection (a) had applied to qualified pre-*  
13           *scription drug coverage instead of this para-*  
14           *graph and subsection (a)(3).*

15           “(4) *RELATED DEFINITIONS.—As used in this*  
16           *section:*

17           “(A) *EMPLOYMENT-BASED RETIREE*  
18           *HEALTH COVERAGE.—The term ‘employment-*  
19           *based retiree health coverage’ means health in-*  
20           *surance or other coverage of health care costs for*  
21           *individuals eligible to enroll in a prescription*  
22           *drug plan or MA-EFFS Rx plan under this part*  
23           *(or for such individuals and their spouses and*  
24           *dependents) under a group health plan (includ-*  
25           *ing such a plan that is established or main-*



1           *tained under or pursuant to one or more collec-*  
2           *tive bargaining agreements) based on their status*  
3           *as retired participants in such plan.*

4           “(B) *QUALIFYING COVERED RETIREE.*—*The*  
5           *term ‘qualifying covered retiree’ means an indi-*  
6           *vidual who is eligible to obtain qualified pre-*  
7           *scription drug coverage under section 1860D–1*  
8           *but did not elect such coverage under this part*  
9           *(either through a prescription drug plan or*  
10           *through a MA-EFFS Rx plan) but is covered*  
11           *under a qualified retiree prescription drug plan.*

12           “(C) *SPONSOR.*—*The term ‘sponsor’ means*  
13           *a plan sponsor, as defined in section 3(16)(B) of*  
14           *the Employee Retirement Income Security Act of*  
15           *1974, except that, in the case of a single-em-*  
16           *ployer plan (as defined in section 3(41) of such*  
17           *Act), such term means the employer of the plan*  
18           *participants if such employer has been des-*  
19           *ignated as the plan sponsor in all prior sum-*  
20           *mary plan descriptions and annual reports*  
21           *issued with respect to the plan under part 1 of*  
22           *subtitle B of title I of such Act.*

23           “(5) *CONSTRUCTION.*—*Nothing in this subsection*  
24           *shall be construed as—*



1           “(A) precluding an individual who is cov-  
2           ered under employment-based retiree health cov-  
3           erage from enrolling in a prescription drug plan  
4           or in a MA-EFFS plan;

5           “(B) precluding such employment-based re-  
6           tiree health coverage or an employer or other  
7           person from paying all or any portion of any  
8           premium required for coverage under such a pre-  
9           scription drug plan or MA-EFFS plan on behalf  
10          of such an individual; or

11          “(C) preventing such employment-based re-  
12          tiree health coverage from providing coverage for  
13          retirees—

14               “(i) who are covered under a qualified  
15               retiree prescription plan that is better than  
16               standard coverage; or

17               “(ii) who are not covered under a  
18               qualified retiree prescription plan but who  
19               are enrolled in a prescription drug plan or  
20               a MA-EFFS Rx plan, that is supplemental  
21               to the benefits provided under such prescrip-  
22               tion drug plan or MA-EFFS Rx plan, ex-  
23               cept that any such supplemental coverage  
24               (not including payment of any premium re-  
25               ferred to in subparagraph (B)) shall be



1                   *treated as primary coverage to which sec-*  
2                   *tion 1862(b)(2)(A)(i) is deemed to apply.*

3           “(g) *COMPUTATION OF NATIONAL AVERAGE MONTHLY*  
4 *BID AMOUNT.—*

5                   “(1) *IN GENERAL.—For each year (beginning*  
6                   *with 2006) the Administrator shall compute a na-*  
7                   *tional average monthly bid amount equal to the aver-*  
8                   *age of the benchmark bid amounts for each prescrip-*  
9                   *tion drug plan and for each MA-EFFS Rx plan (as*  
10                   *computed under paragraph (2), but excluding plans*  
11                   *described in section 1851(a)(2)(C)) adjusted under*  
12                   *paragraph (4) to take into account reinsurance pay-*  
13                   *ments.*

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

18                                   “(A) *a prescription drug plan that—*

19   “(i) *provides standard coverage (or al-*  
20   *ternative prescription drug coverage the ac-*  
21   *tuarial value of which is equivalent to that*  
22   *of standard coverage), the PDP bid; or*

23   “(ii) *provides alternative prescription*  
24   *drug coverage the actuarial value of which*  
25   *is greater than that of standard coverage,*





1           the PDP bid multiplied by the ratio of (I)  
2           the actuarial value of standard coverage, to  
3           (II) the actuarial value of the alternative  
4           coverage; or

5           “(B) a MA-EFFS Rx plan, the portion of  
6           the bid amount that is attributable to statutory  
7           drug benefits (described in section  
8           1853(a)(1)(A)(ii)(II)).

9           For purposes of subparagraph (A), the term ‘PDP  
10          bid’ means, with respect to a prescription drug plan,  
11          the bid amount for enrollment under the plan under  
12          this part (determined without regard to any low-in-  
13          come subsidy under section 1860D-7 or any late en-  
14          rollment penalty under section 1860D-1(c)(2)(B)).

15          “(3) WEIGHTED AVERAGE.—

16                 “(A) IN GENERAL.—The monthly national  
17                 average monthly bid amount computed under  
18                 paragraph (1) shall be a weighted average, with  
19                 the weight for each plan being equal to the aver-  
20                 age number of beneficiaries enrolled under such  
21                 plan in the previous year.

22                 “(B) SPECIAL RULE FOR 2006.—For pur-  
23                 poses of applying this subsection for 2006, the  
24                 Administrator shall establish procedures for de-





1 *the provisions of subsections (b) through (i) of section 1841*  
2 *shall apply to the Trust Fund in the same manner as they*  
3 *apply to the Federal Supplementary Medical Insurance*  
4 *Trust Fund under such section.*

5 “(b) *PAYMENTS FROM TRUST FUND.—*

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

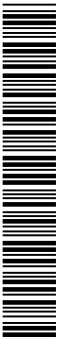
10 “(A) *payments under section 1860D–7 (re-*  
11 *lating to low-income subsidy payments);*

12 “(B) *payments under section 1860D–8 (re-*  
13 *lating to subsidy payments); and*

14 “(C) *payments with respect to administra-*  
15 *tive expenses under this part in accordance with*  
16 *section 201(g).*

17 “(2) *TRANSFERS TO MEDICAID ACCOUNT FOR IN-*  
18 *CREASED ADMINISTRATIVE COSTS.—The Managing*  
19 *Trustee shall transfer from time to time from the*  
20 *Trust Fund to the Grants to States for Medicaid ac-*  
21 *count amounts the Administrator certifies are attrib-*  
22 *utable to increases in payment resulting from the ap-*  
23 *plication of a higher Federal matching percentage*  
24 *under section 1935(b).*

25 “(c) *DEPOSITS INTO TRUST FUND.—*



1           “(1) *LOW-INCOME TRANSFER.*—*There is hereby*  
2           *transferred to the Trust Fund, from amounts appro-*  
3           *propriated for Grants to States for Medicaid, amounts*  
4           *equivalent to the aggregate amount of the reductions*  
5           *in payments under section 1903(a)(1) attributable to*  
6           *the application of section 1935(c).*

7           “(2) *APPROPRIATIONS TO COVER GOVERNMENT*  
8           *CONTRIBUTIONS.*—*There are authorized to be appro-*  
9           *priated from time to time, out of any moneys in the*  
10           *Treasury not otherwise appropriated, to the Trust*  
11           *Fund, an amount equivalent to the amount of pay-*  
12           *ments made from the Trust Fund under subsection*  
13           *(b), reduced by the amount transferred to the Trust*  
14           *Fund under paragraph (1).*

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

20           “**SEC. 1860D-10. DEFINITIONS; APPLICATION TO MEDICARE**  
21                           **ADVANTAGE AND EFFS PROGRAMS; TREAT-**  
22                           **MENT OF REFERENCES TO PROVISIONS IN**  
23                           **PART C.**

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



1           “(1) *COVERED OUTPATIENT DRUGS.*—The term  
2           ‘covered outpatient drugs’ is defined in section  
3           1860D–2(f).

4           “(2) *INITIAL COVERAGE LIMIT.*—The term ‘ini-  
5           tial coverage limit’ means such limit as established  
6           under section 1860D–2(b)(3), or, in the case of cov-  
7           erage that is not standard coverage, the comparable  
8           limit (if any) established under the coverage.

9           “(3) *MEDICARE PRESCRIPTION DRUG TRUST*  
10          *FUND.*—The term ‘Medicare Prescription Drug Trust  
11          Fund’ means the Trust Fund created under section  
12          1860D–9(a).

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

17          “(5) *PRESCRIPTION DRUG PLAN.*—The term ‘pre-  
18          scription drug plan’ means health benefits coverage  
19          that—

20                 “(A) is offered under a policy, contract, or  
21                 plan by a PDP sponsor pursuant to, and in ac-  
22                 cordance with, a contract between the Adminis-  
23                 trator and the sponsor under section 1860D–  
24                 4(b);



1           “(B) provides qualified prescription drug  
2 coverage; and

3           “(C) meets the applicable requirements of  
4 the section 1860D-3 for a prescription drug  
5 plan.

6           “(6) QUALIFIED PRESCRIPTION DRUG COV-  
7 ERAGE.—The term ‘qualified prescription drug cov-  
8 erage’ is defined in section 1860D-2(a).

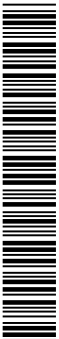
9           “(7) STANDARD COVERAGE.—The term ‘standard  
10 coverage’ is defined in section 1860D-2(b).

11          “(b) OFFER OF QUALIFIED PRESCRIPTION DRUG COV-  
12 ERAGE UNDER MEDICARE ADVANTAGE AND EFFS PRO-  
13 GRAMS.—

14           “(1) AS PART OF MEDICARE ADVANTAGE PLAN.—  
15 Medicare Advantage organizations are required to  
16 offer Medicare Advantage plans that include qualified  
17 prescription drug coverage under part C pursuant to  
18 section 1851(j).

19           “(2) AS PART OF EFFS PLAN.—EFFS organiza-  
20 tions are required to offer EFFS plans that include  
21 qualified prescription drug coverage under part E  
22 pursuant to section 1860E-2(d).

23          “(c) APPLICATION OF PART C PROVISIONS UNDER  
24 THIS PART.—For purposes of applying provisions of part  
25 C under this part with respect to a prescription drug plan



1 *and a PDP sponsor, unless otherwise provided in this part*  
2 *such provisions shall be applied as if—*

3 *“(1) any reference to a Medicare Advantage or*  
4 *other plan included a reference to a prescription drug*  
5 *plan;*

6 *“(2) any reference to a provider-sponsored orga-*  
7 *nization included a reference to a PDP sponsor;*

8 *“(3) any reference to a contract under section*  
9 *1857 included a reference to a contract under section*  
10 *1860D–4(b); and*

11 *“(4) any reference to part C included a reference*  
12 *to this part.*

13 *“(d) REPORT ON PHARMACY SERVICES PROVIDED TO*  
14 *NURSING FACILITY PATIENTS.—*

15 *“(1) REVIEW.—Within 6 months after the date of*  
16 *the enactment of this section, the Secretary shall re-*  
17 *view the current standards of practice for pharmacy*  
18 *services provided to patients in nursing facilities.*

19 *“(2) EVALUATIONS AND RECOMMENDATIONS.—*  
20 *Specifically in the review under paragraph (1), the*  
21 *Secretary shall—*

22 *“(A) assess the current standards of prac-*  
23 *tice, clinical services, and other service require-*  
24 *ments generally utilized for pharmacy services in*  
25 *the long-term care setting;*



1           “(B) evaluate the impact of those standards  
2           with respect to patient safety, reduction of medi-  
3           cation errors and quality of care; and

4           “(C) recommend (in the Secretary’s report  
5           under paragraph (3)) necessary actions and ap-  
6           propriate reimbursement to ensure the provision  
7           of prescription drugs to medicare beneficiaries  
8           residing in nursing facilities in a manner con-  
9           sistent with existing patient safety and quality  
10          of care standards under applicable State and  
11          Federal laws.

12          “(3) REPORT.—The Secretary shall submit a re-  
13          port to the Congress on the Secretary’s findings and  
14          recommendations under this subsection, including a  
15          detailed description of the Secretary’s plans to imple-  
16          ment this part in a manner consistent with applica-  
17          ble State and Federal laws designed to protect the  
18          safety and quality of care of nursing facility pa-  
19          tients.”.

20          (b) ADDITIONAL CONFORMING CHANGES.—

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





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

4                   (A) *by striking “and” at the end of sub-*  
5                   *paragraph (E);*

6                   (B) *by striking the period at the end of sub-*  
7                   *paragraph (F) and inserting “; and”; and*

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

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

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

19           (c) *STUDY ON TRANSITIONING PART B PRESCRIPTION*  
20           *DRUG COVERAGE.—Not later than January 1, 2005, the*  
21           *Medicare Benefits Administrator shall submit a report to*  
22           *Congress that makes recommendations regarding methods*  
23           *for providing benefits under part D of title XVIII of the*  
24           *Social Security Act for outpatient prescription drugs for*  
25           *which benefits are provided under part B of such title.*



1 **SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG**  
2 **COVERAGE UNDER MEDICARE ADVANTAGE**  
3 **AND ENHANCED FEE-FOR-SERVICE (EFFS)**  
4 **PROGRAM.**

5 (a) *MEDICARE ADVANTAGE.*—Section 1851 (42 U.S.C.  
6 1395w–21) is amended by adding at the end the following  
7 new subsection:

8 “(j) *AVAILABILITY OF PRESCRIPTION DRUG BENEFITS*  
9 *AND SUBSIDIES.*—

10 “(1) *OFFERING OF QUALIFIED PRESCRIPTION*  
11 *DRUG COVERAGE.*—A Medicare Advantage organiza-  
12 tion on and after January 1, 2006—

13 “(A) may not offer a Medicare Advantage  
14 plan described in section 1851(a)(2)(A) in an  
15 area unless either that plan (or another Medicare  
16 Advantage plan offered by the organization in  
17 that area) includes qualified prescription drug  
18 coverage; and

19 “(B) may not offer the prescription drug  
20 coverage (other than that required under parts A  
21 and B) to an enrollee under a Medicare Advan-  
22 tage plan, unless such drug coverage is at least  
23 qualified prescription drug coverage and unless  
24 the requirements of this subsection with respect  
25 to such coverage are met.



1           “(2) *REQUIREMENT FOR ELECTION OF PART D*  
2           *COVERAGE TO OBTAIN QUALIFIED PRESCRIPTION*  
3           *DRUG COVERAGE.*—*For purposes of this part, an in-*  
4           *dividual who has not elected qualified prescription*  
5           *drug coverage under section 1860D–1(b) shall be*  
6           *treated as being ineligible to enroll in a Medicare Ad-*  
7           *vantage plan under this part that offers such cov-*  
8           *erage.*

9           “(3) *COMPLIANCE WITH CERTAIN ADDITIONAL*  
10           *BENEFICIARY PROTECTIONS FOR PRESCRIPTION DRUG*  
11           *COVERAGE.*—*With respect to the offering of qualified*  
12           *prescription drug coverage by a Medicare Advantage*  
13           *organization under this part on and after January 1,*  
14           *2006, the organization and plan shall meet the re-*  
15           *quirements of subsections (a) through (d) of section*  
16           *1860D–3 in the same manner as they apply to a*  
17           *PDP sponsor and a prescription drug plan under*  
18           *part D and shall submit to the Administrator the in-*  
19           *formation described in section 1860D–6(a)(2). The*  
20           *Administrator shall waive such requirements to the*  
21           *extent the Administrator determines that such re-*  
22           *quirements duplicate requirements otherwise applica-*  
23           *ble to the organization or plan under this part.*

24           “(4) *AVAILABILITY OF PREMIUM AND COST-SHAR-*  
25           *ING SUBSIDIES.*—*In the case of low-income individ-*



1 *uals who are enrolled in a Medicare Advantage plan*  
2 *that provides qualified prescription drug coverage,*  
3 *premium and cost-sharing subsidies are provided for*  
4 *such coverage under section 1860D–7.*

5 *“(5) AVAILABILITY OF DIRECT AND REINSUR-*  
6 *ANCE SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—*  
7 *Medicare Advantage organizations are provided direct*  
8 *and reinsurance subsidy payments for providing*  
9 *qualified prescription drug coverage under this part*  
10 *under section 1860D–8.*

11 *“(6) CONSOLIDATION OF DRUG AND NON-DRUG*  
12 *PREMIUMS.—In the case of a Medicare Advantage*  
13 *plan that includes qualified prescription drug cov-*  
14 *erage, with respect to an enrollee in such plan there*  
15 *shall be a single premium for both drug and non-drug*  
16 *coverage provided under the plan.*

17 *“(7) TRANSITION IN INITIAL ENROLLMENT PE-*  
18 *RIOD.—Notwithstanding any other provision of this*  
19 *part, the annual, coordinated election period under*  
20 *subsection (e)(3)(B) for 2006 shall be the 6-month pe-*  
21 *riod beginning with November 2005.*

22 *“(8) QUALIFIED PRESCRIPTION DRUG COVERAGE;*  
23 *STANDARD COVERAGE.—For purposes of this part, the*  
24 *terms ‘qualified prescription drug coverage’ and*



1       *'standard coverage' have the meanings given such*  
2       *terms in section 1860D-2.*

3               “(9) *SPECIAL RULES FOR PRIVATE FEE-FOR-*  
4       *SERVICE PLANS.— With respect to a Medicare Advan-*  
5       *tage plan described in section 1851(a)(2)(C) that of-*  
6       *fers qualified prescription drug coverage—*

7               “(A) *REQUIREMENTS REGARDING NEGO-*  
8       *TIATED PRICES.—Subsections (a)(1) and (d)(1)*  
9       *of section 1860D-2 shall not be construed to re-*  
10       *quire the plan to negotiate prices or discounts*  
11       *but shall apply to the extent the plan does so.*

12               “(B) *MODIFICATION OF PHARMACY PARTICI-*  
13       *PATION REQUIREMENT.—If the plan provides ac-*  
14       *cess, without charging additional copayments, to*  
15       *all pharmacies without regard to whether they*  
16       *are participating pharmacies in a network, sec-*  
17       *tion 1860D-3(c)(1)(A)(iii) shall not apply to the*  
18       *plan.*

19               “(C) *DRUG UTILIZATION MANAGEMENT PRO-*  
20       *GRAM NOT REQUIRED.—The requirements of sec-*  
21       *tion 1860D-3(d)(1)(A) shall not apply to the*  
22       *plan.*

23               “(D) *NON-PARTICIPATING PHARMACY DIS-*  
24       *CLOSURE EXCEPTION.—If the plan provides cov-*  
25       *erage for drugs purchased from all pharmacies,*



1           *without entering into contracts or agreements*  
2           *with pharmacies to provide drugs to enrollees*  
3           *covered by the plan, section 1860D-3(d)(5) shall*  
4           *not apply to the plan.”.*

5           ***(b) APPLICATION TO EFFS PLANS.—****Subsection (d) of*  
6 *section 1860E-2, as added by section 201(a), is amended*  
7 *to read as follows:*

8           ***“(d) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS***  
9 ***AND SUBSIDIES.—***

10           ***“(1) OFFERING OF QUALIFIED PRESCRIPTION***  
11 ***DRUG COVERAGE.—****An EFFS organization—*

12                   ***“(A) may not offer an EFFS plan in an***  
13 ***area unless either that plan (or another EFFS***  
14 ***plan offered by the organization in that area)***  
15 ***includes qualified prescription drug coverage;***  
16 ***and***

17                   ***“(B) may not offer the prescription drug***  
18 ***coverage (other than that required under parts A***  
19 ***and B) to an enrollee under an EFFS plan, un-***  
20 ***less such drug coverage is at least qualified pre-***  
21 ***scription drug coverage and unless the require-***  
22 ***ments of this subsection with respect to such cov-***  
23 ***erage are met.***

24           ***“(2) REQUIREMENT FOR ELECTION OF PART D***  
25 ***COVERAGE TO OBTAIN QUALIFIED PRESCRIPTION***



1       *DRUG COVERAGE.—For purposes of this part, an in-*  
2       *dividual who has not elected qualified prescription*  
3       *drug coverage under section 1860D–1(b) shall be*  
4       *treated as being ineligible to enroll in an EFFS plan*  
5       *under this part that offers such coverage.*

6               “(3) *COMPLIANCE WITH CERTAIN ADDITIONAL*  
7       *BENEFICIARY PROTECTIONS FOR PRESCRIPTION DRUG*  
8       *COVERAGE.—With respect to the offering of qualified*  
9       *prescription drug coverage by an EFFS organization*  
10       *under this part, the organization and plan shall meet*  
11       *the requirements of subsections (a) through (d) of sec-*  
12       *tion 1860D–3 in the same manner as they apply to*  
13       *a PDP sponsor and a prescription drug plan under*  
14       *part D and shall submit to the Administrator the in-*  
15       *formation described in section 1860D–6(a)(2). The*  
16       *Administrator shall waive such requirements to the*  
17       *extent the Administrator determines that such re-*  
18       *quirements duplicate requirements otherwise applica-*  
19       *ble to the organization or plan under this part.*

20               “(4) *AVAILABILITY OF PREMIUM AND COST-SHAR-*  
21       *ING SUBSIDIES.—In the case of low-income individ-*  
22       *uals who are enrolled in an EFFS plan that provides*  
23       *qualified prescription drug coverage, premium and*  
24       *cost-sharing subsidies are provided for such coverage*  
25       *under section 1860D–7.*



1           “(5) *AVAILABILITY OF DIRECT AND REINSUR-*  
2           *ANCE SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—*  
3           *EFFS organizations are provided direct and reinsur-*  
4           *ance subsidy payments for providing qualified pre-*  
5           *scription drug coverage under this part under section*  
6           *1860D–8.*

7           “(6) *CONSOLIDATION OF DRUG AND NON-DRUG*  
8           *PREMIUMS.—In the case of an EFFS plan that in-*  
9           *cludes qualified prescription drug coverage, with re-*  
10           *spect to an enrollee in such plan there shall be a sin-*  
11           *gle premium for both drug and non-drug coverage*  
12           *provided under the plan.*

13           “(7) *QUALIFIED PRESCRIPTION DRUG COVERAGE;*  
14           *STANDARD COVERAGE.—For purposes of this part, the*  
15           *terms ‘qualified prescription drug coverage’ and*  
16           *‘standard coverage’ have the meanings given such*  
17           *terms in section 1860D–2.”.*

18           “(c) *CONFORMING AMENDMENTS.—Section 1851 (42*  
19           *U.S.C. 1395w–21) is amended—*

20                   (1) *in subsection (a)(1)—*

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

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





1                   (C) by adding after and below subpara-  
2                   graph (B) the following:

3                   “and may elect qualified prescription drug coverage  
4                   in accordance with section 1860D-1.”; and

5                   (2) in subsection (g)(1), by inserting “and sec-  
6                   tion 1860D-1(c)(2)(B)” after “in this subsection”.

7                   (d) *EFFECTIVE DATE.*—The amendments made by this  
8                   section apply to coverage provided on or after January 1,  
9                   2006.

10 **SEC. 103. MEDICAID AMENDMENTS.**

11                   (a) *DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-*  
12 *COME SUBSIDIES.*—

13                   (1) *REQUIREMENT.*—Section 1902(a) (42 U.S.C.  
14                   1396a(a)) is amended—

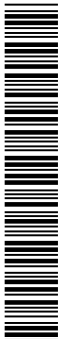
15                   (A) by striking “and” at the end of para-  
16                   graph (64);

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

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

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

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



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

3                   (B) by inserting after section 1934 the fol-  
4                   lowing new section:

5                   “SPECIAL PROVISIONS RELATING TO MEDICARE

6                                   PRESCRIPTION DRUG BENEFIT

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

12                                   “(1) make determinations of eligibility for pre-  
13                   mium and cost-sharing subsidies under (and in ac-  
14                   cordance with) section 1860D-7;

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

18                                   “(3) otherwise provide such Administrator with  
19                   such information as may be required to carry out  
20                   part D of title XVIII (including section 1860D-7).

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

23                                   “(1) IN GENERAL.—The amounts expended by a  
24                   State in carrying out subsection (a) are, subject to  
25                   paragraph (2), expenditures reimbursable under the  
26                   appropriate paragraph of section 1903(a); except



1        *that, notwithstanding any other provision of such sec-*  
2        *tion, the applicable Federal matching rates with re-*  
3        *spect to such expenditures under such section shall be*  
4        *increased as follows (but in no case shall the rate as*  
5        *so increased exceed 100 percent):*

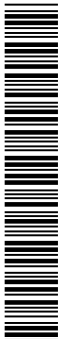
6                *“(A) For expenditures attributable to costs*  
7                *incurred during 2005, the otherwise applicable*  
8                *Federal matching rate shall be increased by 10*  
9                *percent of the percentage otherwise payable (but*  
10               *for this subsection)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

11               *“(B)(i) For expenditures attributable to*  
12               *costs incurred during 2006 and each subsequent*  
13               *year through 2013, the otherwise applicable Fed-*  
14               *eral matching rate shall be increased by the ap-*  
15               *plicable percent (as defined in clause (ii)) of the*  
16               *percentage otherwise payable (but for this sub-*  
17               *section) by the State.*

18               *“(ii) For purposes of clause (i), the ‘appli-*  
19               *cable percent’ for—*

20                        *“(I) 2006 is 20 percent; or*

21                        *“(II) a subsequent year is the applica-*  
22                        *ble percent under this clause for the pre-*  
23                        *vious year increased by 10 percentage*  
24                        *points.*



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

5           “(2) COORDINATION.—The State shall provide  
6           the Administrator with such information as may be  
7           necessary to properly allocate administrative expendi-  
8           tures described in paragraph (1) that may otherwise  
9           be made for similar eligibility determinations.”.

10          (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID  
11          RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-  
12          SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

13                 (1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C.  
14                 1396b(a)(1)) is amended by inserting before the semi-  
15                 colon the following: “, reduced by the amount com-  
16                 puted under section 1935(c)(1) for the State and the  
17                 quarter”.

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

21                 “(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIP-  
22                 TION DRUG COSTS FOR DUALY-ELIGIBLE BENE-  
23                 FIICIARIES.—

24                 “(1) IN GENERAL.—For purposes of section  
25                 1903(a)(1), for a State that is one of the 50 States



1        *or the District of Columbia for a calendar quarter in*  
2        *a year (beginning with 2005) the amount computed*  
3        *under this subsection is equal to the product of the*  
4        *following:*

5                *“(A) MEDICARE SUBSIDIES.—The total*  
6                *amount of payments made in the quarter under*  
7                *section 1860D–7 (relating to premium and cost-*  
8                *sharing prescription drug subsidies for low-in-*  
9                *come medicare beneficiaries) that are attrib-*  
10               *utable to individuals who are residents of the*  
11               *State and are entitled to benefits with respect to*  
12               *prescribed drugs under the State plan under this*  
13               *title (including such a plan operating under a*  
14               *waiver under section 1115).*

15               *“(B) STATE MATCHING RATE.—A propor-*  
16               *tion computed by subtracting from 100 percent*  
17               *the Federal medical assistance percentage (as de-*  
18               *finied in section 1905(b)) applicable to the State*  
19               *and the quarter.*

20               *“(C) PHASE-OUT PROPORTION.—The phase-*  
21               *out proportion (as defined in paragraph (2)) for*  
22               *the quarter.*

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



1                   “(A) 2006 is 93-<sup>1</sup>/<sub>3</sub> percent;

2                   “(B) a subsequent year before 2021, is the  
3                   phase-out proportion for calendar quarters in the  
4                   previous year decreased by 6-<sup>2</sup>/<sub>3</sub> percentage  
5                   points; or

6                   “(C) a year after 2020 is 0 percent.”.

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

10           “(d) *ADDITIONAL PROVISIONS.*—

11                   “(1) *MEDICAID AS SECONDARY PAYOR.*—In the  
12 case of an individual who is entitled to qualified pre-  
13 scription drug coverage under a prescription drug  
14 plan under part D of title XVIII (or under a MA-  
15 EFFS Rx plan under part C or E of such title) and  
16 medical assistance for prescribed drugs under this  
17 title, medical assistance shall continue to be provided  
18 under this title (other than for copayment amounts  
19 specified in section 1860D–7(a)(1)(B), notwith-  
20 standing section 1916) for prescribed drugs to the ex-  
21 tent payment is not made under the prescription drug  
22 plan or MA-EFFS Rx plan selected by the individual.

23                   “(2) *CONDITION.*—A State may require, as a  
24 condition for the receipt of medical assistance under  
25 this title with respect to prescription drug benefits for



1       *an individual eligible to obtain qualified prescription*  
2       *drug coverage described in paragraph (1), that the in-*  
3       *dividual elect qualified prescription drug coverage*  
4       *under section 1860D-1.”.*

5       *(d) TREATMENT OF TERRITORIES.—*

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

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

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

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

15       *“(e) TREATMENT OF TERRITORIES.—*

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

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

20                    *“(B) if the State establishes a plan de-*  
21       *scribed in paragraph (2) (for providing medical*  
22       *assistance with respect to the provision of pre-*  
23       *scription drugs to medicare beneficiaries), the*  
24       *amount otherwise determined under section*  
25       *1108(f) (as increased under section 1108(g)) for*



1           *the State shall be increased by the amount speci-*  
2           *fied in paragraph (3).*

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

5                   “(A) *provides medical assistance with re-*  
6                   *spect to the provision of covered outpatient drugs*  
7                   *(as defined in section 1860D–2(f)) to low-income*  
8                   *medicare beneficiaries; and*

9                   “(B) *assures that additional amounts re-*  
10                   *ceived by the State that are attributable to the*  
11                   *operation of this subsection are used only for*  
12                   *such assistance.*

13           “(3) *INCREASED AMOUNT.—*

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

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

19                           “(ii) *the amount specified in section*  
20                           *1108(g)(1) for that State, divided by the*  
21                           *sum of the amounts specified in such section*  
22                           *for all such States.*

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

25                           “(i) *2006, is equal to \$25,000,000; or*





1                   “(ii) a subsequent year, is equal to the  
2                   aggregate amount specified in this subpara-  
3                   graph for the previous year increased by  
4                   annual percentage increase specified in sec-  
5                   tion 1860D-2(b)(5) for the year involved.

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

11                  (2) CONFORMING AMENDMENT.—Section 1108(f)  
12                  (42 U.S.C. 1308(f)) is amended by inserting “and sec-  
13                  tion 1935(e)(1)(B)” after “Subject to subsection (g)”.

14                  (e) AMENDMENT TO BEST PRICE.—Section  
15                  1927(c)(1)(C)(i) (42 U.S.C. 1396r-8(c)(1)(C)(i)) is  
16                  amended—

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

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

21                  (3) by adding at the end the following new sub-  
22                  clause:

23                                  “(V) any prices charged which are  
24                                  negotiated by a prescription drug plan  
25                                  under part D of title XVIII, by a MA-



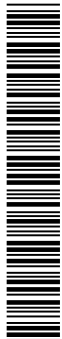
1 *EFFS Rx plan under part C or E of*  
2 *such title with respect to covered out-*  
3 *patient drugs, or by a qualified retiree*  
4 *prescription drug plan (as defined in*  
5 *section 1860D–8(f)(1)) with respect to*  
6 *such drugs on behalf of individuals en-*  
7 *titled to benefits under part A or en-*  
8 *rolled under part B of such title.”.*

9 **SEC. 104. MEDIGAP TRANSITION.**

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

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

13 *“(1) IN GENERAL.—Notwithstanding any other*  
14 *provision of law, except as provided in paragraph (3)*  
15 *no new medicare supplemental policy that provides*  
16 *coverage of expenses for prescription drugs may be*  
17 *issued under this section on or after January 1, 2006,*  
18 *to an individual unless it replaces a medicare supple-*  
19 *mental policy that was issued to that individual and*  
20 *that provided some coverage of expenses for prescrip-*  
21 *tion drugs. Nothing in this subsection shall be con-*  
22 *strued as preventing the policy holder of a medicare*  
23 *supplemental policy issued before January 1, 2006,*  
24 *from continuing to receive benefits under such policy*  
25 *on and after such date.*



1           “(2) *ISSUANCE OF SUBSTITUTE POLICIES FOR*  
2           *BENEFICIARIES ENROLLED WITH A PLAN UNDER PART*  
3           *D.—*

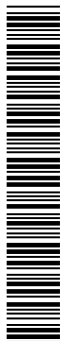
4           “(A) *IN GENERAL.—The issuer of a medi-*  
5           *care supplemental policy—*

6                   “(i) *may not deny or condition the*  
7                   *issuance or effectiveness of a medicare sup-*  
8                   *plemental policy that has a benefit package*  
9                   *classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’, or ‘G’*  
10                   *(under the standards established under sub-*  
11                   *section (p)(2)) and that is offered and is*  
12                   *available for issuance to new enrollees by*  
13                   *such issuer;*

14                   “(ii) *may not discriminate in the pric-*  
15                   *ing of such policy, because of health status,*  
16                   *claims experience, receipt of health care, or*  
17                   *medical condition; and*

18                   “(iii) *may not impose an exclusion of*  
19                   *benefits based on a pre-existing condition*  
20                   *under such policy,*

21                   *in the case of an individual described in sub-*  
22                   *paragraph (B) who seeks to enroll under the pol-*  
23                   *icy not later than 63 days after the date of the*  
24                   *termination of enrollment described in such*  
25                   *paragraph and who submits evidence of the date*



1           *of termination or disenrollment along with the*  
2           *application for such medicare supplemental pol-*  
3           *icy.*

4           “(B) *INDIVIDUAL COVERED.*—*An individual*  
5           *described in this subparagraph is an individual*  
6           *who—*

7                   “(i) *enrolls in a prescription drug*  
8                   *plan under part D; and*

9                   “(ii) *at the time of such enrollment*  
10                  *was enrolled and terminates enrollment in*  
11                  *a medicare supplemental policy which has a*  
12                  *benefit package classified as ‘H’, ‘I’, or ‘J’*  
13                  *under the standards referred to in subpara-*  
14                  *graph (A)(i) or terminates enrollment in a*  
15                  *policy to which such standards do not apply*  
16                  *but which provides benefits for prescription*  
17                  *drugs.*

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

23           “(3) *NEW STANDARDS.*—*In applying subsection*  
24           *(p)(1)(E) (including permitting the NAIC to revise*  
25           *its model regulations in response to changes in law)*



1       *with respect to the change in benefits resulting from*  
2       *title I of the Medicare Prescription Drug and Mod-*  
3       *ernization Act of 2003, with respect to policies issued*  
4       *to individuals who are enrolled in a plan under part*  
5       *D, the changes in standards shall only provide for*  
6       *substituting (for the benefit packages described in*  
7       *paragraph (2)(B)(ii) that included coverage for pre-*  
8       *scription drugs) two benefit packages that may pro-*  
9       *vide for coverage of cost-sharing (other than the pre-*  
10       *scription drug deductible) with respect to qualified*  
11       *prescription drug coverage under such part. The two*  
12       *benefit packages shall be consistent with the following:*

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

17                       “(i) *Coverage of 50 percent of the cost-*  
18                       *sharing otherwise applicable under parts A*  
19                       *and B, except coverage of 100 percent of*  
20                       *any cost-sharing otherwise applicable for*  
21                       *preventive benefits.*

22                       “(ii) *No coverage of the part B deduct-*  
23                       *ible.*



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

4                   “(iv) A limitation on annual out-of-  
5                   pocket expenditures under parts A and B to  
6                   \$4,000 in 2005 (or, in a subsequent year, to  
7                   such limitation for the previous year in-  
8                   creased by an appropriate inflation adjust-  
9                   ment specified by the Secretary).

10                  “(B) SECOND NEW POLICY.—The policy de-  
11                  scribed in this subparagraph has the same bene-  
12                  fits as the policy described in subparagraph (A),  
13                  except as follows:

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

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

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

23                  (b) NAIC REPORT TO CONGRESS ON MEDIGAP MOD-  
24                  ERNIZATION.—The Secretary shall request the National As-  
25                  sociation of Insurance Commissioners to submit to Con-



1 *gress, not later than 18 months after the date of the enact-*  
2 *ment of this Act, a report that includes recommendations*  
3 *on the modernization of coverage under the medigap pro-*  
4 *gram under section 1882 of the Social Security Act (42*  
5 *U.S.C. 1395ss).*

6 **SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD**  
7 **ENDORSEMENT PROGRAM.**

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

10 *“MEDICARE PRESCRIPTION DRUG DISCOUNT CARD*  
11 *ENDORSEMENT PROGRAM*

12 *“SEC. 1807. (a) ESTABLISHMENT OF PROGRAM.—*

13 *“(1) IN GENERAL.—The Secretary (or the Medi-*  
14 *care Benefits Administrator pursuant to section*  
15 *1809(c)(3)(C)) shall establish a program to endorse*  
16 *prescription drug discount card programs (each such*  
17 *program referred to as an ‘endorsed program’) that*  
18 *meet the requirements of this section in order to pro-*  
19 *vide access to prescription drug discounts for medi-*  
20 *care beneficiaries throughout the United States. The*  
21 *Secretary shall make available to medicare bene-*  
22 *ficiaries information regarding endorsed programs*  
23 *under this section.*

24 *“(2) LIMITED PERIOD OF OPERATION.—The Sec-*  
25 *retary shall begin the program under this section as*  
26 *soon as possible, but in no case later than 90 days*



1       *after the date of the enactment of this section. The*  
2       *Secretary shall provide for an appropriate transition*  
3       *and discontinuation of such program at the time*  
4       *medicare prescription drug benefits first become*  
5       *available under part D.*

6       “(b) *REQUIREMENTS FOR CARD ENDORSEMENT PRO-*  
7       *GRAM.—The Secretary may not endorse a prescription drug*  
8       *discount card program under this section unless the pro-*  
9       *gram meets the following requirements:*

10           “(1) *SAVINGS TO MEDICARE BENEFICIARIES.—*  
11       *The program passes on to medicare beneficiaries who*  
12       *enroll in the program discounts, rebates, and other*  
13       *price concessions on prescription drugs, including dis-*  
14       *counts negotiated with pharmacies and manufactur-*  
15       *ers.*

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

19           “(3) *BENEFICIARY SERVICES.—The program*  
20       *provides pharmaceutical support services, such as*  
21       *education and counseling, and services to prevent ad-*  
22       *verse drug interactions.*

23           “(4) *INFORMATION.—The program makes avail-*  
24       *able to medicare beneficiaries through the Internet*  
25       *and otherwise information, including information on*





1 *enrollment fees, prices charged to beneficiaries, and*  
2 *services offered under the program, that the Secretary*  
3 *identifies as being necessary to provide for informed*  
4 *choice by beneficiaries among endorsed programs.*

5 “(5) *DEMONSTRATED EXPERIENCE.*—*The pro-*  
6 *gram is operated directly, or through arrangements*  
7 *with affiliated organization, by an entity that has*  
8 *demonstrated experience and expertise in operating*  
9 *such a program or a similar program.*

10 “(6) *QUALITY ASSURANCE.*—*Such operating en-*  
11 *tity has in place adequate procedures for assuring*  
12 *quality service under the program.*

13 “(7) *ENROLLMENT FEES.*—*The program may*  
14 *charge an annual enrollment fee, but the amount of*  
15 *such annual fee may not exceed \$30. A State may*  
16 *pay some or all of the fee for individuals residing in*  
17 *the State.*

18 “(8) *CONFIDENTIALITY PROTECTIONS.*—*The pro-*  
19 *gram implements policies and procedures to safeguard*  
20 *the use and disclosure of program beneficiaries’ indi-*  
21 *vidually identifiable health information in a manner*  
22 *consistent with the Federal regulations (concerning*  
23 *the privacy of individually identifiable health infor-*  
24 *mation) promulgated under section 264(c) of the*



1       *Health Insurance Portability and Accountability Act*  
2       *of 1996.*

3               “(9) *PERIODIC REPORTS TO SECRETARY.*—*The*  
4       *entity operating the program shall submit to the Sec-*  
5       *retary periodic reports on performance, utilization,*  
6       *finances, and such other matters as the Secretary*  
7       *may specify.*

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

15       *The prices negotiated by a prescription drug discount card*  
16       *program endorsed under this section shall (notwithstanding*  
17       *any other provision of law) not be taken into account for*  
18       *the purposes of establishing the best price under section*  
19       *1927(c)(1)(C).*

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

23               “(1) *PROMOTION OF INFORMED CHOICE.*—*In*  
24       *order to promote informed choice among endorsed*  
25       *prescription drug discount card programs, the Sec-*



1        *retary shall provide for the dissemination of informa-*  
2        *tion which compares the prices and services of such*  
3        *programs in a manner coordinated with the dissemi-*  
4        *nation of educational information on Medicare Ad-*  
5        *vantage plans under part C.*

6            *“(2) OVERSIGHT.—The Secretary shall provide*  
7        *appropriate oversight to ensure compliance of en-*  
8        *dorsed programs with the requirements of this section,*  
9        *including verification and disclosure (upon request)*  
10       *of the discounts and services provided, the amount of*  
11       *dispensing fees recognized, and audits under section*  
12       *1860D–2(d)(3).*

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

18           *“(4) SANCTIONS FOR ABUSIVE PRACTICES.—The*  
19       *Secretary may implement intermediate sanctions or*  
20       *may revoke the endorsement of a program in the case*  
21       *of a program that the Secretary determines no longer*  
22       *meets the requirements of this section or that has en-*  
23       *gaged in false or misleading marketing practices.*

24           *“(5) ENROLLMENT PRACTICES.—A medicare ben-*  
25       *eficiary may not be enrolled in more than one en-*



1        *dorsed program at any time. A medicare beneficiary*  
2        *may change the endorsed program in which the bene-*  
3        *ficiary is enrolled, but may not make such change*  
4        *until the beneficiary has been enrolled in a program*  
5        *for a minimum period of time specified by the Sec-*  
6        *retary.*

7        *“(d) AUTHORIZATION OF APPROPRIATIONS.—There*  
8        *are authorized to be appropriated such sums as may be nec-*  
9        *essary to carry out this section.*

10        *“(e) INTERIM, FINAL REGULATORY AUTHORITY.—In*  
11        *order to carry out this section in a timely manner, the Sec-*  
12        *retary may promulgate regulations that take effect on an*  
13        *interim basis, after notice and pending opportunity for*  
14        *public comment.*

15        *“TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE*  
16        *PROGRAM FOR LOW-INCOME BENEFICIARIES*

17        *“SEC. 1807A. (a) PURPOSE.—The purpose of this sec-*  
18        *tion is to provide low-income medicare beneficiaries with*  
19        *incomes below 150 percent of the Federal poverty level im-*  
20        *mediate assistance in the purchase of covered outpatient*  
21        *prescription drugs during the period before the program*  
22        *under part D becomes effective.*

23        *“(b) APPROPRIATIONS.—For the purpose of carrying*  
24        *out this section, there is appropriated, out of any money*  
25        *in the Treasury not otherwise appropriated—*

26                *“(1) for fiscal year 2004, \$2,000,000,000; and*



1           “(2) for fiscal year 2005, \$3,000,000,000.

2           “(c) *ELIGIBILITY.*—

3           “(1) *IN GENERAL.*—*The Secretary shall establish*  
4 *eligibility standards consistent with this subsection.*

5           “(2) *SPECIFICS.*—*In no case shall an individual*  
6 *be eligible for assistance under this section unless the*  
7 *individual—*

8           “(A) *is entitled to benefits under part A or*  
9 *enrolled under part B;*

10           “(B) *has income that is at or below 150*  
11 *percent of the Federal poverty line;*

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

14           “(D) *is enrolled under a prescription drug*  
15 *discount card program under section 1807 (or*  
16 *under an alternative program authorized under*  
17 *subsection (d)(2)); and*

18           “(E) *is not eligible for coverage of, or assist-*  
19 *ance for, outpatient prescription drugs under*  
20 *any of the following:*

21           “(i) *A medicaid plan under title XIX*  
22 *(including under any waiver approved*  
23 *under section 1115).*

24           “(ii) *Enrollment under a group health*  
25 *plan or health insurance coverage.*



1                   “(iii) *Enrollment under a medicare*  
2                   *supplemental insurance policy.*

3                   “(iv) *Chapter 55 of title 10, United*  
4                   *States Code (relating to medical and dental*  
5                   *care for members of the uniformed services).*

6                   “(v) *Chapter 17 of title 38, United*  
7                   *States Code (relating to Veterans’ medical*  
8                   *care).*

9                   “(vi) *Enrollment under a plan under*  
10                   *chapter 89 of title 5, United States Code*  
11                   *(relating to the Federal employees’ health*  
12                   *benefits program).*

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

15                   “(d) *FORM OF ASSISTANCE.—*

16                   “(1) *IN GENERAL.—Subject to paragraph (2), the*  
17                   *assistance under this section to an eligible individual*  
18                   *shall be in such form as the Secretary shall specify,*  
19                   *including the use of a debit card mechanism to pay*  
20                   *for drugs purchased through the use of the prescrip-*  
21                   *tion drug discount card program to eligible individ-*  
22                   *uals who are enrolled in such program.*

23                   “(2) *THROUGH ALTERNATIVE STATE PRO-*  
24                   *GRAM.—A State may apply to the Secretary for au-*  
25                   *thorization to provide the assistance under this sec-*



1        *tion to an eligible individual through a State phar-*  
2        *maceutical assistance program or private program of*  
3        *pharmaceutical assistance. The Secretary shall not*  
4        *authorize the use of such a program unless the Sec-*  
5        *retary finds that the program—*

6                *“(A) was in existence before the date of the*  
7                *enactment of this section; and*

8                *“(B) is reasonably designed to provide for*  
9                *pharmaceutical assistance for a number of indi-*  
10               *viduals, and in a scope, that is not less than the*  
11               *number of individuals, and minimum required*  
12               *amount, that would occur if the provisions of*  
13               *this paragraph had not applied in the State.*

14               *“(3) RELATIONSHIP TO DISCOUNTS.—The assist-*  
15               *ance provided under this section is in addition to the*  
16               *discount otherwise available to individuals enrolled in*  
17               *prescription drug discount card programs who are*  
18               *not eligible individuals.*

19               *“(4) LIMITATION ON ASSISTANCE.—*

20               *“(A) IN GENERAL.—The assistance under*  
21               *this section for an eligible individual shall be*  
22               *limited to assistance—*

23               *“(i) for covered outpatient drugs (as*  
24               *defined for purposes of part D) and for en-*



1 *rollment fees imposed under prescription*  
2 *drug discount card programs; and*

3 *“(ii) for expenses incurred—*

4 *“(I) on and after the date the in-*  
5 *dividual is both enrolled in the pre-*  
6 *scription drug discount card program*  
7 *and determined to be an eligible indi-*  
8 *vidual under this section; and*

9 *“(II) before the date benefits are*  
10 *first available under the program*  
11 *under part D.*

12 *“(B) AUTHORITY.—The Secretary shall take*  
13 *such steps as may be necessary to assure compli-*  
14 *ance with the expenditure limitations described*  
15 *in subsection (b).*

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

17 *“(1) IN GENERAL.—Insofar as assistance is pro-*  
18 *vided under this section through programs under sec-*  
19 *tion 1807, the Secretary shall make payment (within*  
20 *the amounts under subsection (b), less the administra-*  
21 *tive costs relating to determinations of eligibility) to*  
22 *the sponsor of the prescription drug discount card*  
23 *program (or to a State or other entity operating an*  
24 *alternative program under subsection (d)(2)) in*  
25 *which an eligible individual is enrolled of the amount*





1       *of the assistance provided by the sponsor pursuant to*  
2       *this section.*

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

12       “(f) *DEFINITIONS.*—*For purposes of this section:*

13           “(1) *ELIGIBLE INDIVIDUAL.*—*The term ‘eligible*  
14       *individual’ means an individual who is determined*  
15       *by a State to be eligible for assistance under this sec-*  
16       *tion.*

17           “(2) *PRESCRIPTION DRUG DISCOUNT CARD PRO-*  
18       *GRAM.*—*The term ‘prescription drug discount card*  
19       *program’ means such a program that is endorsed*  
20       *under section 1807.*

21           “(3) *SPONSOR.*—*The term ‘sponsor’ means the*  
22       *sponsor of a prescription drug discount card pro-*  
23       *gram, or, in the case of an alternative program au-*  
24       *thorized under subsection (d)(2), the State or other*  
25       *entity operating the program.”.*



1           (b)           *CONFORMING           AMENDMENT.—Section*  
 2 *1927(c)(1)(C)(i)(V) (42 U.S.C. 1396r-8(c)(1)(C)(i)(V)), as*  
 3 *added by section 103(e), is amended by striking “or by a*  
 4 *qualified retiree prescription drug plan (as defined in sec-*  
 5 *tion 1860D-8(f)(1))” and inserting “by a qualified retiree*  
 6 *prescription drug plan (as defined in section 1860D-*  
 7 *8(f)(1)), or by a prescription drug discount card program*  
 8 *endorsed under section 1807”.*

9   **SEC. 106. DISCLOSURE OF RETURN INFORMATION FOR PUR-**  
 10                           **POSES OF CARRYING OUT MEDICARE CATA-**  
 11                           **STROPHIC PRESCRIPTION DRUG PROGRAM.**

12           (a) *IN GENERAL.—Subsection (l) of section 6103 of the*  
 13 *Internal Revenue Code of 1986 (relating to disclosure of re-*  
 14 *turns and return information for purposes other than tax*  
 15 *administration) is amended by adding at the end the fol-*  
 16 *lowing new paragraph:*

17                           “(19) *DISCLOSURE OF RETURN INFORMATION*  
 18                           *FOR PURPOSES OF CARRYING OUT MEDICARE CATA-*  
 19                           *STROPHIC PRESCRIPTION DRUG PROGRAM.—*

20                           “(A) *IN GENERAL.—The Secretary may,*  
 21                           *upon written request from the Secretary of*  
 22                           *Health and Human Services under section*  
 23                           *1860D-2(b)(4)(E)(i) of the Social Security Act,*  
 24                           *disclose to officers and employees of the Depart-*  
 25                           *ment of Health and Human Services with re-*



1           *spect to a specified taxpayer for the taxable year*  
2           *specified by the Secretary of Health and Human*  
3           *Services in such request—*

4                     *“(i) the taxpayer identity information*  
5                     *with respect to such taxpayer, and*

6                     *“(ii) the adjusted gross income of such*  
7                     *taxpayer for the taxable year (or, if less, the*  
8                     *income threshold limit specified in section*  
9                     *1860D–2(b)(4)(D)(ii) for the calendar year*  
10                    *specified by such Secretary in such request).*

11                    *“(B) SPECIFIED TAXPAYER.—For purposes*  
12                    *of this paragraph, the term ‘specified taxpayer’*  
13                    *means any taxpayer who—*

14                             *“(i) is identified by the Secretary of*  
15                             *Health and Human Services in the request*  
16                             *referred to in subparagraph (A), and*

17                             *“(ii) either—*

18                                     *“(I) has an adjusted gross income*  
19                                     *for the taxable year referred to in sub-*  
20                                     *paragraph (A) in excess of the income*  
21                                     *threshold specified in section 1860D–*  
22                                     *2(b)(4)(D)(ii) of such Act for the cal-*  
23                                     *endar year referred to in such subpara-*  
24                                     *graph, or*



1                   “(II) is identified by such Sec-  
2                   retary under subparagraph (A) as  
3                   being an individual who elected to use  
4                   more recent information under section  
5                   1860D-2(b)(4)(D)(v) of such Act.

6                   “(C) JOINT RETURNS.—In the case of a  
7                   joint return, the Secretary shall, for purposes of  
8                   applying this paragraph, treat each spouse as a  
9                   separate taxpayer having an adjusted gross in-  
10                  come equal to one-half of the adjusted gross in-  
11                  come determined with respect to such return.

12                  “(D) RESTRICTION ON USE OF DISCLOSED  
13                  INFORMATION.—Return information disclosed  
14                  under subparagraph (A) may be used by officers  
15                  and employees of the Department of Health and  
16                  Human Services only for the purpose of admin-  
17                  istering the prescription drug benefit under title  
18                  XVIII of the Social Security Act. Such officers  
19                  and employees may disclose the annual out-of-  
20                  pocket threshold which applies to an individual  
21                  under such part to the entity that offers the plan  
22                  referred to in section 1860D-2(b)(4)(E)(ii) of  
23                  such Act in which such individual is enrolled.  
24                  Such sponsor may use such information only for  
25                  purposes of administering such benefit.”.





1 *gram participants, due to the implementation of the*  
2 *medicare prescription drug program under part D of*  
3 *title XVIII of the Social Security Act.*

4 (2) *DEFINITIONS.—For purposes of this section:*

5 (A) *STATE PHARMACEUTICAL ASSISTANCE*  
6 *PROGRAM DEFINED.—The term “State pharma-*  
7 *ceutical assistance program” means a program*  
8 *(other than the medicaid program) operated by*  
9 *a State (or under contract with a State) that*  
10 *provides as of the date of the enactment of this*  
11 *Act assistance to low-income medicare bene-*  
12 *ficiaries for the purchase of prescription drugs.*

13 (B) *PROGRAM PARTICIPANT.—The term*  
14 *“program participant” means a low-income*  
15 *medicare beneficiary who is a participant in a*  
16 *State pharmaceutical assistance program.*

17 (b) *COMPOSITION.—The Commission shall include the*  
18 *following:*

19 (1) *A representative of each governor of each*  
20 *State that the Secretary identifies as operating on a*  
21 *statewide basis a State pharmaceutical assistance*  
22 *program that provides for eligibility and benefits that*  
23 *are comparable or more generous than the low-income*  
24 *assistance eligibility and benefits offered under part*  
25 *D of title XVIII of the Social Security Act.*



1           (2) *Representatives from other States that the*  
2           *Secretary identifies have in operation other State*  
3           *pharmaceutical assistance programs, as appointed by*  
4           *the Secretary.*

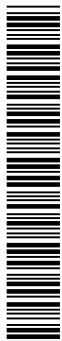
5           (3) *Representatives of organizations that have an*  
6           *inherent interest in program participants or the pro-*  
7           *gram itself, as appointed by the Secretary but not to*  
8           *exceed the number of representatives under para-*  
9           *graphs (1) and (2).*

10          (4) *Representatives of Medicare Advantage orga-*  
11          *nizations and other private health insurance plans, as*  
12          *appointed by the Secretary.*

13          (5) *The Secretary (or the Secretary's designee)*  
14          *and such other members as the Secretary may specify*  
15          *The Secretary shall designate a member to serve as chair*  
16          *of the Commission and the Commission shall meet at the*  
17          *call of the chair.*

18          (c) *DEVELOPMENT OF PROPOSAL.—The Commission*  
19          *shall develop the proposal described in subsection (a) in a*  
20          *manner consistent with the following principles:*

21               (1) *Protection of the interests of program par-*  
22               *ticipants in a manner that is the least disruptive to*  
23               *such participants and that includes a single point of*  
24               *contact for enrollment and processing of benefits.*



1           (2) *Protection of the financial and flexibility in-*  
2           *terests of States so that States are not financially*  
3           *worse off as a result of the enactment of this title.*

4           (3) *Principles of medicare modernization pro-*  
5           *vided under title II of this Act.*

6           (d) *REPORT.—By not later than January 1, 2005, the*  
7           *Commission shall submit to the President and the Congress*  
8           *a report that contains a detailed proposal (including spe-*  
9           *cific legislative or administrative recommendations, if any)*  
10          *and such other recommendations as the Commission deems*  
11          *appropriate.*

12          (e) *SUPPORT.—The Secretary shall provide the Com-*  
13          *mission with the administrative support services necessary*  
14          *for the Commission to carry out its responsibilities under*  
15          *this section.*

16          (f) *TERMINATION.—The Commission shall terminate*  
17          *30 days after the date of submission of the report under*  
18          *subsection (d).*





1 **TITLE II—MEDICARE ENHANCED**  
2 **FEE-FOR-SERVICE AND MEDI-**  
3 **CARE ADVANTAGE PRO-**  
4 **GRAMS; MEDICARE COMPETI-**  
5 **TION**

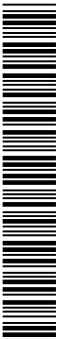
6 **SEC. 200. MEDICARE MODERNIZATION AND REVITALIZA-**  
7 **TION.**

8 *This title provides for—*

9 *(1) establishment of the medicare enhanced fee-*  
10 *for-service (FFFS) program under which medicare*  
11 *beneficiaries are provided access to a range of en-*  
12 *hanced fee-for-service (FFFS) plans that may use*  
13 *preferred provider networks to offer an enhanced*  
14 *range of benefits;*

15 *(2) establishment of a Medicare Advantage pro-*  
16 *gram that offers improved managed care plans with*  
17 *coordinated care; and*

18 *(3) competitive bidding, in the style of the Fed-*  
19 *eral Employees Health Benefits program (FEHBP),*  
20 *among enhanced fee-for-service plans and Medicare*  
21 *Advantage plans in order to promote greater effi-*  
22 *ciency and responsiveness to medicare beneficiaries.*



1       ***Subtitle A—Medicare Enhanced***  
2                   ***Fee-for-Service Program***

3       ***SEC. 201. ESTABLISHMENT OF ENHANCED FEE-FOR-SERV-***  
4                   ***ICE (EFFS) PROGRAM UNDER MEDICARE.***

5           (a) *IN GENERAL.*—*Title XVIII, as amended by section*  
6 *101(a), is amended—*

- 7                   (1) *by redesignating part E as part F; and*  
8                   (2) *by inserting after part D the following new*  
9                   *part:*

10       “*PART E—ENHANCED FEE-FOR-SERVICE PROGRAM*  
11       “*OFFERING OF ENHANCED FEE-FOR-SERVICE PLANS*  
12                   *THROUGHOUT THE UNITED STATES*

13       “*SEC. 1860E–1. (a) ESTABLISHMENT OF PROGRAM.*—

14           “*(1) IN GENERAL.*—*The Administrator shall es-*  
15       *tablish under this part beginning January 1, 2006,*  
16       *an enhanced fee-for-service program under which en-*  
17       *hanced fee-for-service plans (as defined in subsection*  
18       *(b)) are offered to EFFS-eligible individuals (as so*  
19       *defined) in EFFS regions throughout the United*  
20       *States.*

21           “*(2) EFFS REGIONS.*—*For purposes of this part*  
22       *the Administrator shall establish EFFS regions*  
23       *throughout the United States by dividing the entire*  
24       *United States into at least 10 such regions. Before es-*  
25       *tablishing such regions, the Administrator shall con-*



1        *duct a market survey and analysis, including an ex-*  
2        *amination of current insurance markets, to determine*  
3        *how the regions should be established. The regions*  
4        *shall be established in a manner to take into consider-*  
5        *ation maximizing full access for all EFFS-eligible in-*  
6        *dividuals, especially those residing in rural areas.*

7        *“(b) DEFINITIONS.—For purposes of this part:*

8                *“(1) EFFS ORGANIZATION.—The ‘EFFS organi-*  
9                *zation’ means an entity that the Administrator cer-*  
10                *tifies as meeting the requirements and standards ap-*  
11                *plicable to such organization under this part.*

12                *“(2) ENHANCED FEE-FOR-SERVICE PLAN; EFFS*  
13                *PLAN.—The terms ‘enhanced fee-for-service plan’ and*  
14                *‘EFFS plan’ mean health benefits coverage offered*  
15                *under a policy, contract, or plan by an EFFS organi-*  
16                *zation pursuant to and in accordance with a contract*  
17                *pursuant to section 1860E–4(c), but only if the plan*  
18                *provides either fee-for-service coverage described in the*  
19                *following subparagraph (A) or preferred provider cov-*  
20                *erage described in the following subparagraph (B):*

21                *“(A) FEE-FOR-SERVICE COVERAGE.—The*  
22                *plan—*

23                        *“(i) reimburses hospitals, physicians,*  
24                        *and other providers at a rate determined by*



1           *the plan on a fee-for-service basis without*  
2           *placing the provider at financial risk;*

3           “(ii) *does not vary such rates for such*  
4           *a provider based on utilization relating to*  
5           *such provider; and*

6           “(iii) *does not restrict the selection of*  
7           *providers among those who are lawfully au-*  
8           *thorized to provide the covered services and*  
9           *agree to accept the terms and conditions of*  
10          *payment established by the plan.*

11          “(B) *PREFERRED PROVIDER COVERAGE.—*

12          *The plan—*

13               “(i) *has a network of providers that*  
14               *have agreed to a contractually specified re-*  
15               *imbursement for covered benefits with the*  
16               *organization offering the plan; and*

17               “(ii) *provides for reimbursement for all*  
18               *covered benefits regardless of whether such*  
19               *benefits are provided within such network of*  
20               *providers.*

21               “(3) *EFFS ELIGIBLE INDIVIDUAL.—The term*  
22               *‘EFFS eligible individual’ means an eligible indi-*  
23               *vidual described in section 1851(a)(3).*

24               “(4) *EFFS REGION.—The term ‘EFFS region’*  
25               *means a region established under subsection (a)(2).*



1           “(c) *APPLICATION OF CERTAIN ELIGIBILITY, ENROLL-*  
2 *MENT, ETC. REQUIREMENTS.*—*The provisions of section*  
3 *1851 (other than subsection (h)(4)(A)) shall apply to EFFS*  
4 *plans offered by an EFFS organization in an EFFS region,*  
5 *including subsection (g) (relating to guaranteed issue and*  
6 *renewal).*

7           “*OFFERING OF ENHANCED FEE-FOR-SERVICE (EFFS) PLANS*

8           “*SEC. 1860E-2. (a) PLAN REQUIREMENTS.*—*No*  
9 *EFFS plan may be offered under this part in an EFFS*  
10 *region unless the requirements of this part are met with*  
11 *respect to the plan and EFFS organization offering the*  
12 *plan.*

13           “(b) *AVAILABLE TO ALL EFFS BENEFICIARIES IN THE*  
14 *ENTIRE REGION.*—*With respect to an EFFS plan offered*  
15 *in an EFFS region—*

16           “*(1) IN GENERAL.*—*The plan must be offered to*  
17 *all EFFS-eligible individuals residing in the region.*

18           “*(2) ASSURING ACCESS TO SERVICES.*—*The plan*  
19 *shall comply with the requirements of section*  
20 *1852(d)(4).*

21           “(c) *BENEFITS.*—

22           “*(1) IN GENERAL.*—*Each EFFS plan shall pro-*  
23 *vide to members enrolled in the plan under this part*  
24 *benefits, through providers and other persons that*  
25 *meet the applicable requirements of this title and part*  
26 *A of title XI—*



1           “(A) for the items and services described in  
2           section 1852(a)(1);

3           “(B) that are uniform for the plan for all  
4           EFFS eligible individuals residing in the same  
5           EFFS region;

6           “(C) that include a single deductible appli-  
7           cable to benefits under parts A and B and in-  
8           clude a catastrophic limit on out-of-pocket ex-  
9           penditures for such covered benefits; and

10           “(D) that include benefits for prescription  
11           drug coverage for each enrollee who elects under  
12           part D to be provided qualified prescription  
13           drug coverage through the plan.

14           “(2) *DISAPPROVAL AUTHORITY.*—*The Adminis-*  
15           *trator shall not approve a plan of an EFFS organi-*  
16           *zation if the Administrator determines (pursuant to*  
17           *the last sentence of section 1852(b)(1)(A)) that the*  
18           *benefits are designed to substantially discourage en-*  
19           *rollment by certain EFFS eligible individuals with*  
20           *the organization.*

21           “(d) *OUTPATIENT PRESCRIPTION DRUG COVERAGE.*—  
22           *For rules concerning the offering of prescription drug cov-*  
23           *erage under EFFS plans, see the amendment made by sec-*  
24           *tion 102(b) of the Medicare Prescription Drug and Mod-*  
25           *ernization Act of 2003.*





1       *EFFS eligible individuals residing in the EFFS re-*  
2       *gion involved.*

3               “(3) *SUBMISSION OF BID AMOUNT INFORMATION*  
4       *BY EFFS ORGANIZATIONS.—*

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

8                       “(i) *The EFFS monthly bid amount*  
9                       *for provision of all items and services under*  
10                      *this part, which amount shall be based on*  
11                      *average costs for a typical beneficiary resid-*  
12                      *ing in the region, and the actuarial basis*  
13                      *for determining such amount.*

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

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

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

23                       “(III) *the provision of non-statu-*  
24                       *tory benefits;*





1                   *and the actuarial basis for determining*  
2                   *such proportions.*

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

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

9                   “(i) *The term ‘statutory non-drug ben-*  
10                  *efits’ means benefits under section*  
11                  *1852(a)(1).*

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

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

17                  “(C) *ACCEPTANCE AND NEGOTIATION OF*  
18                  *BID AMOUNTS.—The Administrator has the au-*  
19                  *thority to negotiate regarding monthly bid*  
20                  *amounts submitted under subparagraph (A)*  
21                  *(and the proportion described in subparagraph*  
22                  *(A)(ii)), and for such purpose, the Administrator*  
23                  *has negotiation authority that the Director of the*  
24                  *Office of Personnel Management has with respect*  
25                  *to health benefits plans under chapter 89 of title*



1           5, *United States Code*. *The Administrator may*  
2           *reject such a bid amount or proportion if the Ad-*  
3           *ministrator determines that such amount or pro-*  
4           *portion is not supported by the actuarial bases*  
5           *provided under subparagraph (A).*

6           “(D) *CONTRACT AUTHORITY.*—*The Admin-*  
7           *istrator may, taking into account the unadjusted*  
8           *EFFS statutory non-drug monthly bid amounts*  
9           *accepted under subparagraph (C), enter into con-*  
10          *tracts for the offering of up to 3 EFFS plans in*  
11          *any region.*

12          “(b) *PROVISION OF BENEFICIARY SAVINGS FOR CER-*  
13          *TAIN PLANS.*—

14                 “(1) *BENEFICIARY REBATE RULE.*—

15                         “(A) *REQUIREMENT.*—*The EFFS plan shall*  
16                         *provide to the enrollee a monthly rebate equal to*  
17                         *75 percent of the average per capita savings (if*  
18                         *any) described in paragraph (2) applicable to*  
19                         *the plan and year involved.*

20                         “(B) *FORM OF REBATE.*—*A rebate required*  
21                         *under this paragraph shall be provided—*

22                                 “(i) *through the crediting of the*  
23                                 *amount of the rebate towards the EFFS*  
24                                 *monthly prescription drug beneficiary pre-*  
25                                 *mium (as defined in section 1860E-*



1                   4(a)(3)(B)) and the *EFFS* monthly supple-  
2                   mental beneficiary premium (as defined in  
3                   section 1860E-4(a)(3)(C));

4                   “*(ii) through a direct monthly pay-*  
5                   *ment (through electronic funds transfer or*  
6                   *otherwise); or*

7                   “*(iii) through other means approved by*  
8                   *the Medicare Benefits Administrator,*  
9                   *or any combination thereof.*

10                  “(2) *COMPUTATION OF AVERAGE PER CAPITA*  
11                  *MONTHLY SAVINGS.—For purposes of paragraph*  
12                  *(1)(A), the average per capita monthly savings re-*  
13                  *ferred to in such paragraph for an EFFS plan and*  
14                  *year is computed as follows:*

15                  “(A) *DETERMINATION OF REGION-WIDE AV-*  
16                  *ERAGE RISK ADJUSTMENT.—*

17                  “(i) *IN GENERAL.—The Medicare Ben-*  
18                  *efits Administrator shall determine, at the*  
19                  *same time rates are promulgated under sec-*  
20                  *tion 1853(b)(1) (beginning with 2006), for*  
21                  *each EFFS region the average of the risk*  
22                  *adjustment factors described in subsection*  
23                  *(c)(3) to be applied to enrollees under this*  
24                  *part in that region. In the case of an EFFS*  
25                  *region in which an EFFS plan was offered*



1           *in the previous year, the Administrator*  
2           *may compute such average based upon risk*  
3           *adjustment factors applied under subsection*  
4           *(c)(3) in that region in a previous year.*

5           “(ii) *TREATMENT OF NEW REGIONS.—*  
6           *In the case of a region in which no EFFS*  
7           *plan was offered in the previous year, the*  
8           *Administrator shall estimate such average.*  
9           *In making such estimate, the Administrator*  
10          *may use average risk adjustment factors ap-*  
11          *plied to comparable EFFS regions or ap-*  
12          *plied on a national basis.*

13          “(B) *DETERMINATION OF RISK ADJUSTED*  
14          *BENCHMARK AND RISK-ADJUSTED BID.—For*  
15          *each EFFS plan offered in an EFFS region, the*  
16          *Administrator shall—*

17                 “(i) *adjust the EFFS region-specific*  
18                 *non-drug monthly benchmark amount (as*  
19                 *defined in paragraph (3)) by the applicable*  
20                 *average risk adjustment factor computed*  
21                 *under subparagraph (A); and*

22                 “(ii) *adjust the unadjusted EFFS stat-*  
23                 *utory non-drug monthly bid amount by*  
24                 *such applicable average risk adjustment fac-*  
25                 *tor.*



1           “(C) *DETERMINATION OF AVERAGE PER*  
2           *CAPITA MONTHLY SAVINGS.—The average per*  
3           *capita monthly savings described in this sub-*  
4           *paragraph is equal to the amount (if any) by*  
5           *which—*

6                     “(i) *the risk-adjusted benchmark*  
7                     *amount computed under subparagraph*  
8                     *(B)(i), exceeds*

9                     “(ii) *the risk-adjusted bid computed*  
10                    *under subparagraph (B)(ii).*

11           “(3) *COMPUTATION OF EFFS REGION-SPECIFIC*  
12           *NON-DRUG MONTHLY BENCHMARK AMOUNT.—For pur-*  
13           *poses of this part, the term ‘EFFS region-specific*  
14           *non-drug monthly benchmark amount’ means, with*  
15           *respect to an EFFS region for a month in a year, an*  
16           *amount equal to  $\frac{1}{12}$  of the average (weighted by num-*  
17           *ber of EFFS eligible individuals in each payment*  
18           *area described in section 1853(d)) of the annual capi-*  
19           *tation rate as calculated under section 1853(c)(1) for*  
20           *that area.*

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

22                     “(1) *NON-DRUG BENEFITS.—Under a contract*  
23                     *under section 1860E-4(c) and subject to section*  
24                     *1853(g) (as made applicable under subsection (d)),*  
25                     *the Administrator shall make monthly payments*

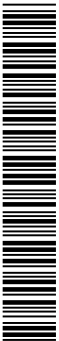


1        *under this subsection in advance to each EFFS orga-*  
2        *nization, with respect to coverage of an individual*  
3        *under this part in an EFFS region for a month, in*  
4        *an amount determined as follows:*

5                *“(A) PLANS WITH BIDS BELOW BENCH-*  
6                *MARK.—In the case of a plan for which there are*  
7                *average per capita monthly savings described in*  
8                *subsection (b)(2)(C), the payment under this sub-*  
9                *section is equal to the unadjusted EFFS statu-*  
10               *tory non-drug monthly bid amount, adjusted*  
11               *under paragraphs (3) and (4), plus the amount*  
12               *of the monthly rebate computed under subsection*  
13               *(b)(1)(A) for that plan and year.*

14               *“(B) PLANS WITH BIDS AT OR ABOVE*  
15               *BENCHMARK.—In the case of a plan for which*  
16               *there are no average per capita monthly savings*  
17               *described in subsection (b)(2)(C), the payment*  
18               *amount under this subsection is equal to the*  
19               *EFFS region-specific non-drug monthly bench-*  
20               *mark amount, adjusted under paragraphs (3)*  
21               *and (4).*

22               *“(2) FOR FEDERAL DRUG SUBSIDIES.—In the*  
23               *case in which an enrollee who elects under part D to*  
24               *be provided qualified prescription drug coverage*



1       *through the plan, the EFFS organization offering*  
2       *such plan also is entitled—*

3               “(A) to direct subsidy payment under sec-  
4               tion 1860D–8(a)(1);

5               “(B) to reinsurance subsidy payments  
6               under section 1860D–8(a)(2); and

7               “(C) to reimbursement for premium and  
8               cost-sharing reductions for low-income individ-  
9               uals under section 1860D–7(c)(3).

10              “(3) *DEMOGRAPHIC RISK ADJUSTMENT, INCLUD-*  
11              *ING ADJUSTMENT FOR HEALTH STATUS.—The Admin-*  
12              *istrator shall adjust under paragraph (1)(A) the*  
13              *unadjusted EFFS statutory non-drug monthly bid*  
14              *amount and under paragraph (1)(B) the EFFS re-*  
15              *gion-specific non-drug monthly benchmark amount*  
16              *for such risk factors as age, disability status, gender,*  
17              *institutional status, and such other factors as the Ad-*  
18              *ministrator determines to be appropriate, including*  
19              *adjustment for health status under section 1853(a)(3)*  
20              *(as applied under subsection (d)), so as to ensure ac-*  
21              *tuarial equivalence. The Administrator may add to,*  
22              *modify, or substitute for such adjustment factors if*  
23              *such changes will improve the determination of actu-*  
24              *arial equivalence.*



1           “(4) *ADJUSTMENT FOR INTRA-REGIONAL GEO-*  
2           *GRAPHIC VARIATIONS.—The Administrator shall also*  
3           *adjust such amounts in a manner to take into ac-*  
4           *count variations in payments rates under part C*  
5           *among the different payment areas under such part*  
6           *included in each EFFS region.*

7           “(d) *APPLICATION OF ADDITIONAL PAYMENT*  
8           *RULES.—The provisions of section 1853 (other than sub-*  
9           *sections (a)(1)(A), (d), and (e)) shall apply to an EFFS*  
10           *plan under this part, except as otherwise provided in this*  
11           *section.*

12           “*PREMIUMS; ORGANIZATIONAL AND FINANCIAL REQUIRE-*  
13           *MENTS; ESTABLISHMENT OF STANDARDS; CONTRACTS*  
14           *WITH EFFS ORGANIZATIONS*

15           “*SEC. 1860E-4. (a) PREMIUMS.—*

16           “(1) *IN GENERAL.—The provisions of section*  
17           *1854 (other than subsections (a)(6)(C) and (h)), in-*  
18           *cluding subsection (b)(5) relating to the consolidation*  
19           *of drug and non-drug beneficiary premiums and sub-*  
20           *section (c) relating to uniform bids and premiums,*  
21           *shall apply to an EFFS plan under this part, subject*  
22           *to paragraph (2).*

23           “(2) *CROSS-WALK.—In applying paragraph (1),*  
24           *any reference in section 1854(b)(1)(A) or 1854(d)*  
25           *to—*





1           “(A) a Medicare Advantage monthly basic  
2 beneficiary premium is deemed a reference to the  
3 *EFFS* monthly basic beneficiary premium (as  
4 defined in paragraph (3)(A));

5           “(B) a Medicare Advantage monthly pre-  
6 scription drug beneficiary premium is deemed a  
7 reference to the *EFFS* monthly prescription drug  
8 beneficiary premium (as defined in paragraph  
9 (3)(B)); and

10          “(C) a Medicare Advantage monthly supple-  
11 mental beneficiary premium is deemed a ref-  
12 erence to the *EFFS* monthly supplemental bene-  
13 ficiary premium (as defined in paragraph  
14 (3)(C)).

15          “(3) *DEFINITIONS.*—For purposes of this part:

16           “(A) *EFFS MONTHLY BASIC BENEFICIARY*  
17 *PREMIUM.*—The term ‘*EFFS* monthly basic ben-  
18 eficiary premium’ means, with respect to an  
19 *EFFS* plan—

20           “(i) described in section 1860E–  
21 3(c)(1)(A) (relating to plans providing re-  
22 bates), zero; or

23           “(ii) described in section 1860E–  
24 3(c)(1)(B), the amount (if any) by which  
25 the unadjusted *EFFS* statutory non-drug



1                   *monthly bid amount exceeds the EFFS re-*  
2                   *gion-specific non-drug monthly benchmark*  
3                   *amount (as defined in section 1860E-*  
4                   *3(b)(3)).*

5                   “(B) *EFFS MONTHLY PRESCRIPTION DRUG*  
6                   *BENEFICIARY PREMIUM.—The term ‘EFFS*  
7                   *monthly prescription drug beneficiary premium’*  
8                   *means, with respect to an EFFS plan, the por-*  
9                   *tion of the aggregate monthly bid amount sub-*  
10                   *mitted under clause (i) of section 1860E-*  
11                   *3(a)(3)(A) for the year that is attributable under*  
12                   *such section to the provision of statutory pre-*  
13                   *scription drug benefits.*

14                   “(C) *EFFS MONTHLY SUPPLEMENTAL BEN-*  
15                   *EFICIARY PREMIUM.—The term ‘EFFS monthly*  
16                   *supplemental beneficiary premium’ means, with*  
17                   *respect to an EFFS plan, the portion of the ag-*  
18                   *gregate monthly bid amount submitted under*  
19                   *clause (i) of section 1860E-3(a)(3)(A) for the*  
20                   *year that is attributable under such section to*  
21                   *the provision of nonstatutory benefits.*

22                   “(b) *ORGANIZATIONAL AND FINANCIAL REQUIRE-*  
23                   *MENTS.—The provisions of section 1855 shall apply to an*  
24                   *EFFS plan offered by an EFFS organization under this*  
25                   *part.*



1           “(c) *CONTRACTS WITH EFFS ORGANIZATIONS.*—The  
2 *provisions of section 1857 shall apply to an EFFS plan*  
3 *offered by an EFFS organization under this part, except*  
4 *that any reference in such section to part C is deemed a*  
5 *reference to this part.*”.

6           (b) *PROHIBITION ON COVERAGE UNDER MEDIGAP*  
7 *PLANS OF DEDUCTIBLE IMPOSED UNDER EFFS PLANS.*—  
8 *Section 1882 (42 U.S.C. 1395ss), as amended by section*  
9 *104(a), is amended by adding at the end the following new*  
10 *subsection:*

11           “(w) *PROHIBITION ON COVERAGE OF DEDUCTIBLE*  
12 *AND CERTAIN COST-SHARING IMPOSED UNDER EFFS*  
13 *PLANS.*—*Notwithstanding any other provision of law, no*  
14 *medicare supplemental policy (other than the 2 benefit*  
15 *packages described in subsection (v)(3)) may provide for*  
16 *coverage of the single deductible or more than 50 percent*  
17 *of other cost-sharing imposed under an EFFS plan under*  
18 *part E.*”.

19           (c) *CONFORMING PROVISIONS.*—*Section 1882 of the*  
20 *Social Security Act (42 U.S.C. 1395ss) shall be adminis-*  
21 *tered as if any reference to a Medicare+Choice organization*  
22 *offering a Medicare+Choice plan under part C of title*  
23 *XVIII of such Act were a reference both to a Medicare Ad-*  
24 *vantage organization offering a Medicare Advantage plan*



1 *under such part and an EFFS organization offering an*  
2 *EFFS plan under part E of such title.*

3 ***Subtitle B—Medicare Advantage***  
4 ***Program***

5 ***CHAPTER 1—IMPLEMENTATION OF***  
6 ***PROGRAM***

7 ***SEC. 211. IMPLEMENTATION OF MEDICARE ADVANTAGE***  
8 ***PROGRAM.***

9 *(a) IN GENERAL.—There is hereby established the*  
10 *Medicare Advantage program. The Medicare Advantage*  
11 *program shall consist of the program under part C of title*  
12 *XVIII of the Social Security Act, as amended by this title.*

13 *(b) REFERENCES.—Any reference to the program*  
14 *under part C of title XVIII of the Social Security Act shall*  
15 *be deemed a reference to the Medicare Advantage program*  
16 *and, with respect to such part, any reference to*  
17 *“Medicare+Choice” is deemed a reference to “Medicare Ad-*  
18 *vantage”.*

19 ***SEC. 212. MEDICARE ADVANTAGE IMPROVEMENTS.***

20 *(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERV-*  
21 *ICE.—*

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



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

3                   “(i) *IN GENERAL.—For 2004, the ad-*  
4                   *justed average per capita cost for the year*  
5                   *involved, determined under section*  
6                   *1876(a)(4) for the Medicare Advantage pay-*  
7                   *ment area for services covered under parts*  
8                   *A and B for individuals entitled to benefits*  
9                   *under part A and enrolled under part B*  
10                   *who are not enrolled in a Medicare Advan-*  
11                   *tage under this part for the year, but ad-*  
12                   *justed to exclude costs attributable to pay-*  
13                   *ments under section 1886(h).*

14                   “(ii) *INCLUSION OF COSTS OF VA AND*  
15                   *DOD MILITARY FACILITY SERVICES TO MEDI-*  
16                   *CARE-ELIGIBLE BENEFICIARIES.—In deter-*  
17                   *mining the adjusted average per capita cost*  
18                   *under clause (i) for a year, such cost shall*  
19                   *be adjusted to include the Secretary’s esti-*  
20                   *mate, on a per capita basis, of the amount*  
21                   *of additional payments that would have*  
22                   *been made in the area involved under this*  
23                   *title if individuals entitled to benefits under*  
24                   *this title had not received services from fa-*



1                    *cilities of the Department of Veterans Af-*  
2                    *fairs or the Department of Defense.”.*

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

6                    (b) *CHANGE IN BUDGET NEUTRALITY FOR BLEND.*—  
7                    *Section 1853(c) (42 U.S.C. 1395w-23(c)) is amended—*

8                    (1) *in paragraph (1)(A), by inserting “(for a*  
9                    *year other than 2004)” after “multiplied”; and*

10                    (2) *in paragraph (5), by inserting “(other than*  
11                    *2004)” after “for each year”.*

12                    (c) *INCREASING MINIMUM PERCENTAGE INCREASE TO*  
13                    *NATIONAL GROWTH RATE.*—

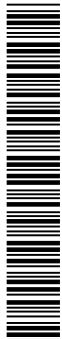
14                    (1) *IN GENERAL.*—*Section 1853(c)(1) (42 U.S.C.*  
15                    *1395w-23(c)(1)) is amended—*

16                    (A) *in subparagraph (B)(iv), by striking*  
17                    *“and each succeeding year” and inserting “,*  
18                    *2003, and 2004”;*

19                    (B) *in subparagraph (C)(iv), by striking*  
20                    *“and each succeeding year” and inserting “and*  
21                    *2003”;* and

22                    (C) *by adding at the end of subparagraph*  
23                    (C) *the following new clause:*

24                    *“(v) For 2004 and each succeeding*  
25                    *year, the greater of—*



1                   “(I) 102 percent of the annual  
2                   *Medicare Advantage* capitation rate  
3                   under this paragraph for the area for  
4                   the previous year; or

5                   “(II) the annual *Medicare Advan-*  
6                   *tage* capitation rate under this para-  
7                   graph for the area for the previous  
8                   year increased by the national per cap-  
9                   ita *Medicare Advantage* growth per-  
10                  centage, described in paragraph (6) for  
11                  that succeeding year, but not taking  
12                  into account any adjustment under  
13                  paragraph (6)(C) for a year before  
14                  2004.”.

15                  (2)       CONFORMING        AMENDMENT.—Section  
16                  1853(c)(6)(C) (42 U.S.C. 1395w-23(c)(6)(C)) is  
17                  amended by inserting before the period at the end the  
18                  following: “, except that for purposes of paragraph  
19                  (1)(C)(v)(II), no such adjustment shall be made for a  
20                  year before 2004”.

21                  (d) INCLUSION OF COSTS OF DOD AND VA MILITARY  
22                  FACILITY SERVICES TO MEDICARE-ELIGIBLE BENE-  
23                  FICIARIES IN CALCULATION OF MEDICARE+CHOICE PAY-  
24                  MENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-  
25                  23(c)(3)) is amended—



1           (1) *in subparagraph (A), by striking “subpara-*  
2 *graph (B)” and inserting “subparagraphs (B) and*  
3 *(E)”*, and

4           (2) *by adding at the end the following new sub-*  
5 *paragraph:*

6                   “(E) *INCLUSION OF COSTS OF DOD AND VA*  
7 *MILITARY FACILITY SERVICES TO MEDICARE-ELI-*  
8 *GIBLE BENEFICIARIES.—In determining the*  
9 *area-specific Medicare+Choice capitation rate*  
10 *under subparagraph (A) for a year (beginning*  
11 *with 2004), the annual per capita rate of pay-*  
12 *ment for 1997 determined under section*  
13 *1876(a)(1)(C) shall be adjusted to include in the*  
14 *rate the Secretary’s estimate, on a per capita*  
15 *basis, of the amount of additional payments that*  
16 *would have been made in the area involved*  
17 *under this title if individuals entitled to benefits*  
18 *under this title had not received services from fa-*  
19 *cilities of the Department of Defense or the De-*  
20 *partment of Veterans Affairs.”.*

21           (e) *EXTENDING SPECIAL RULE FOR CERTAIN INPA-*  
22 *TIENT HOSPITAL STAYS TO REHABILITATION HOS-*  
23 *PITALS.—*

24                   (1) *IN GENERAL.—Section 1853(g) (42 U.S.C.*  
25 *1395w-23(g)) is amended—*





1           (A) by inserting “or from a rehabilitation  
2           facility (as defined in section 1886(j)(1)(A))”  
3           after “1886(d)(1)(B)”; and

4           (B) in paragraph (2)(B), by inserting “or  
5           section 1886(j), as the case may be,” after  
6           “1886(d)”.

7           (2) *EFFECTIVE DATE.*—The amendments made  
8           by paragraph (1) shall apply to contract years begin-  
9           ning on or after January 1, 2004.

10          (f) *MEDPAC STUDY OF AAPCC.*—

11           (1) *STUDY.*—The Medicare Payment Advisory  
12           Commission shall conduct a study that assesses the  
13           method used for determining the adjusted average per  
14           capita cost (AAPCC) under section 1876(a)(4) of the  
15           Social Security Act (42 U.S.C. 1395mm(a)(4)) as ap-  
16           plied under section 1853(c)(1)(A) of such Act (as  
17           amended by subsection (a)). Such study shall include  
18           an examination of—

19           (A) the bases for variation in such costs be-  
20           tween different areas, including differences in  
21           input prices, utilization, and practice patterns;

22           (B) the appropriate geographic area for  
23           payment under the Medicare Advantage program  
24           under part C of title XVIII of such Act; and



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

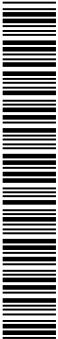
5           (2) *REPORT.—Not later than 18 months after the*  
6           *date of the enactment of this Act, the Commission*  
7           *shall submit to Congress a report on the study con-*  
8           *ducted under paragraph (1).*

9           (g) *REPORT ON IMPACT OF INCREASED FINANCIAL AS-*  
10          *SISTANCE TO MEDICARE ADVANTAGE PLANS.—Not later*  
11          *than July 1, 2006, the Medicare Benefits Administrator*  
12          *shall submit to Congress a report that describes the impact*  
13          *of additional financing provided under this Act and other*  
14          *Acts (including the Medicare, Medicaid, and SCHIP Bal-*  
15          *anced Budget Refinement Act of 1999 and BIPA) on the*  
16          *availability of Medicare Advantage plans in different areas*  
17          *and its impact on lowering premiums and increasing bene-*  
18          *fits under such plans.*

19                   **CHAPTER 2—IMPLEMENTATION OF**  
20                   **COMPETITION PROGRAM**

21           **SEC. 221. COMPETITION PROGRAM BEGINNING IN 2006.**

22           (a) *SUBMISSION OF EFFS-LIKE BIDDING INFORMA-*  
23          *TION BEGINNING IN 2006.—Section 1854 (42 U.S.C.*  
24          *1395w-24) is amended—*



1           (1) *by amending the section heading to read as*  
2 *follows:*

3                   “*PREMIUMS AND BID AMOUNT*”;

4           (2) *in subsection (a)(1)(A)—*

5                   (A) *by striking “(A)” and inserting “(A)(i)*  
6 *if the following year is before 2006,”; and*

7                   (B) *by inserting before the semicolon at the*  
8 *end the following: “or (ii) if the following year*  
9 *is 2006 or later, the information described in*  
10 *paragraph (3) or (6)(A) for the type of plan in-*  
11 *volved”; and*

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

14                   “*(6) SUBMISSION OF BID AMOUNTS BY MEDICARE*  
15 *ADVANTAGE ORGANIZATIONS.—*

16                   “*(A) INFORMATION TO BE SUBMITTED.—*

17                   *The information described in this subparagraph*  
18 *is as follows:*

19                   “*(i) The monthly aggregate bid*  
20 *amount for provision of all items and serv-*  
21 *ices under this part, which amount shall be*  
22 *based on average costs for a typical bene-*  
23 *ficiary residing in the area, and the actu-*  
24 *arial basis for determining such amount.*

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



1                   “(I) *the provision of statutory*  
2                   *non-drug benefits (such portion re-*  
3                   *ferred to in this part as the*  
4                   *‘unadjusted Medicare Advantage statu-*  
5                   *tory non-drug monthly bid amount’);*

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

8                   “(III) *the provision of non-statu-*  
9                   *tory benefits;*

10                  *and the actuarial basis for determining*  
11                  *such proportions.*

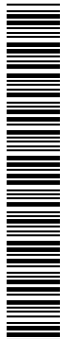
12                  “(iii) *Such additional information as*  
13                  *the Administrator may require to verify the*  
14                  *actuarial bases described in clauses (i) and*  
15                  *(ii).*

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

18                  “(i) *The term ‘statutory non-drug ben-*  
19                  *efits’ means benefits under section*  
20                  *1852(a)(1).*

21                  “(ii) *The term ‘statutory prescription*  
22                  *drug benefits’ means benefits under part D.*

23                  “(iii) *The term ‘statutory benefits’*  
24                  *means statutory prescription drug benefits*  
25                  *and statutory non-drug benefits.*



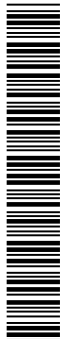
1                   “(C) *ACCEPTANCE AND NEGOTIATION OF*  
2                   *BID AMOUNTS.—*

3                   “(i) *IN GENERAL.—Subject to clause*  
4                   *(ii)—*

5                   “(I) *the Administrator has the au-*  
6                   *thority to negotiate regarding monthly*  
7                   *bid amounts submitted under subpara-*  
8                   *graph (A) (and the proportion de-*  
9                   *scribed in subparagraph (A)(ii)), and*  
10                  *for such purpose and subject to such*  
11                  *clause, the Administrator has negotia-*  
12                  *tion authority that the Director of the*  
13                  *Office of Personnel Management has*  
14                  *with respect to health benefits plans*  
15                  *under chapter 89 of title 5, United*  
16                  *States Code; and*

17                  “(II) *the Administrator may re-*  
18                  *ject such a bid amount or proportion if*  
19                  *the Administrator determines that such*  
20                  *amount or proportion is not supported*  
21                  *by the actuarial bases provided under*  
22                  *subparagraph (A).*

23                  “(ii) *EXCEPTION.—In the case of a*  
24                  *plan described in section 1851(a)(2)(C), the*  
25                  *provisions of clause (i) shall not apply and*



1           *the provisions of paragraph (5)(B), prohib-*  
2           *iting the review, approval, or disapproval of*  
3           *amounts described in such paragraph, shall*  
4           *apply to the negotiation and rejection of the*  
5           *monthly bid amounts and proportion re-*  
6           *ferred to in subparagraph (A).”.*

7           ***(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CER-***  
8           ***TAIN PLANS.—***

9                   ***(1) IN GENERAL.—Section 1854(b) (42 U.S.C.***  
10            ***1395w-24(b)) is amended—***

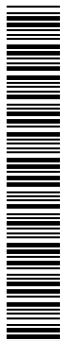
11                           ***(A) by adding at the end of paragraph (1)***  
12            ***the following new subparagraph:***

13                                   ***“(C) BENEFICIARY REBATE RULE.—***

14   ***“(i) REQUIREMENT.—The Medicare***  
15            ***Advantage plan shall provide to the enrollee***  
16            ***a monthly rebate equal to 75 percent of the***  
17            ***average per capita savings (if any) de-***  
18            ***scribed in paragraph (3) applicable to the***  
19            ***plan and year involved.***

20   ***“(iii) FORM OF REBATE.—A rebate re-***  
21            ***quired under this subparagraph shall be***  
22            ***provided—***

23   ***“(I) through the crediting of the***  
24            ***amount of the rebate towards the Medi-***  
25            ***care Advantage monthly supple-***



1                   *mentary beneficiary premium or the*  
2                   *premium imposed for prescription*  
3                   *drug coverage under part D;*

4                   *“(II) through a direct monthly*  
5                   *payment (through electronic funds*  
6                   *transfer or otherwise); or*

7                   *“(III) through other means ap-*  
8                   *proved by the Medicare Benefits Ad-*  
9                   *ministrator,*

10                   *or any combination thereof.”; and*

11                   *(B) by adding at the end the following new*  
12                   *paragraphs:*

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

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

20                   *“(i) IN GENERAL.—The Medicare Ben-*  
21                   *efits Administrator shall determine, at the*  
22                   *same time rates are promulgated under sec-*  
23                   *tion 1853(b)(1) (beginning with 2006), for*  
24                   *each State the average of the risk adjust-*  
25                   *ment factors to be applied under section*



1           1853(a)(1)(A) to payment for enrollees in  
2           that State. In the case of a State in which  
3           a Medicare Advantage plan was offered in  
4           the previous year, the Administrator may  
5           compute such average based upon risk ad-  
6           justment factors applied in that State in a  
7           previous year.

8           “(i) *TREATMENT OF NEW STATES.*—In  
9           the case of a State in which no Medicare  
10          Advantage plan was offered in the previous  
11          year, the Administrator shall estimate such  
12          average. In making such estimate, the Ad-  
13          ministrator may use average risk adjust-  
14          ment factors applied to comparable States  
15          or applied on a national basis.

16          “(B) *DETERMINATION OF RISK ADJUSTED*  
17          *BENCHMARK AND RISK-ADJUSTED BID.*—For  
18          each Medicare Advantage plan offered in a State,  
19          the Administrator shall—

20                 “(i) adjust the Medicare Advantage  
21                 area-specific non-drug monthly benchmark  
22                 amount (as defined in subsection (j)) by the  
23                 applicable average risk adjustment factor  
24                 computed under subparagraph (A); and





1                   “(ii) adjust the unadjusted Medicare  
2                   Advantage statutory non-drug monthly bid  
3                   amount by such applicable average risk ad-  
4                   justment factor.

5                   “(C) DETERMINATION OF AVERAGE PER  
6                   CAPITA MONTHLY SAVINGS.—The average per  
7                   capita monthly savings described in this sub-  
8                   paragraph is equal to the amount (if any) by  
9                   which—

10                   “(i) the risk-adjusted benchmark  
11                   amount computed under subparagraph  
12                   (B)(i), exceeds

13                   “(ii) the risk-adjusted bid computed  
14                   under subparagraph (B)(i).

15                   “(D) AUTHORITY TO DETERMINE RISK AD-  
16                   JUSTMENT FOR AREAS OTHER THAN STATES.—  
17                   The Administrator may provide for the deter-  
18                   mination and application of risk adjustment fac-  
19                   tors under this paragraph on the basis of areas  
20                   other than States.

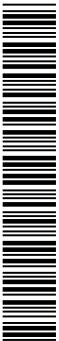
21                   “(4) BENEFICIARY’S OPTION OF PAYMENT  
22                   THROUGH WITHHOLDING FROM SOCIAL SECURITY  
23                   PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER  
24                   MECHANISM.—In accordance with regulations, a  
25                   Medicare Advantage organization shall permit each



1        *enrollee, at the enrollee's option, to make payment of*  
2        *premiums under this part to the organization indi-*  
3        *rectly through withholding from benefit payments in*  
4        *the manner provided under section 1840 with respect*  
5        *to monthly premiums under section 1839 or through*  
6        *an electronic funds transfer mechanism (such as auto-*  
7        *matic charges of an account at a financial institution*  
8        *or a credit or debit card account) or otherwise. All*  
9        *premium payments that are withheld under this*  
10       *paragraph that are credited to the Federal Supple-*  
11       *mentary Medical Insurance Drug Trust Fund shall be*  
12       *paid to the Medicare Advantage organization in-*  
13       *volved.”.*

14                *(2) PROVISION OF SINGLE CONSOLIDATED PRE-*  
15        *MIUM.—Section 1854(b) (42 U.S.C. 1395w-24(b)), as*  
16        *amended by paragraph (1), is further amended by*  
17        *adding at the end the following new paragraph:*

18                *“(5) SINGLE CONSOLIDATED PREMIUM.—In the*  
19        *case of an enrollee in a Medicare Advantage plan who*  
20        *elects under part D to be provided qualified prescrip-*  
21        *tion drug coverage through the plan, the Adminis-*  
22        *trator shall provide a mechanism for the consolida-*  
23        *tion of the beneficiary premium amount for non-drug*  
24        *benefits under this part with the premium amount for*



1       *prescription drug coverage under part D provided*  
2       *through the plan.”.*

3               (3) *COMPUTATION OF MEDICARE ADVANTAGE*  
4       *AREA-SPECIFIC NON-DRUG BENCHMARK.—Section*  
5       *1853 (42 U.S.C. 1395w–23) is amended by adding at*  
6       *the end the following new subsection:*

7       “*(j) COMPUTATION OF MEDICARE ADVANTAGE AREA-*  
8       *SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNT.—*  
9       *For purposes of this part, the term ‘Medicare Advantage*  
10       *area-specific non-drug monthly benchmark amount’ means,*  
11       *with respect to a Medicare Advantage payment area for a*  
12       *month in a year, an amount equal to  $\frac{1}{12}$  of the annual*  
13       *Medicare Advantage capitation rate under section*  
14       *1853(c)(1) for the area for the year.”.*

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

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

20                       “*(i) PAYMENT BEFORE 2006.—For*  
21                       *years before 2006, the payment amount*  
22                       *shall be equal to  $\frac{1}{12}$  of the annual Medicare*  
23                       *Advantage capitation rate (as calculated*  
24                       *under subsection (c)(1)) with respect to that*  
25                       *individual for that area, reduced by the*



1                   *amount of any reduction elected under sec-*  
2                   *tion 1854(f)(1)(E) and adjusted under*  
3                   *clause (iv).*

4                   “(i) *PAYMENT FOR STATUTORY NON-*  
5                   *DRUG BENEFITS BEGINNING WITH 2006.—*  
6                   *For years beginning with 2006—*

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

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



1                   *cific non-drug monthly benchmark*  
2                   *amount, adjusted under clause (iv).*

3                   “(iii) *FOR FEDERAL DRUG SUB-*  
4                   *SIDIES.—In the case in which an enrollee*  
5                   *who elects under part D to be provided*  
6                   *qualified prescription drug coverage through*  
7                   *the plan, the Medicare Advantage organiza-*  
8                   *tion offering such plan also is entitled—*

9                   *“(I) to direct subsidy payment*  
10                   *under section 1860D–8(a)(1);*

11                   *“(II) to reinsurance subsidy pay-*  
12                   *ments under section 1860D–8(a)(2);*  
13                   *and*

14                   *“(III) to reimbursement for pre-*  
15                   *mium and cost-sharing reductions for*  
16                   *low-income individuals under section*  
17                   *1860D–7(c)(3).*

18                   “(iv) *DEMOGRAPHIC ADJUSTMENT, IN-*  
19                   *CLUDING ADJUSTMENT FOR HEALTH STA-*  
20                   *TUS.—The Administrator shall adjust the*  
21                   *payment amount under clause (i), the*  
22                   *unadjusted Medicare Advantage statutory*  
23                   *non-drug monthly bid amount under clause*  
24                   *(ii)(I), and the Medicare Advantage area-*  
25                   *specific non-drug monthly benchmark*



1           *amount under clause (ii)(II) for such risk*  
2           *factors as age, disability status, gender, in-*  
3           *stitutional status, and such other factors as*  
4           *the Administrator determines to be appro-*  
5           *priate, including adjustment for health sta-*  
6           *tus under paragraph (3), so as to ensure ac-*  
7           *tuarial equivalence. The Administrator may*  
8           *add to, modify, or substitute for such ad-*  
9           *justment factors if such changes will im-*  
10           *prove the determination of actuarial equiva-*  
11           *lence.”.*

12           *(d) CONFORMING AMENDMENTS.—*

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

21           *(2) CONFORMING AMENDMENT TO PREMIUM TER-*  
22           *MINOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w-*  
23           *24(b)(2)) is amended by redesignating subparagraph*  
24           *(C) as subparagraph (D) and by striking subpara-*  
25           *graphs (A) and (B) and inserting the following:*



1           “(A) *MEDICARE ADVANTAGE MONTHLY*  
2           *BASIC BENEFICIARY PREMIUM.—The term ‘Medi-*  
3           *care Advantage monthly basic beneficiary pre-*  
4           *mium’ means, with respect to a Medicare Advan-*  
5           *tage plan—*

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

9                     “(ii)       *described        in        section*  
10                    *1853(a)(1)(A)(ii)(II), the amount (if any)*  
11                    *by which the unadjusted Medicare Advan-*  
12                    *tage statutory non-drug monthly bid*  
13                    *amount exceeds the Medicare Advantage*  
14                    *area-specific non-drug monthly benchmark*  
15                    *amount.*

16           “(B) *MEDICARE ADVANTAGE MONTHLY PRE-*  
17           *SCRIPTION DRUG BENEFICIARY PREMIUM.—The*  
18           *term ‘Medicare Advantage monthly prescription*  
19           *drug beneficiary premium’ means, with respect*  
20           *to a Medicare Advantage plan, that portion of*  
21           *the bid amount submitted under clause (i) of*  
22           *subsection (a)(6)(A) for the year that is attrib-*  
23           *utable under such section to the provision of stat-*  
24           *utory prescription drug benefits.*



1                   “(C) *MEDICARE ADVANTAGE MONTHLY SUP-*  
2                   *PLEMENTAL BENEFICIARY PREMIUM.*—*The term*  
3                   *‘Medicare Advantage monthly supplemental ben-*  
4                   *eficiary premium’ means, with respect to a*  
5                   *Medicare Advantage plan, the portion of the ag-*  
6                   *gregate monthly bid amount submitted under*  
7                   *clause (i) of subsection (a)(6)(A) for the year*  
8                   *that is attributable under such section to the pro-*  
9                   *vision of nonstatutory benefits.”.*

10                   (3) *REQUIREMENT FOR UNIFORM PREMIUM AND*  
11                   *BID AMOUNTS.*—*Section 1854(c) (42 U.S.C. 1395w-*  
12                   *24(c)) is amended to read as follows:*

13                   “(c) *UNIFORM PREMIUM AND BID AMOUNTS.*—*The*  
14                   *Medicare Advantage monthly bid amount submitted under*  
15                   *subsection (a)(6), the Medicare Advantage monthly basic,*  
16                   *prescription drug, and supplemental beneficiary premiums,*  
17                   *and the Medicare Advantage monthly MSA premium*  
18                   *charged under subsection (b) of a Medicare Advantage orga-*  
19                   *nization under this part may not vary among individuals*  
20                   *enrolled in the plan.”.*

21                   (4) *PERMITTING BENEFICIARY REBATES.*—

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





1           (B) *Section 1854(d) (42 U.S.C. 1395w-*  
2           *24(d)) is amended by inserting “, except as pro-*  
3           *vided under subsection (b)(1)(C),” after “and*  
4           *may not provide”.*

5           (5) *OTHER CONFORMING AMENDMENTS RELATING*  
6           *TO BIDS.—Section 1854 (42 U.S.C. 1395w-24) is*  
7           *amended—*

8                   (A) *in the heading of subsection (a), by in-*  
9                   *serting “AND BID AMOUNTS” after “PREMIUMS”;*  
10                   *and*

11                   (B) *in subsection (a)(5)(A), by inserting*  
12                   *“paragraphs (2), (3), and (4) of” after “filed*  
13                   *under”.*

14           (e) *ADDITIONAL CONFORMING AMENDMENTS.—*

15                   (1) *ANNUAL DETERMINATION AND ANNOUNCE-*  
16                   *MENT OF CERTAIN FACTORS.—Section 1853(b)(1) (42*  
17                   *U.S.C. 1395w-23(b)(1)) is amended by striking “the*  
18                   *respective calendar year” and all that follows and in-*  
19                   *serting the following: “the calendar year concerned*  
20                   *with respect to each Medicare Advantage payment*  
21                   *area, the following:*

22                           (A) *PRE-COMPETITION INFORMATION.—*  
23                           *For years before 2006, the following:*

24                                   (i) *MEDICARE ADVANTAGE CAPITA-*  
25                                   *TION RATES.—The annual Medicare Advan-*



1                    *tage capitation rate for each Medicare Ad-*  
2                    *vantage payment area for the year.*

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

7                    “(B) *COMPETITION INFORMATION.*—*For*  
8                    *years beginning with 2006, the following:*

9                    “(i) *BENCHMARK.*—*The Medicare Ad-*  
10                    *vantage area-specific non-drug benchmark*  
11                    *under section 1853(j).*

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

19                    (2) *REPEAL OF PROVISIONS RELATING TO AD-*  
20                    *JUSTED COMMUNITY RATE (ACR).*—

21                    (A) *IN GENERAL.*—*Subsections (e) and (f)*  
22                    *of section 1854 (42 U.S.C. 1395w-24) are re-*  
23                    *pealed.*

24                    (B) *CONFORMING AMENDMENTS.*—(i) *Sec-*  
25                    *tion 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is*



1           *amended by striking “, and to reflect” and all*  
2           *that follows and inserting a period.*

3           *(ii) Section 1852(a)(1) (42 U.S.C. 1395w-*  
4           *22(a)(1)) is amended by striking “title XI” and*  
5           *all that follows and inserting the following: “title*  
6           *XI those items and services (other than hospice*  
7           *care) for which benefits are available under parts*  
8           *A and B to individuals residing in the area*  
9           *served by the plan.”.*

10           *(iii) Section 1857(d)(1) (42 U.S.C. 1395w-*  
11           *27(d)(1)) is amended by striking “, costs, and*  
12           *computation of the adjusted community rate”*  
13           *and inserting “and costs”.*

14           *(f) REFERENCES UNDER PART E.—Section 1859 (42*  
15           *U.S.C. 1395w-29) is amended by adding at the end the fol-*  
16           *lowing new subsection:*

17           *“(f) APPLICATION UNDER PART E.—In the case of any*  
18           *reference under part E to a requirement or provision of this*  
19           *part in the relation to an EFFS plan or organization under*  
20           *such part, except as otherwise specified any such require-*  
21           *ment or provision shall be applied to such organization or*  
22           *plan in the same manner as such requirement or provision*  
23           *applies to a Medicare Advantage private fee-for-service plan*  
24           *(and the Medicare Advantage organization that offers such*  
25           *plan) under this part.”.*



1           (g) *EFFECTIVE DATE.*—*The amendments made by this*  
2 *section shall apply to payments and premiums for months*  
3 *beginning with January 2006.*

4           **CHAPTER 3—ADDITIONAL REFORMS**

5           **SEC. 231. MAKING PERMANENT CHANGE IN MEDICARE AD-**  
6                           **VANTAGE REPORTING DEADLINES AND AN-**  
7                           **NUAL, COORDINATED ELECTION PERIOD.**

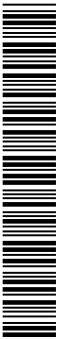
8           (a) *CHANGE IN REPORTING DEADLINE.*—*Section*  
9 *1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by sec-*  
10 *tion 532(b)(1) of the Public Health Security and Bioter-*  
11 *rorism Preparedness and Response Act of 2002, is amended*  
12 *by striking “2002, 2003, and 2004 (or July 1 of each other*  
13 *year)” and inserting “2002 and each subsequent year”.*

14           (b) *DELAY IN ANNUAL, COORDINATED ELECTION PE-*  
15 *RIOD.*—*Section 1851(e)(3)(B) (42 U.S.C. 1395w–*  
16 *21(e)(3)(B)), as amended by section 532(c)(1)(A) of the*  
17 *Public Health Security and Bioterrorism Preparedness and*  
18 *Response Act of 2002, is amended—*

19                   (1) *by striking “and after 2005”; and*

20                   (2) *by striking “, 2004, and 2005” and inserting*  
21 *“and any subsequent year”.*

22           (c) *ANNUAL ANNOUNCEMENT OF PAYMENT RATES.*—  
23 *Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amend-*  
24 *ed by section 532(d)(1) of the Public Health Security and*



1 *Bioterrorism Preparedness and Response Act of 2002, is*  
2 *amended—*

3 (1) *by striking “and after 2005”; and*

4 (2) *by striking “and 2005” and inserting “and*  
5 *each subsequent year”.*

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

12 **SEC. 232. AVOIDING DUPLICATIVE STATE REGULATION.**

13 (a) *IN GENERAL.—Section 1856(b)(3) (42 U.S.C.*  
14 *1395w–26(b)(3)) is amended to read as follows:*

15 “(3) *RELATION TO STATE LAWS.—The standards*  
16 *established under this subsection shall supersede any*  
17 *State law or regulation (other than State licensing*  
18 *laws or State laws relating to plan solvency) with re-*  
19 *spect to Medicare Advantage plans which are offered*  
20 *by Medicare Advantage organizations under this*  
21 *part.”.*

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



1 **SEC. 233. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**  
2 **SPECIAL NEEDS BENEFICIARIES.**

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

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

13 “(4) *SPECIALIZED MEDICARE ADVANTAGE PLANS*  
14 *FOR SPECIAL NEEDS BENEFICIARIES.*—

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

20 “(B) *SPECIAL NEEDS BENEFICIARY.*—*The*  
21 *term ‘special needs beneficiary’ means a Medi-*  
22 *care Advantage eligible individual who—*

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

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

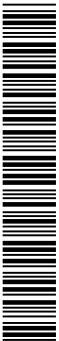


1                   “(iii) meets such requirements as the  
2                   Secretary may determine would benefit  
3                   from enrollment in such a specialized Medi-  
4                   care Advantage plan described in subpara-  
5                   graph (A) for individuals with severe or  
6                   disabling chronic conditions.”.

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

10           “(f) *RESTRICTION ON ENROLLMENT FOR SPECIALIZED*  
11   *MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS BENE-*  
12   *FICIARIES.*—In the case of a specialized Medicare Advan-  
13   tage plan (as defined in subsection (b)(4)), notwithstanding  
14   any other provision of this part and in accordance with  
15   regulations of the Secretary and for periods before January  
16   1, 2007, the plan may restrict the enrollment of individuals  
17   under the plan to individuals who are within one or more  
18   classes of special needs beneficiaries.”.

19           (d) *REPORT TO CONGRESS.*—Not later than December  
20   31, 2005, the Medicare Benefits Administrator shall submit  
21   to Congress a report that assesses the impact of specialized  
22   Medicare Advantage plans for special needs beneficiaries on  
23   the cost and quality of services provided to enrollees. Such  
24   report shall include an assessment of the costs and savings



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

3 *(e) EFFECTIVE DATES.—*

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

7 *(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS*  
8 *FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—*  
9 *No later than 6 months after the date of the enact-*  
10 *ment of this Act, the Secretary shall issue interim*  
11 *final regulations to establish requirements for special*  
12 *needs beneficiaries under section 1859(b)(4)(B)(iii) of*  
13 *the Social Security Act, as added by subsection (b).*

14 **SEC. 234. MEDICARE MSAS.**

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

17 *(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C.*  
18 *1395w-22(e)(1)) is amended by inserting “(other than*  
19 *MSA plans)” after “plans”.*

20 *(2) CONFORMING AMENDMENTS.—Section 1852*  
21 *(42 U.S.C. 1395w-22) is amended—*

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





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

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

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

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

12           (3) by striking the second sentence of subpara-  
13           graph (C).

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

18           (d) *ADDITIONAL AMENDMENT.*—Section 1851(e)(5)(A)  
19 (42 U.S.C. 1395w-21(e)(5)(A)) is amended—

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

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

23           (3) by striking clause (iii).



1 **SEC. 235. EXTENSION OF REASONABLE COST CONTRACTS.**

2 *Subparagraph (C) of section 1876(h)(5) (42 U.S.C.*  
3 *1395mm(h)(5)) is amended to read as follows:*

4 *“(C)(i) Subject to clause (ii), may be extended or re-*  
5 *newed under this subsection indefinitely.*

6 *“(ii) For any period beginning on or after January*  
7 *1, 2008, a reasonable cost reimbursement contract under*  
8 *this subsection may not be extended or renewed for a service*  
9 *area insofar as such area, during the entire previous year,*  
10 *was within the service area of 2 or more plans which were*  
11 *coordinated care Medicare Advantage plans under part C*  
12 *or 2 or more enhanced fee-for-service plans under part E*  
13 *and each of which plan for that previous year for the area*  
14 *involved meets the following minimum enrollment require-*  
15 *ments:*

16 *“(I) With respect to any portion of the area in-*  
17 *volved that is within a Metropolitan Statistical Area*  
18 *with a population of more than 250,000 and counties*  
19 *contiguous to such Metropolitan Statistical Area,*  
20 *5,000 individuals.*

21 *“(II) With respect to any other portion of such*  
22 *area, 1,500 individuals.”.*

23 **SEC. 236. EXTENSION OF MUNICIPAL HEALTH SERVICE**  
24 **DEMONSTRATION PROJECTS.**

25 *Section 9215(a) of the Consolidated Omnibus Budget*  
26 *Reconciliation Act of 1985 (42 U.S.C. 1395b-1 note), as*



1 *amended by section 6135 of the Omnibus Budget Reconcili-*  
2 *ation Act of 1989, section 13557 of the Omnibus Budget*  
3 *Reconciliation Act of 1993, section 4017 of BBA, section*  
4 *534 of BBRA (113 Stat. 1501A–390), and section 633 of*  
5 *BIPA, is amended by striking “December 31, 2004” and*  
6 *inserting “December 31, 2009”.*

7 ***Subtitle C—Application of FEHBP-***  
8 ***Style Competitive Reforms***

9 ***SEC. 241. APPLICATION OF FEHBP-STYLE COMPETITIVE RE-***  
10 ***FORM BEGINNING IN 2010.***

11 *(a) IDENTIFICATION OF COMPETITIVE EFFS REGIONS;*  
12 *COMPUTATION OF COMPETITIVE EFFS NON-DRUG BENCH-*  
13 *MARKS UNDER EFFS PROGRAM.—*

14 *(1) IN GENERAL.—Section 1860E–3, as added by*  
15 *section 201(a), is amended by adding at the end the*  
16 *following new subsection:*

17 *“(e) APPLICATION OF COMPETITION.—*

18 *“(1) DETERMINATION OF COMPETITIVE EFFS RE-*  
19 *GIONS.—*

20 *“(A) IN GENERAL.—For purposes of this*  
21 *part, the term ‘competitive EFFS region’ means,*  
22 *for a year beginning with 2010, an EFFS region*  
23 *that the Administrator finds—*

24 *“(i) there will be offered in the region*  
25 *during the annual, coordinated election pe-*



1                    *riod under section 1851(e)(3)(B) (as ap-*  
2                    *plied under section 1860E-1(c)) before the*  
3                    *beginning of the year at least 2 EFFS plans*  
4                    *(in addition to the fee-for-service program*  
5                    *under parts A and B), each offered by a dif-*  
6                    *ferent EFFS organization and each of*  
7                    *which met the minimum enrollment re-*  
8                    *quirements of paragraph (1) of section*  
9                    *1857(b) (as applied without regard to para-*  
10                   *graph (3) thereof) as of March of the pre-*  
11                   *vious year; and*

12                   *“(ii) during March of the previous*  
13                   *year at least the percentage specified in sub-*  
14                   *paragraph (C) of the number of EFFS eli-*  
15                   *gible individuals who reside in the region*  
16                   *were enrolled in an EFFS plan.*

17                   *“(B) PERCENTAGE SPECIFIED.—*

18                   *“(i) IN GENERAL.—For purposes of*  
19                   *subparagraph (A), subject to clause (ii), the*  
20                   *percentage specified in this subparagraph*  
21                   *for a year is equal the lesser of 20 percent*  
22                   *or to the sum of—*

23                   *“(I) the percentage, as estimated*  
24                   *by the Administrator, of EFFS eligible*  
25                   *individuals in the United States who*



1                   are enrolled in *EFFS* plans during  
2                   March of the previous year; and

3                   “(II) the percentage, as estimated  
4                   by the Administrator, of Medicare Ad-  
5                   vantage eligible individuals in the  
6                   United States who are enrolled in  
7                   Medicare Advantage plans during  
8                   March of the previous year.

9                   “(ii) *EXCEPTION*.—In the case of an  
10                  *EFFS* region that was a competitive *EFFS*  
11                  region for the previous year, the Medicare  
12                  Benefits Administrator may continue to  
13                  treat the region as meeting the requirement  
14                  of subparagraph (A)(ii) if the region would  
15                  meet such requirement but for a *de minimis*  
16                  reduction below the percentage specified in  
17                  clause (i).

18                  “(2) *COMPETITIVE EFFS NON-DRUG MONTHLY*  
19                  *BENCHMARK AMOUNT*.—For purposes of this part, the  
20                  term ‘competitive *EFFS* non-drug monthly bench-  
21                  mark amount’ means, with respect to an *EFFS* re-  
22                  gion for a month in a year and subject to paragraph  
23                  (8), the sum of the 2 components described in para-  
24                  graph (3) for the region and year. The Administrator  
25                  shall compute such benchmark amount for each com-



1        *petitive EFFS region before the beginning of each an-*  
2        *nual, coordinated election period under section*  
3        *1851(e)(3)(B) for each year (beginning with 2010) in*  
4        *which it is designated as such a region.*

5                *“(3) 2 COMPONENTS.—For purposes of para-*  
6        *graph (2), the 2 components described in this para-*  
7        *graph for an EFFS region and a year are the fol-*  
8        *lowing:*

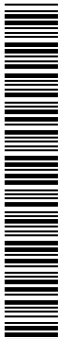
9                *“(A) EFFS COMPONENT.—The product of*  
10        *the following:*

11                *“(i) WEIGHTED AVERAGE OF PLAN*  
12        *BIDS IN REGION.—The weighted average of*  
13        *the EFFS plan bids for the region and year*  
14        *(as determined under paragraph (4)(A)).*

15                *“(ii) NON-FFS MARKET SHARE.—1*  
16        *minus the fee-for-service market share per-*  
17        *centage determined under paragraph (5) for*  
18        *the region and the year.*

19                *“(B) FEE-FOR-SERVICE COMPONENT.—The*  
20        *product of the following:*

21                *“(i) FEE-FOR-SERVICE REGION-SPE-*  
22        *CIFIC NON-DRUG AMOUNT.—The fee-for-serv-*  
23        *ice region-specific non-drug amount (as de-*  
24        *finied in paragraph (6)) for the region and*  
25        *year.*



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

5                   “(4) *DETERMINATION OF WEIGHTED AVERAGE*  
6                   *EFFS PLAN BIDS FOR A REGION.—*

7                   “(A) *IN GENERAL.—For purposes of para-*  
8                   *graph (3)(A)(i), the weighted average of EFFS*  
9                   *plan bids for an EFFS region and a year is the*  
10                   *sum of the following products for EFFS plans*  
11                   *described in subparagraph (C) in the region and*  
12                   *year:*

13                   “(i) *UNADJUSTED EFFS STATUTORY*  
14                   *NON-DRUG MONTHLY BID AMOUNT.—The*  
15                   *unadjusted EFFS statutory non-drug*  
16                   *monthly bid amount (as defined in sub-*  
17                   *section (a)(3)(A)(i)(I)) for the region and*  
18                   *year.*

19                   “(ii) *PLAN’S SHARE OF EFFS ENROLL-*  
20                   *MENT IN REGION.—The number of individ-*  
21                   *uals described in subparagraph (B), divided*  
22                   *by the total number of such individuals for*  
23                   *all EFFS plans described in subparagraph*  
24                   *(C) for that region and year.*



1           “(B) *COUNTING OF INDIVIDUALS.*—*The Ad-*  
2           *ministrators shall count, for each EFFS plan de-*  
3           *scribed in subparagraph (C) for an EFFS region*  
4           *and year, the number of individuals who reside*  
5           *in the region and who were enrolled under such*  
6           *plan under this part during March of the pre-*  
7           *vious year.*

8           “(C) *EXCLUSION OF PLANS NOT OFFERED*  
9           *IN PREVIOUS YEAR.*—*For an EFFS region and*  
10           *year, the EFFS plans described in this subpara-*  
11           *graph are plans that are offered in the region*  
12           *and year and were offered in the region in*  
13           *March of the previous year.*

14           “(5) *COMPUTATION OF FEE-FOR-SERVICE MAR-*  
15           *KET SHARE PERCENTAGE.*—*The Administrator shall*  
16           *determine, for a year and an EFFS region, the pro-*  
17           *portion (in this subsection referred to as the ‘fee-for-*  
18           *service market share percentage’) of the EFFS eligible*  
19           *individuals who are residents of the region during*  
20           *March of the previous year, of such individuals who*  
21           *were not enrolled in an EFFS plan or in a Medicare*  
22           *Advantage plan (or, if greater, such proportion deter-*  
23           *mined for individuals nationally).*

24           “(6) *FEE-FOR-SERVICE REGION-SPECIFIC NON-*  
25           *DRUG AMOUNT.*—





1           “(A) *IN GENERAL.*—For purposes of para-  
2           graph (3)(B)(i) and section 1839(h)(2)(A), sub-  
3           ject to subparagraph (B), the term ‘fee-for-service  
4           region-specific non-drug amount’ means, for a  
5           competitive *EFFS* region and a year, the ad-  
6           justed average per capita cost for the year in-  
7           volved, determined under section 1876(a)(4) for  
8           such region for services covered under parts A  
9           and B for individuals entitled to benefits under  
10          part A and enrolled under this part who are not  
11          enrolled in an *EFFS* plan under part E or a  
12          Medicare Advantage plan under part C for the  
13          year, but adjusted to exclude costs attributable to  
14          payments under section 1886(h).

15           “(B) *INCLUSION OF COSTS OF VA AND DOD*  
16          *MILITARY FACILITY SERVICES TO MEDICARE-ELI-*  
17          *GIBLE BENEFICIARIES.*—In determining the ad-  
18          justed average per capita cost under subpara-  
19          graph (A) for a year, such cost shall be adjusted  
20          to include the Administrator’s estimate, on a per  
21          capita basis, of the amount of additional pay-  
22          ments that would have been made in the region  
23          involved under this title if individuals entitled to  
24          benefits under this title had not received services



1           *from facilities of the Department of Veterans Af-*  
2           *fairs or the Department of Defense.*

3           “(7) *APPLICATION OF COMPETITION.*—*In the case*  
4           *of an EFFS region that is a competitive EFFS re-*  
5           *gion for a year, for purposes of applying subsections*  
6           *(b) and (c)(1) and section 1860E-4(a), any reference*  
7           *to an EFFS region-specific non-drug monthly bench-*  
8           *mark amount shall be treated as a reference to the*  
9           *competitive EFFS non-drug monthly benchmark*  
10           *amount under paragraph (2) for the region and year.*

11           “(8) *PHASE-IN OF BENCHMARK FOR EACH RE-*  
12           *GION.*—

13           “(A) *USE OF BLENDED BENCHMARK.*—*In*  
14           *the case of a region that has not been a competi-*  
15           *tive EFFS region for each of the previous 4*  
16           *years, the competitive EFFS non-drug monthly*  
17           *benchmark amount shall be equal to the sum of*  
18           *the following:*

19           “(i) *NEW COMPETITIVE COMPONENT.*—

20           *The product of—*

21           “(I) *the weighted average phase-in*  
22           *proportion for that area and year, as*  
23           *specified in subparagraph (B); and*

24           “(II) *the competitive EFFS non-*  
25           *drug monthly benchmark amount for*



1 *the region and year, determined under*  
2 *paragraph (2) without regard to this*  
3 *paragraph.*

4 *“(ii) OLD COMPETITIVE COMPONENT.—*

5 *The product of—*

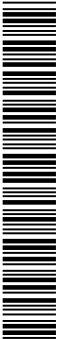
6 *“(I) 1 minus the weighted average*  
7 *phase-in proportion for that region*  
8 *and year; and*

9 *“(II) the EFFS region-specific*  
10 *non-drug benchmark amount for the*  
11 *region and the year.*

12 *“(B) COMPUTATION OF WEIGHTED AVERAGE*  
13 *PHASE-IN PROPORTION.—For purposes of this*  
14 *paragraph, the ‘weighted average phase-in pro-*  
15 *portion’ for an EFFS region for a year shall be*  
16 *determined as follows:*

17 *“(i) FIRST YEAR (AND REGION NOT*  
18 *COMPETITIVE REGION IN PREVIOUS*  
19 *YEAR).—If the area was not a competitive*  
20 *EFFS region in the previous year, the*  
21 *weighted average phase-in proportion for*  
22 *the region for the year is equal to  $\frac{1}{5}$ .*

23 *“(ii) COMPETITIVE REGION IN PRE-*  
24 *VIOUS YEAR.—If the region was a competi-*  
25 *tive EFFS region in the previous year, the*



1 *weighted average phase-in proportion for*  
2 *the region for the year is equal to the*  
3 *weighted average phase-in proportion deter-*  
4 *mined under this subparagraph for the re-*  
5 *gion for the previous year plus  $\frac{1}{5}$ , but in*  
6 *no case more than 1.”.*

7 (2) *CONFORMING AMENDMENTS.—*

8 (A) *Such section 1860E–3 is further*  
9 *amended—*

10 (i) *in subsection (b), by adding at the*  
11 *end the following new paragraph:*

12 “(4) *APPLICATION IN COMPETITIVE RE-*  
13 *GIONS.—For special rules applying this sub-*  
14 *section in competitive EFFS regions, see sub-*  
15 *section (e)(7).”;*

16 (ii) *in subsection (c)(1), by inserting*  
17 *“and subsection (e)(7)” after “(as made ap-*  
18 *plicable under subsection (d))”;* and

19 (iii) *in subsection (d) , by striking*  
20 *“and (e)” and inserting “(e), and (k) ”.*

21 (B) *Section 1860E–4(a)(1), as inserted by*  
22 *section 201(a)(2), is amended by inserting “, ex-*  
23 *cept as provided in section 1860E–3(e)(7)” after*  
24 *“paragraph (2)”.*



1           **(b) IDENTIFICATION OF COMPETITIVE MEDICARE AD-**  
2 **VANTAGE AREAS; APPLICATION OF COMPETITIVE MEDICARE**  
3 **ADVANTAGE NON-DRUG BENCHMARKS UNDER MEDICARE**  
4 **ADVANTAGE PROGRAM.—**

5           **(1) IN GENERAL.—***Section 1853, as amended by*  
6 *section 221(b)(3), is amended by adding at the end*  
7 *the following new subsection:*

8           **“(k) APPLICATION OF COMPETITION.—**

9           **“(1) DETERMINATION OF COMPETITIVE MEDI-**  
10 **CARE ADVANTAGE AREAS.—**

11           **“(A) IN GENERAL.—***For purposes of this*  
12 *part, the terms ‘competitive Medicare Advantage*  
13 *area’ and ‘CMA area’ mean, for a year begin-*  
14 *ning with 2010, an area (which is a metropoli-*  
15 *tan statistical area or other area with a substan-*  
16 *tial number of Medicare Advantage enrollees)*  
17 *that the Administrator finds—*

18           **“(i) there will be offered during the an-**  
19 *nual, coordinated election period under sec-*  
20 *tion 1851(e)(3)(B) under this part before*  
21 *the beginning of the year at least 2 Medi-*  
22 *care Advantage plans (in addition to the*  
23 *fee-for-service program under parts A and*  
24 *B), each offered by a different Medicare Ad-*  
25 *vantage organization and each of which met*



1           *the minimum enrollment requirements of*  
2           *paragraph (1) of section 1857(b) (as ap-*  
3           *plied without regard to paragraph (3)*  
4           *thereof) as of March of the previous year*  
5           *with respect to the area; and*

6                   “(ii) *during March of the previous*  
7                   *year at least the percentage specified in sub-*  
8                   *paragraph (B) of the number of Medicare*  
9                   *Advantage eligible individuals who reside in*  
10                  *the area were enrolled in a Medicare Ad-*  
11                  *vantage plan.*

12                  “(B) *PERCENTAGE SPECIFIED.—*

13                       “(i) *IN GENERAL.—For purposes of*  
14                       *subparagraph (A), subject to clause (ii), the*  
15                       *percentage specified in this subparagraph*  
16                       *for a year is equal the lesser of 20 percent*  
17                       *or to the sum of—*

18                               “(I) *the percentage, as estimated*  
19                               *by the Administrator, of EFFS eligible*  
20                               *individuals in the United States who*  
21                               *are enrolled in EFFS plans during*  
22                               *March of the previous year; and*

23                               “(II) *the percentage, as estimated*  
24                               *by the Administrator, of Medicare Ad-*  
25                               *vantage eligible individuals in the*



1                    *United States who are enrolled in*  
2                    *Medicare Advantage plans during*  
3                    *March of the previous year.*

4                    “(ii) *EXCEPTION.—In the case of an*  
5                    *area that was a competitive area for the*  
6                    *previous year, the Medicare Benefits Ad-*  
7                    *ministrator may continue to treat the area*  
8                    *as meeting the requirement of subparagraph*  
9                    *(A)(ii) if the area would meet such require-*  
10                    *ment but for a de minimis reduction below*  
11                    *the percentage specified in clause (i).*

12                    “(2) *COMPETITIVE MEDICARE ADVANTAGE NON-*  
13                    *DRUG MONTHLY BENCHMARK AMOUNT.—For purposes*  
14                    *of this part, the term ‘competitive Medicare Advan-*  
15                    *tage non-drug monthly benchmark amount’ means,*  
16                    *with respect to a competitive Medicare Advantage*  
17                    *area for a month in a year subject to paragraph (8),*  
18                    *the sum of the 2 components described in paragraph*  
19                    *(3) for the area and year. The Administrator shall*  
20                    *compute such benchmark amount for each competitive*  
21                    *Medicare Advantage area before the beginning of each*  
22                    *annual, coordinated election period under section*  
23                    *1851(e)(3)(B) for each year (beginning with 2010) in*  
24                    *which it is designated as such an area.*



1           “(3) 2 COMPONENTS.—For purposes of para-  
2           graph (2), the 2 components described in this para-  
3           graph for a competitive Medicare Advantage area and  
4           a year are the following:

5                   “(A) MEDICARE ADVANTAGE COMPONENT.—  
6           The product of the following:

7                           “(i) WEIGHTED AVERAGE OF MEDI-  
8                           CARE ADVANTAGE PLAN BIDS IN AREA.—The  
9                           weighted average of the plan bids for the  
10                           area and year (as determined under para-  
11                           graph (4)(A)).

12                           “(ii) NON-FFS MARKET SHARE.—1  
13                           minus the fee-for-service market share per-  
14                           centage, determined under paragraph (5)  
15                           for the area and year.

16                   “(B) FEE-FOR-SERVICE COMPONENT.—The  
17           product of the following:

18                           “(i) FEE-FOR-SERVICE AREA-SPECIFIC  
19                           NON-DRUG AMOUNT.—The fee-for-service  
20                           area-specific non-drug amount (as defined  
21                           in paragraph (6)) for the area and year.

22                           “(ii) FEE-FOR-SERVICE MARKET  
23                           SHARE.—The fee-for-service market share  
24                           percentage, determined under paragraph (5)  
25                           for the area and year.





1           “(4) *DETERMINATION OF WEIGHTED AVERAGE*  
2           *MEDICARE ADVANTAGE BIDS FOR AN AREA.*—

3           “(A) *IN GENERAL.*—*For purposes of para-*  
4           *graph (3)(A)(i), the weighted average of plan*  
5           *bids for an area and a year is the sum of the*  
6           *following products for Medicare Advantage plans*  
7           *described in subparagraph (C) in the area and*  
8           *year:*

9           “(i) *MONTHLY MEDICARE ADVANTAGE*  
10           *STATUTORY NON-DRUG BID AMOUNT.*—*The*  
11           *unadjusted Medicare Advantage statutory*  
12           *non-drug monthly bid amount.*

13           “(ii) *PLAN’S SHARE OF MEDICARE AD-*  
14           *VANTAGE ENROLLMENT IN AREA.*—*The*  
15           *number of individuals described in subpara-*  
16           *graph (B), divided by the total number of*  
17           *such individuals for all Medicare Advantage*  
18           *plans described in subparagraph (C) for*  
19           *that area and year.*

20           “(B) *COUNTING OF INDIVIDUALS.*—*The Ad-*  
21           *ministrators shall count, for each Medicare Ad-*  
22           *vantage plan described in subparagraph (C) for*  
23           *an area and year, the number of individuals*  
24           *who reside in the area and who were enrolled*



1           *under such plan under this part during March*  
2           *of the previous year.*

3           “(C) *EXCLUSION OF PLANS NOT OFFERED*  
4           *IN PREVIOUS YEAR.—For an area and year, the*  
5           *Medicare Advantage plans described in this sub-*  
6           *paragraph are plans described in the first sen-*  
7           *tence of section 1851(a)(2)(A) that are offered in*  
8           *the area and year and were offered in the area*  
9           *in March of the previous year.*

10          “(5) *COMPUTATION OF FEE-FOR-SERVICE MAR-*  
11          *KET SHARE PERCENTAGE.—The Administrator shall*  
12          *determine, for a year and a competitive Medicare Ad-*  
13          *vantage area, the proportion (in this subsection re-*  
14          *ferred to as the ‘fee-for-service market share percent-*  
15          *age’) of Medicare Advantage eligible individuals re-*  
16          *siding in the area who during March of the previous*  
17          *year were not enrolled in a Medicare Advantage plan*  
18          *or in an EFFS plan (or, if greater, such proportion*  
19          *determined for individuals nationally).*

20          “(6) *FEE-FOR-SERVICE AREA-SPECIFIC NON-*  
21          *DRUG AMOUNT.—*

22          “(A) *IN GENERAL.—For purposes of para-*  
23          *graph (3)(B)(i) and section 1839(h)(1)(A), sub-*  
24          *ject to subparagraph (B), the term ‘fee-for-service*  
25          *area-specific non-drug amount’ means, for a*



1           *competitive Medicare Advantage area and a*  
2           *year, the adjusted average per capita cost for the*  
3           *year involved, determined under section*  
4           *1876(a)(4) for such area for services covered*  
5           *under parts A and B for individuals entitled to*  
6           *benefits under part A and enrolled under this*  
7           *part who are not enrolled in a Medicare Advan-*  
8           *tage plan under part C or an EFFS plan under*  
9           *part E for the year, but adjusted to exclude costs*  
10          *attributable to payments under section 1886(h).*

11           “(B) *INCLUSION OF COSTS OF VA AND DOD*  
12          *MILITARY FACILITY SERVICES TO MEDICARE-ELI-*  
13          *GIBLE BENEFICIARIES.—In determining the ad-*  
14          *justed average per capita cost under subpara-*  
15          *graph (A) for a year, such cost shall be adjusted*  
16          *to include the Administrator’s estimate, on a per*  
17          *capita basis, of the amount of additional pay-*  
18          *ments that would have been made in the area in-*  
19          *volved under this title if individuals entitled to*  
20          *benefits under this title had not received services*  
21          *from facilities of the Department of Veterans Af-*  
22          *fairs or the Department of Defense.*

23           “(7) *APPLICATION OF COMPETITION.—In the case*  
24          *of an area that is a competitive Medicare Advantage*  
25          *area for a year, for purposes of applying subsection*



1        *(a)(1)(A)(ii) and sections 1854(b)(2)(A)(ii) and*  
2        *1854(b)(3)(B)(i), any reference to a Medicare Advan-*  
3        *tage area-specific non-drug monthly benchmark*  
4        *amount shall be treated as a reference to the competi-*  
5        *tive Medicare Advantage non-drug monthly bench-*  
6        *mark amount under paragraph (2) for the area and*  
7        *year.*

8                *“(8) PHASE-IN OF BENCHMARK FOR EACH*  
9        *AREA.—*

10                *“(A) USE OF BLENDED BENCHMARK.—In*  
11        *the case of an area that has not been a competi-*  
12        *tive Medicare Advantage area for each of the pre-*  
13        *vious 4 years, the competitive Medicare Advan-*  
14        *tage non-drug monthly benchmark amount shall*  
15        *be equal to the sum of the following:*

16                *“(i) NEW COMPETITIVE COMPONENT.—*

17                *The product of—*

18                        *“(I) the weighted average phase-in*  
19                        *proportion for that area and year, as*  
20                        *specified in subparagraph (B); and*

21                        *“(II) the competitive Medicare*  
22                        *Advantage non-drug monthly bench-*  
23                        *mark amount for the area and year,*  
24                        *determined under paragraph (2) with-*  
25                        *out regard to this paragraph.*



1                   “(i) *OLD COMPETITIVE COMPONENT.*—

2                   *The product of—*

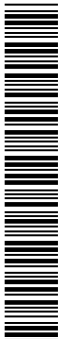
3                   “(I) *1 minus the weighted average*  
4                   *phase-in proportion for that area and*  
5                   *year; and*

6                   “(II) *the Medicare Advantage*  
7                   *area-wide non-drug benchmark amount*  
8                   *for the area and the year.*

9                   “(B) *COMPUTATION OF WEIGHTED AVERAGE*  
10                  *PHASE-IN PROPORTION.*—*For purposes of this*  
11                  *paragraph, the ‘weighted average phase-in pro-*  
12                  *portion’ for a Medicare Advantage payment area*  
13                  *for a year shall be determined as follows:*

14                  “(i) *FIRST YEAR (AND AREA NOT COM-*  
15                  *PETITIVE AREA IN PREVIOUS YEAR).*—*If the*  
16                  *area was not a Medicare Advantage com-*  
17                  *petitive area in the previous year, the*  
18                  *weighted average phase-in proportion for*  
19                  *the area for the year is equal to  $\frac{1}{5}$ .*

20                  “(ii) *COMPETITIVE AREA IN PREVIOUS*  
21                  *YEAR.*—*If the area was a competitive Medi-*  
22                  *care Advantage area in the previous year,*  
23                  *the weighted average phase-in proportion*  
24                  *for the area for the year is equal to the*  
25                  *weighted average phase-in proportion deter-*



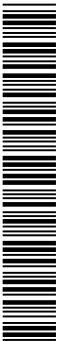
1            *mined under this subparagraph for the area*  
2            *for the previous year plus  $\frac{1}{5}$ , but in no case*  
3            *more than 1.*

4            “(C) *MEDICARE ADVANTAGE AREA-WIDE*  
5            *NON-DRUG BENCHMARK AMOUNT.*—*For purposes*  
6            *of subparagraph (A)(i)(II), the term ‘Medicare*  
7            *Advantage area-wide non-drug benchmark*  
8            *amount’ means, for an area and year, the*  
9            *weighted average of the amounts described in sec-*  
10           *tion 1853(j) for Medicare Advantage payment*  
11           *area or areas included in the area (based on the*  
12           *number of traditional fee-for-service enrollees in*  
13           *such payment area or areas) and year.”.*

14           (2) *APPLICATION.*—*Section 1854 (42 U.S.C.*  
15           *1395w-24) is amended—*

16           (A) *in subsection (b)(1)(C)(i), as added by*  
17           *section 221(b)(1)(A), by striking “(i) REQUIRE-*  
18           *MENT.—The” and inserting “(i) REQUIREMENT*  
19           *FOR NON-COMPETITIVE AREAS.—In the case of a*  
20           *Medicare Advantage payment area that is not a*  
21           *competitive Medicare Advantage area designated*  
22           *under section 1853(k)(1), the”;*

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



1                   “(i) *REQUIREMENT FOR COMPETITIVE*  
2                   *MEDICARE ADVANTAGE AREAS.*—*In the case*  
3                   *of a Medicare Advantage payment area that*  
4                   *is designated as a competitive Medicare Ad-*  
5                   *vantage area under section 1853(k)(1), if*  
6                   *there are average per capita monthly sav-*  
7                   *ings described in paragraph (6) for a Medi-*  
8                   *care Advantage plan and year, the Medicare*  
9                   *Advantage plan shall provide to the enrollee*  
10                  *a monthly rebate equal to 75 percent of such*  
11                  *savings.”; and*

12                  *(C) by adding at the end of subsection (b),*  
13                  *as amended by sections 221(b)(1)(B) and*  
14                  *221(b)(2), the following new paragraph:*

15                  “(6) *COMPUTATION OF AVERAGE PER CAPITA*  
16                  *MONTHLY SAVINGS FOR COMPETITIVE MEDICARE AD-*  
17                  *VANTAGE AREAS.*—*For purposes of paragraph*  
18                  *(1)(C)(i), the average per capita monthly savings re-*  
19                  *ferred to in such paragraph for a Medicare Advantage*  
20                  *plan and year shall be computed in the same manner*  
21                  *as the average per capita monthly savings is com-*  
22                  *puted under paragraph (3) except that the reference*  
23                  *to the Medicare Advantage area-specific non-drug*  
24                  *monthly benchmark amount in paragraph (3)(B)(i)*  
25                  *(or to the benchmark amount as adjusted under para-*



1 *graph (3)(C)(i) is deemed to be a reference to the*  
2 *competitive Medicare Advantage non-drug monthly*  
3 *benchmark amount (or such amount as adjusted in*  
4 *the manner described in paragraph (3)(B)(i)).”.*

5 *(3) ADDITIONAL CONFORMING AMENDMENTS.—*

6 *(A) PAYMENT OF PLANS.—Section*  
7 *1853(a)(1)(A)(ii), as amended by section*  
8 *221(c)(1), is amended—*

9 *(i) in subclauses (I) and (II), by in-*  
10 *serting “(or, insofar as such payment area*  
11 *is a competitive Medicare Advantage area,*  
12 *described in section 1854(b)(6))” after “sec-*  
13 *tion 1854(b)(3)(C)”;* and

14 *(ii) in subclause (II), by inserting*  
15 *“(or, insofar as such payment area is a*  
16 *competitive Medicare Advantage area, the*  
17 *competitive Medicare Advantage non-drug*  
18 *monthly benchmark amount)” after “Medi-*  
19 *care Advantage area-specific non-drug*  
20 *monthly benchmark amount”;* and

21 *(B) DISCLOSURE OF INFORMATION.—Sec-*  
22 *tion 1853(b)(1)(B), as amended by section*  
23 *221(e)(1), is amended to read as follows:*

24 *“(B) COMPETITION INFORMATION.—For*  
25 *years beginning with 2006, the following:*





1                   “(i) *BENCHMARKS.*—*The Medicare Ad-*  
2                   *vantage area-specific non-drug benchmark*  
3                   *under section 1853(j) and, if applicable, the*  
4                   *competitive Medicare Advantage non-drug*  
5                   *benchmark under section 1853(k)(2), for the*  
6                   *year and competitive Medicare Advantage*  
7                   *area involved and the national fee-for-serv-*  
8                   *ice market share percentage for the area*  
9                   *and year.*

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

17                   “(iii) *CERTAIN BENCHMARKS AND*  
18                   *AMOUNTS.*—*In the case of a competitive*  
19                   *Medicare Advantage area, the Medicare Ad-*  
20                   *vantage area-wide non-drug benchmark*  
21                   *amount (as defined in subsection (k)(8)(C))*  
22                   *and the fee-for-service area-specific non-*  
23                   *drug amount (as defined in section*  
24                   *1853(k)(6)) for the area.*



1                   “(iv) *INDIVIDUALS.*—*The number of*  
2                   *individuals counted under subsection*  
3                   *(k)(4)(B) and enrolled in each Medicare Ad-*  
4                   *vantage plan in the area.*”.

5                   (C) *DEFINITION OF MONTHLY BASIC PRE-*  
6                   *MIUM.*—*Section 1854(b)(2)(A)(ii), as amended*  
7                   *by section 221(d)(2), is amended by inserting*  
8                   *“(or, in the case of a competitive Medicare Ad-*  
9                   *vantage area, the competitive Medicare Advan-*  
10                   *tage non-drug monthly benchmark amount or, in*  
11                   *applying this paragraph under part E in the*  
12                   *case of a competitive EFFS region, the competi-*  
13                   *tive EFFS non-drug monthly benchmark*  
14                   *amount)” after “benchmark amount”.*

15                   (c) *PREMIUM ADJUSTMENT.*—

16                   (1) *IN GENERAL.*—*Section 1839 (42 U.S.C.*  
17                   *1395r) is amended by adding at the end the following*  
18                   *new subsection:*

19                   “(h)(1)(A) *In the case of an individual who resides in*  
20                   *a competitive Medicare Advantage area under section*  
21                   *1853(k)(1) (regardless of whether such area is in a competi-*  
22                   *tive EFFS region under section 1860E–3(e)) and who is*  
23                   *not enrolled in a Medicare Advantage plan under part C*  
24                   *or in an EFFS plan under part E, the monthly premium*  
25                   *otherwise applied under this part (determined without re-*



1 *gard to subsections (b) and (f) or any adjustment under*  
2 *this subsection) shall be adjusted as follows: If the fee-for-*  
3 *service area-specific non-drug amount (as defined in section*  
4 *1853(k)(6)) for the competitive Medicare Advantage area in*  
5 *which the individual resides for a month—*

6           *“(i) does not exceed the competitive Medicare Ad-*  
7 *vantage non-drug benchmark (as determined under*  
8 *paragraph (2) of section 1853(k), without regard to*  
9 *paragraph (8) thereof) for such area, the amount of*  
10 *the premium for the individual for the month shall be*  
11 *reduced by an amount equal to the product of the ad-*  
12 *justment factor under subparagraph (C) and 75 per-*  
13 *cent of the amount by which such competitive bench-*  
14 *mark exceeds such fee-for-service area-specific non-*  
15 *drug amount; or*

16           *“(ii) exceeds such competitive Medicare Advan-*  
17 *tage non-drug benchmark, the amount of the premium*  
18 *for the individual for the month shall be adjusted to*  
19 *ensure, subject to subparagraph (B), that—*

20           *“(I) the sum of the amount of the adjusted*  
21 *premium and the competitive Medicare Advan-*  
22 *tage non-drug benchmark for the area, is equal*  
23 *to*



1                   “(II) the sum of the unadjusted premium  
2                   plus amount of the fee-for-service area-specific  
3                   non-drug amount for the area.

4                   “(B) In no case shall the actual amount of an adjust-  
5                   ment under subparagraph (A)(ii) exceed the product of the  
6                   adjustment factor under subparagraph (C) and the amount  
7                   of the adjustment otherwise computed under subparagraph  
8                   (A)(ii) without regard to this subparagraph.

9                   “(C) The adjustment factor under this subparagraph  
10                  for an area for a year is equal to—

11                  “(i) the number of consecutive years (in the 5-  
12                  year period ending with the year involved) in which  
13                  such area was a competitive Medicare Advantage  
14                  area; divided by

15                  “(ii) 5.

16                  “(2)(A) In the case of an individual who resides in  
17                  an area that is within a competitive *EFFS* region under  
18                  section 1860E-3(e) but is not within a competitive Medi-  
19                  care Advantage area under section 1853(k)(1) and who is  
20                  not enrolled in a Medicare Advantage plan under part C  
21                  or in an *EFFS* plan under part E, the monthly premium  
22                  otherwise applied under this part (determined without re-  
23                  gard to subsections (b) and (f) or any adjustment under  
24                  this subsection) shall be adjusted as follows: If the fee-for-



1 *service region-specific non-drug amount (as defined in sec-*  
2 *tion 1860E-3(e)(6)) for a region for a month—*

3           “(i) *does not exceed the competitive EFFS non-*  
4 *drug monthly benchmark amount (as determined*  
5 *under paragraph (2) of section 1860E-3(e), without*  
6 *regard to paragraph (8) thereof) for such region, the*  
7 *amount of the premium for the individual for the*  
8 *month shall be reduced by an amount equal to the*  
9 *product of the adjustment factor under subparagraph*  
10 *(C) and 75 percent of the amount by which such com-*  
11 *petitive benchmark amount exceeds such fee-for-service*  
12 *region-specific non-drug benchmark amount; or*

13           “(ii) *exceeds such competitive EFFS non-drug*  
14 *monthly benchmark amount, the amount of the pre-*  
15 *mium for the individual for the month shall be ad-*  
16 *justed to ensure, subject to subparagraph (B), that—*

17           “(I) *the sum of the amount of the adjusted*  
18 *premium and the competitive EFFS non-drug*  
19 *monthly benchmark amount for the region, is*  
20 *equal to*

21           “(II) *the sum of the unadjusted premium*  
22 *plus the amount of the EFFS region-specific*  
23 *non-drug monthly bid for the region.*

24           “(B) *In no case shall the actual amount of an adjust-*  
25 *ment under subparagraph (A)(ii) exceed the product of the*



1 *adjustment factor under subparagraph (C) and the amount*  
2 *of the adjustment otherwise computed under subparagraph*  
3 *(A)(ii) without regard to this subparagraph.*

4       “(C) *The adjustment factor under this subparagraph*  
5 *for an EFFS region for a year is equal to—*

6               “(i) *the number of consecutive years (in the 5-*  
7 *year period ending with the year involved) in which*  
8 *such region was a competitive EFFS region; divided*  
9 *by*

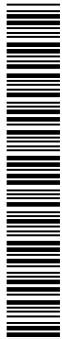
10              “(ii) *5.*

11       “(3) *Nothing in this subsection shall be construed as*  
12 *preventing a reduction under paragraph (1)(A) or para-*  
13 *graph (2)(A) in the premium otherwise applicable under*  
14 *this part to zero or from requiring the provision of a rebate*  
15 *to the extent such premium would otherwise be required to*  
16 *be less than zero.*

17       “(4) *The adjustment in the premium under this sub-*  
18 *section shall be effected in such manner as the Medicare*  
19 *Benefits Administrator determines appropriate.*

20       “(5) *In order to carry out this subsection (insofar as*  
21 *it is effected through the manner of collection of premiums*  
22 *under 1840(a)), the Medicare Benefits Administrator shall*  
23 *transmit to the Commissioner of Social Security—*

24              “(A) *at the beginning of each year, the name, so-*  
25 *cial security account number, and the amount of the*



1       *adjustment (if any) under this subsection for each in-*  
2       *dividual enrolled under this part for each month dur-*  
3       *ing the year; and*

4               “(B) periodically throughout the year, informa-

5       *tion to update the information previously transmitted*  
6       *under this paragraph for the year.”.*

7               (2) *CONFORMING AMENDMENT.—Section 1844(c)*  
8       *(42 U.S.C. 1395w(c)) is amended by inserting “and*  
9       *without regard to any premium adjustment effected*  
10       *under section 1839(h)” before the period at the end.*

11       (d) *EFFECTIVE DATE.—The amendments made by this*  
12       *section shall take effect on January 1, 2010.*

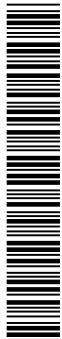
13       ***TITLE III—COMBATTING WASTE,***  
14       ***FRAUD, AND ABUSE***

15       ***SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVI-***  
16       ***SIONS.***

17       (a) *TECHNICAL AMENDMENT CONCERNING SEC-*  
18       *RETARY’S AUTHORITY TO MAKE CONDITIONAL PAYMENT*  
19       *WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPT-*  
20       *LY.—*

21               (1) *IN GENERAL.—Section 1862(b)(2) (42 U.S.C.*  
22       *1395y(b)(2)) is amended—*

23               (A) *in subparagraph (A)(ii), by striking*  
24       *“promptly (as determined in accordance with*  
25       *regulations)”;*



1                   (B) in subparagraph (B)—

2                   (i) by redesignating clauses (i) through  
3                   (iii) as clauses (ii) through (iv), respec-  
4                   tively; and

5                   (ii) by inserting before clause (ii), as  
6                   so redesignated, the following new clause:

7                   “(i) *AUTHORITY TO MAKE CONDI-*  
8                   *TIONAL PAYMENT.*—*The Secretary may*  
9                   *make payment under this title with respect*  
10                  *to an item or service if a primary plan de-*  
11                  *scribed in subparagraph (A)(ii) has not*  
12                  *made or cannot reasonably be expected to*  
13                  *make payment with respect to such item or*  
14                  *service promptly (as determined in accord-*  
15                  *ance with regulations). Any such payment*  
16                  *by the Secretary shall be conditioned on re-*  
17                  *imbursement to the appropriate Trust Fund*  
18                  *in accordance with the succeeding provi-*  
19                  *sions of this subsection.”.*

20                  (2) *EFFECTIVE DATE.*—*The amendments made*  
21                  *by paragraph (1) shall be effective as if included in*  
22                  *the enactment of title III of the Medicare and Med-*  
23                  *icaid Budget Reconciliation Amendments of 1984*  
24                  *(Public Law 98-369).*





1           (b) *CLARIFYING AMENDMENTS TO CONDITIONAL PAY-*  
2 *MENT PROVISIONS.*—Section 1862(b)(2) (42 U.S.C.  
3 1395y(b)(2)) is further amended—

4           (1) in subparagraph (A), in the matter following  
5 clause (ii), by inserting the following sentence at the  
6 end: “An entity that engages in a business, trade, or  
7 profession shall be deemed to have a self-insured plan  
8 if it carries its own risk (whether by a failure to ob-  
9 tain insurance, or otherwise) in whole or in part.”;

10           (2) in subparagraph (B)(ii), as redesignated by  
11 subsection (a)(2)(B)—

12           (A) by striking the first sentence and insert-  
13 ing the following: “A primary plan, and an enti-  
14 ty that receives payment from a primary plan,  
15 shall reimburse the appropriate Trust Fund for  
16 any payment made by the Secretary under this  
17 title with respect to an item or service if it is  
18 demonstrated that such primary plan has or had  
19 a responsibility to make payment with respect to  
20 such item or service. A primary plan’s responsi-  
21 bility for such payment may be demonstrated by  
22 a judgment, a payment conditioned upon the re-  
23 cipient’s compromise, waiver, or release (whether  
24 or not there is a determination or admission of  
25 liability) of payment for items or services in-



1           *cluded in a claim against the primary plan or*  
2           *the primary plan's insured, or by other means.”;*  
3           *and*

4           *(B) in the final sentence, by striking “on*  
5           *the date such notice or other information is re-*  
6           *ceived” and inserting “on the date notice of, or*  
7           *information related to, a primary plan's respon-*  
8           *sibility for such payment or other information is*  
9           *received”;* and

10          *(3) in subparagraph (B)(iii), , as redesignated*  
11          *by subsection (a)(2)(B), by striking the first sentence*  
12          *and inserting the following: “In order to recover pay-*  
13          *ment made under this title for an item or service, the*  
14          *United States may bring an action against any or all*  
15          *entities that are or were required or responsible (di-*  
16          *rectly, as an insurer or self-insurer, as a third-party*  
17          *administrator, as an employer that sponsors or con-*  
18          *tributes to a group health plan, or large group health*  
19          *plan, or otherwise) to make payment with respect to*  
20          *the same item or service (or any portion thereof)*  
21          *under a primary plan. The United States may, in ac-*  
22          *cordance with paragraph (3)(A) collect double dam-*  
23          *ages against any such entity. In addition, the United*  
24          *States may recover under this clause from any entity*  
25          *that has received payment from a primary plan or*



1       *from the proceeds of a primary plan's payment to*  
2       *any entity.”.*

3       (c) *CLERICAL AMENDMENTS.—Section 1862(b) (42*  
4 *U.S.C. 1395y(b)) is amended—*

5             (1) *in paragraph (1)(A), by moving the indenta-*  
6       *tion of clauses (ii) through (v) 2 ems to the left; and*

7             (2) *in paragraph (3)(A), by striking “such” be-*  
8       *fore “paragraphs”.*

9       **SEC. 302. COMPETITIVE ACQUISITION OF CERTAIN ITEMS**  
10            **AND SERVICES.**

11       (a) *IN GENERAL.—Section 1847 (42 U.S.C. 1395w-*  
12 *3) is amended to read as follows:*

13       “*COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND*  
14                                    *SERVICES*

15       “*SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE*  
16 *ACQUISITION PROGRAMS.—*

17             “*(1) IMPLEMENTATION OF PROGRAMS.—*

18                     “*(A) IN GENERAL.—The Secretary shall es-*  
19       *tablish and implement programs under which*  
20       *competitive acquisition areas are established*  
21       *throughout the United States for contract award*  
22       *purposes for the furnishing under this part of*  
23       *competitively priced items and services (de-*  
24       *scribed in paragraph (2)) for which payment is*  
25       *made under this part. Such areas may differ for*  
26       *different items and services.*



1                   “(B) *PHASED-IN IMPLEMENTATION.*—*The*  
2                   *programs shall be phased-in—*

3                   “(i) *among competitive acquisition*  
4                   *areas over a period of not longer than 3*  
5                   *years in a manner so that the competition*  
6                   *under the programs occurs in—*

7                   “(I) *at least  $\frac{1}{3}$  of such areas in*  
8                   *2005; and*

9                   “(II) *at least  $\frac{2}{3}$  of such areas in*  
10                   *2006; and*

11                   “(ii) *among items and services in a*  
12                   *manner such that the programs apply to the*  
13                   *highest cost and highest volume items and*  
14                   *services first.*

15                   “(C) *WAIVER OF CERTAIN PROVISIONS.*—*In*  
16                   *carrying out the programs, the Secretary may*  
17                   *waive such provisions of the Federal Acquisition*  
18                   *Regulation as are necessary for the efficient im-*  
19                   *plementation of this section, other than provi-*  
20                   *sions relating to confidentiality of information*  
21                   *and such other provisions as the Secretary deter-*  
22                   *mines appropriate.*

23                   “(2) *ITEMS AND SERVICES DESCRIBED.*—*The*  
24                   *items and services referred to in paragraph (1) are*  
25                   *the following:*



1           “(A) *DURABLE MEDICAL EQUIPMENT AND*  
2           *MEDICAL SUPPLIES.*—Covered items (as defined  
3           in section 1834(a)(13)) for which payment is  
4           otherwise made under section 1834(a), including  
5           items used in infusion and drugs and supplies  
6           used in conjunction with durable medical equip-  
7           ment, but excluding class III devices under the  
8           Federal Food, Drug, and Cosmetic Act.

9           “(B) *OTHER EQUIPMENT AND SUPPLIES.*—  
10          Items, equipment, and supplies (as described in  
11          section 1842(s)(2)(D) other than enteral nutri-  
12          ents).

13          “(C) *OFF-THE-SHELF ORTHOTICS.*—  
14          Orthotics (described in section 1861(s)(9)) for  
15          which payment is otherwise made under section  
16          1834(h) which require minimal self-adjustment  
17          for appropriate use and does not require exper-  
18          tise in trimming, bending, molding, assembling,  
19          or customizing to fit to the patient.

20          “(3) *EXCEPTION AUTHORITY.*—In carrying out  
21          the programs under this section, the Secretary may  
22          exempt—

23                 “(A) rural areas and areas with low popu-  
24                 lation density within urban areas that are not  
25                 competitive, unless there is a significant national



1           *market through mail order for a particular item*  
2           *or service; and*

3           “(B) *items and services for which the appli-*  
4           *cation of competitive acquisition is not likely to*  
5           *result in significant savings.*

6           “(4) *SPECIAL RULE FOR CERTAIN RENTED ITEMS*  
7           *OF DURABLE MEDICAL EQUIPMENT.—In the case of a*  
8           *covered item for which payment is made on a rental*  
9           *basis under section 1834(a), the Secretary shall estab-*  
10          *lish a process by which rental agreements for the cov-*  
11          *ered items entered into before the application of the*  
12          *competitive acquisition program under this section*  
13          *for the item may be continued notwithstanding this*  
14          *section. In the case of any such continuation, the sup-*  
15          *plier involved shall provide for appropriate servicing*  
16          *and replacement, as required under section 1834(a).*

17          “(5) *PHYSICIAN AUTHORIZATION.—The Sec-*  
18          *retary may establish a process under which a physi-*  
19          *cian may prescribe a particular brand or mode of de-*  
20          *livery of an item or service if the item or service in-*  
21          *volved is clinically more appropriate than other simi-*  
22          *lar items or services.*

23          “(6) *APPLICATION.—For each competitive acqui-*  
24          *sition area in which the program is implemented*  
25          *under this subsection with respect to items and serv-*



1        *ices, the payment basis determined under the competi-*  
2        *tion conducted under subsection (b) shall be sub-*  
3        *stituted for the payment basis otherwise applied*  
4        *under section 1834(a).*

5        *“(b) PROGRAM REQUIREMENTS.—*

6                *“(1) IN GENERAL.—The Secretary shall conduct*  
7        *a competition among entities supplying items and*  
8        *services described in subsection (a)(2) for each com-*  
9        *petitive acquisition area in which the program is im-*  
10       *plemented under subsection (a) with respect to such*  
11       *items and services.*

12               *“(2) CONDITIONS FOR AWARDING CONTRACT.—*

13               *“(A) IN GENERAL.—The Secretary may not*  
14       *award a contract to any entity under the com-*  
15       *petition conducted in an competitive acquisition*  
16       *area pursuant to paragraph (1) to furnish such*  
17       *items or services unless the Secretary finds all of*  
18       *the following:*

19               *“(i) The entity meets quality and fi-*  
20       *nancial standards specified by the Secretary*  
21       *or developed by the Program Advisory and*  
22       *Oversight Committee established under sub-*  
23       *section (c).*

24               *“(ii) The total amounts to be paid*  
25       *under the contract (including costs associ-*



1            *ated with the administration of the con-*  
2            *tract) are expected to be less than the total*  
3            *amounts that would otherwise be paid.*

4            *“(iii) Beneficiary access to a choice of*  
5            *multiple suppliers in the area is main-*  
6            *tained.*

7            *“(iv) Beneficiary liability is limited to*  
8            *20 percent of the applicable contract award*  
9            *price, except in such cases where a supplier*  
10           *has furnished an upgraded item and has ex-*  
11           *ecuted an advanced beneficiary notice.*

12           *“(B) DEVELOPMENT OF QUALITY STAND-*  
13           *ARDS FOR DME PRODUCTS.—*

14           *“(i) IN GENERAL.—The quality stand-*  
15           *ards specified under subparagraph (A)(i)*  
16           *shall not be less than the quality standards*  
17           *that would otherwise apply if this section*  
18           *did not apply and shall include consumer*  
19           *services standards. Not later than July 1,*  
20           *2004, the Secretary shall establish new*  
21           *quality standards for products subject to*  
22           *competitive acquisition under this section.*  
23           *Such standards shall be applied prospec-*  
24           *tively and shall be published on the website*





1                   *of the Department of Health and Human*  
2                   *Services.*

3                   “(ii) *CONSULTATION WITH PROGRAM*  
4                   *ADVISORY AND OVERSIGHT COMMITTEE.—*  
5                   *The Secretary shall consult with the Pro-*  
6                   *gram Advisory and Oversight Committee*  
7                   *(established under subsection (c)) to review*  
8                   *(and advise the Secretary concerning) the*  
9                   *quality standards referred to in clause (i).*

10                  “(3) *CONTENTS OF CONTRACT.—*

11                  “(A) *IN GENERAL.—A contract entered into*  
12                  *with an entity under the competition conducted*  
13                  *pursuant to paragraph (1) is subject to terms*  
14                  *and conditions that the Secretary may specify.*

15                  “(B) *TERM OF CONTRACTS.—The Secretary*  
16                  *shall recompete contracts under this section not*  
17                  *less often than once every 3 years.*

18                  “(4) *LIMIT ON NUMBER OF CONTRACTORS.—*

19                  “(A) *IN GENERAL.—The Secretary may*  
20                  *limit the number of contractors in a competitive*  
21                  *acquisition area to the number needed to meet*  
22                  *projected demand for items and services covered*  
23                  *under the contracts. In awarding contracts, the*  
24                  *Secretary shall take into account the ability of*  
25                  *bidding entities to furnish items or services in*



1           *sufficient quantities to meet the anticipated*  
2           *needs of beneficiaries for such items or services*  
3           *in the geographic area covered under the contract*  
4           *on a timely basis.*

5           “(B) *MULTIPLE WINNERS.*—*The Secretary*  
6           *shall award contracts to multiple entities sub-*  
7           *mitting bids in each area for an item or service.*

8           “(5) *PAYMENT.*—*Payment under this part for*  
9           *competitively priced items and services described in*  
10          *subsection (a)(2) shall be based on the bids submitted*  
11          *and accepted under this section for such items and*  
12          *services.*

13          “(6) *PARTICIPATING CONTRACTORS.*—*Payment*  
14          *shall not be made for items and services described in*  
15          *subsection (a)(2) furnished by a contractor and for*  
16          *which competition is conducted under this section*  
17          *unless—*

18                 “(A) *the contractor has submitted a bid for*  
19                 *such items and services under this section; and*

20                 “(B) *the Secretary has awarded a contract*  
21                 *to the contractor for such items and services*  
22                 *under this section.*

23           *In this section, the term ‘bid’ means a request for a*  
24           *proposal for an item or service that includes the cost*  
25           *of the item or service, and where appropriate, any*



1        *services that are attendant to the provision of the*  
2        *item or service.*

3            “(7) *CONSIDERATION IN DETERMINING CAT-*  
4        *EGORIES FOR BIDS.—The Secretary shall consider the*  
5        *similarity of the clinical efficiency and value of spe-*  
6        *cific codes and products, including products that may*  
7        *provide a therapeutic advantage to beneficiaries, be-*  
8        *fore delineating the categories and products that will*  
9        *be subject to bidding.*

10           “(8) *AUTHORITY TO CONTRACT FOR EDUCATION,*  
11        *MONITORING, OUTREACH AND COMPLAINT SERV-*  
12        *ICES.—The Secretary may enter into a contract with*  
13        *an appropriate entity to address complaints from*  
14        *beneficiaries who receive items and services from an*  
15        *entity with a contract under this section and to con-*  
16        *duct appropriate education of and outreach to such*  
17        *beneficiaries and monitoring quality of services with*  
18        *respect to the program.*

19           “(c) *PROGRAM ADVISORY AND OVERSIGHT COM-*  
20        *MITTEE.—*

21           “(1) *ESTABLISHMENT.—There is established a*  
22        *Program Advisory and Oversight Committee (herein-*  
23        *after in this section referred to as the ‘Committee’).*

24           “(2) *MEMBERSHIP; TERMS.—The Committee*  
25        *shall consist of such members as the Secretary may*



1       *appoint who shall serve for such term as the Secretary*  
2       *may specify.*

3               “(3) *DUTIES.—*

4                       “(A) *TECHNICAL ASSISTANCE.—The Com-*  
5                       *mittee shall provide advice and technical assist-*  
6                       *ance to the Secretary with respect to the fol-*  
7                       *lowing functions:*

8                               “(i) *The implementation of the pro-*  
9                               *gram under this section.*

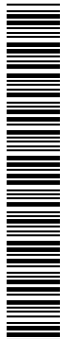
10                              “(ii) *The establishment of requirements*  
11                              *for collection of data.*

12                              “(iii) *The development of proposals for*  
13                              *efficient interaction among manufacturers*  
14                              *and distributors of the items and services*  
15                              *and providers and beneficiaries.*

16                              “(B) *ADDITIONAL DUTIES.—The Committee*  
17                              *shall perform such additional functions to assist*  
18                              *the Secretary in carrying out this section as the*  
19                              *Secretary may specify.*

20                              “(4) *INAPPLICABILITY OF FACA.—The provisions*  
21                              *of the Federal Advisory Committee Act (5 U.S.C.*  
22                              *App.) shall not apply.*

23                              “(d) *ANNUAL REPORTS.—The Secretary shall submit*  
24                              *to Congress an annual management report on the programs*  
25                              *under this section. Each such report shall include informa-*



1 *tion on savings, reductions in beneficiary cost-sharing, ac-*  
2 *cess to and quality of items and services, and beneficiary*  
3 *satisfaction.*

4 “(e) *DEMONSTRATION PROJECT FOR CLINICAL LAB-*  
5 *ORATORY SERVICES.—*

6 “(1) *IN GENERAL.—The Secretary shall conduct*  
7 *a demonstration project on the application of com-*  
8 *petitive acquisition under this section to clinical di-*  
9 *agnostic laboratory tests—*

10 “(A) *for which payment is otherwise made*  
11 *under section 1833(h) or 1834(d)(1) (relating to*  
12 *colorectal cancer screening tests); and*

13 “(B) *which are furnished by entities that*  
14 *did not have a face-to-face encounter with the in-*  
15 *dividual.*

16 “(2) *TERMS AND CONDITIONS.—Such project*  
17 *shall be under the same conditions as are applicable*  
18 *to items and services described in subsection (a)(2).*

19 “(3) *REPORT.—The Secretary shall submit to*  
20 *Congress—*

21 “(A) *an initial report on the project not*  
22 *later than December 31, 2005; and*

23 “(B) *such progress and final reports on the*  
24 *project after such date as the Secretary deter-*  
25 *mines appropriate.”.*



1       **(b) CONFORMING AMENDMENTS.—**

2               **(1) DURABLE MEDICAL EQUIPMENT; ELIMI-**  
3       **NATION OF INHERENT REASONABLENESS AUTHOR-**  
4       **ITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is**  
5       **amended—**

6               **(A) in paragraph (1)(B), by striking “The**  
7       **payment basis” and inserting “Subject to sub-**  
8       **paragraph (E)(i), the payment basis”;**

9               **(B) in paragraph (1)(C), by striking “This**  
10       **subsection” and inserting “Subject to subpara-**  
11       **graph (E)(ii), this subsection”;**

12               **(C) by adding at the end of paragraph (1)**  
13       **the following new subparagraph:**

14               **“(E) APPLICATION OF COMPETITIVE ACQUI-**  
15       **SITION; ELIMINATION OF INHERENT REASON-**  
16       **ABLENESS AUTHORITY.—In the case of covered**  
17       **items and services that are included in a com-**  
18       **petitive acquisition program in a competitive ac-**  
19       **quisition area under section 1847(a)—**

20               **“(i) the payment basis under this sub-**  
21       **section for such items and services furnished**  
22       **in such area shall be the payment basis de-**  
23       **termined under such competitive acquisition**  
24       **program; and**



1           “(ii) the Secretary may use informa-  
2           tion on the payment determined under such  
3           competitive acquisition programs to adjust  
4           the payment amount otherwise recognized  
5           under subparagraph (B)(ii) for an area  
6           that is not a competitive acquisition area  
7           under section 1847 and in the case of such  
8           adjustment, paragraph (10)(B) shall not be  
9           applied.”; and

10           (D) in paragraph (10)(B), by inserting “in  
11           an area and with respect to covered items and  
12           services for which the Secretary does not make a  
13           payment amount adjustment under paragraph  
14           (1)(E)” after “under this subsection”.

15           (2) *OFF-THE-SHELF ORTHOTICS; ELIMINATION*  
16           *OF INHERENT REASONABLENESS AUTHORITY.*—*Sec-*  
17           *tion 1834(h) (42 U.S.C. 1395m(h)) is amended—*

18           (A) in paragraph (1)(B), by striking “and  
19           (E)” and inserting “, (E) , and (H)(i)”;

20           (B) in paragraph (1)(D), by striking “This  
21           subsection” and inserting “Subject to subpara-  
22           graph (H)(ii), this subsection”;

23           (C) by adding at the end of paragraph (1)  
24           the following new subparagraph:



1                   “(H) *APPLICATION OF COMPETITIVE ACQUI-*  
2                   *SITION TO ORTHOTICS; ELIMINATION OF INHER-*  
3                   *ENT REASONABLENESS AUTHORITY.*—*In the case*  
4                   *of orthotics described in paragraph (2)(B) of sec-*  
5                   *tion 1847(a) that are included in a competitive*  
6                   *acquisition program in a competitive acquisition*  
7                   *area under such section—*

8                   “(i) *the payment basis under this sub-*  
9                   *section for such orthotics furnished in such*  
10                  *area shall be the payment basis determined*  
11                  *under such competitive acquisition pro-*  
12                  *gram; and*

13                  “(ii) *the Secretary may use informa-*  
14                  *tion on the payment determined under such*  
15                  *competitive acquisition programs to adjust*  
16                  *the payment amount otherwise recognized*  
17                  *under subparagraph (B)(ii) for an area*  
18                  *that is not a competitive acquisition area*  
19                  *under section 1847, and in the case of such*  
20                  *adjustment, paragraphs (8) and (9) of sec-*  
21                  *tion 1842(b) shall not be applied.”.*

22                  “(c) *REPORT ON ACTIVITIES OF SUPPLIERS.*—*The Sec-*  
23                  *retary shall conduct a study to determine the extent to*  
24                  *which (if any) suppliers of covered items of durable medical*  
25                  *equipment that are subject to the competitive acquisition*





1 *program under section 1847 of the Social Security Act, as*  
2 *amended by subsection (a), are soliciting physicians to pre-*  
3 *scribe certain brands or modes of delivery of covered items*  
4 *based on profitability.*

5 **SEC. 303. COMPETITIVE ACQUISITION OF COVERED OUT-**  
6 **PATIENT DRUGS AND BIOLOGICALS.**

7 *(a) ADJUSTMENT TO PHYSICIAN FEE SCHEDULE.—*

8 *(1) ADJUSTMENT IN PRACTICE EXPENSE REL-*  
9 *ATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C.*  
10 *1395w-4(c)(2)) is amended—*

11 *(A) in subparagraph (B)—*

12 *(i) in clause (ii)(II), by striking “The*  
13 *adjustments” and inserting “Subject to*  
14 *clause (iv), the adjustments”; and*

15 *(ii) by adding at the end of subpara-*  
16 *graph (B), the following new clause:*

17 *“(iv) EXCEPTION TO BUDGET NEU-*  
18 *TRALITY.—The additional expenditures at-*  
19 *tributable to clauses (ii) and (iii) of sub-*  
20 *paragraph (H) shall not be taken into ac-*  
21 *count in applying clause (ii)(II) for 2005.”;*  
22 *and*

23 *(B) by adding at the end the following new*  
24 *subparagraph:*



1                   “(H) *ADJUSTMENTS IN PRACTICE EXPENSE*  
2                   *RELATIVE VALUE UNITS FOR 2004.—*

3                   “(i) *IN GENERAL.—As part of the an-*  
4                   *annual process of establishing the physician*  
5                   *fee schedule under subsection (b) for 2004,*  
6                   *the Secretary shall increase the practice ex-*  
7                   *penditure relative value units for 2004 con-*  
8                   *sistent with clauses (ii) and (iii).*

9                   “(ii) *USE OF SUPPLEMENTAL SURVEY*  
10                   *DATA.—For 2004 for any specialty that*  
11                   *submitted survey data that included ex-*  
12                   *penses for the administration of drugs and*  
13                   *biologicals for which payment is made*  
14                   *under section 1842(o) (or section 1847A),*  
15                   *the Secretary shall use such supplemental*  
16                   *survey data in carrying out this subpara-*  
17                   *graph insofar as they are collected and pro-*  
18                   *vided by entities and organizations con-*  
19                   *sistent with the criteria established by the*  
20                   *Secretary pursuant to section 212(a) of the*  
21                   *Medicare, Medicaid, and SCHIP Balanced*  
22                   *Budget Refinement Act of 1999 and insofar*  
23                   *as such data are submitted to the Secretary*  
24                   *by the date of the enactment of this sub-*  
25                   *paragraph.*



1                   “(iii) *EXPEDITING CONSIDERATION OF*  
2                   *CPT CODES FOR AFFECTED PHYSICIAN SPE-*  
3                   *CIALTIES.—The Secretary shall, in coopera-*  
4                   *tion with representatives of physician speci-*  
5                   *alities affected by section 1847A, take such*  
6                   *actions as are necessary to expedite consid-*  
7                   *erations of CPT codes, or expand the ability*  
8                   *to appropriately bill for physicians’ services*  
9                   *under existing CPT codes, for costs associ-*  
10                   *ated with the administration of covered out-*  
11                   *patient drugs. The Secretary shall consult*  
12                   *with representatives of advisory physician*  
13                   *groups in expediting such considerations.*

14                   “(iv) *SUBSEQUENT, BUDGET NEUTRAL*  
15                   *ADJUSTMENTS PERMITTED.—Nothing in*  
16                   *this subparagraph shall be construed as pre-*  
17                   *venting the Secretary from providing for*  
18                   *adjustments in practice expense relative*  
19                   *value units under (and consistent with)*  
20                   *subparagraph (B) for years after 2004.*

21                   “(v) *CONSULTATION.—Before pub-*  
22                   *lishing the notice of proposed rulemaking to*  
23                   *carry out this subparagraph, the Secretary*  
24                   *shall consult with the Comptroller General*



1                   *of the United States and with groups rep-*  
2                   *resenting the physician specialties involved.*

3                   “(vi) *TREATMENT AS CHANGE IN LAW*  
4                   *AND REGULATION IN SUSTAINABLE GROWTH*  
5                   *RATE DETERMINATION.—The enactment of*  
6                   *subparagraph (B)(iv) and this subpara-*  
7                   *graph shall be treated as a change in law*  
8                   *for purposes of applying subsection*  
9                   *(f)(2)(D).”.*

10                   (2) *PROHIBITION OF ADMINISTRATIVE AND JUDI-*  
11                   *CIAL REVIEW.—Section 1848(i)(1) (42 U.S.C. 1395w-*  
12                   *4(i)(1)) is amended—*

13                   (A) *by striking “and” at the end of subpara-*  
14                   *graph (D);*

15                   (B) *by striking the period at the end of subpara-*  
16                   *graph (E) and inserting “, and”; and*

17                   (C) *by adding at the end the following new sub-*  
18                   *paragraph:*

19                   “(F) *adjustments in practice expense rel-*  
20                   *ative value units for 2005 under subsection*  
21                   *(c)(2)(H).”.*

22                   (3) *TREATMENT OF OTHER SERVICES CUR-*  
23                   *RRENTLY IN THE NON-PHYSICIAN WORK POOL.—The*  
24                   *Secretary shall make adjustments to the non-physi-*  
25                   *cian work pool methodology (as such term is used in*



1       *the regulations promulgated by the Secretary in the*  
2       *Federal Register as of December 31, 2002) for deter-*  
3       *mination of practice expense relative value units*  
4       *under the physician fee schedule described in section*  
5       *1848(c)(2)(C)(ii) of the Social Security Act so that*  
6       *the practice expense relative value units for services*  
7       *determined under such methodology are not dis-*  
8       *proportionately reduced relative to the practice ex-*  
9       *penditure relative value units of other services not deter-*  
10      *mined under such non-physician work pool method-*  
11      *ology, as the result of amendments made by para-*  
12      *graph (1).*

13               (4) *SUBMISSION OF PRACTICE EXPENSE SURVEY*  
14      *DATA.—Any physician specialty may submit survey*  
15      *data related to practice expenses to the Secretary*  
16      *through December 31, 2004. Nothing in this para-*  
17      *graph shall be construed as waiving the application*  
18      *of budget neutrality under section 1848 of the Social*  
19      *Security Act.*

20               (b) *PAYMENT BASED ON COMPETITION.—Title XVIII*  
21      *is amended by inserting after section 1847 (42 U.S.C.*  
22      *1395w-3), as amended by section 302, the following new*  
23      *sections:*



1 “*COMPETITIVE ACQUISITION OF COVERED OUTPATIENT*  
2 *DRUGS AND BIOLOGICALS*

3 “*SEC. 1847A. (a) IMPLEMENTATION OF COMPETITIVE*  
4 *ACQUISITION.—*

5 “*(1) IMPLEMENTATION OF PROGRAM.—*

6 “*(A) IN GENERAL.—The Secretary shall es-*  
7 *tablish and implement a competitive acquisition*  
8 *program under which—*

9 “*(i) competitive acquisition areas are*  
10 *established throughout the United States for*  
11 *contract award purposes for acquisition of*  
12 *and payment for categories of covered out-*  
13 *patient drugs and biologicals (as defined in*  
14 *paragraph (2)) under this part; and*

15 “*(ii) each physician who does not elect*  
16 *section 1847B to apply makes an annual*  
17 *selection, under paragraph (5) of the con-*  
18 *tractor through which drugs and biologicals*  
19 *within a category of drugs and biologicals*  
20 *will be acquired and delivered to the physi-*  
21 *cian under this part.*

22 “*(B) IMPLEMENTATION.—The Secretary*  
23 *shall implement the program so that the pro-*  
24 *gram applies to—*



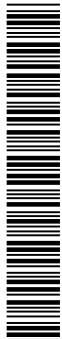
1                   “(i) the oncology category beginning in  
2                   2005; and

3                   “(ii) the non-oncology category begin-  
4                   ning in 2006.

5                   *This section shall not apply in the case of a phy-*  
6                   *sician who elects section 1847B to apply.*

7                   “(C) *WAIVER OF CERTAIN PROVISIONS.*—*In*  
8                   *order to promote competition, efficient service,*  
9                   *and product quality, in carrying out the pro-*  
10                  *gram the Secretary may waive such provisions of*  
11                  *the Federal Acquisition Regulation as are nec-*  
12                  *essary for the efficient implementation of this*  
13                  *section, other than provisions relating to con-*  
14                  *fidentiality of information and such other provi-*  
15                  *sions as the Secretary determines appropriate.*

16                  “(D) *EXCLUSION AUTHORITY.*—*The Sec-*  
17                  *retary may exclude covered outpatient drugs and*  
18                  *biologicals (including a class of such drugs and*  
19                  *biologicals) from the competitive bidding system*  
20                  *under this section if the drugs or biologicals (or*  
21                  *class) are not appropriate for competitive bid-*  
22                  *ding due to low volume of utilization by bene-*  
23                  *ficiaries under this part or a unique mode or*  
24                  *method of delivery or similar reasons.*



1           “(2) *COVERED OUTPATIENT DRUGS AND*  
2           *BIOLOGICALS, CATEGORIES, PROGRAM DEFINED.—For*  
3           *purposes of this section—*

4                   “(A) *COVERED OUTPATIENT DRUGS AND*  
5                   *BIOLOGICALS DEFINED.—The term ‘covered out-*  
6                   *patient drugs and biologicals’ means drugs and*  
7                   *biologicals to which section 1842(o) applies and*  
8                   *which are not covered under section 1847 (relat-*  
9                   *ing to competitive acquisition for items of dura-*  
10                   *ble medical equipment). Such term does not in-*  
11                   *clude the following:*

12                           “(i) *Blood clotting factors.*

13                           “(ii) *Drugs and biologicals furnished*  
14                           *to individuals in connection with the treat-*  
15                           *ment of end stage renal disease.*

16                           “(iii) *Radiopharmaceuticals.*

17                   “(B) *2 CATEGORIES.—Each of the following*  
18                   *shall be a separate category of covered outpatient*  
19                   *drugs and biologicals, as identified by the Sec-*  
20                   *retary:*

21                           “(i) *ONCOLOGY CATEGORY.—A cat-*  
22                           *egory (in this section referred to as the ‘on-*  
23                           *cology category’) consisting of those covered*  
24                           *outpatient drugs and biologicals that, as de-*  
25                           *termined by the Secretary, are typically*





1                    *primarily billed by oncologists or are other-*  
2                    *wise used to treat cancer.*

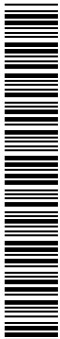
3                    “(ii) *NON-ONCOLOGY CATEGORIES.*—  
4                    *Such numbers of categories (in this section*  
5                    *referred to as the ‘non-oncology categories’)*  
6                    *consisting of covered outpatient drugs and*  
7                    *biologicals not described in clause (i), and*  
8                    *appropriate subcategories of such drugs and*  
9                    *biologicals as the Secretary may specify.*

10                  “(C) *PROGRAM.*—*The term ‘program’*  
11                  *means the competitive acquisition program*  
12                  *under this section.*

13                  “(D) *COMPETITIVE ACQUISITION AREA;*  
14                  *AREA.*—*The terms ‘competitive acquisition area’*  
15                  *and ‘area’ mean an appropriate geographic re-*  
16                  *gion established by the Secretary under the pro-*  
17                  *gram.*

18                  “(E) *CONTRACTOR.*—*The term ‘contractor’*  
19                  *means an entity that has entered into a contract*  
20                  *with the Secretary under this section.*

21                  “(3) *APPLICATION OF PROGRAM PAYMENT METH-*  
22                  *ODOLOGY.*—*With respect to covered outpatient drugs*  
23                  *and biologicals which are supplied under the program*  
24                  *in an area and which are prescribed by a physician*  
25                  *who has not elected section 1847B to apply—*



1           “(A) the claim for such drugs and  
2           biologicals shall be submitted by the contractor  
3           that supplied the drugs and biologicals;

4           “(B) collection of amounts of any deductible  
5           and coinsurance applicable with respect to such  
6           drugs and biologicals shall be the responsibility  
7           of such contractor and shall not be collected un-  
8           less the drug or biological is administered to the  
9           beneficiary involved; and

10          “(C) the payment under this section (and  
11          related coinsurance amounts) for such drugs and  
12          biologicals—

13                 “(i) shall be made only to such con-  
14                 tractor;

15                 “(ii) shall be conditioned upon the ad-  
16                 ministration of such drugs and biologicals;  
17                 and

18                 “(iii) shall be based on the average of  
19                 the bid prices for such drugs and biologicals  
20                 in the area, as computed under subsection  
21                 (d).

22           The Secretary shall provide a process for  
23           recoupment in the case in which payment is  
24           made for drugs and biologicals which were billed



1           *at the time of dispensing but which were not ac-*  
2           *tually administered.*

3           “(4) *CONTRACT REQUIRED.*—

4                   “(A) *IN GENERAL.*—*Payment may not be*  
5           *made under this part for covered outpatient*  
6           *drugs and biologicals prescribed by a physician*  
7           *who has not elected section 1847B to apply with-*  
8           *in a category and a competitive acquisition area*  
9           *with respect to which the program applies*  
10           *unless—*

11                           “(i) *the drugs or biologicals are sup-*  
12                           *plied by a contractor with a contract under*  
13                           *this section for such category of drugs and*  
14                           *biologicals and area; and*

15                           “(ii) *the physician has elected such*  
16                           *contractor under paragraph (5) for such*  
17                           *category and area.*

18                   “(B) *PHYSICIAN CHOICE.*—*Subparagraph*  
19           *(A) shall not apply for a category of drugs for*  
20           *an area if the physician prescribing the covered*  
21           *outpatient drug in such category and area has*  
22           *elected to apply section 1847B instead of this*  
23           *section.*

24           “(5) *CONTRACTOR SELECTION PROCESS.*—



1           “(A) *IN GENERAL.*—*The Secretary shall*  
2           *provide a process for the selection of a con-*  
3           *tractor, on an annual basis and in such exigent*  
4           *circumstances as the Secretary may provide and*  
5           *with respect to each category of covered out-*  
6           *patient drugs and biologicals for an area, by*  
7           *physicians prescribing such drugs and*  
8           *biologicals in the area of the contractor under*  
9           *this section that will supply the drugs and*  
10           *biologicals within that category and area. Such*  
11           *selection shall also include the election described*  
12           *in section 1847B(a).*

13           “(B) *INFORMATION ON CONTRACTORS.*—*The*  
14           *Secretary shall make available to physicians on*  
15           *an ongoing basis, through a directory posted on*  
16           *the Department’s Internet website or otherwise*  
17           *and upon request, a list of the contractors under*  
18           *this section in the different competitive acquisi-*  
19           *tion areas.*

20           “(C) *SELECTING PHYSICIAN DEFINED.*—*For*  
21           *purposes of this section, the term ‘selecting phy-*  
22           *si- cian’ means, with respect to a contractor and*  
23           *category and competitive acquisition area, a*  
24           *physician who has not elected section 1847B to*



1           *apply and has selected to apply under this sec-*  
2           *tion such contractor for such category and area.*

3           “(b) *PROGRAM REQUIREMENTS.*—

4           “(1) *CONTRACT FOR COVERED OUTPATIENT*  
5           *DRUGS AND BIOLOGICALS.*—*The Secretary shall con-*  
6           *duct a competition among entities for the acquisition*  
7           *of a covered outpatient drug or biological within each*  
8           *HCPCS code within each category for each competi-*  
9           *tive acquisition area.*

10          “(2) *CONDITIONS FOR AWARDING CONTRACT.*—

11           “(A) *IN GENERAL.*—*The Secretary may not*  
12           *award a contract to any entity under the com-*  
13           *petition conducted in a competitive acquisition*  
14           *area pursuant to paragraph (1) with respect to*  
15           *the acquisition of covered outpatient drugs and*  
16           *biologicals within a category unless the Secretary*  
17           *finds that the entity meets all of the following*  
18           *with respect to the contract period involved:*

19           “(i) *CAPACITY TO SUPPLY COVERED*  
20           *OUTPATIENT DRUG OR BIOLOGICAL WITHIN*  
21           *CATEGORY.*—

22           “(I) *IN GENERAL.*—*The entity has*  
23           *sufficient arrangements to acquire and*  
24           *to deliver covered outpatient drugs and*  
25           *biologicals within such category in the*



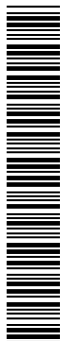
1                    *area specified in the contract at the bid*  
2                    *price specified in the contract for all*  
3                    *physicians that may elect such entity.*

4                    “(II)        *SHIPMENT        METHOD-*  
5                    *LOGY.—The entity has arrangements*  
6                    *in effect for the shipment at least 5*  
7                    *days each week of covered outpatient*  
8                    *drugs and biologicals under the con-*  
9                    *tract and for the timely delivery (in-*  
10                   *cluding for emergency situations) of*  
11                   *such drugs and biologicals in the area*  
12                   *under the contract.*

13                   “(ii)   *QUALITY,   SERVICE,   FINANCIAL*  
14                   *PERFORMANCE   AND   SOLVENCY   STAND-*  
15                   *ARDS.—The entity meets quality, service, fi-*  
16                   *nancial performance, and solvency stand-*  
17                   *ards specified by the Secretary, including—*

18                          *“(I) the establishment of proce-*  
19                          *dures for the prompt response and res-*  
20                          *olution of physician and beneficiary*  
21                          *complaints and inquiries regarding the*  
22                          *shipment of covered outpatient drugs*  
23                          *and biologicals; and*

24                          *“(II) a grievance process for the*  
25                          *resolution of disputes.*



1           “(B) *ADDITIONAL CONSIDERATIONS.—The*  
2           *Secretary may refuse to award a contract under*  
3           *this section, and may terminate such a contract,*  
4           *with an entity based upon—*

5                     “(i) *the suspension or revocation, by*  
6                     *the Federal Government or a State govern-*  
7                     *ment, of the entity’s license for the distribu-*  
8                     *tion of drugs or biologicals (including con-*  
9                     *trolled substances); or*

10                    “(ii) *the exclusion of the entity under*  
11                    *section 1128 from participation under this*  
12                    *title.*

13           “(C) *APPLICATION OF MEDICARE PROVIDER*  
14           *OMBUDSMAN.—For provision providing for a*  
15           *program-wide Medicare Provider Ombudsman to*  
16           *review complaints, see section 1868(b), as added*  
17           *by section 923 of the Medicare Prescription Drug*  
18           *and Modernization Act of 2003.*

19           “(3) *AWARDING MULTIPLE CONTRACTS FOR A*  
20           *CATEGORY AND AREA.—In order to provide a choice*  
21           *of at least 2 contractors in each competitive acquisi-*  
22           *tion area for a category of drugs and biologicals, the*  
23           *Secretary may limit (but not below 2) the number of*  
24           *qualified entities that are awarded such contracts for*



1        *any category and area. The Secretary shall select*  
2        *among qualified entities based on the following:*

3                *“(A) The bid prices for covered outpatient*  
4                *drugs and biologicals within the category and*  
5                *area.*

6                *“(B) Bid price for distribution of such*  
7                *drugs and biologicals.*

8                *“(C) Ability to ensure product integrity.*

9                *“(D) Customer service.*

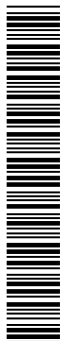
10               *“(E) Past experience in the distribution of*  
11               *drugs and biologicals, including controlled sub-*  
12               *stances.*

13               *“(F) Such other factors as the Secretary*  
14               *may specify.*

15               *“(4) TERMS OF CONTRACTS.—*

16               *“(A) IN GENERAL.—A contract entered into*  
17               *with an entity under the competition conducted*  
18               *pursuant to paragraph (1) is subject to terms*  
19               *and conditions that the Secretary may specify*  
20               *consistent with this section.*

21               *“(B) PERIOD OF CONTRACTS.—A contract*  
22               *under this section shall be for a term of 2 years,*  
23               *but may be terminated by the Secretary or the*  
24               *entity with appropriate, advance notice.*



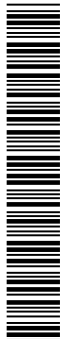


1                   “(C) *INTEGRITY OF DRUG AND BIOLOGICAL*  
2                   *DISTRIBUTION SYSTEM.—The Secretary—*

3                   “*(i) shall require that for all drug and*  
4                   *biological products distributed by a con-*  
5                   *tractor under this section be acquired di-*  
6                   *rectly from the manufacturer or from a dis-*  
7                   *tributor that has acquired the products di-*  
8                   *rectly from the manufacturer; and*

9                   “*(ii) may require, in the case of such*  
10                   *products that are particularly susceptible to*  
11                   *counterfeit or diversion, that the contractor*  
12                   *comply with such additional product integ-*  
13                   *egrity safeguards as may be determined to be*  
14                   *necessary.*

15                   “(D) *IMPLEMENTATION OF ANTI-COUNTER-*  
16                   *FEITING, QUALITY, SAFETY, AND RECORD KEEP-*  
17                   *ING REQUIREMENTS.—The Secretary shall re-*  
18                   *quire each contractor to implement (through its*  
19                   *officers, agents, representatives, and employees)*  
20                   *requirements relating to the storage and han-*  
21                   *dling of covered outpatient drugs and biologicals*  
22                   *and for the establishment and maintenance of*  
23                   *distribution records for such drugs and*  
24                   *biologicals. A contract under this section may*  
25                   *include requirements relating to the following:*



1                   “(i) *Secure facilities.*

2                   “(ii) *Safe and appropriate storage of*  
3                   *drugs and biologicals.*

4                   “(iii) *Examination of drugs and*  
5                   *biologicals received and dispensed.*

6                   “(iv) *Disposition of damaged and out-*  
7                   *dated drugs and biologicals.*

8                   “(v) *Record keeping and written poli-*  
9                   *cies and procedures.*

10                  “(vi) *Compliance personnel.*

11                  “(E) *COMPLIANCE WITH CODE OF CONDUCT*  
12                  *AND FRAUD AND ABUSE RULES.—Under the*  
13                  *contract—*

14                   “(i) *the contractor shall comply with a*  
15                   *code of conduct, specified or recognized by*  
16                   *the Secretary, that includes standards relat-*  
17                   *ing to conflicts of interest; and*

18                   “(ii) *the contractor shall comply with*  
19                   *all applicable provisions relating to preven-*  
20                   *tion of fraud and abuse, including compli-*  
21                   *ance with applicable guidelines of the De-*  
22                   *partment of Justice and the Inspector Gen-*  
23                   *eral of the Department of Health and*  
24                   *Human Services.*



1           “(F) *DIRECT DELIVERY OF DRUGS AND*  
2           *BIOLOGICALS TO PHYSICIANS.*—Under the con-  
3           tract the contractor shall only supply covered  
4           outpatient drugs and biologicals directly to the  
5           selecting physicians and not directly to bene-  
6           ficiaries, except under circumstances and settings  
7           where a beneficiary currently receives a drug or  
8           biological in the beneficiary’s home or other non-  
9           physician office setting as the Secretary may  
10          provide. The contractor shall not deliver drugs  
11          and biologicals to a selecting physician except  
12          upon receipt of a prescription for such drugs and  
13          biologicals, and such necessary data as may be  
14          required by the Secretary to carry out this sec-  
15          tion. This section does not require a physician to  
16          submit a prescription for each individual treat-  
17          ment and does not change the physician’s flexi-  
18          bility in terms of writing a prescription for  
19          drugs for a single treatment or a course of treat-  
20          ment.

21          “(5) *PERMITTING ACCESS TO DRUGS AND*  
22          *BIOLOGICALS.*—The Secretary shall establish rules  
23          under this section under which drugs and biologicals  
24          which are acquired through a contractor under this  
25          section may be used to resupply inventories of such



1       *drugs and biologicals which are administered con-*  
2       *sistent with safe drug practices and with adequate*  
3       *safeguards against fraud and abuse. The previous sen-*  
4       *tence shall apply—*

5               “(A) *in cases in which the drugs or*  
6               *biologicals are immediately required;*

7               “(B) *in cases in which the physician could*  
8               *not have reasonably anticipated the immediate*  
9               *requirement for the drugs or biologicals;*

10              “(C) *in cases in which the contractor could*  
11              *not deliver to the physician the drugs or*  
12              *biologicals in a timely manner; and*

13              “(D) *in emergency situations.*

14              “(6) *CONSTRUCTION.—Nothing in this section*  
15              *shall be construed as waiving applicable State re-*  
16              *quirements relating to licensing of pharmacies.*

17              “(c) *BIDDING PROCESS.—*

18              “(1) *IN GENERAL.—In awarding a contract for*  
19              *a category of drugs and biologicals in an area under*  
20              *the program, the Secretary shall consider with respect*  
21              *to each entity seeking to be awarded a contract the*  
22              *prices bid to acquire and supply the covered out-*  
23              *patient drugs and biologicals for that category and*  
24              *area and the other factors referred to in subsection*  
25              *(b)(3).*



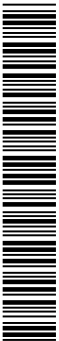
1           “(2) *PRICES BID.*—*The prices bid by an entity*  
2           *under paragraph (1) shall be the prices in effect and*  
3           *available for the supply of contracted drugs and*  
4           *biologicals in the area through the entity for the con-*  
5           *tract period.*

6           “(3) *REJECTION OF CONTRACT OFFER.*—*The Sec-*  
7           *retary shall reject the contract offer of an entity with*  
8           *respect to a category of drugs and biologicals for an*  
9           *area if the Secretary estimates that the prices bid, in*  
10           *the aggregate on average, would exceed 120 percent of*  
11           *the average sales price (as determined under section*  
12           *1847B).*

13           “(4) *BIDDING ON A NATIONAL OR REGIONAL*  
14           *BASIS.*—*Nothing in this section shall be construed as*  
15           *precluding a bidder from bidding for contracts in all*  
16           *areas of the United States or as requiring a bidder*  
17           *to submit a bid for all areas of the United States.*

18           “(5) *UNIFORMITY OF BIDS WITHIN AREA.*—*The*  
19           *amount of the bid submitted under a contract offer for*  
20           *any covered outpatient drug or biological for an area*  
21           *shall be the same for that drug or biological for all*  
22           *portions of that area.*

23           “(6) *CONFIDENTIALITY OF BIDS.*—*The provisions*  
24           *of subparagraph (D) of section 1927(b)(3) shall apply*  
25           *to a bid submitted in a contract offer for a covered*



1        *outpatient drug or biological under this section in the*  
2        *same manner as it applies to information disclosed*  
3        *under such section, except that any reference—*

4                *“(A) in that subparagraph to a ‘manufac-*  
5                *turer or wholesaler’ is deemed a reference to a*  
6                *‘bidder’ under this section;*

7                *“(B) in that section to ‘prices charged for*  
8                *drugs’ is deemed a reference to a ‘bid’ submitted*  
9                *under this section; and*

10               *“(C) in clause (i) of that section to ‘this sec-*  
11               *tion’, is deemed a reference to ‘part B of title*  
12               *XVIII’.*

13               *“(7) INCLUSION OF COSTS.—The bid price sub-*  
14               *mitted in a contract offer for a covered outpatient*  
15               *drug or biological shall—*

16               *“(A) include all costs related to the delivery*  
17               *of the drug or biological to the selecting physi-*  
18               *cian (or other point of delivery); and*

19               *“(B) include the costs of dispensing (includ-*  
20               *ing shipping) of such drug or biological and*  
21               *management fees, but shall not include any costs*  
22               *related to the administration of the drug or bio-*  
23               *logical, or wastage, spillage, or spoilage.*



1           “(8) *PRICE ADJUSTMENTS DURING CONTRACT*  
2 *PERIOD; DISCLOSURE OF COSTS.—Each contract*  
3 *awarded shall provide for—*

4           “(A) *disclosure to the Secretary the contrac-*  
5 *tor’s reasonable, net acquisition costs for periods*  
6 *specified by the Secretary, not more often than*  
7 *quarterly, of the contract; and*

8           “(B) *appropriate price adjustments over the*  
9 *period of the contract to reflect significant in-*  
10 *creases or decreases in a contractor’s reasonable,*  
11 *net acquisition costs, as so disclosed.*

12           “(d) *COMPUTATION OF AVERAGE BID PRICES FOR A*  
13 *CATEGORY AND AREA.—*

14           “(1) *IN GENERAL.—For each year or other con-*  
15 *tract period for each covered outpatient drug or bio-*  
16 *logical and area with respect to which a competition*  
17 *is conducted under the program, the Secretary shall*  
18 *compute an area average of the bid prices submitted,*  
19 *in contract offers accepted for the category and area,*  
20 *for that year or other contract period.*

21           “(2) *SPECIAL RULES.—The Secretary shall es-*  
22 *tablish rules regarding the use under this section of*  
23 *the alternative payment amount provided under sec-*  
24 *tion 1847B to the use of a price for specific covered*



1        *outpatient drugs and biologicals in the following*  
2        *cases:*

3                *“(A) NEW DRUGS AND BIOLOGICALS.—A*  
4                *covered outpatient drug or biological for which*  
5                *an average bid price has not been previously de-*  
6                *termined.*

7                *“(B) OTHER CASES.—Such other excep-*  
8                *tional cases as the Secretary may specify in reg-*  
9                *ulations.*

10        *Such alternative payment amount shall be based*  
11        *upon actual market price information and in no case*  
12        *shall it exceed the average sales price (as determined*  
13        *under section 1847B).*

14        *“(e) COINSURANCE.—*

15                *“(1) IN GENERAL.—Coinsurance under this part*  
16                *with respect to a covered outpatient drug or biological*  
17                *for which payment is payable under this section shall*  
18                *be based on 20 percent of the payment basis under*  
19                *this section.*

20                *“(2) COLLECTION.—Such coinsurance shall be*  
21                *collected by the contractor that supplies the drug or*  
22                *biological involved and, subject to subsection*  
23                *(a)(3)(B), in the same manner as coinsurance is col-*  
24                *lected for durable medical equipment under this part.*

25        *“(f) SPECIAL PAYMENT RULES.—*





1           “(1) *IN GENERAL.*—*The Secretary may not pro-*  
2           *vide for an adjustment to reimbursement for covered*  
3           *outpatient drugs and biologicals unless adjustments to*  
4           *the practice expense payment adjustment are made on*  
5           *the basis of supplemental surveys under section*  
6           *1848(c)(2)(H)(ii) of the Social Security Act, as added*  
7           *by subsection (a)(1)(B).*

8           “(B) *USE IN EXCLUSION CASES.*—*If the*  
9           *Secretary excludes a drug or biological (or class*  
10           *of drugs or biologicals) under subsection*  
11           *(a)(1)(D), the Secretary may provide for reim-*  
12           *bursement to be made under this part for such*  
13           *drugs and biologicals (or class) using the pay-*  
14           *ment methodology under section 1847B or other*  
15           *market based pricing system.*

16           “(2) *COORDINATION RULES.*—*The provisions of*  
17           *section 1842(h)(3) shall apply to a contractor with re-*  
18           *spect to covered outpatients drugs and biologicals sup-*  
19           *plied by that contractor in the same manner as they*  
20           *apply to a participating supplier. In order to admin-*  
21           *ister this section, the Secretary may condition pay-*  
22           *ment under this part to a person for the administra-*  
23           *tion of a drug or biological supplied under this sec-*  
24           *tion upon person’s provision of information on such*  
25           *administration.*



1           “(3) *APPLICATION OF REQUIREMENT FOR AS-*  
2           *SIGNMENT.—For provision requiring assignment of*  
3           *claims for covered outpatient drugs and biologicals,*  
4           *see section 1842(o)(3).*

5           “(4) *PROTECTION FOR BENEFICIARY IN CASE OF*  
6           *MEDICAL NECESSITY DENIAL.—For protection of bene-*  
7           *ficiaries against liability in the case of medical neces-*  
8           *sity determinations, see section 1842(b)(3)(B)(ii)(III).*

9           “(5) *PHYSICIAN ROLE IN APPEALS PROCESS.—*  
10          *The Secretary shall establish a procedure under which*  
11          *a physician who prescribes a drug or biological for*  
12          *which payment is made under this section has appeal*  
13          *rights that are similar to those provided to a physi-*  
14          *cian who prescribes durable medical equipment or a*  
15          *laboratory test.*

16          “(g) *ADVISORY COMMITTEE.—The Secretary shall es-*  
17          *tablish an advisory committee that includes representatives*  
18          *of parties affected by the program under this section, in-*  
19          *cluding physicians, specialty pharmacies, distributors,*  
20          *manufacturers, and beneficiaries. The committee shall ad-*  
21          *vis the Secretary on issues relating to the effective imple-*  
22          *mentation of this section.*

23          “(h) *ANNUAL REPORTS.—The Secretary shall submit*  
24          *to Congress an annual report in each of 2004, 2005, and*  
25          *2006, on the program. Each such report shall include infor-*



1 *mation on savings, reductions in cost-sharing, access to cov-*  
2 *ered outpatient drugs and biologicals, the range of choices*  
3 *of contractors available to providers, and beneficiary and*  
4 *provider satisfaction.*

5       “OPTIONAL USE OF AVERAGE SALES PRICE PAYMENT

6                                   METHODOLOGY

7       “SEC. 1847B. (a) *IN GENERAL.*—*In connection with*  
8 *the election made by a physician under section*  
9 *1847A(a)(5), the physician may elect to apply this section*  
10 *to the payment for covered outpatient drugs instead of the*  
11 *payment methodology under section 1847A. For purposes*  
12 *of this section, the term ‘covered outpatient drug’ has the*  
13 *meaning given such term in section 1847A(a)(2)(A).*

14       “(b) *COMPUTATION OF PAYMENT AMOUNT.*—

15               “(1) *IN GENERAL.*—*If this section applies with*  
16 *respect to a covered outpatient drug, the amount pay-*  
17 *able for the drug (based on a minimum dosage unit)*  
18 *is, subject to applicable deductible and coinsurance—*

19                       “(A) *in the case of a multiple source drug*  
20 *(as defined in subsection (c)(6)(C)), the amount*  
21 *determined under paragraph (3); or*

22                       “(B) *in the case of a single source drug (as*  
23 *defined in subsection (c)(6)(D)), the amount de-*  
24 *termined under paragraph (4).*

25       “(2) *SPECIFICATION OF UNIT.*—



1           “(A) *SPECIFICATION BY MANUFACTURER.*—  
2           *The manufacturer of a covered outpatient drug*  
3           *shall specify the unit associated with each Na-*  
4           *tional Drug Code as part of the submission of*  
5           *data under section 1927(b)(3)(A)(iii).*

6           “(B) *UNIT DEFINED.*—*In this section, the*  
7           *term ‘unit’ means, with respect to a covered out-*  
8           *patient drug, the lowest identifiable quantity*  
9           *(such as a capsule or tablet, milligram of mol-*  
10           *ecules, or grams) of the drug that is dispensed,*  
11           *exclusive of any diluent without reference to vol-*  
12           *ume measures pertaining to liquids.*

13           “(3) *MULTIPLE SOURCE DRUG.*—*For all drug*  
14           *products included within the same multiple source*  
15           *drug, the amount specified in this paragraph is the*  
16           *volume-weighted average of the average sales prices*  
17           *reported under section 1927(b)(3)(A)(iii) computed as*  
18           *follows:*

19           “(A) *Compute the sum of the products (for*  
20           *each national drug code assigned to such drug*  
21           *products) of—*

22                   “(i) *the manufacturer’s average sales*  
23                   *price (as defined in subsection (c)); and*



1                   “(ii) the total number of units specified  
2                   under paragraph (2) sold, as reported under  
3                   section 1927(b)(3)(A)(iii).

4                   “(B) Divide the sum computed under sub-  
5                   paragraph (A) by the sum of the total number  
6                   of units under subparagraph (A)(ii) for all na-  
7                   tional drug codes assigned to such drug products.

8                   “(4) SINGLE SOURCE DRUG.—The amount speci-  
9                   fied in this paragraph for a single source drug is the  
10                  lesser of the following:

11                  “(A) MANUFACTURER’S AVERAGE SALES  
12                  PRICE.—The manufacturer’s average sales price  
13                  for a national drug code, as computed using the  
14                  methodology applied under paragraph (3).

15                  “(B) WHOLESALE ACQUISITION COST  
16                  (WAC).—The wholesale acquisition cost (as de-  
17                  fined in subsection (c)(6)(B)) reported for the  
18                  single source drug.

19                  “(5) BASIS FOR DETERMINATION.—The payment  
20                  amount shall be determined under this subsection  
21                  based on information reported under subsection (e)  
22                  and without regard to any special packaging, label-  
23                  ing, or identifiers on the dosage form or product or  
24                  package.

25                  “(c) MANUFACTURER’S AVERAGE SALES PRICE.—



1           “(1) *IN GENERAL.*—For purposes of this sub-  
2           section, subject to paragraphs (2) and (3), the manu-  
3           facturer’s ‘average sales price’ means, of a covered  
4           outpatient drug for a NDC code for a calendar quar-  
5           ter for a manufacturer for a unit—

6                   “(A) the manufacturer’s total sales (as de-  
7                   fined by the Secretary in regulations for pur-  
8                   poses of section 1927(c)(1)) in the United States  
9                   for such drug in the calendar quarter; divided by

10                   “(B) the total number of such units of such  
11                   drug sold by the manufacturer in such quarter.

12           “(2) *CERTAIN SALES EXEMPTED FROM COMPUTA-*  
13           *TION.*—In calculating the manufacturer’s average  
14           sales price under this subsection, the following sales  
15           shall be excluded:

16                   “(A) *SALES EXEMPT FROM BEST PRICE.*—  
17                   Sales exempt from the inclusion in the deter-  
18                   mination of ‘best price’ under section  
19                   1927(c)(1)(C)(i).

20                   “(B) *SALES AT NOMINAL CHARGE.*—Such  
21                   other sales as the Secretary identifies by regula-  
22                   tion as sales to an entity that are nominal in  
23                   price or do not reflect a market price paid by an  
24                   entity to which payment is made under this sec-  
25                   tion.



1           “(3) *SALE PRICE NET OF DISCOUNTS.*—*In calcu-*  
2           *lating the manufacturer’s average sales price under*  
3           *this subsection, such price shall be determined taking*  
4           *into account volume discounts, prompt pay discounts,*  
5           *cash discounts, the free goods that are contingent on*  
6           *any purchase requirement, chargebacks, and rebates*  
7           *(other than rebates under section 1927), that result in*  
8           *a reduction of the cost to the purchaser. A rebate to*  
9           *a payor or other entity that does not take title to a*  
10           *covered outpatient drug shall not be taken into ac-*  
11           *count in determining such price unless the manufac-*  
12           *turer has an agreement with the payor or other entity*  
13           *under which the purchaser’s price for the drug is re-*  
14           *duced as a consequence of such rebate.*

15           “(4) *AUTHORITY TO DISREGARD AVERAGE SALES*  
16           *PRICE DURING FIRST QUARTER OF SALES.*—*In the*  
17           *case of a covered outpatient drug during an initial*  
18           *period (not to exceed a full calendar quarter) in*  
19           *which data on the prices for sales for the drug is not*  
20           *sufficiently available from the manufacturer to com-*  
21           *pute an average sales price for the drug, the Secretary*  
22           *may determine the amount payable under this section*  
23           *for the drug without considering the manufacturer’s*  
24           *average sales price of that manufacturer for that*  
25           *drug.*



1           “(5) *FREQUENCY OF DETERMINATIONS.*—

2                   “(A) *IN GENERAL ON A QUARTERLY*  
3           *BASIS.*—*The manufacturer’s average sales price,*  
4           *for a covered outpatient drug of a manufacturer,*  
5           *shall be determined by such manufacturer under*  
6           *this subsection on a quarterly basis. In making*  
7           *such determination insofar as there is a lag in*  
8           *the reporting of the information on rebates and*  
9           *chargebacks under paragraph (3) so that ade-*  
10           *quate data are not available on a timely basis,*  
11           *the manufacturer shall apply a methodology es-*  
12           *tablished by the Secretary based on a 12-month*  
13           *rolling average for the manufacturer to estimate*  
14           *costs attributable to rebates and chargebacks.*

15                   “(B) *UPDATES IN RATES.*—*The payment*  
16           *rates under subsection (b)(1) and (b)(2)(A) shall*  
17           *be updated by the Secretary on a quarterly basis*  
18           *and shall be applied based upon the manufactur-*  
19           *er’s average sales price determined for the most*  
20           *recent calendar quarter.*

21                   “(C) *USE OF CONTRACTORS; IMPLEMENTA-*  
22           *TION.*—*The Secretary may use a carrier, fiscal*  
23           *intermediary, or other contractor to determine*  
24           *the payment amount under subsection (b). Not-*  
25           *withstanding any other provision of law, the*





1            *Secretary may implement, by program memo-*  
2            *randum or otherwise, any of the provisions of*  
3            *this section.*

4            “(6) *DEFINITIONS AND OTHER RULES.—In this*  
5            *section:*

6                    “(A) *MANUFACTURER.—The term ‘manufac-*  
7                    *turer’ means, with respect to a covered out-*  
8                    *patient drug, the manufacturer (as defined in*  
9                    *section 1927(k)(5)) whose national drug code ap-*  
10                   *pears on such drug.*

11                   “(i) *WHOLESALE ACQUISITION COST.—The*  
12                   *term ‘wholesale acquisition cost’ means, with re-*  
13                   *spect to a covered outpatient drug, the manufac-*  
14                   *turer’s list price for the drug to wholesalers or*  
15                   *direct purchasers in the United States, not in-*  
16                   *cluding prompt pay or other discounts, rebates*  
17                   *or reductions in price, for the most recent month*  
18                   *for which the information is available, as re-*  
19                   *ported in wholesale price guides or other publica-*  
20                   *tions of drug pricing data.*

21                   “(C) *MULTIPLE SOURCE DRUG.—The term*  
22                   *‘multiple source drug’ means, for a calendar*  
23                   *quarter, a covered outpatient drug for which*  
24                   *there are 2 or more drug products which—*



1                   “(i) are rated as therapeutically equiv-  
2                   alent (under the Food and Drug Adminis-  
3                   tration’s most recent publication of ‘Ap-  
4                   proved Drug Products with Therapeutic  
5                   Equivalence Evaluations’),

6                   “(ii) except as provided in subpara-  
7                   graph (E), are pharmaceutically equivalent  
8                   and bioequivalent, as determined under sub-  
9                   paragraph (F) and as determined by the  
10                  Food and Drug Administration, and

11                  “(iii) are sold or marketed in the  
12                  United States during the quarter.

13                  “(D) SINGLE SOURCE DRUG.—The term  
14                  ‘single source drug’ means a covered outpatient  
15                  drug which is not a multiple source drug and  
16                  which is produced or distributed under an origi-  
17                  nal new drug application approved by the Food  
18                  and Drug Administration, including a drug  
19                  product marketed by any cross-licensed pro-  
20                  ducers or distributors operating under the new  
21                  drug application, or which is a biological.

22                  “(E) EXCEPTION FROM PHARMACEUTICAL  
23                  EQUIVALENCE AND BIOEQUIVALENCE REQUIRE-  
24                  MENT.—Subparagraph (C)(ii) shall not apply if  
25                  the Food and Drug Administration changes by



1 regulation the requirement that, for purposes of  
2 the publication described in subparagraph (C)(i),  
3 in order for drug products to be rated as thera-  
4apeutically equivalent, they must be pharmaceuti-  
5cally equivalent and bioequivalent, as defined in  
6 subparagraph (F).

7 “(F) DETERMINATION OF PHARMACEUTICAL  
8 EQUIVALENCE AND BIOEQUIVALENCE.—For pur-  
9 poses of this paragraph—

10 “(i) drug products are pharmaceuti-  
11cally equivalent if the products contain  
12 identical amounts of the same active drug  
13 ingredient in the same dosage form and  
14 meet compendial or other applicable stand-  
15ards of strength, quality, purity, and iden-  
16tity; and

17 “(ii) drugs are bioequivalent if they do  
18 not present a known or potential bioequiva-  
19lence problem, or, if they do present such a  
20 problem, they are shown to meet an appro-  
21priate standard of bioequivalence.

22 “(G) INCLUSION OF VACCINES.—In apply-  
23ing provisions of section 1927 under this section,  
24 ‘other than a vaccine’ is deemed deleted from sec-  
25tion 1927(k)(2)(B).



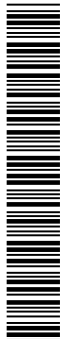
1       “(d) *MONITORING PRICE INFORMATION.*—

2               “(1) *IN GENERAL.*—*The Secretary shall monitor*  
3       *available pricing information, including information*  
4       *on average sales price and average manufacturer*  
5       *price.*

6               “(2) *RESPONSE TO SIGNIFICANT DISCREP-*  
7       *ANCIES.*—

8               “(A) *REPORT TO CONGRESS.*—*If the Sec-*  
9       *retary finds that there are significant discrep-*  
10       *ancies among such prices and that the manufac-*  
11       *turer’s average sales price does not reflect a*  
12       *broad-based market price or a reasonable ap-*  
13       *proximation of the acquisition cost of the covered*  
14       *outpatient drug involved to purchasers reim-*  
15       *bursed under this section, the Secretary shall*  
16       *submit to Congress a report.*

17               “(B) *CONFIDENTIALITY OF INFORMATION*  
18       *REPORTED.*—*Consistent with requirements relat-*  
19       *ing to maintaining the confidentiality of infor-*  
20       *mation reported on manufacturer’s average*  
21       *prices under section 1927(b)(3)(D), such report*  
22       *shall include details regarding such discrepancies*  
23       *and recommendations on how to best address*  
24       *such discrepancies. Such report shall not disclose*



1           *average manufacturer prices or average sales*  
2           *prices.*

3           “(C)    *RECOMMENDATIONS.—Such rec-*  
4           *ommendations may include other changes in*  
5           *payment methodology.*

6           “(D)    *AUTHORITY TO MODIFY PAYMENT*  
7           *METHODOLOGY BY RULE.—Upon submission of*  
8           *such report, the Secretary may commence a rule-*  
9           *making to change such percent or payment meth-*  
10          *odologies under paragraph (1)(D) and (2) as ap-*  
11          *plied to the covered outpatient drug involved*  
12          *under this section.*

13          “(3)    *RESPONSE TO PUBLIC HEALTH EMER-*  
14          *GENCY.—In the case of a public health emergency*  
15          *under section 319 of the Public Health Service Act in*  
16          *which there is a documented inability to access cov-*  
17          *ered outpatient drugs, and a concomitant increase in*  
18          *the price, of a drug which is not reflected in the man-*  
19          *ufacturer’s average sales price for one or more quar-*  
20          *ters, the Secretary may use the wholesale acquisition*  
21          *cost (or other reasonable measure of drug price) in-*  
22          *stead of the manufacturer’s average sales price for*  
23          *such quarters and for subsequent quarters until the*  
24          *price and availability of the drug has stabilized and*



1        *is substantially reflected in the applicable manufac-*  
2        *turer's average sales price.*

3                *“(4) ANNUAL REPORT TO CONGRESS.—The Sec-*  
4        *retary shall submit to the Committees on Energy and*  
5        *Commerce and Ways and Means of the House of Rep-*  
6        *resentatives and the Committee on Finance of the*  
7        *Senate an annual report on the operation of this sec-*  
8        *tion. Such report shall be submitted in coordination*  
9        *with the submission of reports under section 1927(i).*  
10       *Such report shall include information on the fol-*  
11       *lowing:*

12                *“(A) Trends in average sales price under*  
13        *subsection (b).*

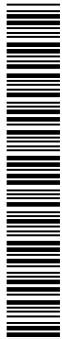
14                *“(B) Administrative costs associated with*  
15        *compliance with this section.*

16                *“(C) Total value of payments made under*  
17        *this section.*

18                *“(D) Comparison of the average manufac-*  
19        *turer price as applied under section 1927 for a*  
20        *covered outpatient drug with the manufacturer's*  
21        *average sales price for the drug under this sec-*  
22        *tion.*

23        *“(e) REPORTS ON PRICING INFORMATION.—*

24                *“(1) REFERENCE TO REPORTING REQUIREMENT*  
25        *ON AVERAGE SALES PRICE.—For requirements for re-*



1        *porting the manufacturer's average sales price (and,*  
2        *if required to make payment, the manufacturer's*  
3        *wholesale acquisition cost) for the covered outpatient*  
4        *drug, see section 1927(b)(3).*

5            *“(2) MEDPAC REVIEW.—The Medicare Payment*  
6        *Advisory Commission shall periodically review the*  
7        *payment methodology established under this section*  
8        *and submit to Congress such recommendations on*  
9        *such methodology as it deems appropriate as part of*  
10       *its annual reports to Congress.*

11           *“(3) CONSTRUCTION.—Nothing in this subsection*  
12        *shall be construed as authorizing the Secretary to re-*  
13        *view for purposes of this section information reported*  
14        *only under section 1927(b)(3).*

15           *“(f) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL*  
16        *REVIEW.—There shall be no administrative or judicial re-*  
17        *view under section 1869, section 1878, or otherwise, of de-*  
18        *terminations of manufacturer's average sales price under*  
19        *subsection (c).”.*

20           *(c) CONTINUATION OF PAYMENT METHODOLOGY FOR*  
21        *RADIOPHARMACEUTICALS.—Nothing in the amendments*  
22        *made by this section shall be construed as changing the pay-*  
23        *ment methodology under part B of title XVIII of the Social*  
24        *Security Act for radiopharmaceuticals, including the use by*  
25        *carriers of invoice pricing methodology.*



1           (d) *CONFORMING AMENDMENTS.*—

2                 (1) *IN GENERAL.*—Section 1842(o) (42 U.S.C.  
3           1395u(o)) is amended—

4                     (A) in paragraph (1), by inserting “, sub-  
5                     ject to section 1847A and 1847B,” before “the  
6                     amount payable for the drug or biological”; and

7                     (B) by adding at the end of paragraph (2)  
8                     the following: “This paragraph shall not apply  
9                     in the case of payment under section 1847A or  
10                    1847B.”.

11                 (2) *NO CHANGE IN COVERAGE BASIS.*—Section  
12           1861(s)(2)(A) (42 U.S.C. 1395x(s)(2)(A)) is amended  
13           by inserting “(or would have been so included but for  
14           the application of section 1847A or 1847B)” after  
15           “included in the physicians’ bills”.

16                 (3) *PAYMENT.*—Section 1833(a)(1)(S) (42  
17           U.S.C. 1395l(a)(1)(S)) is amended by inserting “(or,  
18           if applicable, under section 1847A or 1847B)” after  
19           “1842(o)”.

20                 (4) *CONSOLIDATED REPORTING OF PRICING IN-*  
21           *FORMATION.*—Section 1927 (42 U.S.C. 1396r–8) is  
22           amended—

23                     (A) in subsection (a)(1), by inserting “or  
24                     under part B of title XVIII” after “section  
25                     1903(a)”;





1 *(B) in subsection (b)(3)(A)—*

2 *(i) in clause (i), by striking “and” at*  
3 *the end;*

4 *(ii) in clause (ii), by striking the pe-*  
5 *riod and inserting “; and”; and*

6 *(iii) by adding at the end the following*  
7 *new clause:*

8 *“(iii) for calendar quarters beginning*  
9 *on or after April 1, 2004, in conjunction*  
10 *with reporting required under clause (i)*  
11 *and by national drug code (NDC)—*

12 *“(I) the manufacturer’s average*  
13 *sales price (as defined in section*  
14 *1847B(c)) and the total number of*  
15 *units specified under section*  
16 *1847B(b)(2)(A);*

17 *“(II) if required to make payment*  
18 *under section 1847B, the manufactur-*  
19 *er’s wholesale acquisition cost, as de-*  
20 *fined in subsection (c)(6) of such sec-*  
21 *tion; and*

22 *“(III) information on those sales*  
23 *that were made at a nominal price or*  
24 *otherwise described in section*  
25 *1847B(c)(2)(B), which information is*



1                   *subject to audit by the Inspector Gen-*  
2                   *eral of the Department of Health and*  
3                   *Human Services;*

4                   *for a covered outpatient drug for which*  
5                   *payment is made under section 1847B.”;*

6                   *(C) in subsection (b)(3)(B)—*

7                   (i) *in the heading, by inserting “AND*  
8                   *MANUFACTURER’S AVERAGE SALES PRICE”*  
9                   *after “PRICE”; and*

10                   (ii) *by inserting “and manufacturer’s*  
11                   *average sales prices (including wholesale ac-*  
12                   *quisition cost) if required to make pay-*  
13                   *ment” after “manufacturer prices”; and*

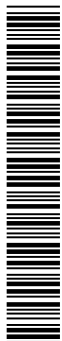
14                   *(D) in subsection (b)(3)(D)(i), by inserting*  
15                   *“and section 1847B” after “this section”.*

16                   *(e) GAO STUDY.—*

17                   (1) *STUDY.—The Comptroller General of the*  
18                   *United States shall conduct a study to assess the im-*  
19                   *pect of the amendments made by this section on the*  
20                   *delivery of services, including their impact on—*

21                   (A) *beneficiary access to drugs and*  
22                   *biologicals for which payment is made under*  
23                   *part B of title XVIII of the Social Security Act;*  
24                   *and*

25                   (B) *the site of delivery of such services.*



1           (2) *REPORT.*—Not later than 2 years after the  
2           year in which the amendment made by subsection  
3           (a)(1) first takes effect, the Comptroller General shall  
4           submit to Congress a report on the study conducted  
5           under paragraph (1).

6           (f) *MEDPAC RECOMMENDATIONS ON BLOOD CLOT-*  
7           *TING FACTORS.*—The Medicare Payment Advisory Commis-  
8           sion shall submit to Congress, in its annual report in 2004,  
9           specific recommendations regarding a payment amount (or  
10          amounts) for blood clotting factors and its administration  
11          under the medicare program.

12          (g) *ESTABLISHMENT OF PHARMACEUTICAL MANAGE-*  
13          *MENT FEE WHERE DRUGS PROVIDED THROUGH A CON-*  
14          *TRACTOR.*—Section 1848(a) (42 U.S.C. 1395w-4(a)) is  
15          amended by adding at the end the following new paragraph:

16                 “(5) *RECOGNITION OF PHARMACEUTICAL MAN-*  
17                 *AGEMENT FEE IN CERTAIN CASES.*—In establishing  
18                 the fee schedule under this section, the Secretary shall  
19                 provide for a separate payment with respect to physi-  
20                 cians’ services consisting of the unique administrative  
21                 and management costs associated with covered drugs  
22                 and biologicals which are furnished to physicians  
23                 through a contractor under section 1847A (compared  
24                 with such costs if such drugs and biologicals were ac-  
25                 quired directly by such physicians).”.



1 **SEC. 304. DEMONSTRATION PROJECT FOR USE OF RECOV-**  
2 **ERY AUDIT CONTRACTORS.**

3 (a) *IN GENERAL.*—*The Secretary of Health and*  
4 *Human Services shall conduct a demonstration project*  
5 *under this section (in this section referred to as the*  
6 *“project”) to demonstrate the use of recovery audit contrac-*  
7 *tors under the Medicare Integrity Program in identifying*  
8 *underpayments and overpayments and recouping overpay-*  
9 *ments under the medicare program for services for which*  
10 *payment is made under part A or part B of title XVIII*  
11 *of the Social Security Act. Under the project—*

12 (1) *payment may be made to such a contractor*  
13 *on a contingent basis;*

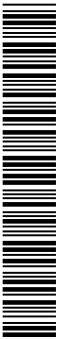
14 (2) *a percentage of the amount recovered may be*  
15 *retained by the Secretary and shall be available to the*  
16 *program management account of the Centers for*  
17 *Medicare & Medicaid Services; and*

18 (3) *the Secretary shall examine the efficacy of*  
19 *such use with respect to duplicative payments, accu-*  
20 *racy of coding, and other payment policies in which*  
21 *inaccurate payments arise.*

22 (b) *SCOPE AND DURATION.*—

23 (1) *SCOPE.*—*The project shall cover at least 2*  
24 *States that are among the States with—*

25 (A) *the highest per capita utilization rates*  
26 *of medicare services, and*



1                   (B) *at least 3 contractors.*

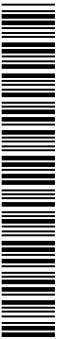
2                   (2) *DURATION.—The project shall last for not*  
3                   *longer than 3 years.*

4                   (c) *WAIVER.—The Secretary of Health and Human*  
5                   *Services shall waive such provisions of title XVIII of the*  
6                   *Social Security Act as may be necessary to provide for pay-*  
7                   *ment for services under the project in accordance with sub-*  
8                   *section (a).*

9                   (d) *QUALIFICATIONS OF CONTRACTORS.—*

10                   (1) *IN GENERAL.—The Secretary shall enter into*  
11                   *a recovery audit contract under this section with an*  
12                   *entity only if the entity has staff that has the appro-*  
13                   *priate clinical knowledge of and experience with the*  
14                   *payment rules and regulations under the medicare*  
15                   *program or the entity has or will contract with an-*  
16                   *other entity that has such knowledgeable and experi-*  
17                   *enced staff.*

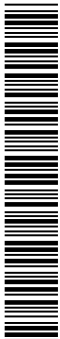
18                   (2) *INELIGIBILITY OF CERTAIN CONTRACTORS.—*  
19                   *The Secretary may not enter into a recovery audit*  
20                   *contract under this section with an entity to the ex-*  
21                   *tent that the entity is a fiscal intermediary under sec-*  
22                   *tion 1816 of the Social Security Act (42 U.S.C.*  
23                   *1395h), a carrier under section 1842 of such Act (42*  
24                   *U.S.C. 1395u), or a Medicare Administrative Con-*  
25                   *tractor under section 1874A of such Act.*



1           (3) *PREFERENCE FOR ENTITIES WITH DEM-*  
2           *ONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—*  
3           *In awarding contracts to recovery audit contractors*  
4           *under this section, the Secretary shall give preference*  
5           *to those risk entities that the Secretary determines*  
6           *have demonstrated more than 3 years direct manage-*  
7           *ment experience and a proficiency in recovery audits*  
8           *with private insurers or under the medicaid program*  
9           *under title XIX of such Act.*

10          (e) *CONSTRUCTION RELATING TO CONDUCT OF INVES-*  
11          *TIGATION OF FRAUD.—A recovery of an overpayment to a*  
12          *provider by a recovery audit contractor shall not be con-*  
13          *strued to prohibit the Secretary or the Attorney General*  
14          *from investigating and prosecuting, if appropriate, allega-*  
15          *tions of fraud or abuse arising from such overpayment.*

16          (f) *REPORT.—The Secretary of Health and Human*  
17          *Services shall submit to Congress a report on the project*  
18          *not later than 6 months after the date of its completion.*  
19          *Such reports shall include information on the impact of the*  
20          *project on savings to the medicare program and rec-*  
21          *ommendations on the cost-effectiveness of extending or ex-*  
22          *panding the project.*



1 **TITLE IV—RURAL HEALTH CARE**  
2 **IMPROVEMENTS**

3 **SEC. 401. ENHANCED DISPROPORTIONATE SHARE HOS-**  
4 **PITAL (DSH) TREATMENT FOR RURAL HOS-**  
5 **PITALS AND URBAN HOSPITALS WITH FEWER**  
6 **THAN 100 BEDS.**

7 (a) *DOUBLING THE CAP.*—

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

11 “(xiv)(I) In the case of discharges in a fiscal year be-  
12 ginning on or after October 1, 2003, subject to subclause  
13 (II), there shall be substituted for the disproportionate share  
14 adjustment percentage otherwise determined under clause  
15 (iv) (other than subclause (I)) or under clause (viii), (x),  
16 (xi), (xii), or (xiii), the disproportionate share adjustment  
17 percentage determined under clause (vii) (relating to large,  
18 urban hospitals).

19 “(II) Under subclause (I), the disproportionate share  
20 adjustment percentage shall not exceed 10 percent for a hos-  
21 pital that is not classified as a rural referral center under  
22 subparagraph (C).”.

23 (2) *CONFORMING AMENDMENTS.*—Section  
24 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
25 amended—



1           (A) in each of subclauses (II), (III), (IV),  
2           (V), and (VI) of clause (iv), by inserting “subject  
3           to clause (xiv) and” before “for discharges occur-  
4           ring”;

5           (B) in clause (viii), by striking “The for-  
6           mula” and inserting “Subject to clause (xiv), the  
7           formula”; and

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

11          (b) *EFFECTIVE DATE.*—The amendments made by this  
12 section shall apply with respect to discharges occurring on  
13 or after October 1, 2003.

14 **SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM**  
15 **STANDARDIZED AMOUNT IN RURAL AND**  
16 **SMALL URBAN AREAS.**

17          (a) *IN GENERAL.*—Section 1886(d)(3)(A) (42 U.S.C.  
18 1395ww(d)(3)(A)) is amended—

19           (1) in clause (iv), by inserting “and ending on  
20           or before September 30, 2003,” after “October 1,  
21           1995,”; and

22           (2) by redesignating clauses (v) and (vi) as  
23           clauses (vii) and (viii), respectively, and inserting  
24           after clause (iv) the following new clauses:





1           “(v) For discharges occurring in the fiscal year  
2           beginning on October 1, 2003, the average standard-  
3           ized amount for hospitals located in areas other than  
4           a large urban area shall be equal to the average  
5           standardized amount for hospitals located in a large  
6           urban area.”.

7           (b) CONFORMING AMENDMENTS.—

8           (1) COMPUTING DRG-SPECIFIC RATES.—Section  
9           1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is  
10          amended—

11           (A) in the heading, by striking “IN DIF-  
12          FERENT AREAS”;

13           (B) in the matter preceding clause (i), by  
14          striking “, each of”;

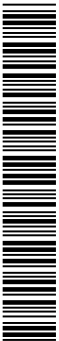
15           (C) in clause (i)—

16           (i) in the matter preceding subclause  
17          (I), by inserting “for fiscal years before fis-  
18          cal year 2004,” before “for hospitals”; and

19           (ii) in subclause (II), by striking  
20          “and” after the semicolon at the end;

21           (D) in clause (ii)—

22           (i) in the matter preceding subclause  
23          (I), by inserting “for fiscal years before fis-  
24          cal year 2004,” before “for hospitals”; and



1                   (ii) in subclause (II), by striking the  
2                   period at the end and inserting “; and”;  
3                   and

4                   (E) by adding at the end the following new  
5                   clause:

6                   “(iii) for a fiscal year beginning after fiscal  
7                   year 2003, for hospitals located in all areas, to  
8                   the product of—

9                   “(I) the applicable standardized  
10                  amount (computed under subparagraph  
11                  (A)), reduced under subparagraph (B), and  
12                  adjusted or reduced under subparagraph (C)  
13                  for the fiscal year; and

14                  “(II) the weighting factor (determined  
15                  under paragraph (4)(B)) for that diagnosis-  
16                  related group.”.

17                  (2) *TECHNICAL CONFORMING SUNSET.*—Section  
18                  1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

19                  (A) in the matter preceding subparagraph  
20                  (A), by inserting “, for fiscal years before fiscal  
21                  year 1997,” before “a regional adjusted DRG  
22                  prospective payment rate”; and

23                  (B) in subparagraph (D), in the matter  
24                  preceding clause (i), by inserting “, for fiscal



1           *years before fiscal year 1997,” before “a regional*  
2           *DRG prospective payment rate for each region,”.*

3   **SEC. 403. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL**  
4                           **CLASSIFICATION.**

5           *(a) CLASSIFICATION.—Section 1861(mm) (42 U.S.C.*  
6   *1395x(mm)) is amended—*

7                   *(1) in the heading by adding “ESSENTIAL*  
8           *RURAL HOSPITALS” at the end; and*

9                   *(2) by adding at the end the following new para-*  
10   *graphs:*

11           *“(4)(A) The term ‘essential rural hospital’ means a*  
12   *subsection (d) hospital (as defined in section 1886(d)(1)(B))*  
13   *that is located in a rural area (as defined for purposes of*  
14   *section 1886(d)), has more than 25 licensed acute care inpa-*  
15   *tient beds, has applied to the Secretary for classification*  
16   *as such a hospital, and with respect to which the Secretary*  
17   *has determined that the closure of the hospital would sig-*  
18   *nificantly diminish the ability of medicare beneficiaries to*  
19   *obtain essential health care services.*

20           *“(B) The determination under subparagraph (A) shall*  
21   *be based on the following criteria:*

22                   *“(i) HIGH PROPORTION OF MEDICARE BENE-*  
23    *FICIARIES RECEIVING CARE FROM HOSPITAL.—(I) A*  
24    *high percentage of such beneficiaries residing in the*  
25    *area of the hospital who are hospitalized (during the*



1        *most recent year for which complete data are avail-*  
2        *able) receive basic inpatient medical care at the hos-*  
3        *pital.*

4            *“(II) For a hospital with more than 200 licensed*  
5        *beds, a high percentage of such beneficiaries residing*  
6        *in such area who are hospitalized (during such recent*  
7        *year) receive specialized surgical inpatient care at the*  
8        *hospital.*

9            *“(III) Almost all physicians described in section*  
10       *1861(r)(1) in such area have privileges at the hospital*  
11       *and provide their inpatient services primarily at the*  
12       *hospital.*

13            *“(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE*  
14       *OF HOSPITAL.—If the hospital were to close—*

15            *“(I) there would be a significant amount of*  
16       *time needed for residents to reach emergency*  
17       *treatment, resulting in a potential significant*  
18       *harm to beneficiaries with critical illnesses or*  
19       *injuries;*

20            *“(II) there would be an inability in the*  
21       *community to stabilize emergency cases for trans-*  
22       *fers to another acute care setting, resulting in a*  
23       *potential for significant harm to medicare bene-*  
24       *ficiaries; and*



1                   “(III) any other nearby hospital lacks the  
2                   physical and clinical capacity to take over the  
3                   hospital’s typical admissions.

4                   “(C) In making such determination, the Secretary  
5 may also consider the following:

6                   “(i) Free-standing ambulatory surgery centers,  
7                   office-based oncology care, and imaging center services  
8                   are insufficient in the hospital’s area to handle the  
9                   outpatient care of the hospital.

10                   “(ii) Beneficiaries in nearby areas would be ad-  
11                   versely affected if the hospital were to close as the hos-  
12                   pital provides specialized knowledge and services to a  
13                   network of smaller hospitals and critical access hos-  
14                   pitals.

15                   “(iii) Medicare beneficiaries would have dif-  
16                   ficulty in accessing care if the hospital were to close  
17                   as the hospital provides significant subsidies to sup-  
18                   port ambulatory care in local clinics, including men-  
19                   tal health clinics and to support post acute care.

20                   “(iv) The hospital has a committment to provide  
21                   graduate medical education in a rural area.

22                   “(C) QUALITY CARE.—The hospital inpatient  
23                   score for quality of care is not less than the median  
24                   hospital score for qualify of care for hospitals in the  
25                   State, as established under standards of the utiliza-



1        *tion and quality control peer review organization*  
2        *under part B of title XI or other quality standards*  
3        *recognized by the Secretary.*

4        *A hospital classified as an essential rural hospital may not*  
5        *change such classification and a hospital so classified shall*  
6        *not be treated as a sole community hospital, medicare de-*  
7        *pendent hospital, or rural referral center for purposes of*  
8        *section 1886.”.*

9        *(b) PAYMENT BASED ON 102 PERCENT OF ALLOWED*  
10       *COSTS.—*

11                *(1) INPATIENT HOSPITAL SERVICES.—Section*  
12                *1886(d) (42 U.S.C. 1395ww(d)) is amended by add-*  
13                *ing at the end the following:*

14                *“(11) In the case of a hospital classified as an essential*  
15                *rural hospital under section 1861(mm)(4) for a cost report-*  
16                *ing period, the payment under this subsection for inpatient*  
17                *hospital services for discharges occurring during the period*  
18                *shall be based on 102 percent of the reasonable costs for such*  
19                *services. Nothing in this paragraph shall be construed as*  
20                *affecting the application or amount of deductibles or copay-*  
21                *ments otherwise applicable to such services under part A*  
22                *or as waiving any requirement for billing for such serv-*  
23                *ices.”.*



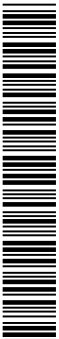
1           (2) *HOSPITAL OUTPATIENT SERVICES.*—Section  
2           1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by  
3           adding at the end the following new subparagraph:

4                       “(B) *SPECIAL RULE FOR ESSENTIAL RURAL*  
5                       *HOSPITALS.*—In the case of a hospital classified  
6                       as an essential rural hospital under section  
7                       1861(mm)(4) for a cost reporting period, the  
8                       payment under this subsection for covered OPD  
9                       services during the period shall be based on 102  
10                      percent of the reasonable costs for such services.  
11                      Nothing in this subparagraph shall be construed  
12                      as affecting the application or amount of  
13                      deductibles or copayments otherwise applicable  
14                      to such services under this part or as waiving  
15                      any requirement for billing for such services.”.

16           (c) *EFFECTIVE DATE.*—The amendments made by this  
17           section shall apply to cost reporting periods beginning on  
18           or after October 1, 2004.

19           **SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED IN**  
20                       **HOSPITAL MARKET BASKET.**

21           (a) *MORE FREQUENT UPDATES IN WEIGHTS.*—After  
22           revising the weights used in the hospital market basket  
23           under section 1886(b)(3)(B)(iii) of the Social Security Act  
24           (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current  
25           data available, the Secretary shall establish a frequency for



1 *revising such weights, including the labor share, in such*  
2 *market basket to reflect the most current data available*  
3 *more frequently than once every 5 years.*

4 *(b) REPORT.—Not later than October 1, 2004, the Sec-*  
5 *retary shall submit a report to Congress on the frequency*  
6 *established under subsection (a), including an explanation*  
7 *of the reasons for, and options considered, in determining*  
8 *such frequency.*

9 **SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL**  
10 **PROGRAM.**

11 *(a) INCREASE IN PAYMENT AMOUNTS.—*

12 *(1) IN GENERAL.—Sections 1814(l), 1834(g)(1),*  
13 *and 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42*  
14 *U.S.C. 1395tt(a)(3)) are each amended by inserting*  
15 *“equal to 102 percent of” before “the reasonable*  
16 *costs”.*

17 *(2) EFFECTIVE DATE.—The amendments made*  
18 *by paragraph (1) shall apply to payments for services*  
19 *furnished during cost reporting periods beginning on*  
20 *or after October 1, 2003.*

21 *(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY*  
22 *ROOM ON-CALL PROVIDERS.—*

23 *(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C.*  
24 *1395m(g)(5)) is amended—*

25 *(A) in the heading—*





1 (i) by inserting “CERTAIN” before  
2 “EMERGENCY”; and

3 (ii) by striking “PHYSICIANS” and in-  
4 serting “PROVIDERS”;

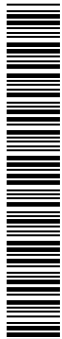
5 (B) by striking “emergency room physicians  
6 who are on-call (as defined by the Secretary)”  
7 and inserting “physicians, physician assistants,  
8 nurse practitioners, and clinical nurse specialists  
9 who are on-call (as defined by the Secretary) to  
10 provide emergency services”; and

11 (C) by striking “physicians’ services” and  
12 inserting “services covered under this title”.

13 (2) *EFFECTIVE DATE.*—The amendment made by  
14 paragraph (1) shall apply with respect to costs in-  
15 curred for services provided on or after January 1,  
16 2004.

17 (c) *MODIFICATION OF THE ISOLATION TEST FOR*  
18 *COST-BASED CAH AMBULANCE SERVICES.*—

19 (1) *IN GENERAL.*—Section 1834(l)(8) (42 U.S.C.  
20 1395m(l)), as added by section 205(a) of BIPA (114  
21 Stat. 2763A–482), is amended by adding at the end  
22 the following: “The limitation described in the matter  
23 following subparagraph (B) in the previous sentence  
24 shall not apply if the ambulance services are fur-  
25 nished by such a provider or supplier of ambulance



1 *services who is a first responder to emergencies (as de-*  
2 *termined by the Secretary).”.*

3 (2) *EFFECTIVE DATE.*—*The amendment made by*  
4 *paragraph (1) shall apply to ambulances services fur-*  
5 *nished on or after the first cost reporting period that*  
6 *begins after the date of the enactment of this Act.*

7 (d) *REINSTATEMENT OF PERIODIC INTERIM PAYMENT*  
8 *(PIP).*—

9 (1) *IN GENERAL.*—*Section 1815(e)(2) (42 U.S.C.*  
10 *1395g(e)(2)) is amended—*

11 (A) *in the matter before subparagraph (A),*  
12 *by inserting “, in the cases described in subpara-*  
13 *graphs (A) through (D)” after “1986”; and*

14 (B) *by striking “and” at the end of sub-*  
15 *paragraph (C);*

16 (C) *by adding “and” at the end of subpara-*  
17 *graph (D); and*

18 (D) *by inserting after subparagraph (D) the*  
19 *following new subparagraph:*

20 *“(E) inpatient critical access hospital services;”.*

21 (2) *DEVELOPMENT OF ALTERNATIVE METHODS*  
22 *OF PERIODIC INTERIM PAYMENTS.*—*With respect to*  
23 *periodic interim payments to critical access hospitals*  
24 *for inpatient critical access hospital services under*  
25 *section 1815(e)(2)(E) of the Social Security Act, as*



1       *added by paragraph (1), the Secretary shall develop*  
2       *alternative methods for such payments that are based*  
3       *on expenditures of the hospital.*

4               (3) *REINSTATEMENT OF PIP.—The amendments*  
5       *made by paragraph (1) shall apply to payments*  
6       *made on or after January 1, 2004.*

7       (e) *CONDITION FOR APPLICATION OF SPECIAL PHYSI-*  
8       *CIAN PAYMENT ADJUSTMENT.—*

9               (1) *IN GENERAL.—Section 1834(g)(2) (42 U.S.C.*  
10       *1395m(g)(2)) is amended by adding after and below*  
11       *subparagraph (B) the following:*

12       *“The Secretary may not require, as a condition for*  
13       *applying subparagraph (B) with respect to a critical*  
14       *access hospital, that each physician providing profes-*  
15       *sional services in the hospital must assign billing*  
16       *rights with respect to such services, except that such*  
17       *subparagraph shall not apply to those physicians who*  
18       *have not assigned such billing rights.”.*

19               (2) *EFFECTIVE DATE.—The amendment made by*  
20       *paragraph (1) shall be effective as if included in the*  
21       *enactment of section 403(d) of the Medicare, Med-*  
22       *icaid, and SCHIP Balanced Budget Refinement Act*  
23       *of 1999 (113 Stat. 1501A–371).*

24       (f) *FLEXIBILITY IN BED LIMITATION FOR HOS-*  
25       *PITALS.—Section 1820 (42 U.S.C. 1395i–4) is amended—*



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

3           (2) by adding at the end of subsection (c) the fol-  
4           lowing new paragraph:

5           “(3) INCREASE IN MAXIMUM NUMBER OF BEDS  
6           FOR HOSPITALS WITH STRONG SEASONAL CENSUS  
7           FLUCTUATIONS.—

8           “(A) IN GENERAL.—Subject to subpara-  
9           graph (C), in the case of a hospital that dem-  
10          onstrates that it meets the standards established  
11          under subparagraph (B) and has not made the  
12          election described in subsection (f)(2)(A), the bed  
13          limitations otherwise applicable under para-  
14          graph (2)(B)(iii) and subsection (f) shall be in-  
15          creased by 5 beds.

16          “(B) STANDARDS.—The Secretary shall  
17          specify standards for determining whether a crit-  
18          ical access hospital has sufficiently strong sea-  
19          sonal variations in patient admissions to justify  
20          the increase in bed limitation provided under  
21          subparagraph (A).”; and

22          (3) in subsection (f)—

23                 (A) by inserting “(1)” after “(f)”; and

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



1           “(2)(A) A hospital may elect to treat the reference in  
2 paragraph (1) to ‘15 beds’ as a reference to ‘25 beds’, but  
3 only if no more than 10 beds in the hospital are at any  
4 time used for non-acute care services. A hospital that makes  
5 such an election is not eligible for the increase provided  
6 under subsection (c)(3)(A).

7           “(B) The limitations in numbers of beds under the first  
8 sentence of paragraph (1) are subject to adjustment under  
9 subsection (c)(3).”.

10           (4) *EFFECTIVE DATE.*—The amendments made  
11 by this subsection shall apply to designations made  
12 before, on, or after January 1, 2004.

13           (g) *ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR*  
14 *GRANT PROGRAM.*—

15           (1) *IN GENERAL.*—Section 1820(g) (42 U.S.C.  
16 1395i-4(g)) is amended by adding at the end the fol-  
17 lowing new paragraph:

18           “(4) *FUNDING.*—

19           “(A) *IN GENERAL.*—Subject to subpara-  
20 graph (B), payment for grants made under this  
21 subsection during fiscal years 2004 through 2008  
22 shall be made from the Federal Hospital Insur-  
23 ance Trust Fund.

24           “(B) *ANNUAL AGGREGATE LIMITATION.*—In  
25 no case may the amount of payment provided for



1 under subparagraph (A) for a fiscal year exceed  
2 \$25,000,000.”.

3 (2) CONFORMING AMENDMENT.—Section 1820  
4 (42 U.S.C. 1395i-4) is amended by striking sub-  
5 section (j).

6 **SEC. 406. REDISTRIBUTION OF UNUSED RESIDENT POSI-**  
7 **TIONS.**

8 (a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C.  
9 1395ww(h)(4)) is amended—

10 (1) in subparagraph (F)(i), by inserting “subject  
11 to subparagraph (I),” after “October 1, 1997,”;

12 (2) in subparagraph (H)(i), by inserting “subject  
13 to subparagraph (I),” after “subparagraphs (F) and  
14 (G),”; and

15 (3) by adding at the end the following new sub-  
16 paragraph:

17 “(I) REDISTRIBUTION OF UNUSED RESI-  
18 DENT POSITIONS.—

19 “(i) REDUCTION IN LIMIT BASED ON  
20 UNUSED POSITIONS.—

21 “(I) IN GENERAL.—If a hospital’s  
22 resident level (as defined in clause  
23 (iii)(I)) is less than the otherwise ap-  
24 plicable resident limit (as defined in  
25 clause (iii)(II)) for each of the ref-



1 *erence periods (as defined in subclause*  
2 *(II)), effective for cost reporting peri-*  
3 *ods beginning on or after January 1,*  
4 *2004, the otherwise applicable resident*  
5 *limit shall be reduced by 75 percent of*  
6 *the difference between such limit and*  
7 *the reference resident level specified in*  
8 *subclause (III) (or subclause (IV) if*  
9 *applicable).*

10 *“(II) REFERENCE PERIODS DE-*  
11 *FINED.—In this clause, the term ‘ref-*  
12 *erence periods’ means, for a hospital,*  
13 *the 3 most recent consecutive cost re-*  
14 *porting periods of the hospital for*  
15 *which cost reports have been settled (or,*  
16 *if not, submitted) on or before Sep-*  
17 *tember 30, 2002.*

18 *“(III) REFERENCE RESIDENT*  
19 *LEVEL.—Subject to subclause (IV), the*  
20 *reference resident level specified in this*  
21 *subclause for a hospital is the highest*  
22 *resident level for the hospital during*  
23 *any of the reference periods.*

24 *“(IV) ADJUSTMENT PROCESS.—*  
25 *Upon the timely request of a hospital,*



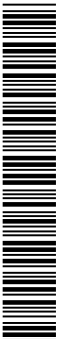
1           *the Secretary may adjust the reference*  
2           *resident level for a hospital to be the*  
3           *resident level for the hospital for the*  
4           *cost reporting period that includes*  
5           *July 1, 2003.*

6           “(V) *AFFILIATION.*—*With respect*  
7           *to hospitals which are members of the*  
8           *same affiliated group (as defined by*  
9           *the Secretary under subparagraph*  
10           *(H)(ii)), the provisions of this section*  
11           *shall be applied with respect to such an*  
12           *affiliated group by deeming the affili-*  
13           *ated group to be a single hospital.*

14           “(ii) *REDISTRIBUTION.*—

15           “(I) *IN GENERAL.*—*The Secretary*  
16           *is authorized to increase the otherwise*  
17           *applicable resident limits for hospitals*  
18           *by an aggregate number estimated by*  
19           *the Secretary that does not exceed the*  
20           *aggregate reduction in such limits at-*  
21           *tributable to clause (i) (without taking*  
22           *into account any adjustment under*  
23           *subclause (IV) of such clause).*

24           “(II) *EFFECTIVE DATE.*—*No in-*  
25           *crease under subclause (I) shall be per-*





1                    *mitted or taken into account for a hos-*  
2                    *pital for any portion of a cost report-*  
3                    *ing period that occurs before July 1,*  
4                    *2004, or before the date of the hos-*  
5                    *pital's application for an increase*  
6                    *under this clause. No such increase*  
7                    *shall be permitted for a hospital unless*  
8                    *the hospital has applied to the Sec-*  
9                    *retary for such increase by December*  
10                   *31, 2005.*

11                    *“(III) CONSIDERATIONS IN REDIS-*  
12                    *TRIBUTION.—In determining for which*  
13                    *hospitals the increase in the otherwise*  
14                    *applicable resident limit is provided*  
15                    *under subclause (I), the Secretary shall*  
16                    *take into account the need for such an*  
17                    *increase by specialty and location in-*  
18                    *volved, consistent with subclause (IV).*

19                    *“(IV) PRIORITY FOR RURAL AND*  
20                    *SMALL URBAN AREAS.—In determining*  
21                    *for which hospitals and residency*  
22                    *training programs an increase in the*  
23                    *otherwise applicable resident limit is*  
24                    *provided under subclause (I), the Sec-*  
25                    *retary shall first distribute the increase*



1                   to programs of hospitals located in  
2                   rural areas or in urban areas that are  
3                   not large urban areas (as defined for  
4                   purposes of subsection (d)) on a first-  
5                   come-first-served basis (as determined  
6                   by the Secretary) based on a dem-  
7                   onstration that the hospital will fill the  
8                   positions made available under this  
9                   clause and not to exceed an increase of  
10                  25 full-time equivalent positions with  
11                  respect to any hospital.

12                   “(V) APPLICATION OF LOCALITY  
13                  ADJUSTED NATIONAL AVERAGE PER  
14                  RESIDENT AMOUNT.—With respect to  
15                  additional residency positions in a  
16                  hospital attributable to the increase  
17                  provided under this clause, notwith-  
18                  standing any other provision of this  
19                  subsection, the approved FTE resident  
20                  amount is deemed to be equal to the lo-  
21                  cality adjusted national average per  
22                  resident amount computed under sub-  
23                  paragraph (E) for that hospital.

24                   “(VI) CONSTRUCTION.—Nothing  
25                  in this clause shall be construed as per-

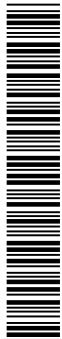


1                    *mitting the redistribution of reductions*  
2                    *in residency positions attributable to*  
3                    *voluntary reduction programs under*  
4                    *paragraph (6) or as affecting the abil-*  
5                    *ity of a hospital to establish new med-*  
6                    *ical residency training programs*  
7                    *under subparagraph (H).*

8                    *“(iii) RESIDENT LEVEL AND LIMIT DE-*  
9                    *FINED.—In this subparagraph:*

10                    *“(I) RESIDENT LEVEL.—The term*  
11                    *‘resident level’ means, with respect to a*  
12                    *hospital, the total number of full-time*  
13                    *equivalent residents, before the applica-*  
14                    *tion of weighting factors (as deter-*  
15                    *mined under this paragraph), in the*  
16                    *fields of allopathic and osteopathic*  
17                    *medicine for the hospital.*

18                    *“(II) OTHERWISE APPLICABLE*  
19                    *RESIDENT LIMIT.—The term ‘otherwise*  
20                    *applicable resident limit’ means, with*  
21                    *respect to a hospital, the limit other-*  
22                    *wise applicable under subparagraphs*  
23                    *(F)(i) and (H) on the resident level for*  
24                    *the hospital determined without regard*  
25                    *to this subparagraph.”.*



1           (b) *CONFORMING AMENDMENT TO IME.*—Section  
2 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is  
3 amended by adding at the end the following: “The provi-  
4 sions of subparagraph (I) of subsection (h)(4) shall apply  
5 with respect to the first sentence of this clause in the same  
6 manner as it applies with respect to subparagraph (F) of  
7 such subsection.”.

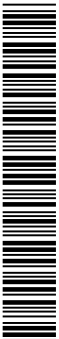
8           (c) *REPORT ON EXTENSION OF APPLICATIONS UNDER*  
9 *REDISTRIBUTION PROGRAM.*—Not later than July 1, 2005,  
10 the Secretary shall submit to Congress a report containing  
11 recommendations regarding whether to extend the deadline  
12 for applications for an increase in resident limits under  
13 section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as  
14 added by subsection (a)).

15 **SEC. 407. TWO-YEAR EXTENSION OF HOLD HARMLESS PRO-**  
16 **VISIONS FOR SMALL RURAL HOSPITALS AND**  
17 **SOLE COMMUNITY HOSPITALS UNDER PRO-**  
18 **SPECTIVE PAYMENT SYSTEM FOR HOSPITAL**  
19 **OUTPATIENT DEPARTMENT SERVICES.**

20           (a) *HOLD HARMLESS PROVISIONS.*—

21                   (1) *IN GENERAL.*—Section 1833(t)(7)(D)(i) (42  
22 U.S.C. 1395l(t)(7)(D)(i)) is amended—

23                           (A) in the heading, by striking “SMALL”  
24                           and inserting “CERTAIN”;



1           (B) by inserting “or a sole community hos-  
2           pital (as defined in section 1886(d)(5)(D)(iii))  
3           located in a rural area” after “100 beds”; and

4           (C) by striking “2004” and inserting  
5           “2006”.

6           (2) *EFFECTIVE DATE.*—The amendment made by  
7           subsection (a)(2) shall apply with respect to payment  
8           for OPD services furnished on and after January 1,  
9           2004.

10          (b) *STUDY; ADJUSTMENT.*—

11           (1) *STUDY.*—The Secretary shall conduct a study  
12           to determine if, under the prospective payment system  
13           for hospital outpatient department services under sec-  
14           tion 1833(t) of the Social Security Act (42 U.S.C.  
15           1395l(t)), costs incurred by rural providers of services  
16           by ambulatory payment classification groups (APCs)  
17           exceed those costs incurred by urban providers of serv-  
18           ices.

19           (2) *ADJUSTMENT.*—Insofar as the Secretary de-  
20           termines under paragraph (1) that costs incurred by  
21           rural providers exceed those costs incurred by urban  
22           providers of services, the Secretary shall provide for  
23           an appropriate adjustment under such section 1833(t)  
24           to reflect those higher costs by January 1, 2005.



1 **SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC**  
2 **AND FEDERALLY QUALIFIED HEALTH CENTER**  
3 **SERVICES FROM THE PROSPECTIVE PAYMENT**  
4 **SYSTEM FOR SKILLED NURSING FACILITIES.**

5 (a) *IN GENERAL.*—Section 1888(e)(2)(A) (42 U.S.C.  
6 1395yy(e)(2)(A)) is amended—

7 (1) in clause (i)(II), by striking “clauses (ii) and  
8 (iii)” and inserting “clauses (ii), (iii), and (iv)”; and

9 (2) by adding at the end the following new  
10 clause:

11 “(iv) *EXCLUSION OF CERTAIN RURAL*  
12 *HEALTH CLINIC AND FEDERALLY QUALIFIED*  
13 *HEALTH CENTER SERVICES.*—Services de-  
14 scribed in this clause are—

15 “(I) *rural health clinic services*  
16 *(as defined in paragraph (1) of section*  
17 *1861(aa)); and*

18 “(II) *Federally qualified health*  
19 *center services (as defined in para-*  
20 *graph (3) of such section);*

21 *that would be described in clause (ii) if such*  
22 *services were not furnished by an individual*  
23 *affiliated with a rural health clinic or a*  
24 *Federally qualified health center.”.*



1           (b) *EFFECTIVE DATE.*—*The amendments made by sub-*  
2 *section (a) shall apply to services furnished on or after Jan-*  
3 *uary 1, 2004.*

4 **SEC. 409. RECOGNITION OF ATTENDING NURSE PRACTI-**  
5 **TIONERS AS ATTENDING PHYSICIANS TO**  
6 **SERVE HOSPICE PATIENTS.**

7           (a) *IN GENERAL.*—*Section 1861(dd)(3)(B) (42 U.S.C.*  
8 *1395x(dd)(3)(B)) is amended by inserting “or nurse practi-*  
9 *tioner (as defined in subsection (aa)(5))” after “the physi-*  
10 *cian (as defined in subsection (r)(1))”.*

11           (b) *PROHIBITION ON NURSE PRACTITIONER CERTI-*  
12 *FYING NEED FOR HOSPICE.*—*Section 1814(a)(7)(A)(i)(I)*  
13 *(42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting*  
14 *“(which for purposes of this subparagraph does not include*  
15 *a nurse practitioner)” after “attending physician (as de-*  
16 *fined in section 1861(dd)(3)(B))”.*

17 **SEC. 410. IMPROVEMENT IN PAYMENTS TO RETAIN EMER-**  
18 **GENCY CAPACITY FOR AMBULANCE SERVICES**  
19 **IN RURAL AREAS.**

20           *Section 1834(l) (42 U.S.C. 1395m(l)) is amended—*

21                   (1) *by redesignating paragraph (8), as added by*  
22 *section 221(a) of BIPA (114 Stat. 2763A–486), as*  
23 *paragraph (9); and*

24                   (2) *by adding at the end the following new para-*  
25 *graph:*



1           “(10) ASSISTANCE FOR RURAL PROVIDERS FUR-  
2           NISHING SERVICES IN LOW MEDICARE POPULATION  
3           DENSITY AREAS.—

4                   “(A) IN GENERAL.—In the case of ground  
5           ambulance services furnished on or after Janu-  
6           ary 1, 2004, for which the transportation origi-  
7           nates in a qualified rural area (as defined in  
8           subparagraph (B)), the Secretary shall provide  
9           for an increase in the base rate of the fee sched-  
10          ule for mileage for a trip established under this  
11          subsection. In establishing such increase, the Sec-  
12          retary shall, based on the relationship of cost  
13          and volume, estimate the average increase in cost  
14          per trip for such services as compared with the  
15          cost per trip for the average ambulance service.

16                   “(B) QUALIFIED RURAL AREA DEFINED.—  
17          For purposes of subparagraph (A), the term  
18          ‘qualified rural area’ is a rural area (as defined  
19          in section 1886(d)(2)(D)) with a population den-  
20          sity of medicare beneficiaries residing in the  
21          area that is in the lowest quartile of all rural  
22          county populations.”.





1 **SEC. 411. TWO-YEAR INCREASE FOR HOME HEALTH SERV-**  
2 **ICES FURNISHED IN A RURAL AREA.**

3 (a) *IN GENERAL.*—*In the case of home health services*  
4 *furnished in a rural area (as defined in section*  
5 *1886(d)(2)(D) of the Social Security Act (42 U.S.C.*  
6 *1395ww(d)(2)(D))) during 2004 and 2005, the Secretary*  
7 *shall increase the payment amount otherwise made under*  
8 *section 1895 of such Act (42 U.S.C. 1395fff) for such serv-*  
9 *ices by 5 percent.*

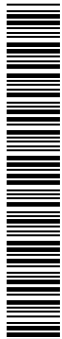
10 (b) *WAIVING BUDGET NEUTRALITY.*—*The Secretary*  
11 *shall not reduce the standard prospective payment amount*  
12 *(or amounts) under section 1895 of the Social Security Act*  
13 *(42 U.S.C. 1395fff) applicable to home health services fur-*  
14 *nished during a period to offset the increase in payments*  
15 *resulting from the application of subsection (a).*

16 **SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COL-**  
17 **LABORATIVE EFFORTS THAT BENEFIT MEDI-**  
18 **CALLY UNDERSERVED POPULATIONS.**

19 (a) *IN GENERAL.*—*Section 1128B(b)(3) (42 U.S.C.*  
20 *1320a-7(b)(3)), as amended by section 101(b)(2), is*  
21 *amended—*

22 (1) *in subparagraph (F), by striking “and” after*  
23 *the semicolon at the end;*

24 (2) *in subparagraph (G), by striking the period*  
25 *at the end and inserting “; and”; and*



1           (3) *by adding at the end the following new sub-*  
2           *paragraph:*

3                   “(H) *any remuneration between a public or*  
4                   *nonprofit private health center entity described*  
5                   *under clause (i) or (ii) of section 1905(l)(2)(B)*  
6                   *and any individual or entity providing goods,*  
7                   *items, services, donations or loans, or a combina-*  
8                   *tion thereof, to such health center entity pursu-*  
9                   *ant to a contract, lease, grant, loan, or other*  
10                   *agreement, if such agreement contributes to the*  
11                   *ability of the health center entity to maintain or*  
12                   *increase the availability, or enhance the quality,*  
13                   *of services provided to a medically underserved*  
14                   *population served by the health center entity.”.*

15           (b) *RULEMAKING FOR EXCEPTION FOR HEALTH CEN-*  
16           *TER ENTITY ARRANGEMENTS.—*

17                   (1) *ESTABLISHMENT.—*

18                           (A) *IN GENERAL.—The Secretary of Health*  
19                           *and Human Services (in this subsection referred*  
20                           *to as the “Secretary”) shall establish, on an ex-*  
21                           *pedited basis, standards relating to the exception*  
22                           *described in section 1128B(b)(3)(H) of the Social*  
23                           *Security Act, as added by subsection (a), for*  
24                           *health center entity arrangements to the*  
25                           *antikickback penalties.*



1           (B) *FACTORS TO CONSIDER.*—*The Secretary*  
2           *shall consider the following factors, among oth-*  
3           *ers, in establishing standards relating to the ex-*  
4           *ception for health center entity arrangements*  
5           *under subparagraph (A):*

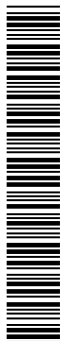
6                   (i) *Whether the arrangement between*  
7                   *the health center entity and the other party*  
8                   *results in savings of Federal grant funds or*  
9                   *increased revenues to the health center enti-*  
10                  *ty.*

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

15                  (iii) *Whether the arrangement between*  
16                  *the health center entity and the other party*  
17                  *protects a health care professional's inde-*  
18                  *pendent medical judgment regarding medi-*  
19                  *cally appropriate treatment.*

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

24           (2) *INTERIM FINAL EFFECT.*—*No later than 180*  
25           *days after the date of enactment of this Act, the Sec-*





1        *and physician specialty and methods used to update*  
2        *the geographic cost of practice index and relative*  
3        *weights for the malpractice component.*

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

12       **SEC. 414. TREATMENT OF MISSING COST REPORTING PERI-**  
13                                **ODS FOR SOLE COMMUNITY HOSPITALS.**

14        *(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C.*  
15        *1395ww(b)(3)(I)) is amended by adding at the end the fol-*  
16        *lowing new clause:*

17                *“(iii) In no case shall a hospital be denied treatment*  
18        *as a sole community hospital or payment (on the basis of*  
19        *a target rate as such as a hospital) because data are un-*  
20        *available for any cost reporting period due to changes in*  
21        *ownership, changes in fiscal intermediaries, or other ex-*  
22        *traordinary circumstances, so long as data for at least one*  
23        *applicable base cost reporting period is available.”.*



1           (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
2 *section (a) shall apply to cost reporting periods beginning*  
3 *on or after January 1, 2004.*

4 **SEC. 415. EXTENSION OF TELEMEDICINE DEMONSTRATION**  
5 **PROJECT.**

6           Section 4207 of Balanced Budget Act of 1997 (Public  
7 Law 105–33) is amended—

8           (1) in subsection (a)(4), by striking “4-year”  
9 and inserting “8-year”; and

10           (2) in subsection (d)(3), by striking  
11 “\$30,000,000” and inserting “\$60,000,000”.

12 **SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOS-**  
13 **PITAL PPS WAGE INDEX TO REVISE THE**  
14 **LABOR-RELATED SHARE OF SUCH INDEX.**

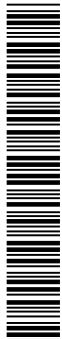
15           (a) *IN GENERAL.*—Section 1886(d)(3)(E) (42 U.S.C.  
16 1395ww(d)(3)(E)) is amended—

17           (1) by striking “WAGE LEVELS.—*The Secretary*”  
18 and inserting “WAGE LEVELS.—

19           “(i) *IN GENERAL.*—*Except as provided in*  
20 *clause (ii), the Secretary*”; and

21           (2) by adding at the end the following new  
22 clause:

23           “(i) *ALTERNATIVE PROPORTION TO BE AD-*  
24 *JUSTED BEGINNING IN FISCAL YEAR 2004.*—



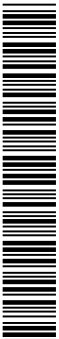
1                   “(I) *IN GENERAL.*—*Except as provided*  
2                   *in subclause (II), for discharges occurring*  
3                   *on or after October 1, 2003, the Secretary*  
4                   *shall substitute the ‘62 percent’ for the pro-*  
5                   *portion described in the first sentence of*  
6                   *clause (i).*

7                   “(II) *HOLD HARMLESS FOR CERTAIN*  
8                   *HOSPITALS.*—*If the application of subclause*  
9                   *(I) would result in lower payments to a hos-*  
10                   *pital than would otherwise be made, then*  
11                   *this subparagraph shall be applied as if this*  
12                   *clause had not been enacted.”.*

13           (b) *WAIVING BUDGET NEUTRALITY.*—*Section*  
14 *1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended*  
15 *by subsection (a), is amended by adding at the end of clause*  
16 *(i) the following new sentence: “The Secretary shall apply*  
17 *the previous sentence for any period as if the amendments*  
18 *made by section 402(a) of the Medicare Prescription Drug*  
19 *and Modernization Act of 2003 had not been enacted.”.*

20 **SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IM-**  
21 **PROVEMENTS FOR PHYSICIAN SCARCITY.**

22           (a) *ADDITIONAL BONUS PAYMENT FOR CERTAIN PHY-*  
23 *SICIAN SCARCITY AREAS.*—



1           (1) *IN GENERAL.*—Section 1833 (42 U.S.C.  
2           1395l) is amended by adding at the end the following  
3           new subsection:

4           “(u) *INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY*  
5           *AREAS.*—

6           “(1) *IN GENERAL.*—*In the case of physicians’*  
7           *services furnished in a year—*

8                   “(A) *by a primary care physician in a pri-*  
9                   *mary care scarcity county (identified under*  
10                   *paragraph (4)); or*

11                   “(B) *by a physician who is not a primary*  
12                   *care physician in a specialist care scarc-*  
13                   *ity (as so identified),*

14           *in addition to the amount of payment that would oth-*  
15           *erwise be made for such services under this part, there*  
16           *also shall be paid an amount equal to 5 percent of*  
17           *the payment amount for the service under this part.*

18           “(2) *DETERMINATION OF RATIOS OF PHYSICIANS*  
19           *TO MEDICARE BENEFICIARIES IN AREA.*—*Based upon*  
20           *available data, the Secretary shall periodically deter-*  
21           *mine, for each county or equivalent area in the*  
22           *United States, the following:*

23                   “(A) *NUMBER OF PHYSICIANS PRACTICING*  
24                   *IN THE AREA.*—*The number of physicians who*  
25                   *furnish physicians’ services in the active practice*





1           *of medicine or osteopathy in that county or area,*  
2           *other than physicians whose practice is exclu-*  
3           *sively for the Federal Government, physicians*  
4           *who are retired, or physicians who only provide*  
5           *administrative services. Of such number, the*  
6           *number of such physicians who are—*

7                     *“(i) primary care physicians; or*

8                     *“(ii) physicians who are not primary*  
9                     *care physicians.*

10                    *“(B) NUMBER OF MEDICARE BENEFICIARIES*  
11                    *RESIDING IN THE AREA.—The number of indi-*  
12                    *viduals who are residing in the county and are*  
13                    *entitled to benefits under part A or enrolled*  
14                    *under this part, or both.*

15                    *“(C) DETERMINATION OF RATIOS.—*

16                    *“(i) PRIMARY CARE RATIO.—The ratio*  
17                    *(in this paragraph referred to as the ‘pri-*  
18                    *mary care ratio’) of the number of primary*  
19                    *care physicians (determined under subpara-*  
20                    *graph (A)(i)), to number of medicare bene-*  
21                    *ficiaries determined under subparagraph*  
22                    *(B).*

23                    *“(ii) SPECIALIST CARE RATIO.—The*  
24                    *ratio (in this paragraph referred to as the*  
25                    *‘specialist care ratio’) of the number of*



1            *other physicians (determined under sub-*  
2            *paragraph (A)(ii)), to number of medicare*  
3            *beneficiaries determined under subpara-*  
4            *graph (B).*

5            *“(3) RANKING OF COUNTIES.—The Secretary*  
6            *shall rank each such county or area based separately*  
7            *on its primary care ratio and its specialist care ratio.*

8            *“(4) IDENTIFICATION OF COUNTIES.—The Sec-*  
9            *retary shall identify—*

10            *“(A) those counties and areas (in this para-*  
11            *graph referred to as ‘primary care scarcity coun-*  
12            *ties’) with the lowest primary care ratios that*  
13            *represent, if each such county or area were*  
14            *weighted by the number of medicare beneficiaries*  
15            *determined under paragraph (2)(B), an aggre-*  
16            *gate total of 20 percent of the total of the medi-*  
17            *care beneficiaries determined under such para-*  
18            *graph; and*

19            *“(B) those counties and areas (in this sub-*  
20            *section referred to as ‘specialist care scarcity*  
21            *counties’) with the lowest specialist care ratios*  
22            *that represent, if each such county or area were*  
23            *weighted by the number of medicare beneficiaries*  
24            *determined under paragraph (2)(B), an aggre-*  
25            *gate total of 20 percent of the total of the medi-*



1           *care beneficiaries determined under such para-*  
2           *graph.*

3           *There is no administrative or judicial review respect-*  
4           *ing the identification of a county or area or the as-*  
5           *signment of a specialty of any physician under this*  
6           *paragraph.*

7           “(5) *RURAL CENSUS TRACKS.*—*To the extent fea-*  
8           *sible, the Secretary shall treat a rural census tract of*  
9           *a metropolitan statistical area (as determined under*  
10           *the most recent modification of the Goldsmith Modi-*  
11           *fication, originally published in the Federal Register*  
12           *on February 27, 1992 (57 Fed. Reg. 6725) as an*  
13           *equivalent area for purposes of qualifying as a pri-*  
14           *mary care scarcity county or specialist care scarcity*  
15           *county under this subsection.*

16           “(6) *PHYSICIAN DEFINED.*—*For purposes of this*  
17           *paragraph, the term ‘physician’ means a physician*  
18           *described in section 1861(r)(1) and the term ‘primary*  
19           *care physician’ means a physician who is identified*  
20           *in the available data as a general practitioner, family*  
21           *practice practitioner, general internist, or obstetrician*  
22           *or gynecologist.*

23           “(7) *PUBLICATION OF LIST OF COUNTIES.*—*In*  
24           *carrying out this subsection for a year, the Secretary*  
25           *shall include, as part of the proposed and final rule*



1       to implement the physician fee schedule under section  
2       1848 for the year, a list of all areas which will qual-  
3       ify as a primary care scarcity county or specialist  
4       care scarcity county under this subsection for the year  
5       involved.”.

6               (2) *EFFECTIVE DATE.*—The amendments made  
7       by subsection (a) shall apply to physicians’ services  
8       furnished or after January 1, 2004.

9       (b) *IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT*  
10    *PROGRAM.*—

11               (1) *IN GENERAL.*—Section 1833(m) (42 U.S.C.  
12       1395l(m)) is amended—

13                       (A) by inserting “(1)” after “(m)”; and

14                       (B) by adding at the end the following new  
15       paragraphs:

16       “(2) The Secretary shall establish procedures under  
17       which the Secretary, and not the physician furnishing the  
18       service, is responsible for determining when a payment is  
19       required to be made under paragraph (1).

20       “(3) In carrying out paragraph (1) for a year, the Sec-  
21       retary shall include, as part of the proposed and final rule  
22       to implement the physician fee schedule under section 1848  
23       for the year, a list of all areas which will qualify as a health  
24       professional shortage area under paragraph (1) for the year  
25       involved.”.





1 **SEC. 502. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**  
2 **UNDER INPATIENT HOSPITAL PPS.**

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

6 “(vii) *Under the mechanism under this subparagraph,*  
7 *the Secretary shall provide for the addition of new diagnosis*  
8 *and procedure codes in April 1 of each year, but the addi-*  
9 *tion of such codes shall not require the Secretary to adjust*  
10 *the payment (or diagnosis-related group classification)*  
11 *under this subsection until the fiscal year that begins after*  
12 *such date.”.*

13 (b) *ELIGIBILITY STANDARD FOR TECHNOLOGY*  
14 *OUTLIERS.*—

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

18 (A) *by inserting “(I)” after “(vi)”;* and  
19 (B) *by adding at the end the following new*  
20 *subclause:*

21 “(II) *Under such criteria, a service or technology shall*  
22 *not be denied treatment as a new service or technology on*  
23 *the basis of the period of time in which the service or tech-*  
24 *nology has been in use if such period ends before the end*  
25 *of the 2-to-3-year period that begins on the effective date*  
26 *of implementation of a code under ICD–9–CM (or a suc-*



1 *cessor coding methodology) that enables the identification*  
2 *of specific discharges in which the service or technology has*  
3 *been used.”.*

4 (2) *ADJUSTMENT OF THRESHOLD.—Section*  
5 *1886(d)(5)(K)(ii)(I) (42 U.S.C.*  
6 *1395ww(d)(5)(K)(ii)(I)) is amended by inserting*  
7 *“(applying a threshold specified by the Secretary that*  
8 *is 75 percent of one standard deviation for the diag-*  
9 *nosis-related group involved)” after “is inadequate”.*

10 (3) *CRITERION FOR SUBSTANTIAL IMPROVE-*  
11 *MENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C.*  
12 *1395ww(d)(5)(K)(vi)), as amended by paragraph (1),*  
13 *is further amended by adding at the end the following*  
14 *subclause:*

15 *“(III) The Secretary shall by regulation provide for*  
16 *further clarification of the criteria applied to determine*  
17 *whether a new service or technology represents an advance*  
18 *in medical technology that substantially improves the diag-*  
19 *nosis or treatment of beneficiaries. Under such criteria, in*  
20 *determining whether a new service or technology represents*  
21 *an advance in medical technology that substantially im-*  
22 *proves the diagnosis or treatment of beneficiaries, the Sec-*  
23 *retary shall deem a service or technology as meeting such*  
24 *requirement if the service or technology is a drug or biologi-*  
25 *cal that is designated under section 506 of the Federal Food,*



1 *Drug, and Cosmetic Act, approved under section 314.510*  
2 *or 601.41 of title 21, Code of Federal Regulations, or des-*  
3 *ignated for priority review when the marketing application*  
4 *for such drug or biological was filed or is a medical device*  
5 *for which an exemption has been granted under section*  
6 *520(m) of such Act, or for which priority review has been*  
7 *provided under section 515(d)(5) of such Act. Nothing in*  
8 *this subclause shall be construed as effecting the authority*  
9 *of the Secretary to determine whether items and services*  
10 *are medically necessary and appropriate under section*  
11 *1862(a)(1).”.*

12 (4) *PROCESS FOR PUBLIC INPUT.—Section*  
13 *1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as*  
14 *amended by paragraph (1), is amended—*

15 (A) *in clause (i), by adding at the end the*  
16 *following: “Such mechanism shall be modified to*  
17 *meet the requirements of clause (viii).”;* and

18 (B) *by adding at the end the following new*  
19 *clause:*

20 *“(viii) The mechanism established pursuant to clause*  
21 *(i) shall be adjusted to provide, before publication of a pro-*  
22 *posed rule, for public input regarding whether a new service*  
23 *or technology not described in the second sentence of clause*  
24 *(vi)(III) represents an advance in medical technology that*





1 *substantially improves the diagnosis or treatment of bene-*  
2 *ficiaries as follows:*

3           “(I) *The Secretary shall make public and peri-*  
4 *odically update a list of all the services and tech-*  
5 *nologies for which an application for additional pay-*  
6 *ment under this subparagraph is pending.*

7           “(II) *The Secretary shall accept comments, rec-*  
8 *ommendations, and data from the public regarding*  
9 *whether the service or technology represents a substan-*  
10 *tial improvement.*

11           “(III) *The Secretary shall provide for a meeting*  
12 *at which organizations representing hospitals, physi-*  
13 *cians, medicare beneficiaries, manufacturers, and any*  
14 *other interested party may present comments, rec-*  
15 *ommendations, and data to the clinical staff of the*  
16 *Centers for Medicare & Medicaid Services before pub-*  
17 *lication of a notice of proposed rulemaking regarding*  
18 *whether service or technology represents a substantial*  
19 *improvement.”.*

20           (c) *PREFERENCE FOR USE OF DRG ADJUSTMENT.—*

21 *Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is fur-*  
22 *ther amended by adding at the end the following new clause:*

23           “(ix) *Before establishing any add-on payment under*  
24 *this subparagraph with respect to a new technology, the*  
25 *Secretary shall seek to identify one or more diagnosis-re-*



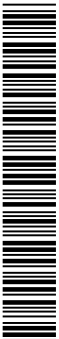
1 *lated groups associated with such technology, based on simi-*  
2 *lar clinical or anatomical characteristics and the cost of*  
3 *the technology. Within such groups the Secretary shall as-*  
4 *sign an eligible new technology into a diagnosis-related*  
5 *group where the average costs of care most closely approxi-*  
6 *mate the costs of care of using the new technology. In such*  
7 *case, the new technology would no longer meet the threshold*  
8 *of exceeding 75 percent of the standard deviation for the*  
9 *diagnosis-related group involved under clause (ii)(I). No*  
10 *add-on payment under this subparagraph shall be made*  
11 *with respect to such new technology and this clause shall*  
12 *not affect the application of paragraph (4)(C)(iii).”.*

13 *(d) IMPROVEMENT IN PAYMENT FOR NEW TECH-*  
14 *NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.*  
15 *1395ww(d)(5)(K)(ii)(III)) is amended by inserting after*  
16 *“the estimated average cost of such service or technology”*  
17 *the following: “(based on the marginal rate applied to costs*  
18 *under subparagraph (A))”.*

19 *(e) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL*  
20 *INPATIENT TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III)*  
21 *(42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by strik-*  
22 *ing “subject to paragraph (4)(C)(iii),”.*

23 *(f) EFFECTIVE DATE.—*

24 *(1) IN GENERAL.—The Secretary shall imple-*  
25 *ment the amendments made by this section so that*



1       *they apply to classification for fiscal years beginning*  
2       *with fiscal year 2005.*

3           (2) *RECONSIDERATIONS OF APPLICATIONS FOR*  
4       *FISCAL YEAR 2003 THAT ARE DENIED.—In the case of*  
5       *an application for a classification of a medical serv-*  
6       *ice or technology as a new medical service or tech-*  
7       *nology under section 1886(d)(5)(K) of the Social Se-*  
8       *curity Act (42 U.S.C. 1395ww(d)(5)(K)) that was*  
9       *filed for fiscal year 2004 and that is denied—*

10           (A) *the Secretary shall automatically recon-*  
11       *sider the application as an application for fiscal*  
12       *year 2005 under the amendments made by this*  
13       *section; and*

14           (B) *the maximum time period otherwise*  
15       *permitted for such classification of the service or*  
16       *technology shall be extended by 12 months.*

17       **SEC. 503. INCREASE IN FEDERAL RATE FOR HOSPITALS IN**  
18           **PUERTO RICO.**

19       *Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is*  
20       *amended—*

21           (1) *in subparagraph (A)—*

22           (A) *in clause (i), by striking “for discharges*  
23       *beginning on or after October 1, 1997, 50 percent*  
24       *(and for discharges between October 1, 1987, and*  
25       *September 30, 1997, 75 percent)” and inserting*



1           *“the applicable Puerto Rico percentage (specified*  
2           *in subparagraph (E))”*; and

3                   *(B) in clause (ii), by striking “for dis-*  
4           *charges beginning in a fiscal year beginning on*  
5           *or after October 1, 1997, 50 percent (and for dis-*  
6           *charges between October 1, 1987, and September*  
7           *30, 1997, 25 percent)” and inserting “the appli-*  
8           *cable Federal percentage (specified in subpara-*  
9           *graph (E))”*; and

10           *(2) by adding at the end the following new sub-*  
11           *paragraph:*

12           *“(E) For purposes of subparagraph (A), for discharges*  
13           *occurring—*

14                   *“(i) on or after October 1, 1987, and before Octo-*  
15           *ber 1, 1997, the applicable Puerto Rico percentage is*  
16           *75 percent and the applicable Federal percentage is*  
17           *25 percent;*

18                   *“(ii) on or after October 1, 1997, and before Oc-*  
19           *tober 1, 2003, the applicable Puerto Rico percentage*  
20           *is 50 percent and the applicable Federal percentage is*  
21           *50 percent;*

22                   *“(iii) during fiscal year 2004, the applicable*  
23           *Puerto Rico percentage is 41 percent and the applica-*  
24           *ble Federal percentage is 59 percent;*



1           “(iv) during fiscal year 2005, the applicable  
2           Puerto Rico percentage is 33 percent and the applica-  
3           ble Federal percentage is 67 percent; and

4           “(v) on or after October 1, 2005, the applicable  
5           Puerto Rico percentage is 25 percent and the applica-  
6           ble Federal percentage is 75 percent.”.

7   **SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICATION**  
8           **REFORM.**

9           (a) *IN GENERAL.*—Section 1886(d) (42 U.S.C.  
10 1395ww(d)) is amended by adding at the end the following:

11           “(11)(A) In order to recognize commuting patterns  
12 among Metropolitan Statistical Areas and between such  
13 Areas and rural areas, the Secretary shall establish a proc-  
14 ess, upon application of a subsection (d) hospital that estab-  
15 lishes that it is a qualifying hospital described in subpara-  
16 graph (B), for an increase of the wage index applied under  
17 paragraph (3)(E) for the hospital in the amount computed  
18 under subparagraph (D).

19           “(B) A qualifying hospital described in this subpara-  
20 graph is a subsection (d) hospital—

21           “(i) the average wages of which exceed the aver-  
22           age wages for the area in which the hospital is lo-  
23           cated; and



1           “(ii) which has at least 10 percent of its employ-  
2           ees who reside in one or more higher wage index  
3           areas.

4           “(C) For purposes of this paragraph, the term ‘higher  
5           wage index area’ means, with respect to a hospital, an area  
6           with a wage index that exceeds that of the area in which  
7           the hospital is located.

8           “(D) The increase in the wage index under subpara-  
9           graph (A) for a hospital shall be equal to the percentage  
10          of the employees of the hospital that resides in any higher  
11          wage index area multiplied by the sum of the products, for  
12          each higher wage index area of—

13           “(i) the difference between (I) the wage index for  
14          such area, and (II) the wage index of the area in  
15          which the hospital is located (before the application of  
16          this paragraph); and

17           “(ii) the number of employees of the hospital that  
18          reside in such higher wage index area divided by the  
19          total number of such employees that reside in all high  
20          wage index areas.

21           “(E) The process under this paragraph shall be based  
22          upon the process used by the Medicare Geographic Classi-  
23          fication Review Board under paragraph (10) with respect  
24          to data submitted by hospitals to the Board on the location



1 *of residence of hospital employees and wages under the ap-*  
2 *plicable schedule established for geographic reclassification.*

3       “(F) *A reclassification under this paragraph shall be*  
4 *effective for a period of 3 fiscal years, except that the Sec-*  
5 *retary shall establish procedures under which a subsection*  
6 *(d) hospital may elect to terminate such reclassification be-*  
7 *fore the end of such period.*

8       “(G) *A hospital that is reclassified under this para-*  
9 *graph for a period is not eligible for reclassification under*  
10 *paragraphs (8) or (10) during that period.*

11       “(H) *Any increase in a wage index under this para-*  
12 *graph for a hospital shall not be taken into account for pur-*  
13 *poses of—*

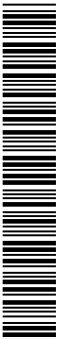
14               “(i) *computing the wage index for the area in*  
15 *which the hospital is located or any other area; or*

16               “(ii) *applying any budget neutrality adjustment*  
17 *with respect to such index under paragraph (8)(D).”.*

18       “(b) *EFFECTIVE DATE.—The amendment made by sub-*  
19 *section (a) shall first apply to the wage index for cost re-*  
20 *porting period beginning on or after October 1, 2004.*

21 **SEC. 505. MEDPAC REPORT ON SPECIALTY HOSPITALS.**

22       “(a) *MEDPAC STUDY.—The Medicare Payment Advi-*  
23 *sory Commission shall conduct a study of specialty hos-*  
24 *pitals compared with other similar general acute care hos-*



1 *pitals under the medicare program. Such study shall*  
2 *examine—*

3 *(1) whether there are excessive self-referrals;*

4 *(2) quality of care furnished;*

5 *(3) the impact of specialty hospitals on such gen-*  
6 *eral acute care hospitals; and*

7 *(4) differences in the scope of services, medicaid*  
8 *utilization, and uncompensated care furnished.*

9 *(b) REPORT.—Not later than 1 year after the date of*  
10 *the enactment of this Act, the Secretary shall submit to Con-*  
11 *gress a report on the study conducted under subsection (a),*  
12 *and shall include any recommendations for legislation or*  
13 *administrative change as the Secretary determines*  
14 *appropriate.*

## 15 ***Subtitle B—Other Provisions***

### 16 ***SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FA-*** 17 ***CILITY SERVICES.***

18 *(a) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—*  
19 *Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e))*  
20 *is amended to read as follows:*

21 *“(12) ADJUSTMENT FOR RESIDENTS WITH*  
22 *AIDS.—*

23 *“(A) IN GENERAL.—Subject to subpara-*  
24 *graph (B), in the case of a resident of a skilled*  
25 *nursing facility who is afflicted with acquired*







1       *have not previously received services under this para-*  
2       *graph, services that are furnished by a physician who*  
3       *is either the medical director or an employee of a hos-*  
4       *pice program and that consist of—*

5               *“(A) an evaluation of the individual’s need*  
6               *for pain and symptom management;*

7               *“(B) counseling the individual with respect*  
8               *to end-of-life issues and care options; and*

9               *“(C) advising the individual regarding ad-*  
10              *vanced care planning.”.*

11       *(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is*  
12       *amended by adding at the end the following new paragraph:*

13              *“(4) The amount paid to a hospice program with re-*  
14       *spect to the services under section 1812(a)(5) for which pay-*  
15       *ment may be made under this part shall be equal to an*  
16       *amount equivalent to the amount established for an office*  
17       *or other outpatient visit for evaluation and management*  
18       *associated with presenting problems of moderate severity*  
19       *under the fee schedule established under section 1848(b),*  
20       *other than the portion of such amount attributable to the*  
21       *practice expense component.”.*

22       *(c) CONFORMING AMENDMENT.—Section*  
23       *1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is*  
24       *amended by inserting before the comma at the end the fol-*  
25       *lowing: “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 pro-*  
3 *gram on or after January 1, 2004.*

4                   **TITLE VI—PROVISIONS**  
5                   **RELATING TO PART B**  
6       **Subtitle A—Physicians’ Services**

7       **SEC. 601. REVISION OF UPDATES FOR PHYSICIANS’ SERV-**  
8                   **ICES.**

9       (a) *UPDATE FOR 2004 AND 2005.*—

10               (1) *IN GENERAL.*—*Section 1848(d) (42 U.S.C.*  
11 *1395w-4(d)) is amended by adding at the end the fol-*  
12 *lowing new paragraph:*

13                   “(5) *UPDATE FOR 2004 AND 2005.*—*The update to*  
14 *the single conversion factor established in paragraph*  
15 *(1)(C) for each of 2004 and 2005 shall be not less*  
16 *than 1.5 percent.”.*

17               (2) *CONFORMING AMENDMENT.*—*Paragraph*  
18 *(4)(B) of such section is amended, in the matter be-*  
19 *fore clause (i), by inserting “and paragraph (5)”*  
20 *after “subparagraph (D)”.*

21               (3) *NOT TREATED AS CHANGE IN LAW AND REG-*  
22 *ULATION IN SUSTAINABLE GROWTH RATE DETERMINA-*  
23 *TION.*—*The amendments made by this subsection shall*  
24 *not be treated as a change in law for purposes of ap-*



1 *plying section 1848(f)(2)(D) of the Social Security*  
2 *Act (42 U.S.C. 1395w-4(f)(2)(D)).*

3 *(b) USE OF 10-YEAR ROLLING AVERAGE IN COM-*  
4 *PUTING GROSS DOMESTIC PRODUCT.—*

5 *(1) IN GENERAL.—Section 1848(f)(2)(C) (42*  
6 *U.S.C. 1395w-4(f)(2)(C)) is amended—*

7 *(A) by striking “projected” and inserting*  
8 *“annual average”; and*

9 *(B) by striking “from the previous applica-*  
10 *ble period to the applicable period involved” and*  
11 *inserting “during the 10-year period ending with*  
12 *the applicable period involved”.*

13 *(2) EFFECTIVE DATE.—The amendment made by*  
14 *paragraph (1) shall apply to computations of the sus-*  
15 *tainable growth rate for years beginning with 2003.*

16 **SEC. 602. STUDIES ON ACCESS TO PHYSICIANS’ SERVICES.**

17 *(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSI-*  
18 *CANS’ SERVICES.—*

19 *(1) STUDY.—The Comptroller General of the*  
20 *United States shall conduct a study on access of*  
21 *medicare beneficiaries to physicians’ services under*  
22 *the medicare program. The study shall include—*

23 *(A) an assessment of the use by beneficiaries*  
24 *of such services through an analysis of claims*



1           *submitted by physicians for such services under*  
2           *part B of the medicare program;*

3                   *(B) an examination of changes in the use*  
4           *by beneficiaries of physicians' services over time;*

5                   *(C) an examination of the extent to which*  
6           *physicians are not accepting new medicare bene-*  
7           *ficiaries as patients.*

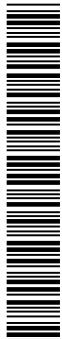
8           (2) *REPORT.*—*Not later than 18 months after the*  
9           *date of the enactment of this Act, the Comptroller*  
10          *General shall submit to Congress a report on the*  
11          *study conducted under paragraph (1). The report*  
12          *shall include a determination whether—*

13                   *(A) data from claims submitted by physi-*  
14          *cians under part B of the medicare program in-*  
15          *dicating potential access problems for medicare*  
16          *beneficiaries in certain geographic areas; and*

17                   *(B) access by medicare beneficiaries to phy-*  
18          *sicians' services may have improved, remained*  
19          *constant, or deteriorated over time.*

20          (b) *STUDY AND REPORT ON SUPPLY OF PHYSICIANS.*—

21                   (1) *STUDY.*—*The Secretary shall request the In-*  
22          *stitute of Medicine of the National Academy of*  
23          *Sciences to conduct a study on the adequacy of the*  
24          *supply of physicians (including specialists) in the*  
25          *United States and the factors that affect such supply.*



1           (2) *REPORT TO CONGRESS.*—Not later than 2  
2           years after the date of enactment of this section, the  
3           Secretary shall submit to Congress a report on the re-  
4           sults of the study described in paragraph (1), includ-  
5           ing any recommendations for legislation.

6           (c) *GAO STUDY OF MEDICARE PAYMENT FOR INHALA-*  
7           *TION THERAPY.*—

8           (1) *STUDY.*—The Comptroller General of the  
9           United States shall conduct a study to examine the  
10          adequacy of current reimbursements for inhalation  
11          therapy under the medicare program.

12          (2) *REPORT.*—Not later than May 1, 2004, the  
13          Comptroller General shall submit to Congress a report  
14          on the study conducted under paragraph (1).

15       **SEC. 603. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS'**  
16                                **SERVICES.**

17          (a) *PRACTICE EXPENSE COMPONENT.*—Not later than  
18          1 year after the date of the enactment of this Act, the Medi-  
19          care Payment Advisory Commission shall submit to Con-  
20          gress a report on the effect of refinements to the practice  
21          expense component of payments for physicians' services,  
22          after the transition to a full resource-based payment system  
23          in 2002, under section 1848 of the Social Security Act (42  
24          U.S.C. 1395w-4). Such report shall examine the following  
25          matters by physician specialty:



1           (1) *The effect of such refinements on payment for*  
2           *physicians' services.*

3           (2) *The interaction of the practice expense com-*  
4           *ponent with other components of and adjustments to*  
5           *payment for physicians' services under such section.*

6           (3) *The appropriateness of the amount of com-*  
7           *ensation by reason of such refinements.*

8           (4) *The effect of such refinements on access to*  
9           *care by medicare beneficiaries to physicians' services.*

10          (5) *The effect of such refinements on physician*  
11          *participation under the medicare program.*

12          (b) *VOLUME OF PHYSICIAN SERVICES.—The Medicare*  
13          *Payment Advisory Commission shall submit to Congress a*  
14          *report on the extent to which increases in the volume of*  
15          *physicians' services under part B of the medicare program*  
16          *are a result of care that improves the health and well-being*  
17          *of medicare beneficiaries. The study shall include the fol-*  
18          *lowing:*

19               (1) *An analysis of recent and historic growth in*  
20               *the components that the Secretary includes under the*  
21               *sustainable growth rate (under section 1848(f) of the*  
22               *Social Security Act).*

23               (2) *An examination of the relative growth of vol-*  
24               *ume in physician services between medicare bene-*  
25               *ficiaries and other populations.*



1           (3) *An analysis of the degree to which new tech-*  
2           *nology, including coverage determinations of the Cen-*  
3           *ters for Medicare & Medicaid Services, has affected*  
4           *the volume of physicians' services.*

5           (4) *An examination of the impact on volume of*  
6           *demographic changes.*

7           (5) *An examination of shifts in the site of service*  
8           *of services that influence the number and intensity of*  
9           *services furnished in physicians' offices and the extent*  
10          *to which changes in reimbursement rates to other pro-*  
11          *viders have affected these changes.*

12          (6) *An evaluation of the extent to which the Cen-*  
13          *ters for Medicare & Medicaid Services takes into ac-*  
14          *count the impact of law and regulations on the sus-*  
15          *tainable growth rate.*

## 16          ***Subtitle B—Preventive Services***

### 17          ***SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL*** 18          ***EXAMINATION.***

19          (a) *COVERAGE.—Section 1861(s)(2) (42 U.S.C.*  
20          *1395x(s)(2)) is amended—*

21                 (1) *in subparagraph (U), by striking “and” at*  
22                 *the end;*

23                 (2) *in subparagraph (V), by inserting “and” at*  
24                 *the end; and*





1           (3) by adding at the end the following new sub-  
2           paragraph:

3           “(W) an initial preventive physical examination  
4           (as defined in subsection (ww));”.

5           (b) *SERVICES DESCRIBED.*—Section 1861 (42 U.S.C.  
6 1395x) is amended by adding at the end the following new  
7 subsection:

8           “*Initial Preventive Physical Examination*  
9           “(ww) The term ‘initial preventive physical examina-  
10          tion’ means physicians’ services consisting of a physical ex-  
11          amination with the goal of health promotion and disease  
12          detection and includes items and services (excluding clinical  
13          laboratory tests), as determined by the Secretary, consistent  
14          with the recommendations of the United States Preventive  
15          Services Task Force.”.

16          (c) *WAIVER OF DEDUCTIBLE AND COINSURANCE.*—

17                 (1) *DEDUCTIBLE.*—The first sentence of section  
18                 1833(b) (42 U.S.C. 1395l(b)) is amended—

19                         (A) by striking “and” before “(6)”, and

20                         (B) by inserting before the period at the end  
21                         the following: “, and (7) such deductible shall not  
22                         apply with respect to an initial preventive phys-  
23                         ical examination (as defined in section  
24                         1861(ww))”.



1           (2) *COINSURANCE.*—Section 1833(a)(1) (42  
2 *U.S.C. 1395l(a)(1)*) is amended—

3           (A) in clause (N), by inserting “(or 100  
4 percent in the case of an initial preventive phys-  
5 ical examination, as defined in section  
6 1861(w))” after “80 percent”; and

7           (B) in clause (O), by inserting “(or 100  
8 percent in the case of an initial preventive phys-  
9 ical examination, as defined in section  
10 1861(w))” after “80 percent”.

11       (d) *PAYMENT AS PHYSICIANS’ SERVICES.*—Section  
12 1848(j)(3) (42 *U.S.C. 1395w-4(j)(3)*) is amended by insert-  
13 ing “(2)(W),” after “(2)(S),”.

14       (e) *OTHER CONFORMING AMENDMENTS.*—Section  
15 1862(a) (42 *U.S.C. 1395y(a)*) is amended—

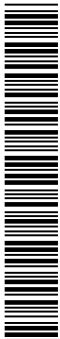
16           (1) in paragraph (1)—

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

19           (B) by striking the semicolon at the end of  
20 subparagraph (I) and inserting “, and”; and

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

23           “(J) in the case of an initial preventive physical  
24 examination, which is performed not later than 6



1       *months after the date the individual's first coverage*  
2       *period begins under part B;"; and*

3               (2) *in paragraph (7), by striking "or (H)" and*  
4       *inserting "(H), or (J)".*

5       (f) *EFFECTIVE DATE.—The amendments made by this*  
6       *section shall apply to services furnished on or after January*  
7       *1, 2004, but only for individuals whose coverage period be-*  
8       *gins on or after such date.*

9       **SEC. 612. COVERAGE OF CHOLESTEROL AND BLOOD LIPID**

10                       **SCREENING.**

11       (a) *COVERAGE.—Section 1861(s)(2) (42 U.S.C.*  
12       *1395x(s)(2)), as amended by section 611(a), is amended—*

13               (1) *in subparagraph (V), by striking "and" at*  
14       *the end;*

15               (2) *in subparagraph (W), by inserting "and" at*  
16       *the end; and*

17               (3) *by adding at the end the following new sub-*  
18       *paragraph:*

19                       “(X) *cholesterol and other blood lipid*  
20               *screening tests (as defined in subsection (XX));”.*

21       (b) *SERVICES DESCRIBED.—Section 1861 (42 U.S.C.*  
22       *1395x), as amended by section 611(b), is amended by add-*  
23       *ing at the end the following new subsection:*



1       *“Cholesterol and Other Blood Lipid Screening Test*

2       *“(xx)(1) The term ‘cholesterol and other blood lipid*  
3 *screening test’ means diagnostic testing of cholesterol and*  
4 *other lipid levels of the blood for the purpose of early detec-*  
5 *tion of abnormal cholesterol and other lipid levels.*

6       *“(2) The Secretary shall establish standards, in con-*  
7 *sultation with appropriate organizations, regarding the fre-*  
8 *quency and type of cholesterol and other blood lipid screen-*  
9 *ing tests, except that such frequency may not be more often*  
10 *than once every 2 years.”.*

11       *(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C.*  
12 *1395y(a)(1)), as amended by section 611(e), is amended—*

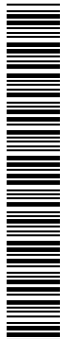
13           *(1) by striking “and” at the end of subpara-*  
14 *graph (I);*

15           *(2) by striking the semicolon at the end of sub-*  
16 *paragraph (J) and inserting “; and”; and*

17           *(3) by adding at the end the following new sub-*  
18 *paragraph:*

19           *“(K) in the case of a cholesterol and other blood*  
20 *lipid screening test (as defined in section*  
21 *1861(xx)(1)), which is performed more frequently*  
22 *than is covered under section 1861(xx)(2).”.*

23       *(d) EFFECTIVE DATE.—The amendments made by this*  
24 *section shall apply to tests furnished on or after January*  
25 *1, 2005.*



1 **SEC. 613. WAIVER OF DEDUCTIBLE FOR COLORECTAL CAN-**  
2 **CER SCREENING TESTS.**

3 (a) *IN GENERAL.*—*The first sentence of section 1833(b)*  
4 *(42 U.S.C. 1395l(b)), as amended by section 611(c)(1), is*  
5 *amended—*

6 (1) *by striking “and” before “(7)”;* and

7 (2) *by inserting before the period at the end the*  
8 *following: “, and (8) such deductible shall not apply*  
9 *with respect to colorectal cancer screening tests (as de-*  
10 *scribed in section 1861(pp)(1))”.*

11 (b) *CONFORMING AMENDMENTS.*—*Paragraphs*  
12 *(2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C.*  
13 *1395m(d)) are each amended—*

14 (1) *by striking “DEDUCTIBLE AND” in the head-*  
15 *ing; and*

16 (2) *in subclause (I), by striking “deductible or”*  
17 *each place it appears.*

18 (c) *EFFECTIVE DATE.*—*The amendment made by this*  
19 *section shall apply to items and services furnished on or*  
20 *after January 1, 2004.*

21 **SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOG-**  
22 **RAPHY SERVICES.**

23 (a) *EXCLUSION FROM OPD FEE SCHEDULE.*—*Section*  
24 *1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amend-*  
25 *ed by inserting before the period at the end the following:*  
26 *“and does not include screening mammography (as defined*



1 *in section 1861(jj) and unilateral and bilateral diagnostic*  
2 *mammography”.*

3 (b) *ADJUSTMENT TO TECHNICAL COMPONENT.—For*  
4 *diagnostic mammography performed on or after January*  
5 *1, 2004, for which payment is made under the physician*  
6 *fee schedule under section 1848 of the Social Security Act*  
7 *(42 U.S.C. 1395w–4), the Secretary, based on the most re-*  
8 *cent cost data available, shall provide for an appropriate*  
9 *adjustment in the payment amount for the technical compo-*  
10 *nent of the diagnostic mammography.*

11 (c) *EFFECTIVE DATE.—The amendment made by sub-*  
12 *section (a) shall apply to mammography performed on or*  
13 *after January 1, 2004.*

## 14 ***Subtitle C—Other Services***

### 15 ***SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD)***

#### 16 ***PAYMENT REFORM.***

17 (a) *PAYMENT FOR DRUGS.—*

18 (1) *MODIFICATION OF AMBULATORY PAYMENT*  
19 *CLASSIFICATION (APC) GROUPS.—Section 1833(t) (42*  
20 *U.S.C. 1395l(t)) is amended—*

21 (A) *by redesignating paragraph (13) as*  
22 *paragraph (14); and*

23 (B) *by inserting after paragraph (12) the*  
24 *following new paragraph:*

25 “(13) *DRUG APC PAYMENT RATES.—*



1           “(A) *IN GENERAL.*—*With respect to pay-*  
2           *ment for covered OPD services that includes a*  
3           *specified covered outpatient drug (defined in sub-*  
4           *paragraph (B)), the amount provided for pay-*  
5           *ment for such drug under the payment system*  
6           *under this subsection for services furnished in—*

7                     “(i) *2004, 2005, or 2006, shall in no*  
8                     *case—*

9                             “(I) *exceed 95 percent of the aver-*  
10                            *age wholesale price for the drug; or*

11                           “(II) *be less than the transition*  
12                            *percentage (under subparagraph (C))*  
13                            *of the average wholesale price for the*  
14                            *drug; or*

15                           “(ii) *a subsequent year, shall be equal*  
16                            *to the average price for the drug for that*  
17                            *area and year established under the com-*  
18                            *petitive acquisition program under section*  
19                            *1847A as calculated and applied by the Sec-*  
20                            *retary for purposes of this paragraph.*

21                     “(B) *SPECIFIED COVERED OUTPATIENT*  
22                     *DRUG DEFINED.*—

23                           “(i) *IN GENERAL.*—*In this paragraph,*  
24                            *the term ‘specified covered outpatient drug’*  
25                            *means, subject to clause (ii), a covered out-*



1                    *patient drug (as defined in 1927(k)(2), that*  
 2                    *is—*

3                    *“(I) a radiopharmaceutical; or*

4                    *“(II) a drug or biological for*  
 5                    *which payment was made under para-*  
 6                    *graph (6) (relating to pass-through*  
 7                    *payments) on or before December 31,*  
 8                    *2002.*

9                    *“(ii) EXCEPTION.—Such term does not*  
 10                   *include—*

11                   *“(I) a drug for which payment is*  
 12                   *first made on or after January 1,*  
 13                   *2003, under paragraph (6); or*

14                   *“(II) a drug for a which a tem-*  
 15                   *porary HCPCS code has not been as-*  
 16                   *signed.*

17                   *“(C) TRANSITION TOWARDS HISTORICAL AV-*  
 18                   *ERAGE ACQUISITION COST.—The transition per-*  
 19                   *centage under this subparagraph for drugs fur-*  
 20                   *nished in a year is determined in accordance*  
 21                   *with the following table:*

<i>The transition percentage for—</i>				
<i>For the year—</i>	<i>Single source drugs are—</i>	<i>Innovator mul- tiple source drugs are—</i>	<i>Generic drugs are—</i>	
2004 .....	83%	81.5%	46%	46%
2005 .....	77%	75%	46%	46%
2006 .....	71%	68%	46%	46%





1           “(D) *PAYMENT FOR NEW DRUGS UNTIL*  
2           *TEMPORARY HCPCS CODE ASSIGNED.*—*With re-*  
3           *spect to payment for covered OPD services that*  
4           *includes a covered outpatient drug (as defined in*  
5           *1927(k)) for a which a temporary HCPCS code*  
6           *has not been assigned, the amount provided for*  
7           *payment for such drug under the payment sys-*  
8           *tem under this subsection shall be equal to 95*  
9           *percent of the average wholesale price for the*  
10           *drug.*

11           “(E) *CLASSES OF DRUGS.*—*For purposes of*  
12           *this paragraph, each of the following shall be*  
13           *treated as a separate class of drugs:*

14           “(i) *SOLE SOURCE DRUGS.*—*A sole*  
15           *source drug which for purposes of this para-*  
16           *graph means a drug or biological that is*  
17           *not a multiple source drug (as defined in*  
18           *subclauses (I) and (II) of section*  
19           *1927(k)(7)(A)(i)) and is not a drug ap-*  
20           *proved under an abbreviated new drug ap-*  
21           *plication under section 355(j) of the Federal*  
22           *Food, Drug, and Cosmetic Act.*

23           “(ii) *INNOVATOR MULTIPLE SOURCE*  
24           *DRUGS.*—*Innovator multiple source drugs*  
25           *(as defined in section 1927(k)(7)(A)(ii)).*



1                   “(iii)   NONINNOVATOR   MULTIPLE  
2                   SOURCE DRUGS.—Noninnovator multiple  
3                   source drugs (as defined in section  
4                   1927(k)(7)(A)(iii)).

5                   “(F) INAPPLICABILITY OF EXPENDITURES  
6                   IN DETERMINING CONVERSION FACTORS.—Addi-  
7                   tional expenditures resulting from this para-  
8                   graph and paragraph (14)(C) in a year shall not  
9                   be taken into account in establishing the conver-  
10                  sion factor for that year.”.

11                  (2) REDUCTION IN THRESHOLD FOR SEPARATE  
12                  APCS FOR DRUGS.—Section 1833(t)(14), as redesign-  
13                  ated by paragraph (1)(A), is amended by adding at  
14                  the end the following new subparagraph:

15                         “(B) THRESHOLD FOR ESTABLISHMENT OF  
16                         SEPARATE APCS FOR DRUGS.—The Secretary  
17                         shall reduce the threshold for the establishment of  
18                         separate ambulatory procedure classification  
19                         groups (APCs) with respect to drugs to \$50 per  
20                         administration.”.

21                  (3) EXCLUSION OF SEPARATE DRUG APCS FROM  
22                  OUTLIER PAYMENTS.—Section 1833(t)(5) is amended  
23                  by adding at the end the following new subparagraph:

24                         “(E) EXCLUSION OF SEPARATE DRUG APCS  
25                         FROM OUTLIER PAYMENTS.—No additional pay-



1           *ment shall be made under subparagraph (A) in*  
2           *the case of ambulatory procedure codes estab-*  
3           *lished separately for drugs.”.*

4           (4) *PAYMENT FOR PASS THROUGH DRUGS.—*  
5           *Clause (i) of section 1833(t)(6)(D) (42 U.S.C.*  
6           *1395l(t)(6)(D)) is amended by inserting after “under*  
7           *section 1842(o)” the following: “(or if the drug is cov-*  
8           *ered under a competitive acquisition contract under*  
9           *section 1847A for an area, an amount determined by*  
10          *the Secretary equal to the average price for the drug*  
11          *for that area and year established under such section*  
12          *as calculated and applied by the Secretary for pur-*  
13          *poses of this paragraph)”.*

14          (5) *EFFECTIVE DATE.—The amendments made*  
15          *by this subsection shall apply to services furnished on*  
16          *or after January 1, 2004.*

17          (b) *SPECIAL PAYMENT FOR BRACHYTHERAPY.—*

18               (1) *IN GENERAL.—Section 1833(t)(14), as so re-*  
19               *designated and amended by subsection (a)(2), is*  
20               *amended by adding at the end the following new sub-*  
21               *paragraph:*

22                       “(C) *PAYMENT FOR DEVICES OF*  
23                       *BRACHYTHERAPY AT CHARGES ADJUSTED TO*  
24                       *COST.—Notwithstanding the preceding provi-*  
25                       *sions of this subsection, for a device of*



1           *brachytherapy furnished on or after January 1,*  
2           *2004, and before January 1, 2007, the payment*  
3           *basis for the device under this subsection shall be*  
4           *equal to the hospital's charges for each device*  
5           *furnished, adjusted to cost.”.*

6           (2)    *SPECIFICATION OF GROUPS FOR*  
7           *BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42*  
8           *U.S.C. 1395l(t)(2) is amended—*

9                   (A) *in subparagraph (F), by striking “and”*  
10                  *at the end;*

11                  (B) *in subparagraph (G), by striking the*  
12                  *period at the end and inserting “; and”; and*

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

15                        (H) *with respect to devices of*  
16                        *brachytherapy, the Secretary shall create addi-*  
17                        *tional groups of covered OPD services that clas-*  
18                        *sify such devices separately from the other serv-*  
19                        *ices (or group of services) paid for under this*  
20                        *subsection in a manner reflecting the number,*  
21                        *isotope, and radioactive intensity of such devices*  
22                        *furnished, including separate groups for palla-*  
23                        *dium-103 and iodine-125 devices.”.*

24           (3) *GAO REPORT.—The Comptroller General of*  
25           *the United States shall conduct a study to determine*

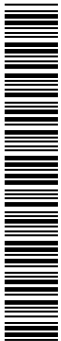


1       *appropriate payment amounts under section*  
2       *1833(t)(13)(B) of the Social Security Act, as added*  
3       *by paragraph (1), for devices of brachytherapy. Not*  
4       *later than January 1, 2005, the Comptroller General*  
5       *shall submit to Congress and the Secretary a report*  
6       *on the study conducted under this paragraph, and*  
7       *shall include specific recommendations for appro-*  
8       *priate payments for such devices.*

9       (c) *APPLICATION OF FUNCTIONAL EQUIVALENCE*  
10      *TEST.—*

11               (1) *IN GENERAL.—Section 1833(t)(6) (42 U.S.C.*  
12               *1395l(t)(6)) is amended by adding at the end the fol-*  
13               *lowing new subparagraph:*

14                       “(F) *LIMITATION ON APPLICATION OF FUNC-*  
15                       *TIONAL EQUIVALENCE STANDARD.—The Sec-*  
16                       *retary may not apply a ‘functional equivalence’*  
17                       *payment standard (including such standard pro-*  
18                       *mulgated on November 1, 2002) or any other*  
19                       *similar standard in order to deem a particular*  
20                       *drug or biological to be identical to or similar to*  
21                       *another drug or biological with respect to its*  
22                       *mechanism of action or clinical effect to deny*  
23                       *pass-through status to new drugs or biologics or*  
24                       *to remove such status of an existing eligible drug*  
25                       *or biologic under this paragraph unless—*



1           “(i) the Secretary develops by regula-  
2           tion (after providing notice and a period  
3           for public comment) criteria for the appli-  
4           cation of such standard; and

5           “(ii) such criteria provide for coordi-  
6           nation with the Federal Food and Drug Ad-  
7           ministration and require scientific studies  
8           that show the clinical relationship between  
9           the drugs or biologicals treated as function-  
10          ally equivalent.”.

11           (2) *EFFECTIVE DATE.*—The amendment made by  
12          paragraph (1) shall apply to the application of a  
13          functional equivalence standard to a drug or biologi-  
14          cal on or after the date of the enactment of this Act,  
15          unless such application was being made to such drug  
16          or biological prior to June 13, 2003.

17          (d) *HOSPITAL ACQUISITION COST STUDY.*—

18           (1) *IN GENERAL.*—The Secretary shall conduct a  
19          study on the costs incurred by hospitals in acquiring  
20          covered outpatient drugs for which payment is made  
21          under section 1833(t) of the Social Security Act (42  
22          U.S.C. 1395l(t)).

23           (2) *DRUGS COVERED.*—The study in paragraph  
24          (1) shall not include those drugs for which the acqui-  
25          sition costs is less than \$50 per administration.



1           (3) *REPRESENTATIVE SAMPLE OF HOSPITALS.*—  
2           *In conducting the study under paragraph (1), the*  
3           *Secretary shall collect data from a statistically valid*  
4           *sample of hospitals with an urban/rural stratifica-*  
5           *tion.*

6           (4) *REPORT.*—*Not later than January 1, 2006,*  
7           *the Secretary shall submit to Congress a report on the*  
8           *study conducted under paragraph (1), and shall in-*  
9           *clude recommendations with respect to the following:*

10                   (A) *Whether the study should be repeated,*  
11                   *and if so, how frequently.*

12                   (B) *Whether the study produced useful data*  
13                   *on hospital acquisition cost.*

14                   (C) *Whether data produced in the study is*  
15                   *appropriate for use in making adjustments to*  
16                   *payments for drugs and biologicals under section*  
17                   *1847A of the Social Security Act.*

18                   (D) *Whether separate estimates can made of*  
19                   *overhead costs, including handing and admin-*  
20                   *istering costs for drugs.*

21 **SEC. 622. PAYMENT FOR AMBULANCE SERVICES.**

22           (a) *PHASE-IN PROVIDING FLOOR USING BLEND OF*  
23           *FEE SCHEDULE AND REGIONAL FEE SCHEDULES.*—*Sec-*  
24           *tion 1834(l) (42 U.S.C. 1395m(l)), as amended by section*  
25           *410(a), is amended—*



1           (1) in paragraph (2)(E), by inserting “consistent  
2           with paragraph (11)” after “in an efficient and fair  
3           manner”; and

4           (2) by adding at the end the following new para-  
5           graph:

6           “(11) PHASE-IN PROVIDING FLOOR USING BLEND  
7           OF FEE SCHEDULE AND REGIONAL FEE SCHED-  
8           ULES.—In carrying out the phase-in under para-  
9           graph (2)(E) for each level of service furnished in a  
10          year, the portion of the payment amount that is based  
11          on the fee schedule shall not be less than the following  
12          blended rate of the fee schedule under paragraph (1)  
13          and of a regional fee schedule for the region involved:

14               “(A) For 2004, the blended rate shall be  
15               based 20 percent on the fee schedule under para-  
16               graph (1) and 80 percent on the regional fee  
17               schedule.

18               “(B) For 2005, the blended rate shall be  
19               based 40 percent on the fee schedule under para-  
20               graph (1) and 60 percent on the regional fee  
21               schedule.

22               “(C) For 2006, the blended rate shall be  
23               based 60 percent on the fee schedule under para-  
24               graph (1) and 40 percent on the regional fee  
25               schedule.





1           “(D) For 2007, 2008, and 2009, the blended  
2           rate shall be based 80 percent on the fee schedule  
3           under paragraph (1) and 20 percent on the re-  
4           gional fee schedule.

5           “(E) For 2010 and each succeeding year,  
6           the blended rate shall be based 100 percent on the  
7           fee schedule under paragraph (1).

8           For purposes of this paragraph, the Secretary shall  
9           establish a regional fee schedule for each of the 9 Cen-  
10          sus divisions using the methodology (used in estab-  
11          lishing the fee schedule under paragraph (1)) to cal-  
12          culate a regional conversion factor and a regional  
13          mileage payment rate and using the same payment  
14          adjustments and the same relative value units as used  
15          in the fee schedule under such paragraph.”.

16          (b) *ADJUSTMENT IN PAYMENT FOR CERTAIN LONG*  
17 *TRIPS.*—Section 1834(l), as amended by subsection (a), is  
18 further amended by adding at the end the following new  
19 paragraph:

20           “(12) *ADJUSTMENT IN PAYMENT FOR CERTAIN*  
21 *LONG TRIPS.*—In the case of ground ambulance serv-  
22          ices furnished on or after January 1, 2004, and before  
23          January 1, 2009, regardless of where the transpor-  
24          tation originates, the fee schedule established under  
25          this subsection shall provide that, with respect to the



1        *payment rate for mileage for a trip above 50 miles*  
2        *the per mile rate otherwise established shall be in-*  
3        *creased by  $\frac{1}{4}$  of the payment per mile otherwise ap-*  
4        *plicable to such miles.”.*

5        *(c) GAO REPORT ON COSTS AND ACCESS.—Not later*  
6        *than December 31, 2005, the Comptroller General of the*  
7        *United States shall submit to Congress an initial report*  
8        *on how costs differ among the types of ambulance providers*  
9        *and on access, supply, and quality of ambulance services*  
10       *in those regions and States that have a reduction in pay-*  
11       *ment under the medicare ambulance fee schedule (under sec-*  
12       *tion 1834(l) of the Social Security Act, as amended by this*  
13       *section). Not later than December 31, 2007, the Comptroller*  
14       *General shall submit to Congress a final report on such ac-*  
15       *cess and supply.*

16       *(d) EFFECTIVE DATE.—The amendments made by this*  
17       *section shall apply to ambulance services furnished on or*  
18       *after January 1, 2004.*

19       **SEC. 623. RENAL DIALYSIS SERVICES.**

20       *(a) DEMONSTRATION OF ALTERNATIVE DELIVERY*  
21       *MODELS.—*

22                *(1) USE OF ADVISORY BOARD.—In carrying out*  
23        *the demonstration project relating to improving care*  
24        *for people with end-stage renal disease through alter-*  
25        *native delivery models (as published in the Federal*



1       *Register of June 4, 2003), the Secretary shall estab-*  
2       *lish an advisory board comprised of representatives*  
3       *described in paragraph (2) to provide advice and rec-*  
4       *ommendations with respect to the establishment and*  
5       *operation of such demonstration project.*

6           (2)   *REPRESENTATIVES.—Representatives re-*  
7       *ferred to in paragraph (1) include representatives of*  
8       *the following:*

9                   (A) *Patient organizations.*

10                   (B) *Clinicians.*

11                   (C) *The medicare payment advisory com-*  
12       *mission, established under section 1805 of the*  
13       *Social Security Act (42 U.S.C. 1395b–6).*

14                   (D) *The National Kidney Foundation.*

15                   (E) *The National Institute of Diabetes and*  
16       *Digestive and Kidney Diseases of National Insti-*  
17       *tutes of Health.*

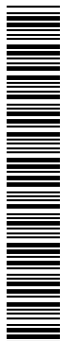
18                   (F) *End-stage renal disease networks.*

19                   (G) *Medicare contractors to monitor quality*  
20       *of care.*

21                   (I) *providers of services and renal dialysis*  
22       *facilities furnishing end-stage renal disease serv-*  
23       *ices.*

24                   (J) *Economists.*

25                   (K) *Researchers.*



1           (b) *RESTORING COMPOSITE RATE EXCEPTIONS FOR*  
2 *PEDIATRIC FACILITIES.*—

3           (1) *IN GENERAL.*—Section 422(a)(2) of BIPA is  
4 amended—

5           (A) in subparagraph (A), by striking “and  
6 (C)” and inserting “; (C), and (D)”;

7           (B) in subparagraph (B), by striking “In  
8 the case” and inserting “Subject to subpara-  
9 graph (D), in the case”; and

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

12           “(D) *INAPPLICABILITY TO PEDIATRIC FA-*  
13 *CILITIES.*—Subparagraphs (A) and (B) shall not  
14 apply, as of October 1, 2002, to pediatric facili-  
15 ties that do not have an exception rate described  
16 in subparagraph (C) in effect on such date. For  
17 purposes of this subparagraph, the term ‘pedi-  
18 atric facility’ means a renal facility at least 50  
19 percent of whose patients are individuals under  
20 18 years of age.”.

21           (2) *CONFORMING AMENDMENT.*—The fourth sen-  
22 tence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)),  
23 as amended by subsection (b), is further amended by  
24 striking “Until” and inserting “Subject to section  
25 422(a)(2) of the Medicare, Medicaid, and SCHIP



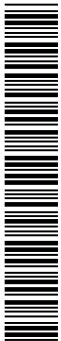
1       *Benefits Improvement and Protection Act of 2000,*  
2       *and until”.*

3       (c) *INCREASE IN RENAL DIALYSIS COMPOSITE RATE*  
4 *FOR SERVICES FURNISHED IN 2004.—Notwithstanding any*  
5 *other provision of law, with respect to payment under part*  
6 *B of title XVIII of the Social Security Act for renal dialysis*  
7 *services furnished in 2004, the composite payment rate oth-*  
8 *erwise established under section 1881(b)(7) of such Act (42*  
9 *U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent.*

10 **SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS; PRO-**  
11 **VISIONS RELATING TO REPORTS.**

12       (a) *1-YEAR MORATORIUM ON THERAPY CAPS.—Sec-*  
13 *tion 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by*  
14 *striking “and 2002” and inserting “2002, and 2004”.*

15       (b) *PROMPT SUBMISSION OF OVERDUE REPORTS ON*  
16 *PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY*  
17 *SERVICES.—Not later than December 31, 2003, the Sec-*  
18 *retary shall submit to Congress the reports required under*  
19 *section 4541(d)(2) of the Balanced Budget Act of 1997 (re-*  
20 *lating to alternatives to a single annual dollar cap on out-*  
21 *patient therapy) and under section 221(d) of the Medicare,*  
22 *Medicaid, and SCHIP Balanced Budget Refinement Act of*  
23 *1999 (relating to utilization patterns for outpatient ther-*  
24 *apy).*



1           (c) *IDENTIFICATION OF CONDITIONS AND DISEASES*  
2 *JUSTIFYING WAIVER OF THERAPY CAP.—*

3           (1) *STUDY.—The Secretary shall request the In-*  
4 *stitute of Medicine of the National Academy of*  
5 *Sciences to identify conditions or diseases that should*  
6 *justify conducting an assessment of the need to waive*  
7 *the therapy caps under section 1833(g)(4) of the So-*  
8 *cial Security Act (42 U.S.C. 1395l(g)(4)).*

9           (2) *REPORTS TO CONGRESS.—*

10           (A) *PRELIMINARY REPORT.—Not later than*  
11 *July 1, 2004, the Secretary shall submit to Con-*  
12 *gress a preliminary report on the conditions and*  
13 *diseases identified under paragraph (1).*

14           (B) *FINAL REPORT.—Not later than Sep-*  
15 *tember 1, 2004, the Secretary shall submit to*  
16 *Congress a final report on such conditions and*  
17 *diseases.*

18           (C) *RECOMMENDATIONS.—Not later than*  
19 *October 1, 2004, the Secretary shall submit to*  
20 *Congress a recommendation of criteria, with re-*  
21 *spect to such conditions and disease, under*  
22 *which a waiver of the therapy caps would apply.*

23           (d) *GAO STUDY OF PATIENT ACCESS TO PHYSICAL*  
24 *THERAPIST SERVICES.—*



1           (1) *STUDY.*—*The Comptroller General of the*  
2           *United States shall conduct a study on access to phys-*  
3           *ical therapist services in States authorizing such serv-*  
4           *ices without a physician referral and in States that*  
5           *require such a physician referral. The study shall—*

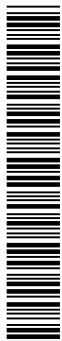
6                   (A) *examine the use of and referral patterns*  
7                   *for physical therapist services for patients age 50*  
8                   *and older in States that authorize such services*  
9                   *without a physician referral and in States that*  
10                  *require such a physician referral;*

11                  (B) *examine the use of and referral patterns*  
12                  *for physical therapist services for patients who*  
13                  *are medicare beneficiaries;*

14                  (C) *examine the potential effect of prohib-*  
15                  *iting a physician from referring patients to*  
16                  *physical therapy services owned by the physician*  
17                  *and provided in the physician's office;*

18                  (D) *examine the delivery of physical thera-*  
19                  *pists' services within the facilities of Department*  
20                  *of Defense; and*

21                  (E) *analyze the potential impact on medi-*  
22                  *care beneficiaries and on expenditures under the*  
23                  *medicare program of eliminating the need for a*  
24                  *physician referral and physician certification for*



1           *physical therapist services under the medicare*  
2           *program.*

3           (2) *REPORT.—The Comptroller General shall*  
4           *submit to Congress a report on the study conducted*  
5           *under paragraph (1) by not later than 1 year after*  
6           *the date of the enactment of this Act.*

7   **SEC. 625. ADJUSTMENT TO PAYMENTS FOR SERVICES FUR-**  
8                   **NISHED IN AMBULATORY SURGICAL CEN-**  
9                   **TERS.**

10          *Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is*  
11          *amended in the last sentence by inserting “and each of fis-*  
12          *cal years 2004 through 2008” after “In each of the fiscal*  
13          *years 1998 through 2002”.*

14   **SEC. 626. PAYMENT FOR CERTAIN SHOES AND INSERTS**  
15                   **UNDER THE FEE SCHEDULE FOR ORTHOTICS**  
16                   **AND PROSTHETICS.**

17          (a) *IN GENERAL.—Section 1833(o) (42 U.S.C.*  
18          *1395l(o)) is amended—*

19               (1) *in paragraph (1), by striking “no more than*  
20               *the limits established under paragraph (2)” and in-*  
21               *serting “no more than the amount of payment appli-*  
22               *cable under paragraph (2)”;* and

23               (2) *in paragraph (2), to read as follows:*

24               “(2)(A) *Except as provided by the Secretary under*  
25               *subparagraphs (B) and (C), the amount of payment under*





1 *this paragraph for custom molded shoes, extra depth shoes,*  
2 *and inserts shall be the amount determined for such items*  
3 *by the Secretary under section 1834(h).*

4       “(B) *The Secretary or a carrier may establish pay-*  
5 *ment amounts for shoes and inserts that are lower than the*  
6 *amount established under section 1834(h) if the Secretary*  
7 *finds that shoes and inserts of an appropriate quality are*  
8 *readily available at or below the amount established under*  
9 *such section.*

10       “(C) *In accordance with procedures established by the*  
11 *Secretary, an individual entitled to benefits with respect*  
12 *to shoes described in section 1861(s)(12) may substitute*  
13 *modification of such shoes instead of obtaining one (or*  
14 *more, as specified by the Secretary) pair of inserts (other*  
15 *than the original pair of inserts with respect to such shoes).*  
16 *In such case, the Secretary shall substitute, for the payment*  
17 *amount established under section 1834(h), a payment*  
18 *amount that the Secretary estimates will assure that there*  
19 *is no net increase in expenditures under this subsection as*  
20 *a result of this subparagraph.”.*

21       (b) *CONFORMING AMENDMENTS.—(1) Section*  
22 *1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by*  
23 *inserting “(and includes shoes described in section*  
24 *1861(s)(12))” after “in section 1861(s)(9)”.*



1       (2) *Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is*  
2 *amended by striking subparagraph (C).*

3       (c) *EFFECTIVE DATE.*—*The amendments made by this*  
4 *section shall apply to items furnished on or after January*  
5 *1, 2004.*

6 **SEC. 627. WAIVER OF PART B LATE ENROLLMENT PENALTY**  
7 **FOR CERTAIN MILITARY RETIREES; SPECIAL**  
8 **ENROLLMENT PERIOD.**

9       (a) *WAIVER OF PENALTY.*—

10           (1) *IN GENERAL.*—*Section 1839(b) (42 U.S.C.*  
11 *1395r(b)) is amended by adding at the end the fol-*  
12 *lowing new sentence: “No increase in the premium*  
13 *shall be effected for a month in the case of an indi-*  
14 *vidual who is 65 years of age or older, who enrolls*  
15 *under this part during 2001, 2002, 2003, or 2004 and*  
16 *who demonstrates to the Secretary before December*  
17 *31, 2004, that the individual is a covered beneficiary*  
18 *(as defined in section 1072(5) of title 10, United*  
19 *States Code). The Secretary of Health and Human*  
20 *Services shall consult with the Secretary of Defense in*  
21 *identifying individuals described in the previous sen-*  
22 *tence.”.*

23           (2) *EFFECTIVE DATE.*—*The amendment made by*  
24 *paragraph (1) shall apply to premiums for months*  
25 *beginning with January 2004. The Secretary of*



1        *Health and Human Services shall establish a method*  
2        *for providing rebates of premium penalties paid for*  
3        *months on or after January 2004 for which a penalty*  
4        *does not apply under such amendment but for which*  
5        *a penalty was previously collected.*

6        *(b) MEDICARE PART B SPECIAL ENROLLMENT PE-*  
7        *RIOD.—*

8                *(1) IN GENERAL.—In the case of any individual*  
9        *who, as of the date of the enactment of this Act, is*  
10        *65 years of age or older, is eligible to enroll but is not*  
11        *enrolled under part B of title XVIII of the Social Se-*  
12        *curity Act, and is a covered beneficiary (as defined*  
13        *in section 1072(5) of title 10, United States Code), the*  
14        *Secretary of Health and Human Services shall pro-*  
15        *vide for a special enrollment period during which the*  
16        *individual may enroll under such part. Such period*  
17        *shall begin as soon as possible after the date of the en-*  
18        *actment of this Act and shall end on December 31,*  
19        *2004.*

20                *(2) COVERAGE PERIOD.—In the case of an indi-*  
21        *vidual who enrolls during the special enrollment pe-*  
22        *riod provided under paragraph (1), the coverage pe-*  
23        *riod under part B of title XVIII of the Social Secu-*  
24        *rity Act shall begin on the first day of the month fol-*  
25        *lowing the month in which the individual enrolls.*



1 **SEC. 628. PART B DEDUCTIBLE.**

2 *Section 1833(b) (42 U.S.C. 1395l(b)) is amended—*

3 *(1) by striking “1991 and” and inserting*  
4 *“1991,”; and*

5 *(2) by striking “and subsequent years” and in-*  
6 *serting “and each subsequent year through 2003, and*  
7 *for a subsequent year after 2003 the amount of such*  
8 *deductible for the previous year increased by the an-*  
9 *nuual percentage increase in the monthly actuarial*  
10 *rate under section 1839(a)(1) ending with such subse-*  
11 *quent year (rounded to the nearest \$1)”.*

12 **SEC. 629. EXTENSION OF COVERAGE OF INTRAVENOUS IM-**  
13 **MUNE GLOBULIN (IVIG) FOR THE TREATMENT**  
14 **OF PRIMARY IMMUNE DEFICIENCY DISEASES**  
15 **IN THE HOME.**

16 *(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as*  
17 *amended by sections 611(a) and 612(a) is amended—*

18 *(1) in subsection (s)(2)—*

19 *(A) by striking “and” at the end of sub-*  
20 *paragraph (W);*

21 *(B) by adding “and” at the end of subpara-*  
22 *graph (X); and*

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

25 *“(Y) intravenous immune globulin for the*  
26 *treatment of primary immune deficiency diseases*



1           *in the home (as defined in subsection (yy));”;*  
2           *and*

3           (2) *by adding at the end the following new sub-*  
4           *section:*

5                           *“Intravenous Immune Globulin*  
6           *“(yy) The term ‘intravenous immune globulin’ means*  
7           *an approved pooled plasma derivative for the treatment in*  
8           *the patient’s home of a patient with a diagnosed primary*  
9           *immune deficiency disease, but not including items or serv-*  
10           *ices related to the administration of the derivative, if a phy-*  
11           *sician determines administration of the derivative in the*  
12           *patient’s home is medically appropriate.”.*

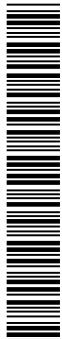
13           (b) *PAYMENT AS A DRUG OR BIOLOGICAL.*—*Section*  
14           *1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by in-*  
15           *serting “(including intravenous immune globulin (as de-*  
16           *finied in section 1861(yy)))” after “with respect to drugs*  
17           *and biologicals”.*

18           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
19           *section shall apply to items furnished administered on or*  
20           *after January 1, 2004.*

21                           ***TITLE VII—PROVISIONS***  
22                           ***RELATING TO PARTS A AND B***  
23                           ***Subtitle A—Home Health Services***

24           ***SEC. 701. UPDATE IN HOME HEALTH SERVICES.***

25           (a) *CHANGE TO CALENDER YEAR UPDATE.*—



1           (1) *IN GENERAL.*—Section 1895(b) (42 U.S.C.  
2     1395fff(b)(3)) is amended—

3           (A) in paragraph (3)(B)(i)—

4                 (i) by striking “each fiscal year (begin-  
5                 ning with fiscal year 2002)” and inserting  
6                 “fiscal year 2002 and for fiscal year 2003  
7                 and for each subsequent year (beginning  
8                 with 2004)”; and

9                 (ii) by inserting “or year” after “the  
10                 fiscal year”;

11           (B) in paragraph (3)(B)(ii)(II), by striking  
12           “any subsequent fiscal year” and inserting  
13           “2004 and any subsequent year”;

14           (C) in paragraph (3)(B)(iii), by inserting  
15           “or year” after “fiscal year” each place it ap-  
16           pears;

17           (D) in paragraph (3)(B)(iv)—

18                 (i) by inserting “or year” after “fiscal  
19                 year” each place it appears; and

20                 (ii) by inserting “or years” after “fis-  
21                 cal years”; and

22           (E) in paragraph (5), by inserting “or  
23           year” after “fiscal year”.

24           (2) *TRANSITION RULE.*—The standard prospec-  
25     tive payment amount (or amounts) under section



1       1895(b)(3) of the Social Security Act for the calendar  
2       quarter beginning on October 1, 2003, shall be such  
3       amount (or amounts) for the previous calendar quar-  
4       ter.

5       (b) *CHANGES IN UPDATES FOR 2004, 2005, AND*  
6       2006.—Section 1895(b)(3)(B)(ii) (42 U.S.C.  
7       1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B),  
8       is amended—

9               (1) by striking “or” at the end of subclause (I);

10              (2) by redesignating subclause (II) as subclause  
11       (III);

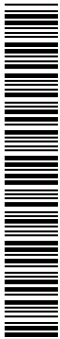
12              (3) in subclause (III), as so redesignated, by  
13       striking “2004” and inserting “2007”; and

14              (4) by inserting after subclause (I) the following  
15       new subclause:

16                                       “(II) each of 2004, 2005, and  
17                                       2006 the home health market basket  
18                                       percentage increase minus 0.4 percent-  
19                                       age points; or”.

20       **SEC. 702. ESTABLISHMENT OF REDUCED COPAYMENT FOR A**  
21                                       **HOME HEALTH SERVICE EPISODE OF CARE**  
22                                       **FOR CERTAIN BENEFICIARIES.**

23       (a) *PART A.*—



1           (1) *IN GENERAL.*—Section 1813(a) (42 U.S.C.  
2           1395e(a)) is amended by adding at the end the fol-  
3           lowing new paragraph:

4           “(5)(A)(i) Subject to clause (ii), the amount payable  
5           for home health services furnished to the individual under  
6           this title for each episode of care beginning in a year (begin-  
7           ning with 2004) shall be reduced by a copayment equal to  
8           the copayment amount specified in subparagraph (B)(ii)  
9           for such year.

10          “(ii) The copayment under clause (i) shall not apply—

11           “(I) in the case of an individual who has been  
12           determined to be entitled to medical assistance under  
13           section 1902(a)(10)(A) or 1902(a)(10)(C) or to be a  
14           qualified medicare beneficiary (as defined in section  
15           1905(p)(1)), a specified low-income medicare bene-  
16           ficiary described in section 1902(a)(10)(E)(iii), or a  
17           qualifying individual described in section  
18           1902(a)(10)(E)(iv)(I); and

19           “(II) in the case of an episode of care which con-  
20           sists of 4 or fewer visits.

21          “(B)(i) The Secretary shall estimate, before the begin-  
22           ning of each year (beginning with 2004), the national aver-  
23           age payment under this title per episode for home health  
24           services projected for the year involved.





1       “(ii) For each year the copayment amount under this  
2 clause is equal to 1.5 percent of the national average pay-  
3 ment estimated for the year involved under clause (i). Any  
4 amount determined under the preceding sentence which is  
5 not a multiple of \$5 shall be rounded to the nearest multiple  
6 of \$5.

7       “(iii) There shall be no administrative or judicial re-  
8 view under section 1869, 1878, or otherwise of the esti-  
9 mation of average payment under clause (i).”.

10           (2) *TIMELY IMPLEMENTATION.*—Unless the Sec-  
11 retary of Health and Human Services otherwise pro-  
12 vides on a timely basis, the copayment amount speci-  
13 fied under section 1813(a)(5)(B)(ii) of the Social Se-  
14 curity Act (as added by paragraph (1)) for 2004 shall  
15 be deemed to be \$40.

16           (b) *CONFORMING PROVISIONS.*—

17           (1) Section 1833(a)(2)(A) (42 U.S.C.  
18 1395l(a)(2)(A)) is amended by inserting “less the co-  
19 payment amount applicable under section  
20 1813(a)(5)” after “1895”.

21           (2) Section 1866(a)(2)(A)(i) (42 U.S.C.  
22 1395cc(a)(2)(A)(i)) is amended—

23                   (A) by striking “or coinsurance” and in-  
24 serting “, coinsurance, or copayment”; and



1 (B) by striking “or (a)(4)” and inserting  
2 “(a)(4), or (a)(5)”.

3 **SEC. 703. MEDPAC STUDY ON MEDICARE MARGINS OF HOME**  
4 **HEALTH AGENCIES.**

5 (a) *STUDY.*—The Medicare Payment Advisory Com-  
6 mission shall conduct a study of payment margins of home  
7 health agencies under the home health prospective payment  
8 system under section 1895 of the Social Security Act (42  
9 U.S.C. 1395fff). Such study shall examine whether system-  
10 atic differences in payment margins are related to dif-  
11 ferences in case mix (as measured by home health resource  
12 groups (HHRGs)) among such agencies. The study shall use  
13 the partial or full-year cost reports filed by home health  
14 agencies.

15 (b) *REPORT.*—Not later than 2 years after the date  
16 of the enactment of this Act, the Commission shall submit  
17 to Congress a report on the study under subsection (a).

18 **Subtitle B—Direct Graduate**  
19 **Medical Education**

20 **SEC. 711. EXTENSION OF UPDATE LIMITATION ON HIGH**  
21 **COST PROGRAMS.**

22 Section 1886(h)(2)(D)(iv) (42 U.S.C.  
23 1395ww(h)(2)(D)(iv)) is amended—  
24 (1) in subclause (I)—



1 (A) by inserting “AND 2004 THROUGH 2013”  
2 after “AND 2002”; and

3 (B) by inserting “or during the period be-  
4 ginning with fiscal year 2004 and ending with  
5 fiscal year 2013” after “during fiscal year 2001  
6 or fiscal year 2002”; and

7 (2) in subclause (II)—

8 (A) by striking “fiscal year 2004, or fiscal  
9 year 2005,” and

10 (B) by striking “For a” and inserting “For  
11 the”.

12 **Subtitle C—Chronic Care**  
13 **Improvement**

14 **SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT**  
15 **UNDER TRADITIONAL FEE-FOR-SERVICE.**

16 *Title XVIII, as amended by section 105(a), is amended*  
17 *by inserting after section 1807 the following new section:*

18 “CHRONIC CARE IMPROVEMENT

19 “SEC. 1808. (a) IN GENERAL.—

20 “(1) IN GENERAL.—The Secretary shall establish  
21 a process for providing chronic care improvement  
22 programs in each CCLA region for medicare bene-  
23 ficiaries who are not enrolled under part C or E and  
24 who have certain chronic conditions, such as conges-  
25 tive heart failure, diabetes, chronic obstructive pul-  
26 monary disease (COPD), stroke, or other disease as



1       *identified by the Secretary as appropriate for chronic*  
2       *care improvement. Such a process shall begin to be*  
3       *implemented no later than 1 year after the date of the*  
4       *enactment of this section.*

5               “(2) *TERMINOLOGY.*—*For purposes of this sec-*  
6       *tion:*

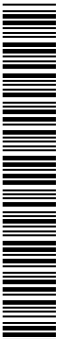
7                       “(A) *CCLIA REGION.*—*The term ‘CCLIA re-*  
8       *gion’ means a chronic care improvement admin-*  
9       *istrative region delineated under subsection*  
10       *(b)(2).*

11                      “(B) *CHRONIC CARE IMPROVEMENT PRO-*  
12       *GRAM.*—*The terms ‘chronic care improvement*  
13       *program’ and ‘program’ means such a program*  
14       *provided by a contractor under this section.*

15                      “(C) *CONTRACTOR.*—*The term ‘contractor’*  
16       *means an entity with a contract to provide a*  
17       *chronic care improvement program in a CCLIA*  
18       *region under this section.*

19                      “(D) *INDIVIDUAL PLAN.*—*The term ‘indi-*  
20       *vidual plan’ means a chronic care improvement*  
21       *plan established under subsection (c)(5) for an*  
22       *individual.*

23                      “(3) *CONSTRUCTION.*—*Nothing in this section*  
24       *shall be construed as expanding the amount, dura-*  
25       *tion, or scope of benefits under this title.*



1       “(b) *COMPETITIVE BIDDING PROCESS.*—

2               “(1) *IN GENERAL.*—Under this section the Sec-  
3       retary shall award contracts to qualified entities for  
4       chronic care improvement programs for each CCLA  
5       region under this section through a competitive bid-  
6       ding process.

7               “(2) *PROCESS.*—Under such process—

8                       “(A) the Secretary shall delineate the  
9       United States into multiple chronic care im-  
10      provement administrative regions; and

11                      “(B) the Secretary shall select at least 2  
12      winning bidders in each CCLA region on the  
13      basis of the ability of each bidder to carry out  
14      a chronic care improvement program in accord-  
15      ance with this section, in order to achieve im-  
16      proved health and financial outcomes.

17               “(3) *ELIGIBLE CONTRACTOR.*—A contractor may  
18      be a disease improvement organization, health in-  
19      surer, provider organization, a group of physicians,  
20      or any other legal entity that the Secretary deter-  
21      mines appropriate.

22       “(c) *CHRONIC CARE IMPROVEMENT PROGRAMS.*—

23               “(1) *IN GENERAL.*—Each contract under this  
24      section shall provide for the operation of a chronic



1       *care improvement program by a contractor in a*  
2       *CCIA region consistent with this subsection.*

3               “(2) *IDENTIFICATION OF PROSPECTIVE PROGRAM*  
4       *PARTICIPANTS.—Each contractor shall have a method*  
5       *for identifying medicare beneficiaries in the region to*  
6       *whom it will offer services under its program. The*  
7       *contractor shall identify such beneficiaries through*  
8       *claims or other data and other means permitted con-*  
9       *sistent with applicable disclosure provisions.*

10              “(3) *INITIAL CONTACT BY SECRETARY.—The Sec-*  
11       *retary shall communicate with each beneficiary iden-*  
12       *tified under paragraph (2) as a prospective partici-*  
13       *part in one or more programs concerning participa-*  
14       *tion in a program. Such communication may be*  
15       *made by the Secretary (or on behalf of the Secretary)*  
16       *and shall include information on the following:*

17                      “(A) *A description of the advantages to the*  
18       *beneficiary in participating in a program.*

19                      “(B) *Notification that the contractor offer-*  
20       *ing a program may contact the beneficiary di-*  
21       *rectly concerning such participation.*

22                      “(C) *Notification that participation in a*  
23       *program is voluntary.*

24                      “(D) *A description of the method for the*  
25       *beneficiary to select the single program in which*



1           *the beneficiary wishes to participate and for de-*  
2           *clining to participate and a method for obtain-*  
3           *ing additional information concerning such par-*  
4           *ticipation.*

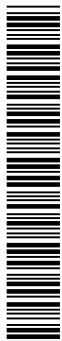
5           “(4) *PARTICIPATION.—A medicare beneficiary*  
6           *may participate in only one program under this sec-*  
7           *tion and may terminate participation at any time in*  
8           *a manner specified by the Secretary.*

9           “(5) *INDIVIDUAL CHRONIC CARE IMPROVEMENT*  
10          *PLANS.—*

11           “(A) *IN GENERAL.—For each beneficiary*  
12           *participating in a program of a contractor*  
13           *under this section, the contractor shall develop*  
14           *with the beneficiary an individualized, goal-ori-*  
15           *ented chronic care improvement plan.*

16           “(B) *ELEMENTS OF INDIVIDUAL PLAN.—*  
17           *Each individual plan developed under subpara-*  
18           *graph (A) shall include a single point of contact*  
19           *to coordinate care and the following, as appro-*  
20           *priate:*

21           “(i) *Self-improvement education for*  
22           *the beneficiary and support education for*  
23           *health care providers, primary caregivers,*  
24           *and family members.*



1                   “(ii) *Coordination of health care serv-*  
2                   *ices, such as application of a prescription*  
3                   *drug regimen and home health services.*

4                   “(iii) *Collaboration with physicians*  
5                   *and other providers to enhance communica-*  
6                   *tion of relevant clinical information.*

7                   “(iv) *The use of monitoring tech-*  
8                   *nologies that enable patient guidance*  
9                   *through the exchange of pertinent clinical*  
10                   *information, such as vital signs, sympto-*  
11                   *matic information, and health self-assess-*  
12                   *ment.*

13                   “(v) *The provision of information*  
14                   *about hospice care, pain and palliative*  
15                   *care, and end-of-life care.*

16                   “(C) *CONTRACTOR RESPONSIBILITIES.—In*  
17                   *establishing and carrying out individual plans*  
18                   *under a program, a contractor shall, directly or*  
19                   *through subcontractors—*

20                   “(i) *guide participants in managing*  
21                   *their health, including all their co-*  
22                   *morbidities, and in performing activities as*  
23                   *specified under the elements of the plan;*





1                   “(ii) use decision support tools such as  
2                   evidence-based practice guidelines or other  
3                   criteria as determined by the Secretary; and

4                   “(iii) develop a clinical information  
5                   database to track and monitor each partici-  
6                   pant across settings and to evaluate out-  
7                   comes.

8                   “(6) *ADDITIONAL REQUIREMENTS.*—The Sec-  
9                   retary may establish additional requirements for pro-  
10                  grams and contractors under this section.

11                  “(7) *ACCREDITATION.*—The Secretary may pro-  
12                  vide that programs that are accredited by qualified  
13                  organizations may be deemed to meet such require-  
14                  ments under this section as the Secretary may speci-  
15                  fy.

16                  “(c) *CONTRACT TERMS.*—

17                  “(1) *IN GENERAL.*—A contract under this section  
18                  shall contain such terms and conditions as the Sec-  
19                  retary may specify consistent with this section. The  
20                  Secretary may not enter into a contract with an enti-  
21                  ty under this section unless the entity meets such clin-  
22                  ical, quality improvement, financial, and other re-  
23                  quirements as the Secretary deems to be appropriate  
24                  for the population to be served.



1           “(2) *USE OF SUBCONTRACTORS PERMITTED.*—A  
2           *contractor may carry out a program directly or*  
3           *through contracts with subcontractors.*

4           “(3) *BUDGET NEUTRAL PAYMENT CONDITION.*—  
5           *In entering into a contract with an entity under this*  
6           *subsection, the Secretary shall establish payment rates*  
7           *that assure that there will be no net aggregate in-*  
8           *crease in payments under this title over any period*  
9           *of 3 years or longer, as agreed to by the Secretary.*  
10          *Under this section, the Secretary shall assure that*  
11          *medicare program outlays plus administrative ex-*  
12          *penses (that would not have been paid under this title*  
13          *without implementation of this section), including*  
14          *contractor fees, shall not exceed the expenditures that*  
15          *would have been incurred under this title for a com-*  
16          *parable population in the absence of the program*  
17          *under this section for the 3-year contract period.*

18          “(4) *AT RISK RELATIONSHIP.*—*For purposes of*  
19          *section 1128B(b)(3)(F), a contract under this section*  
20          *shall be treated as a risk-sharing arrangement re-*  
21          *ferred to in such section.*

22          “(5) *PERFORMANCE STANDARDS.*—*Payment to*  
23          *contractors under this section shall be subject to the*  
24          *contractor’s meeting of clinical and financial per-*  
25          *formance standards set by the Secretary.*



1           “(6) *CONTRACTOR OUTCOMES REPORT.*—*Each*  
2           *contractor offering a program shall monitor and re-*  
3           *port to the Secretary, in a manner specified by the*  
4           *Secretary, the quality of care and efficacy of such*  
5           *program in terms of—*

6                   “(A) *process measures, such as reductions*  
7                   *in errors of treatment and rehospitalization*  
8                   *rates;*

9                   “(B) *beneficiary and provider satisfaction;*

10                   “(C) *health outcomes; and*

11                   “(D) *financial outcomes.*

12           “(7) *PHASED IN IMPLEMENTATION.*—*Nothing in*  
13           *this section shall be construed as preventing the Sec-*  
14           *retary from phasing in the implementation of pro-*  
15           *grams.*

16           “(d) *BIANNUAL OUTCOMES REPORTS.*—*The Secretary*  
17           *shall submit to the Congress biannual reports on the imple-*  
18           *mentation of this section. Each such report shall include*  
19           *information on—*

20                   “(1) *the scope of implementation (in terms of*  
21                   *both regions and chronic conditions);*

22                   “(2) *program design; and*

23                   “(3) *improvements in health outcomes and fi-*  
24                   *nancial efficiencies that result from such implementa-*  
25                   *tion.*



1           “(e) *CLINICAL TRIALS.*—*The Secretary shall conduct*  
2 *randomized clinical trials, that compare program partici-*  
3 *pants with medicare beneficiaries who are offered, but de-*  
4 *cline, to participate, in order to assess the potential of pro-*  
5 *grams to—*

6                   “(1) *reduce costs under this title; and*

7                   “(2) *improve health outcomes under this title.*

8           “(f) *AUTHORIZATION OF APPROPRIATIONS.*—*There are*  
9 *authorized to be appropriated to the Secretary, in appro-*  
10 *priate part from the Hospital Insurance Trust Fund and*  
11 *the Supplementary Medical Insurance Trust Fund, such*  
12 *sums as may be necessary to provide for contracts with*  
13 *chronic care improvement programs under this section.*

14           “(g) *LIMITATION ON FUNDING.*—*In no case shall the*  
15 *funding under this section exceed \$100,000,000 over a pe-*  
16 *riod of 3 years.”.*

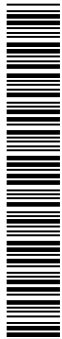
17 **SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDICARE**

18                   **ADVANTAGE AND ENHANCED FEE-FOR-SERV-**

19                   **ICE PROGRAMS.**

20           “(a) *UNDER MEDICARE ADVANTAGE PROGRAM.*—*Sec-*  
21 *tion 1852 (42 U.S.C. 1395w-22) is amended—*

22                   “(1) *by amending subsection (e) to read as fol-*  
23 *lows:*



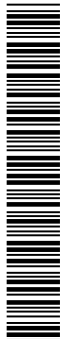
1           “(e) *IMPLEMENTATION OF CHRONIC CARE IMPROVE-*  
2 *MENT PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR*  
3 *SUFFICIENTLY SEVERE CHRONIC CONDITIONS.*—

4                   “(1) *IN GENERAL.*—*Each Medicare Advantage*  
5 *organization with respect to each Medicare Advantage*  
6 *plan it offers shall have in effect, for enrollees with*  
7 *multiple or sufficiently severe chronic conditions, a*  
8 *chronic care improvement program that is designed to*  
9 *manage the needs of such enrollees and that meets the*  
10 *requirements of this subsection.*

11                   “(2) *ENROLLEE WITH MULTIPLE OR SUFFI-*  
12 *CIENTLY SEVERE CHRONIC CONDITIONS.*—*For pur-*  
13 *poses of this subsection, the term ‘enrollee with mul-*  
14 *tiple or sufficiently severe chronic conditions’ means,*  
15 *with respect to an enrollee in a Medicare Advantage*  
16 *plan of a Medicare Advantage organization, an en-*  
17 *rollee in the plan who has one or more chronic condi-*  
18 *tions, such as congestive heart failure, diabetes,*  
19 *COPD, stroke, or other disease as identified by the or-*  
20 *ganization as appropriate for chronic care improve-*  
21 *ment.*

22                   “(3) *GENERAL REQUIREMENTS.*—

23                           “(A) *IN GENERAL.*—*Each chronic care im-*  
24 *provement program under this subsection shall*  
25 *be conducted consistent with this subsection.*



1           “(B) *IDENTIFICATION OF ENROLLEES.*—  
2           *Each such program shall have a method for*  
3           *monitoring and identifying enrollees with mul-*  
4           *ti-ple or sufficiently severe chronic conditions*  
5           *that meet the organization’s criteria for partici-*  
6           *ipation under the program.*

7           “(C) *DEVELOPMENT OF PLANS.*—*For an en-*  
8           *rollee identified under subparagraph (B) for par-*  
9           *ticipation in a program, the program shall de-*  
10          *velop, with the enrollee’s consent, an individual-*  
11          *ized, goal-oriented chronic care improvement*  
12          *plan for chronic care improvement.*

13          “(D) *ELEMENTS OF PLANS.*—*Each chronic*  
14          *care improvement plan developed under subpara-*  
15          *graph (C) shall include a single point of contact*  
16          *to coordinate care and the following, as appro-*  
17          *priate:*

18                  “(i) *Self-improvement education for*  
19                  *the enrollee and support education for*  
20                  *health care providers, primary caregivers,*  
21                  *and family members.*

22                  “(ii) *Coordination of health care serv-*  
23                  *ices, such as application of a prescription*  
24                  *drug regimen and home health services.*



1                   “(iii) *Collaboration with physicians*  
2                   *and other providers to enhance communica-*  
3                   *tion of relevant clinical information.*

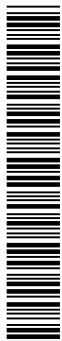
4                   “(iv) *The use of monitoring tech-*  
5                   *nologies that enable patient guidance*  
6                   *through the exchange of pertinent clinical*  
7                   *information, such as vital signs, sympto-*  
8                   *matic information, and health self-assess-*  
9                   *ment.*

10                  “(v) *The provision of information*  
11                  *about hospice care, pain and palliative*  
12                  *care, and end-of-life care.*

13                  “(E) *ORGANIZATION RESPONSIBILITIES.—*  
14                  *In establishing and carrying out chronic care*  
15                  *improvement plans for participants under this*  
16                  *paragraph, a Medicare Advantage organization*  
17                  *shall, directly or through subcontractors—*

18                         “(i) *guide participants in managing*  
19                         *their health, including all their co-*  
20                         *morbidities, and in performing the activi-*  
21                         *ties as specified under the elements of the*  
22                         *plan;*

23                         “(ii) *use decision support tools such as*  
24                         *evidence-based practice guidelines or other*  
25                         *criteria as determined by the Secretary; and*



1                   “(iii) develop a clinical information  
2                   database to track and monitor each partici-  
3                   pant across settings and to evaluate out-  
4                   comes.

5                   “(3) *ADDITIONAL REQUIREMENTS.*—*The Sec-*  
6                   *retary may establish additional requirements for*  
7                   *chronic care improvement programs under this sec-*  
8                   *tion.*

9                   “(4) *ACCREDITATION.*—*The Secretary may pro-*  
10                  *vide that chronic care improvement programs that*  
11                  *are accredited by qualified organizations may be*  
12                  *deemed to meet such requirements under this sub-*  
13                  *section as the Secretary may specify.*

14                  “(5) *OUTCOMES REPORT.*—*Each Medicare Ad-*  
15                  *vantage organization with respect to its chronic care*  
16                  *improvement program under this subsection shall*  
17                  *monitor and report to the Secretary information on*  
18                  *the quality of care and efficacy of such program as*  
19                  *the Secretary may require.”; and*

20                  (2) *by amending subparagraph (I) of subsection*  
21                  *(c)(1) to read as follows:*

22                  “(I) *CHRONIC CARE IMPROVEMENT PRO-*  
23                  *GRAM.*—*A description of the organization’s*  
24                  *chronic care improvement program under sub-*  
25                  *section (e).”.*





1           (b) *APPLICATION UNDER ENHANCED FEE-FOR-SERV-*  
2 *ICE PROGRAM.*—Section 1860E–2(c)(3), as inserted by sec-  
3 *tion 201(a)*, is amended by inserting “, including subsection  
4 *(e) (relating to implementation of chronic care improve-*  
5 *ment programs)”* after “The provisions of section 1852”.

6           (c) *EFFECTIVE DATE.*—The amendments made by this  
7 *section shall apply for contract years beginning on or after*  
8 *1 year after the date of the enactment of this Act.*

9 **SEC. 723. INSTITUTE OF MEDICINE REPORT.**

10           (a) *STUDY.*—

11                   (1) *IN GENERAL.*—The Secretary of Health and  
12 *Human Services shall contract with the Institute of*  
13 *Medicine of the National Academy of Sciences to con-*  
14 *duct a study of the barriers to effective integrated care*  
15 *improvement for medicare beneficiaries with multiple*  
16 *or severe chronic conditions across settings and over*  
17 *time and to submit a report under subsection (b).*

18                   (2) *SPECIFIC ITEMS.*—The study shall examine  
19 *the statutory and regulatory barriers to coordinating*  
20 *care across settings for medicare beneficiaries in tran-*  
21 *sition from one setting to another (such as between*  
22 *hospital, nursing facility, home health, hospice, and*  
23 *home). The study shall specifically identify the fol-*  
24 *lowing:*



1           (A) *Clinical, financial, or administrative*  
2           *requirements in the medicare program that*  
3           *present barriers to effective, seamless transitions*  
4           *across care settings.*

5           (B) *Policies that impede the establishment*  
6           *of administrative and clinical information sys-*  
7           *tems to track health status, utilization, cost, and*  
8           *quality data across settings.*

9           (C) *State-level requirements that may*  
10          *present barriers to better care for medicare bene-*  
11          *ficiaries.*

12          (3) *CONSULTATION.—The study under this sub-*  
13          *section shall be conducted in consultation with experts*  
14          *in the field of chronic care, consumers, and family*  
15          *caregivers, working to integrate care delivery and cre-*  
16          *ate more seamless transitions across settings and over*  
17          *time.*

18          (b) *REPORT.—The report under this subsection shall*  
19          *be submitted to the Secretary and Congress not later than*  
20          *18 months after the date of the enactment of this Act.*

21          **SEC. 724. MEDPAC REPORT.**

22          (a) *EVALUATION.—shall conduct an evaluation that*  
23          *includes a description of the status of the implementation*  
24          *of chronic care improvement programs under section 1808*  
25          *of the Social Security Act, the quality of health care services*



1 *provided to individuals in such program, the health status*  
2 *of the participants of such program, and the cost savings*  
3 *attributed to implementation of such program.*

4 (b) *REPORT.—Not later than 2 years after the date*  
5 *of implementation of such chronic care improvement pro-*  
6 *grams, the Commission shall submit a report on such eval-*  
7 *uation.*

## 8 ***Subtitle D—Other Provisions***

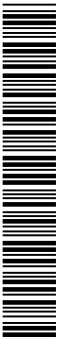
### 9 ***SEC. 731. MODIFICATIONS TO MEDICARE PAYMENT ADVI-*** 10 ***SORY COMMISSION (MEDPAC).***

11 (a) *EXAMINATION OF BUDGET CONSEQUENCES.—Sec-*  
12 *tion 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding*  
13 *at the end the following new paragraph:*

14 “(8) *EXAMINATION OF BUDGET CON-*  
15 *SEQUENCES.—Before making any recommendations,*  
16 *the Commission shall examine the budget con-*  
17 *sequences of such recommendations, directly or*  
18 *through consultation with appropriate expert enti-*  
19 *ties.”.*

20 (b) *CONSIDERATION OF EFFICIENT PROVISION OF*  
21 *SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–*  
22 *6(b)(2)(B)(i)) is amended by inserting “the efficient provi-*  
23 *sion of” after “expenditures for”.*

24 (c) *APPLICATION OF DISCLOSURE REQUIREMENTS.—*



1           (1) *IN GENERAL.*—Section 1805(c)(2)(D) (42  
2           *U.S.C. 1395b–6(c)(2)(D))* is amended by adding at  
3           the end the following: “*Members of the Commission*  
4           *shall be treated as employees of the Congress for pur-*  
5           *poses of applying title I of the Ethics in Government*  
6           *Act of 1978 (Public Law 95-521).”.*

7           (2) *EFFECTIVE DATE.*—The amendment made by  
8           paragraph (1) shall take effect on January 1, 2004.

9           (d) *ADDITIONAL REPORTS.*—

10           (1) *DATA NEEDS AND SOURCES.*—The Medicare  
11           *Payment Advisory Commission shall conduct a study,*  
12           *and submit a report to Congress by not later than*  
13           *June 1, 2004, on the need for current data, and*  
14           *sources of current data available, to determine the sol-*  
15           *vency and financial circumstances of hospitals and*  
16           *other medicare providers of services. The Commission*  
17           *shall examine data on uncompensated care, as well as*  
18           *the share of uncompensated care accounted for by the*  
19           *expenses for treating illegal aliens.*

20           (2) *USE OF TAX-RELATED RETURNS.*—Using re-  
21           *turn information provided under Form 990 of the In-*  
22           *ternal Revenue Service, the Commission shall submit*  
23           *to Congress, by not later than June 1, 2004, a report*  
24           *on the following:*



1           (A) *Investments, endowments, and fund-*  
2           *raising of hospitals participating under the*  
3           *medicare program and related foundations.*

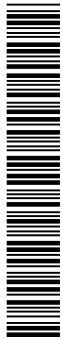
4           (B) *Access to capital financing for private*  
5           *and for not-for-profit hospitals.*

6 **SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT**  
7           **DAY CARE SERVICES.**

8           (a) *ESTABLISHMENT.*—*Subject to the succeeding provi-*  
9           *sions of this section, the Secretary of Health and Human*  
10           *Services shall establish a demonstration project (in this sec-*  
11           *tion referred to as the “demonstration project”) under*  
12           *which the Secretary shall, as part of a plan of an episode*  
13           *of care for home health services established for a medicare*  
14           *beneficiary, permit a home health agency, directly or under*  
15           *arrangements with a medical adult day care facility, to*  
16           *provide medical adult day care services as a substitute for*  
17           *a portion of home health services that would otherwise be*  
18           *provided in the beneficiary’s home.*

19           (b) *PAYMENT.*—

20           (1) *IN GENERAL.*—*The amount of payment for*  
21           *an episode of care for home health services, a portion*  
22           *of which consists of substitute medical adult day care*  
23           *services, under the demonstration project shall be*  
24           *made at a rate equal to 95 percent of the amount that*  
25           *would otherwise apply for such home health services*



1        *under section 1895 of the Social Security Act (42*  
2        *u.s.c. 1395fff). In no case may a home health agency,*  
3        *or a medical adult day care facility under arrange-*  
4        *ments with a home health agency, separately charge*  
5        *a beneficiary for medical adult day care services fur-*  
6        *nished under the plan of care.*

7                (2) *BUDGET NEUTRALITY FOR DEMONSTRATION*  
8        *PROJECT.—Notwithstanding any other provision of*  
9        *law, the Secretary shall provide for an appropriate*  
10        *reduction in the aggregate amount of additional pay-*  
11        *ments made under section 1895 of the Social Security*  
12        *Act (42 U.S.C. 1395fff) to reflect any increase in*  
13        *amounts expended from the Trust Funds as a result*  
14        *of the demonstration project conducted under this sec-*  
15        *tion.*

16                (c) *DEMONSTRATION PROJECT SITES.—The project es-*  
17        *tablished under this section shall be conducted in not more*  
18        *than 5 States selected by the Secretary that license or certify*  
19        *providers of services that furnish medical adult day care*  
20        *services.*

21                (d) *DURATION.—The Secretary shall conduct the dem-*  
22        *onstration project for a period of 3 years.*

23                (e) *VOLUNTARY PARTICIPATION.—Participation of*  
24        *medicare beneficiaries in the demonstration project shall be*  
25        *voluntary. The total number of such beneficiaries that may*



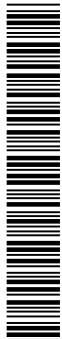
1 *participate in the project at any given time may not exceed*  
2 *15,000.*

3 *(f) PREFERENCE IN SELECTING AGENCIES.—In select-*  
4 *ing home health agencies to participate under the dem-*  
5 *onstration project, the Secretary shall give preference to*  
6 *those agencies that are currently licensed or certified*  
7 *through common ownership and control to furnish medical*  
8 *adult day care services.*

9 *(g) WAIVER AUTHORITY.—The Secretary may waive*  
10 *such requirements of title XVIII of the Social Security Act*  
11 *as may be necessary for the purposes of carrying out the*  
12 *demonstration project, other than waiving the requirement*  
13 *that an individual be homebound in order to be eligible for*  
14 *benefits for home health services.*

15 *(h) EVALUATION AND REPORT.—The Secretary shall*  
16 *conduct an evaluation of the clinical and cost effectiveness*  
17 *of the demonstration project. Not later 30 months after the*  
18 *commencement of the project, the Secretary shall submit to*  
19 *Congress a report on the evaluation, and shall include in*  
20 *the report the following:*

21 *(1) An analysis of the patient outcomes and costs*  
22 *of furnishing care to the medicare beneficiaries par-*  
23 *ticipating in the project as compared to such out-*  
24 *comes and costs to beneficiaries receiving only home*  
25 *health services for the same health conditions.*



1           (2) *Such recommendations regarding the exten-*  
2           *sion, expansion, or termination of the project as the*  
3           *Secretary determines appropriate.*

4           (i) *DEFINITIONS.—In this section:*

5           (1) *HOME HEALTH AGENCY.—The term “home*  
6           *health agency” has the meaning given such term in*  
7           *section 1861(o) of the Social Security Act (42 U.S.C.*  
8           *1395x(o)).*

9           (2) *MEDICAL ADULT DAY CARE FACILITY.—The*  
10          *term “medical adult day care facility” means a facil-*  
11          *ity that—*

12                 (A) *has been licensed or certified by a State*  
13                 *to furnish medical adult day care services in the*  
14                 *State for a continuous 2-year period;*

15                 (B) *is engaged in providing skilled nursing*  
16                 *services and other therapeutic services directly or*  
17                 *under arrangement with a home health agency;*

18                 (C) *meets such standards established by the*  
19                 *Secretary to assure quality of care and such*  
20                 *other requirements as the Secretary finds nec-*  
21                 *essary in the interest of the health and safety of*  
22                 *individuals who are furnished services in the fa-*  
23                 *ility; and*

24                 (D) *provides medical adult day care serv-*  
25                 *ices.*





1           (3) *MEDICAL ADULT DAY CARE SERVICES.*—*The*  
2           *term “medical adult day care services” means—*

3                   (A) *home health service items and services*  
4                   *described in paragraphs (1) through (7) of sec-*  
5                   *tion 1861(m) furnished in a medical adult day*  
6                   *care facility;*

7                   (B) *a program of supervised activities fur-*  
8                   *nished in a group setting in the facility that—*

9                           (i) *meet such criteria as the Secretary*  
10                           *determines appropriate; and*

11                           (ii) *is designed to promote physical*  
12                           *and mental health of the individuals; and*

13                   (C) *such other services as the Secretary may*  
14                   *specify.*

15           (4) *MEDICARE BENEFICIARY.*—*The term “medi-*  
16           *care beneficiary” means an individual entitled to*  
17           *benefits under part A of this title, enrolled under part*  
18           *B of this title, or both.*

19 **SEC. 733. IMPROVEMENTS IN NATIONAL AND LOCAL COV-**  
20                   **ERAGE DETERMINATION PROCESS TO RE-**  
21                   **SPOND TO CHANGES IN TECHNOLOGY.**

22           (a) *NATIONAL AND LOCAL COVERAGE DETERMINATION*  
23           *PROCESS.*—

24                   (1) *IN GENERAL.*—*Section 1862 (42 U.S.C.*  
25                   *1395y) is amended—*



1           (A) *in the third sentence of subsection (a)*  
2           *by inserting “consistent with subsection (k)”*  
3           *after “the Secretary shall ensure”; and*

4           (B) *by adding at the end the following new*  
5           *subsection:*

6           “(k) *NATIONAL AND LOCAL COVERAGE DETERMINA-*  
7           *TION PROCESS.—*

8           “(1) *CRITERIA AND EVIDENCE USED IN MAKING*  
9           *NATIONAL COVERAGE DETERMINATIONS.—The Sec-*  
10           *retary shall make available to the public the criteria*  
11           *the Secretary uses in making national coverage deter-*  
12           *minations, including how evidence to demonstrate*  
13           *that a procedure or device is reasonable and necessary*  
14           *is considered.*

15           “(2) *TIMEFRAME FOR DECISIONS ON REQUESTS*  
16           *FOR NATIONAL COVERAGE DETERMINATIONS.—In the*  
17           *case of a request for a national coverage determina-*  
18           *tion that—*

19           “(A) *does not require a technology assess-*  
20           *ment from an outside entity or deliberation from*  
21           *the Medicare Coverage Advisory Committee, the*  
22           *decision on the request shall be made not later*  
23           *than 6 months after the date of the request; or*

24           “(B) *requires such an assessment or delib-*  
25           *eration and in which a clinical trial is not re-*



1           *quested, the decision on the request shall be made*  
2           *not later than 12 months after the date of the re-*  
3           *quest.*

4           “(3) *PROCESS FOR PUBLIC COMMENT IN NA-*  
5           *TIONAL COVERAGE DETERMINATIONS.—At the end of*  
6           *the 6-month period that begins on the date a request*  
7           *for a national coverage determination is made, the*  
8           *Secretary shall—*

9                   “(A) *make a draft of proposed decision on*  
10                  *the request available to the public through the*  
11                  *Medicare Internet site of the Department of*  
12                  *Health and Human Services or other appro-*  
13                  *priate means;*

14                   “(B) *provide a 30-day period for public*  
15                  *comment on such draft;*

16                   “(C) *make a final decision on the request*  
17                  *within 60 days of the conclusion of the 30-day*  
18                  *period referred to under subparagraph (B);*

19                   “(D) *include in such final decision sum-*  
20                  *maries of the public comments received and re-*  
21                  *sponses thereto;*

22                   “(E) *make available to the public the clin-*  
23                  *ical evidence and other data used in making*  
24                  *such a decision when the decision differs from*



1           *the recommendations of the Medicare Coverage*  
2           *Advisory Committee; and*

3           “(F) *in the case of a decision to grant the*  
4           *coverage determination, assign a temporary or*  
5           *permanent code during the 60-day period re-*  
6           *ferred to in subparagraph (C).*

7           “(4) *CONSULTATION WITH OUTSIDE EXPERTS IN*  
8           *CERTAIN NATIONAL COVERAGE DETERMINATIONS.—*  
9           *With respect to a request for a national coverage de-*  
10          *termination for which there is not a review by the*  
11          *Medicare Coverage Advisory Committee, the Secretary*  
12          *shall consult with appropriate outside clinical ex-*  
13          *perts.*

14          “(5) *LOCAL COVERAGE DETERMINATION PROC-*  
15          *ESS.—With respect to local coverage determinations*  
16          *made on or after January 1, 2004—*

17          “(A) *PLAN TO PROMOTE CONSISTENCY OF*  
18          *COVERAGE DETERMINATIONS.—The Secretary*  
19          *shall develop a plan to evaluate new local cov-*  
20          *erage determinations to determine which deter-*  
21          *minations should be adopted nationally and to*  
22          *what extent greater consistency can be achieved*  
23          *among local coverage determinations.*

24          “(B) *CONSULTATION.—The Secretary shall*  
25          *require the fiscal intermediaries or carriers pro-*



1            *viding services within the same area to consult*  
2            *on all new local coverage determinations within*  
3            *the area.*

4            “(C) *DISSEMINATION OF INFORMATION.*—  
5            *The Secretary should serve as a center to dis-*  
6            *seminate information on local coverage deter-*  
7            *minations among fiscal intermediaries and car-*  
8            *riers to reduce duplication of effort.*

9            “(6) *NATIONAL AND LOCAL COVERAGE DETER-*  
10           *MINATION DEFINED.*—*For purposes of this subsection,*  
11           *the terms ‘national coverage determination’ and ‘local*  
12           *coverage determination’ have the meaning given such*  
13           *terms in paragraphs (1)(B) and (2)(B), respectively,*  
14           *of section 1869(f).”*

15           (2) *EFFECTIVE DATE.*—*The amendments made*  
16           *by paragraph (1) shall apply to national and local*  
17           *coverage determinations as of January 1, 2004.*

18           (b) *MEDICARE COVERAGE OF ROUTINE COSTS ASSOCI-*  
19           *ATED WITH CERTAIN CLINICAL TRIALS.*—

20           (1) *IN GENERAL.*—*With respect to the coverage of*  
21           *routine costs of care for beneficiaries participating in*  
22           *a qualifying clinical trial, as set forth on the date of*  
23           *the enactment of this Act in National Coverage Deter-*  
24           *mination 30-1 of the Medicare Coverage Issues Man-*  
25           *ual, the Secretary shall deem clinical trials conducted*



1        *in accordance with an investigational device exemp-*  
2        *tion approved under section 520(g) of the Federal*  
3        *Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to*  
4        *be automatically qualified for such coverage.*

5            (2) *RULE OF CONSTRUCTION.*—*Nothing in this*  
6        *subsection shall be construed as authorizing or requir-*  
7        *ing the Secretary to modify the regulations set forth*  
8        *on the date of the enactment of this Act at subpart*  
9        *B of part 405 of title 42, Code of Federal Regulations,*  
10       *or subpart A of part 411 of such title, relating to cov-*  
11       *erage of, and payment for, a medical device that is*  
12       *the subject of an investigational device exemption by*  
13       *the Food and Drug Administration (except as may be*  
14       *necessary to implement paragraph (1)).*

15           (3) *EFFECTIVE DATE.*—*This subsection shall*  
16       *apply to clinical trials begun before, on, or after the*  
17       *date of the enactment of this Act and to items and*  
18       *services furnished on or after such date.*

19           (c) *ISSUANCE OF TEMPORARY NATIONAL CODES.*—*Not*  
20       *later than January 1, 2004, the Secretary shall implement*  
21       *revised procedures for the issuance of temporary national*  
22       *HCPCS codes under part B of title XVIII of the Social Se-*  
23       *curity Act.*



1 **SEC. 734. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY**  
2 **SERVICES.**

3 (a) *IN GENERAL.*—Section 1848(i) (42 U.S.C. 1395w-  
4 4(i)) is amended by adding at the end the following new  
5 paragraph:

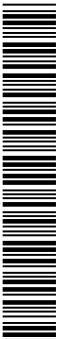
6 “(4) *TREATMENT OF CERTAIN INPATIENT PHYSI-*  
7 *CIAN PATHOLOGY SERVICES.*—

8 “(A) *IN GENERAL.*—With respect to services  
9 furnished on or after January 1, 2001, and be-  
10 fore January 1, 2006, if an independent labora-  
11 tory furnishes the technical component of a phy-  
12 sician pathology service to a fee-for-service medi-  
13 care beneficiary who is an inpatient or out-  
14 patient of a covered hospital, the Secretary shall  
15 treat such component as a service for which pay-  
16 ment shall be made to the laboratory under this  
17 section and not as an inpatient hospital service  
18 for which payment is made to the hospital under  
19 section 1886(d) or as a hospital outpatient serv-  
20 ice for which payment is made to the hospital  
21 under section 1833(t).

22 “(B) *DEFINITIONS.*—In this paragraph:

23 “(i) *COVERED HOSPITAL.*—

24 “(I) *IN GENERAL.*—The term ‘cov-  
25 ered hospital’ means, with respect to  
26 an inpatient or outpatient, a hospital



1           that had an arrangement with an  
2           independent laboratory that was in ef-  
3           fect as of July 22, 1999, under which  
4           a laboratory furnished the technical  
5           component of physician pathology serv-  
6           ices to fee-for-service medicare bene-  
7           ficiaries who were hospital inpatients  
8           or outpatients, respectively, and sub-  
9           mitted claims for payment for such  
10          component to a carrier with a contract  
11          under section 1842 and not to the hos-  
12          pital.

13                   “(II) CHANGE IN OWNERSHIP  
14                   DOES NOT AFFECT DETERMINATION.—  
15                   A change in ownership with respect to  
16                   a hospital on or after the date referred  
17                   to in subclause (I) shall not affect the  
18                   determination of whether such hospital  
19                   is a covered hospital for purposes of  
20                   such subclause.

21                   “(ii) FEE-FOR-SERVICE MEDICARE  
22                   BENEFICIARY.—The term ‘fee-for-service  
23                   medicare beneficiary’ means an individual  
24                   who is entitled to benefits under part A, or





1                   enrolled under this part, or both, but is not  
2                   enrolled in any of the following:

3                   “(I) A Medicare+Choice plan  
4                   under part C.

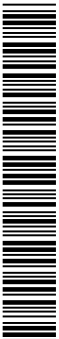
5                   “(II) A plan offered by an eligible  
6                   organization under section 1876.

7                   “(III) A program of all-inclusive  
8                   care for the elderly (PACE) under sec-  
9                   tion 1894.

10                  “(IV) A social health maintenance  
11                  organization (SHMO) demonstration  
12                  project established under section  
13                  4018(b) of the Omnibus Budget Rec-  
14                  onciliation Act of 1987 (Public Law  
15                  100–203).”.

16                  (b) *CONFORMING AMENDMENT.*—Section 542 of the  
17                  Medicare, Medicaid, and SCHIP Benefits Improvement  
18                  and Protection Act of 2000 (114 Stat. 2763A–550), as en-  
19                  acted into law by section 1(a)(6) of Public Law 106–554,  
20                  is repealed.

21                  (c) *EFFECTIVE DATES.*—The amendments made by  
22                  this section shall take effect as if included in the enactment  
23                  of the Medicare, Medicaid, and SCHIP Benefits Improve-  
24                  ment and Protection Act of 2000 (Appendix F, 114 Stat.



1 2763A-463), as enacted into law by section 1(a)(6) of Pub-  
2 lic Law 106-554.

3 **TITLE VIII—MEDICARE**  
4 **BENEFITS ADMINISTRATION**

5 **SEC. 801. ESTABLISHMENT OF MEDICARE BENEFITS ADMIN-**  
6 **ISTRATION.**

7 (a) *IN GENERAL.*—Title XVIII (42 U.S.C. 1395 et  
8 seq.), as amended by sections 105 and 721, is amended by  
9 inserting after 1808 the following new section:

10 “MEDICARE BENEFITS ADMINISTRATION

11 “SEC. 1809. (a) *ESTABLISHMENT.*—There is estab-  
12 lished within the Department of Health and Human Serv-  
13 ices an agency to be known as the Medicare Benefits Admin-  
14 istration.

15 “(b) *ADMINISTRATOR; DEPUTY ADMINISTRATOR;*  
16 *CHIEF ACTUARY.*—

17 “(1) *ADMINISTRATOR.*—

18 “(A) *IN GENERAL.*—The Medicare Benefits  
19 Administration shall be headed by an adminis-  
20 trator to be known as the ‘Medicare Benefits Ad-  
21 ministrator’ (in this section referred to as the  
22 ‘Administrator’) who shall be appointed by the  
23 President, by and with the advice and consent of  
24 the Senate. The Administrator shall be in direct  
25 line of authority to the Secretary.

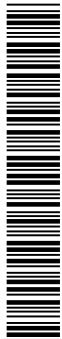


1           “(B) *COMPENSATION.*—*The Administrator*  
2           *shall be paid at the rate of basic pay payable for*  
3           *level III of the Executive Schedule under section*  
4           *5314 of title 5, United States Code.*

5           “(C) *TERM OF OFFICE.*—*The Administrator*  
6           *shall be appointed for a term of 4 years. In any*  
7           *case in which a successor does not take office at*  
8           *the end of an Administrator’s term of office, that*  
9           *Administrator may continue in office until the*  
10           *entry upon office of such a successor. An Admin-*  
11           *istrator appointed to a term of office after the*  
12           *commencement of such term may serve under*  
13           *such appointment only for the remainder of such*  
14           *term.*

15           “(D) *GENERAL AUTHORITY.*—*The Adminis-*  
16           *trator shall be responsible for the exercise of all*  
17           *powers and the discharge of all duties of the Ad-*  
18           *ministration, and shall have authority and con-*  
19           *trol over all personnel and activities thereof.*

20           “(E) *RULEMAKING AUTHORITY.*—*The Ad-*  
21           *ministrator may prescribe such rules and regula-*  
22           *tions as the Administrator determines necessary*  
23           *or appropriate to carry out the functions of the*  
24           *Administration. The regulations prescribed by*  
25           *the Administrator shall be subject to the rule-*



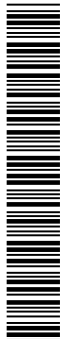
1           *making procedures established under section 553*  
2           *of title 5, United States Code. The Administrator*  
3           *shall provide for the issuance of new regulations*  
4           *to carry out parts C, D, and E.*

5           “(F) *AUTHORITY TO ESTABLISH ORGANIZA-*  
6           *TIONAL UNITS.—The Administrator may estab-*  
7           *lish, alter, consolidate, or discontinue such orga-*  
8           *nizational units or components within the Ad-*  
9           *ministration as the Administrator considers nec-*  
10          *essary or appropriate, except as specified in this*  
11          *section.*

12          “(G) *AUTHORITY TO DELEGATE.—The Ad-*  
13          *ministrator may assign duties, and delegate, or*  
14          *authorize successive redelegations of, authority to*  
15          *act and to render decisions, to such officers and*  
16          *employees of the Administration as the Adminis-*  
17          *trator may find necessary. Within the limita-*  
18          *tions of such delegations, redelegations, or as-*  
19          *signments, all official acts and decisions of such*  
20          *officers and employees shall have the same force*  
21          *and effect as though performed or rendered by*  
22          *the Administrator.*

23          “(2) *DEPUTY ADMINISTRATOR.—*

24                 “(A) *IN GENERAL.—There shall be a Dep-*  
25                 *uty Administrator of the Medicare Benefits Ad-*



1           *ministration who shall be appointed by the*  
2           *President, by and with the advice and consent of*  
3           *the Senate.*

4           “(B) *COMPENSATION.*—*The Deputy Admin-*  
5           *istrator shall be paid at the rate of basic pay*  
6           *payable for level IV of the Executive Schedule*  
7           *under section 5315 of title 5, United States Code.*

8           “(C) *TERM OF OFFICE.*—*The Deputy Ad-*  
9           *ministrator shall be appointed for a term of 4*  
10          *years. In any case in which a successor does not*  
11          *take office at the end of a Deputy Administra-*  
12          *tor’s term of office, such Deputy Administrator*  
13          *may continue in office until the entry upon of-*  
14          *fice of such a successor. A Deputy Administrator*  
15          *appointed to a term of office after the commence-*  
16          *ment of such term may serve under such ap-*  
17          *pointment only for the remainder of such term.*

18          “(D) *DUTIES.*—*The Deputy Administrator*  
19          *shall perform such duties and exercise such pow-*  
20          *ers as the Administrator shall from time to time*  
21          *assign or delegate. The Deputy Administrator*  
22          *shall be Acting Administrator of the Administra-*  
23          *tion during the absence or disability of the Ad-*  
24          *ministrator and, unless the President designates*  
25          *another officer of the Government as Acting Ad-*



1           *ministrator, in the event of a vacancy in the of-*  
2           *fice of the Administrator.*

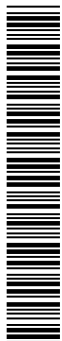
3           “(3) *CHIEF ACTUARY.*—

4                   “(A) *IN GENERAL.*—*There is established in*  
5           *the Administration the position of Chief Actua-*  
6           *ary. The Chief Actuary shall be appointed by,*  
7           *and in direct line of authority to, the Adminis-*  
8           *trator of such Administration. The Chief Actua-*  
9           *ry shall be appointed from among individuals*  
10           *who have demonstrated, by their education and*  
11           *experience, superior expertise in the actuarial*  
12           *sciences. The Chief Actuary may be removed only*  
13           *for cause.*

14                   “(B) *COMPENSATION.*—*The Chief Actuary*  
15           *shall be compensated at the highest rate of basic*  
16           *pay for the Senior Executive Service under sec-*  
17           *tion 5382(b) of title 5, United States Code.*

18                   “(C) *DUTIES.*—*The Chief Actuary shall ex-*  
19           *ercise such duties as are appropriate for the of-*  
20           *fice of the Chief Actuary and in accordance with*  
21           *professional standards of actuarial independence.*

22                   “(4) *SECRETARIAL COORDINATION OF PROGRAM*  
23           *ADMINISTRATION.*—*The Secretary shall ensure appro-*  
24           *priate coordination between the Administrator and*  
25           *the Administrator of the Centers for Medicare & Med-*



1        *icaid Services in carrying out the programs under*  
2        *this title.*

3        “(c) *DUTIES; ADMINISTRATIVE PROVISIONS.—*

4                “(1) *DUTIES.—*

5                        “(A) *GENERAL DUTIES.—The Adminis-*  
6                        *trator shall carry out parts C, D, and E,*  
7                        *including—*

8                                “(i) *negotiating, entering into, and en-*  
9                                *forcing, contracts with plans for the offering*  
10                                *of Medicare Advantage plans under part C*  
11                                *and EFFS plans under part E, including*  
12                                *the offering of qualified prescription drug*  
13                                *coverage under such plans; and*

14                                “(ii) *negotiating, entering into, and*  
15                                *enforcing, contracts with PDP sponsors for*  
16                                *the offering of prescription drug plans*  
17                                *under part D.*

18                        “(B) *OTHER DUTIES.—The Administrator*  
19                        *shall carry out any duty provided for under part*  
20                        *C, part D, or part E, including demonstration*  
21                        *projects carried out in part or in whole under*  
22                        *such parts, the programs of all-inclusive care for*  
23                        *the elderly (PACE program) under section 1894,*  
24                        *the social health maintenance organization*  
25                        *(SHMO) demonstration projects (referred to in*



1           *section 4104(c) of the Balanced Budget Act of*  
2           *1997), medicare cost contractors under section*  
3           *1876(h), and through a Medicare Advantage*  
4           *project that demonstrates the application of capi-*  
5           *tation payment rates for frail elderly medicare*  
6           *beneficiaries through the use of a interdiscipli-*  
7           *nary team and through the provision of primary*  
8           *care services to such beneficiaries by means of*  
9           *such a team at the nursing facility involved).*

10           “(C) *PRESCRIPTION DRUG CARD.*—*The Ad-*  
11           *ministrator shall carry out section 1807 (relat-*  
12           *ing to the medicare prescription drug discount*  
13           *card endorsement program).*

14           “(D) *NONINTERFERENCE.*—*In carrying out*  
15           *its duties with respect to the provision of quali-*  
16           *fied prescription drug coverage to beneficiaries*  
17           *under this title, the Administrator may not—*

18                   “(i) *require a particular formulary or*  
19                   *institute a price structure for the reimburse-*  
20                   *ment of covered outpatient drugs;*

21                   “(ii) *interfere in any way with nego-*  
22                   *tiations between PDP sponsors and Medi-*  
23                   *care Advantage organizations and EFFS*  
24                   *organizations and drug manufacturers,*





1                   *wholesalers, or other suppliers of covered*  
2                   *outpatient drugs; and*

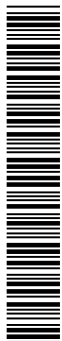
3                   “(iii) *otherwise interfere with the com-*  
4                   *petitive nature of providing such coverage*  
5                   *through such sponsors and organizations.*

6                   “(E) *ANNUAL REPORTS.*—*Not later March*  
7                   *31 of each year, the Administrator shall submit*  
8                   *to Congress and the President a report on the*  
9                   *administration of parts C, D, and E during the*  
10                   *previous fiscal year.*

11                   “(2) *STAFF.*—

12                   “(A) *IN GENERAL.*—*The Administrator,*  
13                   *with the approval of the Secretary, may employ,*  
14                   *without regard to chapter 31 of title 5, United*  
15                   *States Code, other than sections 3102 through*  
16                   *3108, 3110 through 3113, 3136m and 3151, such*  
17                   *officers and employees as are necessary to ad-*  
18                   *minister the activities to be carried out through*  
19                   *the Medicare Benefits Administration. The Ad-*  
20                   *ministrator shall employ staff with appropriate*  
21                   *and necessary expertise in negotiating contracts*  
22                   *in the private sector.*

23                   “(B) *FLEXIBILITY WITH RESPECT TO COM-*  
24                   *PENSATION.*—



1                   “(i) *IN GENERAL.*—*The staff of the*  
2                   *Medicare Benefits Administration shall,*  
3                   *subject to clause (ii), be paid without regard*  
4                   *to the provisions of chapter 51 (other than*  
5                   *section 5101) and chapter 53 (other than*  
6                   *section 5301) of such title (relating to clas-*  
7                   *sification and schedule pay rates).*

8                   “(ii) *MAXIMUM RATE.*—*In no case*  
9                   *may the rate of compensation determined*  
10                  *under clause (i) exceed the rate of basic pay*  
11                  *payable for level IV of the Executive Sched-*  
12                  *ule under section 5315 of title 5, United*  
13                  *States Code.*

14                  “(C) *LIMITATION ON FULL-TIME EQUIVA-*  
15                  *LENT STAFFING FOR CURRENT CMS FUNCTIONS*  
16                  *BEING TRANSFERRED.*—*The Administrator may*  
17                  *not employ under this paragraph a number of*  
18                  *full-time equivalent employees, to carry out func-*  
19                  *tions that were previously conducted by the Cen-*  
20                  *ters for Medicare & Medicaid Services and that*  
21                  *are conducted by the Administrator by reason of*  
22                  *this section, that exceeds the number of such full-*  
23                  *time equivalent employees authorized to be em-*  
24                  *ployed by the Centers for Medicare & Medicaid*



1           *Services to conduct such functions as of the date*  
2           *of the enactment of this Act.*

3           “(3) *REDELEGATION OF CERTAIN FUNCTIONS OF*  
4           *THE CENTERS FOR MEDICARE & MEDICAID SERV-*  
5           *ICES.—*

6                   “(A) *IN GENERAL.—The Secretary, the Ad-*  
7                   *ministrator, and the Administrator of the Cen-*  
8                   *ters for Medicare & Medicaid Services shall es-*  
9                   *tablish an appropriate transition of responsi-*  
10                   *bility in order to redelegate the administration*  
11                   *of part C from the Secretary and the Adminis-*  
12                   *trator of the Centers for Medicare & Medicaid*  
13                   *Services to the Administrator as is appropriate*  
14                   *to carry out the purposes of this section.*

15                   “(B) *TRANSFER OF DATA AND INFORMA-*  
16                   *TION.—The Secretary shall ensure that the Ad-*  
17                   *ministrator of the Centers for Medicare & Med-*  
18                   *icaid Services transfers to the Administrator of*  
19                   *the Medicare Benefits Administration such infor-*  
20                   *mation and data in the possession of the Admin-*  
21                   *istrator of the Centers for Medicare & Medicaid*  
22                   *Services as the Administrator of the Medicare*  
23                   *Benefits Administration requires to carry out the*  
24                   *duties described in paragraph (1).*



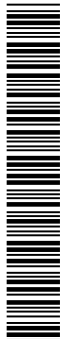
1                   “(C) *CONSTRUCTION.*—*Insofar as a respon-*  
2                   *sibility of the Secretary or the Administrator of*  
3                   *the Centers for Medicare & Medicaid Services is*  
4                   *redelegated to the Administrator under this sec-*  
5                   *tion, any reference to the Secretary or the Ad-*  
6                   *ministrator of the Centers for Medicare & Med-*  
7                   *icaid Services in this title or title XI with re-*  
8                   *spect to such responsibility is deemed to be a ref-*  
9                   *erence to the Administrator.*

10                  “(d) *OFFICE OF BENEFICIARY ASSISTANCE.*—

11                   “(1) *ESTABLISHMENT.*—*The Secretary shall es-*  
12                   *tablish within the Medicare Benefits Administration*  
13                   *an Office of Beneficiary Assistance to coordinate*  
14                   *functions relating to outreach and education of medi-*  
15                   *care beneficiaries under this title, including the func-*  
16                   *tions described in paragraph (2). The Office shall be*  
17                   *separate operating division within the Administra-*  
18                   *tion.*

19                   “(2) *DISSEMINATION OF INFORMATION ON BENE-*  
20                   *FITS AND APPEALS RIGHTS.*—

21                   “(A) *DISSEMINATION OF BENEFITS INFOR-*  
22                   *MATION.*—*The Office of Beneficiary Assistance*  
23                   *shall disseminate, directly or through contract, to*  
24                   *medicare beneficiaries, by mail, by posting on*  
25                   *the Internet site of the Medicare Benefits Admin-*



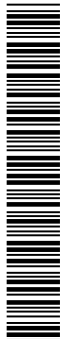
1            *istration and through a toll-free telephone num-*  
2            *ber, information with respect to the following:*

3                    *“(i) Benefits, and limitations on pay-*  
4                    *ment (including cost-sharing, stop-loss pro-*  
5                    *visions, and formulary restrictions) under*  
6                    *parts C, D, and E.*

7                    *“(ii) Benefits, and limitations on pay-*  
8                    *ment under parts A and B, including infor-*  
9                    *mation on medicare supplemental policies*  
10                   *under section 1882.*

11            *Such information shall be presented in a manner*  
12            *so that medicare beneficiaries may compare ben-*  
13            *efits under parts A, B, D, and medicare supple-*  
14            *mental policies with benefits under Medicare Ad-*  
15            *vantage plans under part C and EFFS plans*  
16            *under part E.*

17                    *“(B) DISSEMINATION OF APPEALS RIGHTS*  
18                    *INFORMATION.—The Office of Beneficiary Assist-*  
19                    *ance shall disseminate to medicare beneficiaries*  
20                    *in the manner provided under subparagraph (A)*  
21                    *a description of procedural rights (including*  
22                    *grievance and appeals procedures) of bene-*  
23                    *ficiaries under the original medicare fee-for-serv-*  
24                    *ice program under parts A and B, the Medicare*  
25                    *Advantage program under part C, the Voluntary*



1           *Prescription Drug Benefit Program under part*  
2           *D, and the Enhanced Fee-for-Service program*  
3           *under part E.*

4           “(e) *MEDICARE POLICY ADVISORY BOARD.*—

5                 “(1) *ESTABLISHMENT.*—*There is established*  
6           *within the Medicare Benefits Administration the*  
7           *Medicare Policy Advisory Board (in this section re-*  
8           *ferred to the ‘Board’). The Board shall advise, consult*  
9           *with, and make recommendations to the Adminis-*  
10          *trator of the Medicare Benefits Administration with*  
11          *respect to the administration of parts C, D, and E,*  
12          *including the review of payment policies under such*  
13          *parts.*

14           “(2) *REPORTS.*—

15                 “(A) *IN GENERAL.*—*With respect to matters*  
16          *of the administration of parts C, D, and E the*  
17          *Board shall submit to Congress and to the Ad-*  
18          *ministrator of the Medicare Benefits Administra-*  
19          *tion such reports as the Board determines appro-*  
20          *priate. Each such report may contain such rec-*  
21          *ommendations as the Board determines appro-*  
22          *priate for legislative or administrative changes*  
23          *to improve the administration of such parts, in-*  
24          *cluding the topics described in subparagraph*



1           *(B). Each such report shall be published in the*  
2           *Federal Register.*

3           “*(B) TOPICS DESCRIBED.—Reports required*  
4           *under subparagraph (A) may include the fol-*  
5           *lowing topics:*

6                   “*(i) FOSTERING COMPETITION.—Rec-*  
7                   *ommendations or proposals to increase com-*  
8                   *petition under parts C, D, and E for serv-*  
9                   *ices furnished to medicare beneficiaries.*

10                   “*(ii) EDUCATION AND ENROLLMENT.—*  
11                   *Recommendations for the improvement to*  
12                   *efforts to provide medicare beneficiaries in-*  
13                   *formation and education on the program*  
14                   *under this title, and specifically parts C, D,*  
15                   *and E, and the program for enrollment*  
16                   *under the title.*

17                   “*(iii) IMPLEMENTATION OF RISK-AD-*  
18                   *JUSTMENT.—Evaluation of the implementa-*  
19                   *tion under section 1853(a)(3)(C) of the risk*  
20                   *adjustment methodology to payment rates*  
21                   *under that section to Medicare Advantage*  
22                   *organizations offering Medicare Advantage*  
23                   *plans (and the corresponding payment pro-*  
24                   *visions under part E) that accounts for*  
25                   *variations in per capita costs based on*



1                   *health status, geography, and other demo-*  
2                   *graphic factors.*

3                   “(iv) *RURAL ACCESS.—Recommendations to improve competition and access to*  
4                   *plans under parts C, D, and E in rural*  
5                   *areas.*

6                   “(C) *MAINTAINING INDEPENDENCE OF*  
7                   *BOARD.—The Board shall directly submit to*  
8                   *Congress reports required under subparagraph*  
9                   *(A). No officer or agency of the United States*  
10                  *may require the Board to submit to any officer*  
11                  *or agency of the United States for approval,*  
12                  *comments, or review, prior to the submission to*  
13                  *Congress of such reports.*

14                  “(3) *DUTY OF ADMINISTRATOR OF MEDICARE*  
15                  *BENEFITS ADMINISTRATION.—With respect to any re-*  
16                  *port submitted by the Board under paragraph (2)(A),*  
17                  *not later than 90 days after the report is submitted,*  
18                  *the Administrator of the Medicare Benefits Adminis-*  
19                  *tration shall submit to Congress and the President an*  
20                  *analysis of recommendations made by the Board in*  
21                  *such report. Each such analysis shall be published in*  
22                  *the Federal Register.*

23                  “(4) *MEMBERSHIP.—*  
24





1           “(A) *APPOINTMENT.*—*Subject to the suc-*  
2           *ceeding provisions of this paragraph, the Board*  
3           *shall consist of seven members to be appointed as*  
4           *follows:*

5                     “(i) *Three members shall be appointed*  
6                     *by the President.*

7                     “(ii) *Two members shall be appointed*  
8                     *by the Speaker of the House of Representa-*  
9                     *tives, with the advice of the chairmen and*  
10                    *the ranking minority members of the Com-*  
11                    *mittees on Ways and Means and on Energy*  
12                    *and Commerce of the House of Representa-*  
13                    *tives.*

14                    “(iii) *Two members shall be appointed*  
15                    *by the President pro tempore of the Senate*  
16                    *with the advice of the chairman and the*  
17                    *ranking minority member of the Senate*  
18                    *Committee on Finance.*

19           “(B) *QUALIFICATIONS.*—*The members shall*  
20           *be chosen on the basis of their integrity, impar-*  
21           *tiality, and good judgment, and shall be individ-*  
22           *uals who are, by reason of their education and*  
23           *experience in health care benefits management,*  
24           *exceptionally qualified to perform the duties of*  
25           *members of the Board.*



1           “(C) *PROHIBITION ON INCLUSION OF FED-*  
2           *ERAL EMPLOYEES.*—*No officer or employee of the*  
3           *United States may serve as a member of the*  
4           *Board.*

5           “(5) *COMPENSATION.*—*Members of the Board*  
6           *shall receive, for each day (including travel time) they*  
7           *are engaged in the performance of the functions of the*  
8           *board, compensation at rates not to exceed the daily*  
9           *equivalent to the annual rate in effect for level IV of*  
10          *the Executive Schedule under section 5315 of title 5,*  
11          *United States Code.*

12          “(6) *TERMS OF OFFICE.*—

13                 “(A) *IN GENERAL.*—*The term of office of*  
14                 *members of the Board shall be 3 years.*

15                 “(B) *TERMS OF INITIAL APPOINTEES.*—*As*  
16                 *designated by the President at the time of ap-*  
17                 *pointment, of the members first appointed—*

18                         “(i) *one shall be appointed for a term*  
19                         *of 1 year;*

20                         “(ii) *three shall be appointed for terms*  
21                         *of 2 years; and*

22                         “(iii) *three shall be appointed for*  
23                         *terms of 3 years.*



1           “(C) *REAPPOINTMENTS.*—*Any person ap-*  
2           *pointed as a member of the Board may not serve*  
3           *for more than 8 years.*

4           “(D) *VACANCY.*—*Any member appointed to*  
5           *fill a vacancy occurring before the expiration of*  
6           *the term for which the member’s predecessor was*  
7           *appointed shall be appointed only for the re-*  
8           *mainder of that term. A member may serve after*  
9           *the expiration of that member’s term until a suc-*  
10           *cessor has taken office. A vacancy in the Board*  
11           *shall be filled in the manner in which the origi-*  
12           *nal appointment was made.*

13           “(7) *CHAIR.*—*The Chair of the Board shall be*  
14           *elected by the members. The term of office of the Chair*  
15           *shall be 3 years.*

16           “(8) *MEETINGS.*—*The Board shall meet at the*  
17           *call of the Chair, but in no event less than three times*  
18           *during each fiscal year.*

19           “(9) *DIRECTOR AND STAFF.*—

20           “(A) *APPOINTMENT OF DIRECTOR.*—*The*  
21           *Board shall have a Director who shall be ap-*  
22           *pointed by the Chair.*

23           “(B) *IN GENERAL.*—*With the approval of*  
24           *the Board, the Director may appoint, without re-*  
25           *gard to chapter 31 of title 5, United States Code,*



1           *such additional personnel as the Director con-*  
2           *siders appropriate.*

3           “(C) *FLEXIBILITY WITH RESPECT TO COM-*  
4           *PENSATION.—*

5                   “(i) *IN GENERAL.—The Director and*  
6                   *staff of the Board shall, subject to clause*  
7                   *(ii), be paid without regard to the provi-*  
8                   *sions of chapter 51 and chapter 53 of such*  
9                   *title (relating to classification and schedule*  
10                   *pay rates).*

11                   “(ii) *MAXIMUM RATE.—In no case*  
12                   *may the rate of compensation determined*  
13                   *under clause (i) exceed the rate of basic pay*  
14                   *payable for level IV of the Executive Sched-*  
15                   *ule under section 5315 of title 5, United*  
16                   *States Code.*

17           “(D) *ASSISTANCE FROM THE ADMINIS-*  
18           *TRATOR OF THE MEDICARE BENEFITS ADMINIS-*  
19           *TRATION.—The Administrator of the Medicare*  
20           *Benefits Administration shall make available to*  
21           *the Board such information and other assistance*  
22           *as it may require to carry out its functions.*

23           “(10) *CONTRACT AUTHORITY.—The Board may*  
24           *contract with and compensate government and pri-*  
25           *vate agencies or persons to carry out its duties under*



1        *this subsection, without regard to section 3709 of the*  
2        *Revised Statutes (41 U.S.C. 5).*

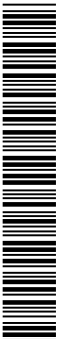
3        “(f) *FUNDING.—There is authorized to be appro-*  
4        *priated, in appropriate part from the Federal Hospital In-*  
5        *surance Trust Fund and from the Federal Supplementary*  
6        *Medical Insurance Trust Fund (including the Medicare*  
7        *Prescription Drug Account), such sums as are necessary to*  
8        *carry out this section.”.*

9        (b) *EFFECTIVE DATE.—*

10            (1) *IN GENERAL.—The amendment made by sub-*  
11            *section (a) shall take effect on the date of the enact-*  
12            *ment of this Act.*

13            (2) *DUTIES WITH RESPECT TO ELIGIBILITY DE-*  
14            *TERMINATIONS AND ENROLLMENT.—The Adminis-*  
15            *trator of the Medicare Benefits Administration shall*  
16            *carry out enrollment under title XVIII of the Social*  
17            *Security Act, make eligibility determinations under*  
18            *such title, and carry out parts C and E of such title*  
19            *for years beginning or after January 1, 2006.*

20            (3) *TRANSITION.—Before the date the Adminis-*  
21            *trator of the Medicare Benefits Administration is ap-*  
22            *pointed and assumes responsibilities under this sec-*  
23            *tion and section 1807 of the Social Security Act, the*  
24            *Secretary of Health and Human Services shall pro-*



1 *vide for the conduct of any responsibilities of such*  
2 *Administrator that are otherwise provided under law.*

3 *(c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—*

4 *(1) ADMINISTRATOR AS MEMBER OF THE BOARD*  
5 *OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—*

6 *Section 1817(b) and section 1841(b) (42 U.S.C.*  
7 *1395i(b), 1395t(b)) are each amended by striking*  
8 *“and the Secretary of Health and Human Services,*  
9 *all ex officio,” and inserting “the Secretary of Health*  
10 *and Human Services, and the Administrator of the*  
11 *Medicare Benefits Administration, all ex officio,”.*

12 *(2) INCREASE IN GRADE TO EXECUTIVE LEVEL*  
13 *III FOR THE ADMINISTRATOR OF THE CENTERS FOR*  
14 *MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDI-*  
15 *CARE BENEFITS ADMINISTRATOR.—*

16 *(A) IN GENERAL.—Section 5314 of title 5,*  
17 *United States Code, by adding at the end the fol-*  
18 *lowing:*

19 *“Administrator of the Centers for Medicare &*  
20 *Medicaid Services.*

21 *“Administrator of the Medicare Benefits Admin-*  
22 *istration.”.*

23 *(B) CONFORMING AMENDMENT.—Section*  
24 *5315 of such title is amended by striking “Ad-*



1           *ministrator of the Health Care Financing Ad-*  
2           *ministration.”.*

3                   (C) *EFFECTIVE DATE.*—*The amendments*  
4           *made by this paragraph take effect on January*  
5           *1, 2004.*

6   ***TITLE IX—REGULATORY REDUC-***  
7       ***TION AND CONTRACTING RE-***  
8       ***FORM***

9       ***Subtitle A—Regulatory Reform***

10 ***SEC. 901. CONSTRUCTION; DEFINITION OF SUPPLIER.***

11       (a) *CONSTRUCTION.*—*Nothing in this title shall be*  
12 *construed—*

13           (1) *to compromise or affect existing legal rem-*  
14 *edies for addressing fraud or abuse, whether it be*  
15 *criminal prosecution, civil enforcement, or adminis-*  
16 *trative remedies, including under sections 3729*  
17 *through 3733 of title 31, United States Code (known*  
18 *as the False Claims Act); or*

19           (2) *to prevent or impede the Department of*  
20 *Health and Human Services in any way from its on-*  
21 *going efforts to eliminate waste, fraud, and abuse in*  
22 *the medicare program.*

23 *Furthermore, the consolidation of medicare administrative*  
24 *contracting set forth in this Act does not constitute consoli-*  
25 *ation of the Federal Hospital Insurance Trust Fund and*



1 *the Federal Supplementary Medical Insurance Trust Fund*  
2 *or reflect any position on that issue.*

3 (b) *DEFINITION OF SUPPLIER.—Section 1861 (42*  
4 *U.S.C. 1395x) is amended by inserting after subsection (c)*  
5 *the following new subsection:*

6 *“Supplier*

7 *“(d) The term ‘supplier’ means, unless the context oth-*  
8 *erwise requires, a physician or other practitioner, a facility,*  
9 *or other entity (other than a provider of services) that fur-*  
10 *nishes items or services under this title.”.*

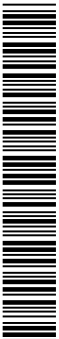
11 **SEC. 902. ISSUANCE OF REGULATIONS.**

12 (a) *REGULAR TIMELINE FOR PUBLICATION OF FINAL*  
13 *RULES.—*

14 (1) *IN GENERAL.—Section 1871(a) (42 U.S.C.*  
15 *1395hh(a)) is amended by adding at the end the fol-*  
16 *lowing new paragraph:*

17 *“(3)(A) The Secretary, in consultation with the Direc-*  
18 *tor of the Office of Management and Budget, shall establish*  
19 *and publish a regular timeline for the publication of final*  
20 *regulations based on the previous publication of a proposed*  
21 *regulation or an interim final regulation.*

22 *“(B) Such timeline may vary among different regula-*  
23 *tions based on differences in the complexity of the regula-*  
24 *tion, the number and scope of comments received, and other*  
25 *relevant factors, but shall not be longer than 3 years except*





1 *under exceptional circumstances. If the Secretary intends*  
2 *to vary such timeline with respect to the publication of a*  
3 *final regulation, the Secretary shall cause to have published*  
4 *in the Federal Register notice of the different timeline by*  
5 *not later than the timeline previously established with re-*  
6 *spect to such regulation. Such notice shall include a brief*  
7 *explanation of the justification for such variation.*

8       “(C) *In the case of interim final regulations, upon the*  
9 *expiration of the regular timeline established under this*  
10 *paragraph for the publication of a final regulation after*  
11 *opportunity for public comment, the interim final regula-*  
12 *tion shall not continue in effect unless the Secretary pub-*  
13 *lishes (at the end of the regular timeline and, if applicable,*  
14 *at the end of each succeeding 1-year period) a notice of con-*  
15 *tinuation of the regulation that includes an explanation of*  
16 *why the regular timeline (and any subsequent 1-year exten-*  
17 *sion) was not complied with. If such a notice is published,*  
18 *the regular timeline (or such timeline as previously ex-*  
19 *tended under this paragraph) for publication of the final*  
20 *regulation shall be treated as having been extended for 1*  
21 *additional year.*

22       “(D) *The Secretary shall annually submit to Congress*  
23 *a report that describes the instances in which the Secretary*  
24 *failed to publish a final regulation within the applicable*



1 *regular timeline under this paragraph and that provides*  
2 *an explanation for such failures.”.*

3 (2) *EFFECTIVE DATE.*—*The amendment made by*  
4 *paragraph (1) shall take effect on the date of the en-*  
5 *actment of this Act. The Secretary shall provide for*  
6 *an appropriate transition to take into account the*  
7 *backlog of previously published interim final regula-*  
8 *tions.*

9 (b) *LIMITATIONS ON NEW MATTER IN FINAL REGULA-*  
10 *TIONS.*—

11 (1) *IN GENERAL.*—*Section 1871(a) (42 U.S.C.*  
12 *1395hh(a)), as amended by subsection (a), is amended*  
13 *by adding at the end the following new paragraph:*

14 “(4) *If the Secretary publishes a final regulation that*  
15 *includes a provision that is not a logical outgrowth of a*  
16 *previously published notice of proposed rulemaking or in-*  
17 *terim final rule, such provision shall be treated as a pro-*  
18 *posed regulation and shall not take effect until there is the*  
19 *further opportunity for public comment and a publication*  
20 *of the provision again as a final regulation.”.*

21 (2) *EFFECTIVE DATE.*—*The amendment made by*  
22 *paragraph (1) shall apply to final regulations pub-*  
23 *lished on or after the date of the enactment of this*  
24 *Act.*



1 **SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS**  
2 **AND POLICIES.**

3 (a) *NO RETROACTIVE APPLICATION OF SUBSTANTIVE*  
4 *CHANGES.—*

5 (1) *IN GENERAL.—Section 1871 (42 U.S.C.*  
6 *1395hh), as amended by section 902(a), is amended*  
7 *by adding at the end the following new subsection:*

8 “(e)(1)(A) *A substantive change in regulations, man-*  
9 *ual instructions, interpretative rules, statements of policy,*  
10 *or guidelines of general applicability under this title shall*  
11 *not be applied (by extrapolation or otherwise) retroactively*  
12 *to items and services furnished before the effective date of*  
13 *the change, unless the Secretary determines that—*

14 “(i) *such retroactive application is necessary to*  
15 *comply with statutory requirements; or*

16 “(ii) *failure to apply the change retroactively*  
17 *would be contrary to the public interest.”.*

18 (2) *EFFECTIVE DATE.—The amendment made by*  
19 *paragraph (1) shall apply to substantive changes*  
20 *issued on or after the date of the enactment of this*  
21 *Act.*

22 (b) *TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE*  
23 *CHANGES AFTER NOTICE.—*

24 (1) *IN GENERAL.—Section 1871(e)(1), as added*  
25 *by subsection (a), is amended by adding at the end*  
26 *the following:*



1           “(B)(i) *Except as provided in clause (ii), a substantive*  
2 *change referred to in subparagraph (A) shall not become*  
3 *effective before the end of the 30-day period that begins on*  
4 *the date that the Secretary has issued or published, as the*  
5 *case may be, the substantive change.*

6           “(ii) *The Secretary may provide for such a substantive*  
7 *change to take effect on a date that precedes the end of the*  
8 *30-day period under clause (i) if the Secretary finds that*  
9 *waiver of such 30-day period is necessary to comply with*  
10 *statutory requirements or that the application of such 30-*  
11 *day period is contrary to the public interest. If the Sec-*  
12 *retary provides for an earlier effective date pursuant to this*  
13 *clause, the Secretary shall include in the issuance or publi-*  
14 *cation of the substantive change a finding described in the*  
15 *first sentence, and a brief statement of the reasons for such*  
16 *finding.*

17           “(C) *No action shall be taken against a provider of*  
18 *services or supplier with respect to noncompliance with*  
19 *such a substantive change for items and services furnished*  
20 *before the effective date of such a change.”*

21           (2) *EFFECTIVE DATE.—The amendment made by*  
22 *paragraph (1) shall apply to compliance actions un-*  
23 *dertaken on or after the date of the enactment of this*  
24 *Act.*

25           (c) *RELIANCE ON GUIDANCE.—*



1           (1) *IN GENERAL.*—Section 1871(e), as added by  
2           subsection (a), is further amended by adding at the  
3           end the following new paragraph:

4           “(2)(A) If—

5                 “(i) a provider of services or supplier follows the  
6                 written guidance (which may be transmitted elec-  
7                 tronically) provided by the Secretary or by a medi-  
8                 care contractor (as defined in section 1889(g)) acting  
9                 within the scope of the contractor’s contract authority,  
10                with respect to the furnishing of items or services and  
11                submission of a claim for benefits for such items or  
12                services with respect to such provider or supplier;

13               “(ii) the Secretary determines that the provider  
14                of services or supplier has accurately presented the  
15                circumstances relating to such items, services, and  
16                claim to the contractor in writing; and

17               “(iii) the guidance was in error;  
18            the provider of services or supplier shall not be subject to  
19            any sanction (including any penalty or requirement for re-  
20            payment of any amount) if the provider of services or sup-  
21            plier reasonably relied on such guidance.

22           “(B) Subparagraph (A) shall not be construed as pre-  
23            venting the recoupment or repayment (without any addi-  
24            tional penalty) relating to an overpayment insofar as the



1 *overpayment was solely the result of a clerical or technical*  
2 *operational error.”.*

3 (2) *EFFECTIVE DATE.*—*The amendment made by*  
4 *paragraph (1) shall take effect on the date of the en-*  
5 *actment of this Act but shall not apply to any sanc-*  
6 *tion for which notice was provided on or before the*  
7 *date of the enactment of this Act.*

8 **SEC. 904. REPORTS AND STUDIES RELATING TO REGU-**  
9 **LATORY REFORM.**

10 (a) *GAO STUDY ON ADVISORY OPINION AUTHORITY.*—

11 (1) *STUDY.*—*The Comptroller General of the*  
12 *United States shall conduct a study to determine the*  
13 *feasibility and appropriateness of establishing in the*  
14 *Secretary authority to provide legally binding advi-*  
15 *sory opinions on appropriate interpretation and ap-*  
16 *plication of regulations to carry out the medicare pro-*  
17 *gram under title XVIII of the Social Security Act.*  
18 *Such study shall examine the appropriate timeframe*  
19 *for issuing such advisory opinions, as well as the need*  
20 *for additional staff and funding to provide such opin-*  
21 *ions.*

22 (2) *REPORT.*—*The Comptroller General shall*  
23 *submit to Congress a report on the study conducted*  
24 *under paragraph (1) by not later than one year after*  
25 *the date of the enactment of this Act.*



1           **(b) REPORT ON LEGAL AND REGULATORY INCONSIST-**  
2 *ENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by*  
3 *section 2(a), is amended by adding at the end the following*  
4 *new subsection:*

5           *“(f)(1) Not later than 2 years after the date of the en-*  
6 *actment of this subsection, and every 2 years thereafter, the*  
7 *Secretary shall submit to Congress a report with respect*  
8 *to the administration of this title and areas of inconsistency*  
9 *or conflict among the various provisions under law and reg-*  
10 *ulation.*

11           *“(2) In preparing a report under paragraph (1), the*  
12 *Secretary shall collect—*

13           *“(A) information from individuals entitled to*  
14 *benefits under part A or enrolled under part B, or*  
15 *both, providers of services, and suppliers and from the*  
16 *Medicare Beneficiary Ombudsman and the Medicare*  
17 *Provider Ombudsman with respect to such areas of*  
18 *inconsistency and conflict; and*

19           *“(B) information from medicare contractors that*  
20 *tracks the nature of written and telephone inquiries.*

21           *“(3) A report under paragraph (1) shall include a de-*  
22 *scription of efforts by the Secretary to reduce such inconsist-*  
23 *ency or conflicts, and recommendations for legislation or*  
24 *administrative action that the Secretary determines appro-*  
25 *priate to further reduce such inconsistency or conflicts.”.*



1           ***Subtitle B—Contracting Reform***

2   ***SEC. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-***  
3                   ***TRATION.***

4           (a) *CONSOLIDATION AND FLEXIBILITY IN MEDICARE*  
5   *ADMINISTRATION.—*

6                   (1) *IN GENERAL.—Title XVIII is amended by in-*  
7   *serting after section 1874 the following new section:*

8                   “*CONTRACTS WITH MEDICARE ADMINISTRATIVE*  
9   *CONTRACTORS*

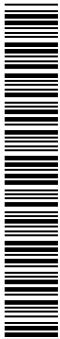
10           “*SEC. 1874A. (a) AUTHORITY.—*

11                   “*(1) AUTHORITY TO ENTER INTO CONTRACTS.—*

12   *The Secretary may enter into contracts with any eli-*  
13   *gible entity to serve as a medicare administrative*  
14   *contractor with respect to the performance of any or*  
15   *all of the functions described in paragraph (4) or*  
16   *parts of those functions (or, to the extent provided in*  
17   *a contract, to secure performance thereof by other en-*  
18   *tities).*

19                   “*(2) ELIGIBILITY OF ENTITIES.—An entity is eli-*  
20   *gible to enter into a contract with respect to the per-*  
21   *formance of a particular function described in para-*  
22   *graph (4) only if—*

23                   “*(A) the entity has demonstrated capability*  
24                   *to carry out such function;*





1           “(B) the entity complies with such conflict  
2 of interest standards as are generally applicable  
3 to Federal acquisition and procurement;

4           “(C) the entity has sufficient assets to fi-  
5 nancially support the performance of such func-  
6 tion; and

7           “(D) the entity meets such other require-  
8 ments as the Secretary may impose.

9           “(3) *MEDICARE ADMINISTRATIVE CONTRACTOR*  
10 *DEFINED.*—For purposes of this title and title XI—

11           “(A) *IN GENERAL.*—The term ‘medicare ad-  
12 ministrative contractor’ means an agency, orga-  
13 nization, or other person with a contract under  
14 this section.

15           “(B) *APPROPRIATE MEDICARE ADMINISTRA-*  
16 *TIVE CONTRACTOR.*—With respect to the perform-  
17 ance of a particular function in relation to an  
18 individual entitled to benefits under part A or  
19 enrolled under part B, or both, a specific pro-  
20 vider of services or supplier (or class of such pro-  
21 viders of services or suppliers), the ‘appropriate’  
22 medicare administrative contractor is the medi-  
23 care administrative contractor that has a con-  
24 tract under this section with respect to the per-  
25 formance of that function in relation to that in-



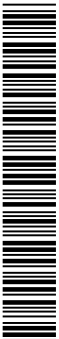
1           *dividual, provider of services or supplier or class*  
2           *of provider of services or supplier.*

3           “(4) *FUNCTIONS DESCRIBED.*—*The functions re-*  
4           *ferred to in paragraphs (1) and (2) are payment*  
5           *functions, provider services functions, and functions*  
6           *relating to services furnished to individuals entitled*  
7           *to benefits under part A or enrolled under part B, or*  
8           *both, as follows:*

9                   “(A)    *DETERMINATION    OF    PAYMENT*  
10                   *AMOUNTS.*—*Determining (subject to the provi-*  
11                   *sions of section 1878 and to such review by the*  
12                   *Secretary as may be provided for by the con-*  
13                   *tracts) the amount of the payments required pur-*  
14                   *suant to this title to be made to providers of*  
15                   *services, suppliers and individuals.*

16                   “(B)    *MAKING PAYMENTS.*—*Making pay-*  
17                   *ments described in subparagraph (A) (including*  
18                   *receipt, disbursement, and accounting for funds*  
19                   *in making such payments).*

20                   “(C)    *BENEFICIARY EDUCATION AND ASSIST-*  
21                   *ANCE.*—*Providing education and outreach to in-*  
22                   *dividuals entitled to benefits under part A or en-*  
23                   *rolled under part B, or both, and providing as-*  
24                   *sistance to those individuals with specific issues,*  
25                   *concerns or problems.*



1           “(D) *PROVIDER CONSULTATIVE SERV-*  
2           *ICES.—Providing consultative services to institu-*  
3           *tions, agencies, and other persons to enable them*  
4           *to establish and maintain fiscal records nec-*  
5           *essary for purposes of this title and otherwise to*  
6           *qualify as providers of services or suppliers.*

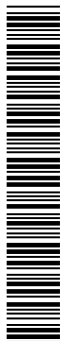
7           “(E) *COMMUNICATION WITH PROVIDERS.—*  
8           *Communicating to providers of services and sup-*  
9           *pliers any information or instructions furnished*  
10          *to the medicare administrative contractor by the*  
11          *Secretary, and facilitating communication be-*  
12          *tween such providers and suppliers and the Sec-*  
13          *retary.*

14          “(F) *PROVIDER EDUCATION AND TECHNICAL*  
15          *ASSISTANCE.—Performing the functions relating*  
16          *to provider education, training, and technical*  
17          *assistance.*

18          “(G) *ADDITIONAL FUNCTIONS.—Performing*  
19          *such other functions as are necessary to carry*  
20          *out the purposes of this title.*

21          “(5) *RELATIONSHIP TO MIP CONTRACTS.—*

22                 “(A) *NONDUPLICATION OF DUTIES.—In en-*  
23                 *tering into contracts under this section, the Sec-*  
24                 *retary shall assure that functions of medicare*  
25                 *administrative contractors in carrying out ac-*



1            *tivities under parts A and B do not duplicate*  
2            *activities carried out under the Medicare Integ-*  
3            *egrity Program under section 1893. The previous*  
4            *sentence shall not apply with respect to the ac-*  
5            *tivity described in section 1893(b)(5) (relating to*  
6            *prior authorization of certain items of durable*  
7            *medical equipment under section 1834(a)(15)).*

8            *“(B) CONSTRUCTION.—An entity shall not*  
9            *be treated as a medicare administrative con-*  
10           *tractor merely by reason of having entered into*  
11           *a contract with the Secretary under section*  
12           *1893.*

13           *“(6) APPLICATION OF FEDERAL ACQUISITION*  
14           *REGULATION.—Except to the extent inconsistent with*  
15           *a specific requirement of this title, the Federal Acqui-*  
16           *sition Regulation applies to contracts under this title.*

17           *“(b) CONTRACTING REQUIREMENTS.—*

18           *“(1) USE OF COMPETITIVE PROCEDURES.—*

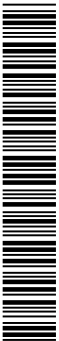
19           *“(A) IN GENERAL.—Except as provided in*  
20           *laws with general applicability to Federal acqui-*  
21           *sition and procurement or in subparagraph (B),*  
22           *the Secretary shall use competitive procedures*  
23           *when entering into contracts with medicare ad-*  
24           *ministrative contractors under this section, tak-*



1            *ing into account performance quality as well as*  
2            *price and other factors.*

3            “(B) *RENEWAL OF CONTRACTS.*—*The Sec-*  
4            *retary may renew a contract with a medicare*  
5            *administrative contractor under this section*  
6            *from term to term without regard to section 5 of*  
7            *title 41, United States Code, or any other provi-*  
8            *sion of law requiring competition, if the medi-*  
9            *care administrative contractor has met or ex-*  
10           *ceeded the performance requirements applicable*  
11           *with respect to the contract and contractor, ex-*  
12           *cept that the Secretary shall provide for the ap-*  
13           *plication of competitive procedures under such a*  
14           *contract not less frequently than once every five*  
15           *years.*

16           “(C) *TRANSFER OF FUNCTIONS.*—*The Sec-*  
17           *retary may transfer functions among medicare*  
18           *administrative contractors consistent with the*  
19           *provisions of this paragraph. The Secretary shall*  
20           *ensure that performance quality is considered in*  
21           *such transfers. The Secretary shall provide pub-*  
22           *lic notice (whether in the Federal Register or*  
23           *otherwise) of any such transfer (including a de-*  
24           *scription of the functions so transferred, a de-*  
25           *scription of the providers of services and sup-*



1           pliers affected by such transfer, and contact in-  
2           formation for the contractors involved).

3                   “(D) INCENTIVES FOR QUALITY.—The Sec-  
4           retary shall provide incentives for medicare ad-  
5           ministrative contractors to provide quality serv-  
6           ice and to promote efficiency.

7                   “(2) COMPLIANCE WITH REQUIREMENTS.—No  
8           contract under this section shall be entered into with  
9           any medicare administrative contractor unless the  
10          Secretary finds that such medicare administrative  
11          contractor will perform its obligations under the con-  
12          tract efficiently and effectively and will meet such re-  
13          quirements as to financial responsibility, legal au-  
14          thority, quality of services provided, and other mat-  
15          ters as the Secretary finds pertinent.

16                   “(3) PERFORMANCE REQUIREMENTS.—

17                           “(A) DEVELOPMENT OF SPECIFIC PERFORM-  
18           ANCE REQUIREMENTS.—In developing contract  
19           performance requirements, the Secretary shall  
20           develop performance requirements applicable to  
21           functions described in subsection (a)(4).

22                           “(B) CONSULTATION.— In developing such  
23           requirements, the Secretary may consult with  
24           providers of services and suppliers, organizations  
25           representing individuals entitled to benefits



1           *under part A or enrolled under part B, or both,*  
2           *and organizations and agencies performing func-*  
3           *tions necessary to carry out the purposes of this*  
4           *section with respect to such performance require-*  
5           *ments.*

6           “(C) *INCLUSION IN CONTRACTS.*—*All con-*  
7           *tractor performance requirements shall be set*  
8           *forth in the contract between the Secretary and*  
9           *the appropriate medicare administrative con-*  
10          *tractor. Such performance requirements—*

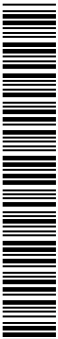
11           “(i) *shall reflect the performance re-*  
12           *quirements developed under subparagraph*  
13           *(A), but may include additional perform-*  
14           *ance requirements;*

15           “(ii) *shall be used for evaluating con-*  
16           *tractor performance under the contract; and*

17           “(iii) *shall be consistent with the writ-*  
18           *ten statement of work provided under the*  
19           *contract.*

20          “(4) *INFORMATION REQUIREMENTS.*—*The Sec-*  
21          *retary shall not enter into a contract with a medicare*  
22          *administrative contractor under this section unless*  
23          *the contractor agrees—*

24           “(A) *to furnish to the Secretary such timely*  
25           *information and reports as the Secretary may*



1           *find necessary in performing his functions under*  
2           *this title; and*

3           “(B) *to maintain such records and afford*  
4           *such access thereto as the Secretary finds nec-*  
5           *essary to assure the correctness and verification*  
6           *of the information and reports under subpara-*  
7           *graph (A) and otherwise to carry out the pur-*  
8           *poses of this title.*

9           “(5) *SURETY BOND.—A contract with a medi-*  
10          *care administrative contractor under this section may*  
11          *require the medicare administrative contractor, and*  
12          *any of its officers or employees certifying payments or*  
13          *disbursing funds pursuant to the contract, or other-*  
14          *wise participating in carrying out the contract, to*  
15          *give surety bond to the United States in such amount*  
16          *as the Secretary may deem appropriate.*

17          “(c) *TERMS AND CONDITIONS.—*

18                 “(1) *IN GENERAL.—A contract with any medi-*  
19          *care administrative contractor under this section may*  
20          *contain such terms and conditions as the Secretary*  
21          *finds necessary or appropriate and may provide for*  
22          *advances of funds to the medicare administrative con-*  
23          *tractor for the making of payments by it under sub-*  
24          *section (a)(4)(B).*





1           “(2) *PROHIBITION ON MANDATES FOR CERTAIN*  
2           *DATA COLLECTION.*—*The Secretary may not require,*  
3           *as a condition of entering into, or renewing, a con-*  
4           *tract under this section, that the medicare adminis-*  
5           *trative contractor match data obtained other than in*  
6           *its activities under this title with data used in the ad-*  
7           *ministration of this title for purposes of identifying*  
8           *situations in which the provisions of section 1862(b)*  
9           *may apply.*

10          “(d) *LIMITATION ON LIABILITY OF MEDICARE ADMIN-*  
11          *ISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.*—

12                 “(1) *CERTIFYING OFFICER.*—*No individual des-*  
13                 *ignated pursuant to a contract under this section as*  
14                 *a certifying officer shall, in the absence of the reckless*  
15                 *disregard of the individual’s obligations or the intent*  
16                 *by that individual to defraud the United States, be*  
17                 *liable with respect to any payments certified by the*  
18                 *individual under this section.*

19                 “(2) *DISBURSING OFFICER.*—*No disbursing offi-*  
20                 *cer shall, in the absence of the reckless disregard of the*  
21                 *officer’s obligations or the intent by that officer to de-*  
22                 *fraud the United States, be liable with respect to any*  
23                 *payment by such officer under this section if it was*  
24                 *based upon an authorization (which meets the appli-*  
25                 *cable requirements for such internal controls estab-*



1 *lished by the Comptroller General) of a certifying offi-*  
2 *cer designated as provided in paragraph (1) of this*  
3 *subsection.*

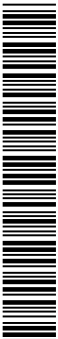
4 *“(3) LIABILITY OF MEDICARE ADMINISTRATIVE*  
5 *CONTRACTOR.—*

6 *“(A) IN GENERAL.—No medicare administrative*  
7 *contractor shall be liable to the United States for a*  
8 *payment by a certifying or disbursing officer unless,*  
9 *in connection with such payment, the medicare ad-*  
10 *ministrative contractor acted with reckless disregard*  
11 *of its obligations under its medicare administrative*  
12 *contract or with intent to defraud the United States.*

13 *“(B) RELATIONSHIP TO FALSE CLAIMS ACT.—*  
14 *Nothing in this subsection shall be construed to limit*  
15 *liability for conduct that would constitute a violation*  
16 *of sections 3729 through 3731 of title 31, United*  
17 *States Code (commonly known as the ‘False Claims*  
18 *Act’).*

19 *“(4) INDEMNIFICATION BY SECRETARY.—*

20 *“(A) IN GENERAL.—Subject to subpara-*  
21 *graphs (B) and (D), in the case of a medicare*  
22 *administrative contractor (or a person who is a*  
23 *director, officer, or employee of such a contractor*  
24 *or who is engaged by the contractor to partici-*  
25 *pate directly in the claims administration proc-*



1           *ess) who is made a party to any judicial or ad-*  
2           *ministrative proceeding arising from or relating*  
3           *directly to the claims administration process*  
4           *under this title, the Secretary may, to the extent*  
5           *the Secretary determines to be appropriate and*  
6           *as specified in the contract with the contractor,*  
7           *indemnify the contractor and such persons.*

8           “(B) *CONDITIONS.—The Secretary may not*  
9           *provide indemnification under subparagraph (A)*  
10          *insofar as the liability for such costs arises di-*  
11          *rectly from conduct that is determined by the ju-*  
12          *dicial proceeding or by the Secretary to be crimi-*  
13          *nal in nature, fraudulent, or grossly negligent. If*  
14          *indemnification is provided by the Secretary*  
15          *with respect to a contractor before a determina-*  
16          *tion that such costs arose directly from such con-*  
17          *duct, the contractor shall reimburse the Secretary*  
18          *for costs of indemnification.*

19          “(C) *SCOPE OF INDEMNIFICATION.—Indem-*  
20          *nification by the Secretary under subparagraph*  
21          *(A) may include payment of judgments, settle-*  
22          *ments (subject to subparagraph (D)), awards,*  
23          *and costs (including reasonable legal expenses).*

24          “(D) *WRITTEN APPROVAL FOR SETTLE-*  
25          *MENTS.—A contractor or other person described*



1           *in subparagraph (A) may not propose to nego-*  
2           *tiate a settlement or compromise of a proceeding*  
3           *described in such subparagraph without the*  
4           *prior written approval of the Secretary to nego-*  
5           *tiate such settlement or compromise. Any indem-*  
6           *nification under subparagraph (A) with respect*  
7           *to amounts paid under a settlement or com-*  
8           *promise of a proceeding described in such sub-*  
9           *paragraph are conditioned upon prior written*  
10          *approval by the Secretary of the final settlement*  
11          *or compromise.*

12           “(E) CONSTRUCTION.—Nothing in this  
13          paragraph shall be construed—

14                   “(i) to change any common law immu-  
15                   nity that may be available to a medicare  
16                   administrative contractor or person de-  
17                   scribed in subparagraph (A); or

18                   “(ii) to permit the payment of costs  
19                   not otherwise allowable, reasonable, or allo-  
20                   cable under the Federal Acquisition Regula-  
21                   tions.”.

22           (2) CONSIDERATION OF INCORPORATION OF CUR-  
23          RENT LAW STANDARDS.—In developing contract per-  
24          formance requirements under section 1874A(b) of the  
25          Social Security Act, as inserted by paragraph (1), the



1        *Secretary shall consider inclusion of the performance*  
2        *standards described in sections 1816(f)(2) of such Act*  
3        *(relating to timely processing of reconsiderations and*  
4        *applications for exemptions) and section*  
5        *1842(b)(2)(B) of such Act (relating to timely review*  
6        *of determinations and fair hearing requests), as such*  
7        *sections were in effect before the date of the enactment*  
8        *of this Act.*

9        *(b) CONFORMING AMENDMENTS TO SECTION 1816 (RE-*  
10       *LATING TO FISCAL INTERMEDIARIES).—Section 1816 (42*  
11       *U.S.C. 1395h) is amended as follows:*

12                *(1) The heading is amended to read as follows:*  
13        *“PROVISIONS RELATING TO THE ADMINISTRATION OF PART*  
14                                *A”.*

15                *(2) Subsection (a) is amended to read as follows:*  
16        *“(a) The administration of this part shall be conducted*  
17        *through contracts with medicare administrative contractors*  
18        *under section 1874A.”.*

19                *(3) Subsection (b) is repealed.*

20                *(4) Subsection (c) is amended—*

21                        *(A) by striking paragraph (1); and*

22                        *(B) in each of paragraphs (2)(A) and*  
23        *(3)(A), by striking “agreement under this sec-*  
24        *tion” and inserting “contract under section*  
25        *1874A that provides for making payments under*  
26        *this part”.*





1                   (ii) in subparagraph (C), by striking  
2                   “carriers” and inserting “medicare admin-  
3                   istrative contractors”; and

4                   (iii) by striking subparagraphs (D)  
5                   and (E);  
6                   (C) in paragraph (3)—

7                   (i) in the matter before subparagraph  
8                   (A), by striking “Each such contract shall  
9                   provide that the carrier” and inserting  
10                  “The Secretary”;

11                  (ii) by striking “will” the first place it  
12                  appears in each of subparagraphs (A), (B),  
13                  (F), (G), (H), and (L) and inserting  
14                  “shall”;

15                  (iii) in subparagraph (B), in the mat-  
16                  ter before clause (i), by striking “to the pol-  
17                  icyholders and subscribers of the carrier”  
18                  and inserting “to the policyholders and sub-  
19                  scribers of the medicare administrative con-  
20                  tractor”;

21                  (iv) by striking subparagraphs (C),  
22                  (D), and (E);

23                  (v) in subparagraph (H)—

24                         (I) by striking “if it makes deter-  
25                         minations or payments with respect to



1                    *physicians' services," in the matter*  
2                    *preceding clause (i); and*

3                    *(II) by striking "carrier" and in-*  
4                    *serting "medicare administrative con-*  
5                    *tractor" in clause (i);*

6                    *(vi) by striking subparagraph (I);*

7                    *(vii) in subparagraph (L), by striking*  
8                    *the semicolon and inserting a period;*

9                    *(viii) in the first sentence, after sub-*  
10                    *paragraph (L), by striking "and shall con-*  
11                    *tain" and all that follows through the pe-*  
12                    *riod; and*

13                    *(ix) in the seventh sentence, by insert-*  
14                    *ing "medicare administrative contractor,"*  
15                    *after "carrier,"; and*

16                    *(D) by striking paragraph (5);*

17                    *(E) in paragraph (6)(D)(iv), by striking*  
18                    *"carrier" and inserting "medicare administra-*  
19                    *tive contractor"; and*

20                    *(F) in paragraph (7), by striking "the car-*  
21                    *rier" and inserting "the Secretary" each place it*  
22                    *appears.*

23                    *(4) Subsection (c) is amended—*

24                    *(A) by striking paragraph (1);*





1           (B) in paragraph (2)(A), by striking “con-  
2           tract under this section which provides for the  
3           disbursement of funds, as described in subsection  
4           (a)(1)(B),” and inserting “contract under section  
5           1874A that provides for making payments under  
6           this part”;

7           (C) in paragraph (3)(A), by striking “sub-  
8           section (a)(1)(B)” and inserting “section  
9           1874A(a)(3)(B)”;

10           (D) in paragraph (4), in the matter pre-  
11           ceding subparagraph (A), by striking “carrier”  
12           and inserting “medicare administrative con-  
13           tractor”; 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 “car-  
17           rier or carriers” and inserting “medicare administra-  
18           tive contractor or contractors”.

19           (7) Subsection (h) is amended—

20           (A) in paragraph (2)—

21           (i) by striking “Each carrier having  
22           an agreement with the Secretary under sub-  
23           section (a)” and inserting “The Secretary”;  
24           and



1                   (ii) by striking “Each such carrier”  
2                   and inserting “The Secretary”;

3                   (B) in paragraph (3)(A)—

4                   (i) by striking “a carrier having an  
5                   agreement with the Secretary under sub-  
6                   section (a)” and inserting “medicare ad-  
7                   ministrative contractor having a contract  
8                   under section 1874A that provides for mak-  
9                   ing payments under this part”; and

10                   (ii) by striking “such carrier” and in-  
11                   serting “such contractor”;

12                   (C) in paragraph (3)(B)—

13                   (i) by striking “a carrier” and insert-  
14                   ing “a medicare administrative contractor”  
15                   each place it appears; and

16                   (ii) by striking “the carrier” and in-  
17                   serting “the contractor” each place it ap-  
18                   pears; and

19                   (D) in paragraphs (5)(A) and (5)(B)(iii),  
20                   by striking “carriers” and inserting “medicare  
21                   administrative contractors” each place it ap-  
22                   pears.

23                   (8) Subsection (l) is amended—



1           (A) in paragraph (1)(A)(iii), by striking  
2           “carrier” and inserting “medicare administra-  
3           tive contractor”; and

4           (B) in paragraph (2), by striking “carrier”  
5           and inserting “medicare administrative con-  
6           tractor”.

7           (9) Subsection (p)(3)(A) is amended by striking  
8           “carrier” and inserting “medicare administrative  
9           contractor”.

10          (10) Subsection (q)(1)(A) is amended by striking  
11          “carrier”.

12          (d) *EFFECTIVE DATE; TRANSITION RULE.*—

13           (1) *EFFECTIVE DATE.*—

14           (A) *IN GENERAL.*—*Except as otherwise pro-*  
15           *vided in this subsection, the amendments made*  
16           *by this section shall take effect on October 1,*  
17           *2005, and the Secretary is authorized to take*  
18           *such steps before such date as may be necessary*  
19           *to implement such amendments on a timely*  
20           *basis.*

21           (B) *CONSTRUCTION FOR CURRENT CON-*  
22           *TRACTS.*—*Such amendments shall not apply to*  
23           *contracts in effect before the date specified under*  
24           *subparagraph (A) that continue to retain the*  
25           *terms and conditions in effect on such date (ex-*



1           *cept as otherwise provided under this Act, other*  
2           *than under this section) until such date as the*  
3           *contract is let out for competitive bidding under*  
4           *such amendments.*

5           (C) *DEADLINE FOR COMPETITIVE BID-*  
6           *DING.—The Secretary shall provide for the let-*  
7           *ting by competitive bidding of all contracts for*  
8           *functions of medicare administrative contractors*  
9           *for annual contract periods that begin on or*  
10          *after October 1, 2010.*

11          (D) *WAIVER OF PROVIDER NOMINATION*  
12          *PROVISIONS DURING TRANSITION.—During the*  
13          *period beginning on the date of the enactment of*  
14          *this Act and before the date specified under sub-*  
15          *paragraph (A), the Secretary may enter into*  
16          *new agreements under section 1816 of the Social*  
17          *Security Act (42 U.S.C. 1395h) without regard*  
18          *to any of the provider nomination provisions of*  
19          *such section.*

20          (2) *GENERAL TRANSITION RULES.—The Sec-*  
21          *retary shall take such steps, consistent with para-*  
22          *graph (1)(B) and (1)(C), as are necessary to provide*  
23          *for an appropriate transition from contracts under*  
24          *section 1816 and section 1842 of the Social Security*



1       *Act (42 U.S.C. 1395h, 1395u) to contracts under sec-*  
2       *tion 1874A, as added by subsection (a)(1).*

3               (3) *AUTHORIZING CONTINUATION OF MIP FUNC-*  
4       *TIONS UNDER CURRENT CONTRACTS AND AGREE-*  
5       *MENTS AND UNDER ROLLOVER CONTRACTS.—The pro-*  
6       *visions contained in the exception in section*  
7       *1893(d)(2) of the Social Security Act (42 U.S.C.*  
8       *1395ddd(d)(2)) shall continue to apply notwith-*  
9       *standing the amendments made by this section, and*  
10       *any reference in such provisions to an agreement or*  
11       *contract shall be deemed to include a contract under*  
12       *section 1874A of such Act, as inserted by subsection*  
13       *(a)(1), that continues the activities referred to in such*  
14       *provisions.*

15              (e) *REFERENCES.—On and after the effective date pro-*  
16       *vided under subsection (d)(1), any reference to a fiscal*  
17       *intermediary or carrier under title XI or XVIII of the So-*  
18       *cial Security Act (or any regulation, manual instruction,*  
19       *interpretative rule, statement of policy, or guideline issued*  
20       *to carry out such titles) shall be deemed a reference to a*  
21       *medicare administrative contractor (as provided under sec-*  
22       *tion 1874A of the Social Security Act).*

23              (f) *REPORTS ON IMPLEMENTATION.—*

24                      (1) *PLAN FOR IMPLEMENTATION.—By not later*  
25       *than October 1, 2004, the Secretary shall submit a re-*



1        *port to Congress and the Comptroller General of the*  
2        *United States that describes the plan for implementa-*  
3        *tion of the amendments made by this section. The*  
4        *Comptroller General shall conduct an evaluation of*  
5        *such plan and shall submit to Congress, not later*  
6        *than 6 months after the date the report is received, a*  
7        *report on such evaluation and shall include in such*  
8        *report such recommendations as the Comptroller Gen-*  
9        *eral deems appropriate.*

10            (2) *STATUS OF IMPLEMENTATION.—The Sec-*  
11        *retary shall submit a report to Congress not later*  
12        *than October 1, 2008, that describes the status of im-*  
13        *plementation of such amendments and that includes*  
14        *a description of the following:*

15                    (A) *The number of contracts that have been*  
16                    *competitively bid as of such date.*

17                    (B) *The distribution of functions among*  
18                    *contracts and contractors.*

19                    (C) *A timeline for complete transition to*  
20                    *full competition.*

21                    (D) *A detailed description of how the Sec-*  
22                    *retary has modified oversight and management*  
23                    *of medicare contractors to adapt to full competi-*  
24                    *tion.*



1 **SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY**  
2 **FOR MEDICARE ADMINISTRATIVE CONTRAC-**  
3 **TORS.**

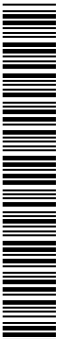
4 (a) *IN GENERAL.*—Section 1874A, as added by section  
5 911(a)(1), is amended by adding at the end the following  
6 new subsection:

7 “(e) *REQUIREMENTS FOR INFORMATION SECURITY.*—

8 “(1) *DEVELOPMENT OF INFORMATION SECURITY*  
9 *PROGRAM.*—A medicare administrative contractor  
10 that performs the functions referred to in subpara-  
11 graphs (A) and (B) of subsection (a)(4) (relating to  
12 determining and making payments) shall implement  
13 a contractor-wide information security program to  
14 provide information security for the operation and  
15 assets of the contractor with respect to such functions  
16 under this title. An information security program  
17 under this paragraph shall meet the requirements for  
18 information security programs imposed on Federal  
19 agencies under paragraphs (1) through (8) of section  
20 3544(b) of title 44, United States Code (other than the  
21 requirements under paragraphs (2)(D)(i), (5)(A), and  
22 (5)(B) of such section).

23 “(2) *INDEPENDENT AUDITS.*—

24 “(A) *PERFORMANCE OF ANNUAL EVALUA-*  
25 *TIONS.*—Each year a medicare administrative  
26 contractor that performs the functions referred to



1           *in subparagraphs (A) and (B) of subsection*  
2           *(a)(4) (relating to determining and making pay-*  
3           *ments) shall undergo an evaluation of the infor-*  
4           *mation security of the contractor with respect to*  
5           *such functions under this title. The evaluation*  
6           *shall—*

7                     *“(i) be performed by an entity that*  
8                     *meets such requirements for independence as*  
9                     *the Inspector General of the Department of*  
10                    *Health and Human Services may establish;*  
11                    *and*

12                    *“(ii) test the effectiveness of informa-*  
13                    *tion security control techniques of an ap-*  
14                    *propriate subset of the contractor’s informa-*  
15                    *tion systems (as defined in section 3502(8)*  
16                    *of title 44, United States Code) relating to*  
17                    *such functions under this title and an as-*  
18                    *essment of compliance with the require-*  
19                    *ments of this subsection and related infor-*  
20                    *mation security policies, procedures, stand-*  
21                    *ards and guidelines, including policies and*  
22                    *procedures as may be prescribed by the Di-*  
23                    *rector of the Office of Management and*  
24                    *Budget and applicable information security*





1                   standards promulgated under section 11331  
2                   of title 40, United States Code.

3                   “(B) DEADLINE FOR INITIAL EVALUA-  
4                   TION.—

5                   “(i) NEW CONTRACTORS.—In the case  
6                   of a medicare administrative contractor  
7                   covered by this subsection that has not pre-  
8                   viously performed the functions referred to  
9                   in subparagraphs (A) and (B) of subsection  
10                  (a)(4) (relating to determining and making  
11                  payments) as a fiscal intermediary or car-  
12                  rier under section 1816 or 1842, the first  
13                  independent evaluation conducted pursuant  
14                  subparagraph (A) shall be completed prior  
15                  to commencing such functions.

16                  “(ii) OTHER CONTRACTORS.—In the  
17                  case of a medicare administrative con-  
18                  tractor covered by this subsection that is not  
19                  described in clause (i), the first independent  
20                  evaluation conducted pursuant subpara-  
21                  graph (A) shall be completed within 1 year  
22                  after the date the contractor commences  
23                  functions referred to in clause (i) under this  
24                  section.

25                  “(C) REPORTS ON EVALUATIONS.—



1                   “(i) *TO THE DEPARTMENT OF HEALTH*  
2                   *AND HUMAN SERVICES.—The results of*  
3                   *independent evaluations under subpara-*  
4                   *graph (A) shall be submitted promptly to*  
5                   *the Inspector General of the Department of*  
6                   *Health and Human Services and to the Sec-*  
7                   *retary.*

8                   “(ii) *TO CONGRESS.—The Inspector*  
9                   *General of Department of Health and*  
10                  *Human Services shall submit to Congress*  
11                  *annual reports on the results of such eval-*  
12                  *uations, including assessments of the scope*  
13                  *and sufficiency of such evaluations.*

14                  “(iii) *AGENCY REPORTING.—The Sec-*  
15                  *retary shall address the results of such eval-*  
16                  *uations in reports required under section*  
17                  *3544(c) of title 44, United States Code.”.*

18                  (b) *APPLICATION OF REQUIREMENTS TO FISCAL*  
19                  *INTERMEDIARIES AND CARRIERS.—*

20                  (1) *IN GENERAL.—The provisions of section*  
21                  *1874A(e)(2) of the Social Security Act (other than*  
22                  *subparagraph (B)), as added by subsection (a), shall*  
23                  *apply to each fiscal intermediary under section 1816*  
24                  *of the Social Security Act (42 U.S.C. 1395h) and*  
25                  *each carrier under section 1842 of such Act (42*



1       *U.S.C. 1395u) in the same manner as they apply to*  
2       *medicare administrative contractors under such pro-*  
3       *visions.*

4               (2) *DEADLINE FOR INITIAL EVALUATION.*—*In the*  
5       *case of such a fiscal intermediary or carrier with an*  
6       *agreement or contract under such respective section in*  
7       *effect as of the date of the enactment of this Act, the*  
8       *first evaluation under section 1874A(e)(2)(A) of the*  
9       *Social Security Act (as added by subsection (a)), pur-*  
10       *suant to paragraph (1), shall be completed (and a re-*  
11       *port on the evaluation submitted to the Secretary) by*  
12       *not later than 1 year after such date.*

13                       ***Subtitle C—Education and***  
14                       ***Outreach***

15       ***SEC. 921. PROVIDER EDUCATION AND TECHNICAL ASSIST-***  
16                       ***ANCE.***

17               (1) *COORDINATION OF EDUCATION FUNDING.*—

18                       (1) *IN GENERAL.*—*Title XVIII is amended by in-*  
19       *serting after section 1888 the following new section:*

20       “*PROVIDER EDUCATION AND TECHNICAL ASSISTANCE*

21       “*SEC. 1889. (a) COORDINATION OF EDUCATION FUND-*  
22       *ING.*—*The Secretary shall coordinate the educational activi-*  
23       *ties provided through medicare contractors (as defined in*  
24       *subsection (g), including under section 1893) in order to*  
25       *maximize the effectiveness of Federal education efforts for*  
26       *providers of services and suppliers.”.*



1           (2) *EFFECTIVE DATE.*—*The amendment made by*  
2           *paragraph (1) shall take effect on the date of the en-*  
3           *actment of this Act.*

4           (3) *REPORT.*—*Not later than October 1, 2004,*  
5           *the Secretary shall submit to Congress a report that*  
6           *includes a description and evaluation of the steps*  
7           *taken to coordinate the funding of provider education*  
8           *under section 1889(a) of the Social Security Act, as*  
9           *added by paragraph (1).*

10          (b) *INCENTIVES TO IMPROVE CONTRACTOR PERFORM-*  
11          *ANCE.*—

12                 (1) *IN GENERAL.*—*Section 1874A, as added by*  
13                 *section 911(a)(1) and as amended by section 912(a),*  
14                 *is amended by adding at the end the following new*  
15                 *subsection:*

16                 “(f) *INCENTIVES TO IMPROVE CONTRACTOR PERFORM-*  
17                 *ANCE IN PROVIDER EDUCATION AND OUTREACH.*—*The Sec-*  
18                 *retary shall use specific claims payment error rates or simi-*  
19                 *lar methodology of medicare administrative contractors in*  
20                 *the processing or reviewing of medicare claims in order to*  
21                 *give such contractors an incentive to implement effective*  
22                 *education and outreach programs for providers of services*  
23                 *and suppliers.”.*

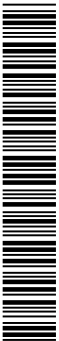
24                 (2) *APPLICATION TO FISCAL INTERMEDIARIES*  
25                 *AND CARRIERS.*—*The provisions of section 1874A(f) of*



1        *the Social Security Act, as added by paragraph (1),*  
2        *shall apply to each fiscal intermediary under section*  
3        *1816 of the Social Security Act (42 U.S.C. 1395h)*  
4        *and each carrier under section 1842 of such Act (42*  
5        *U.S.C. 1395u) in the same manner as they apply to*  
6        *medicare administrative contractors under such pro-*  
7        *visions.*

8                *(3) GAO REPORT ON ADEQUACY OF METHOD-*  
9                *LOGY.—Not later than October 1, 2004, the Comp-*  
10              *troller General of the United States shall submit to*  
11              *Congress and to the Secretary a report on the ade-*  
12              *quacy of the methodology under section 1874A(f) of*  
13              *the Social Security Act, as added by paragraph (1),*  
14              *and shall include in the report such recommendations*  
15              *as the Comptroller General determines appropriate*  
16              *with respect to the methodology.*

17              *(4) REPORT ON USE OF METHODOLOGY IN AS-*  
18              *SESSING CONTRACTOR PERFORMANCE.—Not later*  
19              *than October 1, 2004, the Secretary shall submit to*  
20              *Congress a report that describes how the Secretary in-*  
21              *tends to use such methodology in assessing medicare*  
22              *contractor performance in implementing effective edu-*  
23              *cation and outreach programs, including whether to*  
24              *use such methodology as a basis for performance bo-*  
25              *nuses. The report shall include an analysis of the*



1 *sources of identified errors and potential changes in*  
2 *systems of contractors and rules of the Secretary that*  
3 *could reduce claims error rates.*

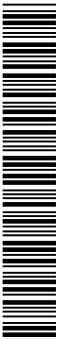
4 *(c) PROVISION OF ACCESS TO AND PROMPT RE-*  
5 *SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-*  
6 *TORS.—*

7 *(1) IN GENERAL.—Section 1874A, as added by*  
8 *section 911(a)(1) and as amended by section 912(a)*  
9 *and subsection (b), is further amended by adding at*  
10 *the end the following new subsection:*

11 *“(g) COMMUNICATIONS WITH BENEFICIARIES, PRO-*  
12 *VIDERS OF SERVICES AND SUPPLIERS.—*

13 *“(1) COMMUNICATION STRATEGY.—The Secretary*  
14 *shall develop a strategy for communications with in-*  
15 *dividuals entitled to benefits under part A or enrolled*  
16 *under part B, or both, and with providers of services*  
17 *and suppliers under this title.*

18 *“(2) RESPONSE TO WRITTEN INQUIRIES.—Each*  
19 *medicare administrative contractor shall, for those*  
20 *providers of services and suppliers which submit*  
21 *claims to the contractor for claims processing and for*  
22 *those individuals entitled to benefits under part A or*  
23 *enrolled under part B, or both, with respect to whom*  
24 *claims are submitted for claims processing, provide*  
25 *general written responses (which may be through elec-*



1        *tronic transmission) in a clear, concise, and accurate*  
2        *manner to inquiries of providers of services, suppliers*  
3        *and individuals entitled to benefits under part A or*  
4        *enrolled under part B, or both, concerning the pro-*  
5        *grams under this title within 45 business days of the*  
6        *date of receipt of such inquiries.*

7            *“(3) RESPONSE TO TOLL-FREE LINES.—The Sec-*  
8        *retary shall ensure that each medicare administrative*  
9        *contractor shall provide, for those providers of services*  
10       *and suppliers which submit claims to the contractor*  
11       *for claims processing and for those individuals enti-*  
12       *tled to benefits under part A or enrolled under part*  
13       *B, or both, with respect to whom claims are submitted*  
14       *for claims processing, a toll-free telephone number at*  
15       *which such individuals, providers of services and sup-*  
16       *pliers may obtain information regarding billing, cod-*  
17       *ing, claims, coverage, and other appropriate informa-*  
18       *tion under this title.*

19            *“(4) MONITORING OF CONTRACTOR RE-*  
20        *SPONSES.—*

21            *“(A) IN GENERAL.—Each medicare admin-*  
22        *istrative contractor shall, consistent with stand-*  
23        *ards developed by the Secretary under subpara-*  
24        *graph (B)—*



1           “(i) maintain a system for identifying  
2           who provides the information referred to in  
3           paragraphs (2) and (3); and

4           “(ii) monitor the accuracy, consist-  
5           ency, and timeliness of the information so  
6           provided.

7           “(B) DEVELOPMENT OF STANDARDS.—

8           “(i) IN GENERAL.—The Secretary shall  
9           establish and make public standards to  
10          monitor the accuracy, consistency, and  
11          timeliness of the information provided in  
12          response to written and telephone inquiries  
13          under this subsection. Such standards shall  
14          be consistent with the performance require-  
15          ments established under subsection (b)(3).

16          “(ii) EVALUATION.—In conducting  
17          evaluations of individual medicare admin-  
18          istrative contractors, the Secretary shall  
19          take into account the results of the moni-  
20          toring conducted under subparagraph (A)  
21          taking into account as performance require-  
22          ments the standards established under  
23          clause (i). The Secretary shall, in consulta-  
24          tion with organizations representing pro-  
25          viders of services, suppliers, and individuals





1                   *entitled to benefits under part A or enrolled*  
2                   *under part B, or both, establish standards*  
3                   *relating to the accuracy, consistency, and*  
4                   *timeliness of the information so provided.*

5                   “(C) *DIRECT MONITORING.*—*Nothing in this*  
6                   *paragraph shall be construed as preventing the*  
7                   *Secretary from directly monitoring the accuracy,*  
8                   *consistency, and timeliness of the information so*  
9                   *provided.”.*

10                  (2) *EFFECTIVE DATE.*—*The amendment made by*  
11                  *paragraph (1) shall take effect October 1, 2004.*

12                  (3) *APPLICATION TO FISCAL INTERMEDIARIES*  
13                  *AND CARRIERS.*—*The provisions of section 1874A(g)*  
14                  *of the Social Security Act, as added by paragraph*  
15                  *(1), shall apply to each fiscal intermediary under sec-*  
16                  *tion 1816 of the Social Security Act (42 U.S.C.*  
17                  *1395h) and each carrier under section 1842 of such*  
18                  *Act (42 U.S.C. 1395u) in the same manner as they*  
19                  *apply to medicare administrative contractors under*  
20                  *such provisions.*

21                  (d) *IMPROVED PROVIDER EDUCATION AND TRAIN-*  
22                  *ING.*—

23                  (1) *IN GENERAL.*—*Section 1889, as added by*  
24                  *subsection (a), is amended by adding at the end the*  
25                  *following new subsections:*



1       “(b) *ENHANCED EDUCATION AND TRAINING.*—

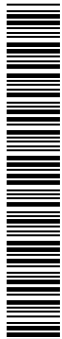
2               “(1) *ADDITIONAL RESOURCES.*—*There are au-*  
3 *thorized to be appropriated to the Secretary (in ap-*  
4 *propriate part from the Federal Hospital Insurance*  
5 *Trust Fund and the Federal Supplementary Medical*  
6 *Insurance Trust Fund) \$25,000,000 for each of fiscal*  
7 *years 2005 and 2006 and such sums as may be nec-*  
8 *essary for succeeding fiscal years.*

9               “(2) *USE.*—*The funds made available under*  
10 *paragraph (1) shall be used to increase the conduct by*  
11 *medicare contractors of education and training of*  
12 *providers of services and suppliers regarding billing,*  
13 *coding, and other appropriate items and may also be*  
14 *used to improve the accuracy, consistency, and timeli-*  
15 *ness of contractor responses.*

16       “(c) *TAILORING EDUCATION AND TRAINING ACTIVI-*  
17 *TIES FOR SMALL PROVIDERS OR SUPPLIERS.*—

18               “(1) *IN GENERAL.*—*Insofar as a medicare con-*  
19 *tractor conducts education and training activities, it*  
20 *shall tailor such activities to meet the special needs*  
21 *of small providers of services or suppliers (as defined*  
22 *in paragraph (2)).*

23               “(2) *SMALL PROVIDER OF SERVICES OR SUP-*  
24 *PLIER.*—*In this subsection, the term ‘small provider*  
25 *of services or supplier’ means—*



1                   “(A) a provider of services with fewer than  
2                   25 full-time-equivalent employees; or

3                   “(B) a supplier with fewer than 10 full-  
4                   time-equivalent employees.”.

5                   (2) *EFFECTIVE DATE.*—*The amendment made by*  
6                   *paragraph (1) shall take effect on October 1, 2004.*

7                   (e) *REQUIREMENT TO MAINTAIN INTERNET SITES.*—

8                   (1) *IN GENERAL.*—*Section 1889, as added by*  
9                   *subsection (a) and as amended by subsection (d), is*  
10                  *further amended by adding at the end the following*  
11                  *new subsection:*

12                  “(d) *INTERNET SITES; FAQs.*—*The Secretary, and*  
13                  *each medicare contractor insofar as it provides services (in-*  
14                  *cluding claims processing) for providers of services or sup-*  
15                  *pliers, shall maintain an Internet site which—*

16                   “(1) *provides answers in an easily accessible for-*  
17                   *mat to frequently asked questions, and*

18                   “(2) *includes other published materials of the*  
19                   *contractor,*

20                   *that relate to providers of services and suppliers under the*  
21                   *programs under this title (and title XI insofar as it relates*  
22                   *to such programs).”.*

23                   (2) *EFFECTIVE DATE.*—*The amendment made by*  
24                   *paragraph (1) shall take effect on October 1, 2004.*

25                   (f) *ADDITIONAL PROVIDER EDUCATION PROVISIONS.*—



1           (1) *IN GENERAL.*—Section 1889, as added by  
2           subsection (a) and as amended by subsections (d) and  
3           (e), is further amended by adding at the end the fol-  
4           lowing new subsections:

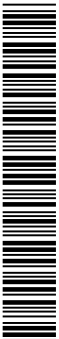
5           “(e) *ENCOURAGEMENT OF PARTICIPATION IN EDU-*  
6           *CATION PROGRAM ACTIVITIES.*—A medicare contractor  
7           may not use a record of attendance at (or failure to attend)  
8           educational activities or other information gathered during  
9           an educational program conducted under this section or  
10          otherwise by the Secretary to select or track providers of  
11          services or suppliers for the purpose of conducting any type  
12          of audit or prepayment review.

13          “(f) *CONSTRUCTION.*—Nothing in this section or sec-  
14          tion 1893(g) shall be construed as providing for disclosure  
15          by a medicare contractor of information that would com-  
16          promise pending law enforcement activities or reveal find-  
17          ings of law enforcement-related audits.

18          “(g) *DEFINITIONS.*—For purposes of this section, the  
19          term ‘medicare contractor’ includes the following:

20                 “(1) A medicare administrative contractor with  
21                 a contract under section 1874A, including a fiscal  
22                 intermediary with a contract under section 1816 and  
23                 a carrier with a contract under section 1842.

24                 “(2) An eligible entity with a contract under sec-  
25                 tion 1893.



1 *Such term does not include, with respect to activities of a*  
2 *specific provider of services or supplier an entity that has*  
3 *no authority under this title or title IX with respect to such*  
4 *activities and such provider of services or supplier.”.*

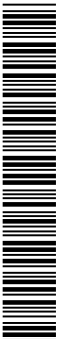
5 (2) *EFFECTIVE DATE.*—*The amendment made by*  
6 *paragraph (1) shall take effect on the date of the en-*  
7 *actment of this Act.*

8 **SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**  
9 **ONSTRATION PROGRAM.**

10 (a) *ESTABLISHMENT.*—

11 (1) *IN GENERAL.*—*The Secretary shall establish*  
12 *a demonstration program (in this section referred to*  
13 *as the “demonstration program”) under which tech-*  
14 *nical assistance described in paragraph (2) is made*  
15 *available, upon request and on a voluntary basis, to*  
16 *small providers of services or suppliers in order to*  
17 *improve compliance with the applicable requirements*  
18 *of the programs under medicare program under title*  
19 *XVIII of the Social Security Act (including provi-*  
20 *sions of title XI of such Act insofar as they relate to*  
21 *such title and are not administered by the Office of*  
22 *the Inspector General of the Department of Health*  
23 *and Human Services).*

24 (2) *FORMS OF TECHNICAL ASSISTANCE.*—*The*  
25 *technical assistance described in this paragraph is—*



1           (A) *evaluation and recommendations re-*  
2           *garding billing and related systems; and*

3           (B) *information and assistance regarding*  
4           *policies and procedures under the medicare pro-*  
5           *gram, including coding and reimbursement.*

6           (3) *SMALL PROVIDERS OF SERVICES OR SUP-*  
7           *PLIERS.—In this section, the term “small providers of*  
8           *services or suppliers” means—*

9           (A) *a provider of services with fewer than*  
10           *25 full-time-equivalent employees; or*

11           (B) *a supplier with fewer than 10 full-time-*  
12           *equivalent employees.*

13           (b) *QUALIFICATION OF CONTRACTORS.—In conducting*  
14           *the demonstration program, the Secretary shall enter into*  
15           *contracts with qualified organizations (such as peer review*  
16           *organizations or entities described in section 1889(g)(2) of*  
17           *the Social Security Act, as inserted by section 5(f)(1)) with*  
18           *appropriate expertise with billing systems of the full range*  
19           *of providers of services and suppliers to provide the tech-*  
20           *nical assistance. In awarding such contracts, the Secretary*  
21           *shall consider any prior investigations of the entity’s work*  
22           *by the Inspector General of Department of Health and*  
23           *Human Services or the Comptroller General of the United*  
24           *States.*



1           (c) *DESCRIPTION OF TECHNICAL ASSISTANCE.*—The  
2 *technical assistance provided under the demonstration pro-*  
3 *gram shall include a direct and in-person examination of*  
4 *billing systems and internal controls of small providers of*  
5 *services or suppliers to determine program compliance and*  
6 *to suggest more efficient or effective means of achieving such*  
7 *compliance.*

8           (d) *AVOIDANCE OF RECOVERY ACTIONS FOR PROB-*  
9 *LEMS IDENTIFIED AS CORRECTED.*—The Secretary shall  
10 *provide that, absent evidence of fraud and notwithstanding*  
11 *any other provision of law, any errors found in a compli-*  
12 *ance review for a small provider of services or supplier that*  
13 *participates in the demonstration program shall not be sub-*  
14 *ject to recovery action if the technical assistance personnel*  
15 *under the program determine that—*

16                 (1) *the problem that is the subject of the compli-*  
17 *ance review has been corrected to their satisfaction*  
18 *within 30 days of the date of the visit by such per-*  
19 *sonnel to the small provider of services or supplier;*  
20 *and*

21                 (2) *such problem remains corrected for such pe-*  
22 *riod as is appropriate.*

23 *The previous sentence applies only to claims filed as part*  
24 *of the demonstration program and lasts only for the dura-*



1 *tion of such program and only as long as the small provider*  
2 *of services or supplier is a participant in such program.*

3 *(e) GAO EVALUATION.—Not later than 2 years after*  
4 *the date of the date the demonstration program is first im-*  
5 *plemented, the Comptroller General, in consultation with*  
6 *the Inspector General of the Department of Health and*  
7 *Human Services, shall conduct an evaluation of the dem-*  
8 *onstration program. The evaluation shall include a deter-*  
9 *mination of whether claims error rates are reduced for*  
10 *small providers of services or suppliers who participated*  
11 *in the program and the extent of improper payments made*  
12 *as a result of the demonstration program. The Comptroller*  
13 *General shall submit a report to the Secretary and the Con-*  
14 *gress on such evaluation and shall include in such report*  
15 *recommendations regarding the continuation or extension*  
16 *of the demonstration program.*

17 *(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The*  
18 *provision of technical assistance to a small provider of serv-*  
19 *ices or supplier under the demonstration program is condi-*  
20 *tioned upon the small provider of services or supplier pay-*  
21 *ing an amount estimated (and disclosed in advance of a*  
22 *provider's or supplier's participation in the program) to*  
23 *be equal to 25 percent of the cost of the technical assistance.*

24 *(g) AUTHORIZATION OF APPROPRIATIONS.—There are*  
25 *authorized to be appropriated to the Secretary (in appro-*





1 *priate part from the Federal Hospital Insurance Trust*  
2 *Fund and the Federal Supplementary Medical Insurance*  
3 *Trust Fund) to carry out the demonstration program—*

4 *(1) for fiscal year 2005, \$1,000,000, and*

5 *(2) for fiscal year 2006, \$6,000,000.*

6 **SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDICARE**  
7 **BENEFICIARY OMBUDSMAN.**

8 *(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868*  
9 *(42 U.S.C. 1395ee) is amended—*

10 *(1) by adding at the end of the heading the fol-*  
11 *lowing: “; MEDICARE PROVIDER OMBUDSMAN”;*

12 *(2) by inserting “PRACTICING PHYSICIANS ADVI-*  
13 *SORY COUNCIL.—(1)” after “(a)”;*

14 *(3) in paragraph (1), as so redesignated under*  
15 *paragraph (2), by striking “in this section” and in-*  
16 *serting “in this subsection”;*

17 *(4) by redesignating subsections (b) and (c) as*  
18 *paragraphs (2) and (3), respectively; and*

19 *(5) by adding at the end the following new sub-*  
20 *section:*

21 *“(b) MEDICARE PROVIDER OMBUDSMAN.—The Sec-*  
22 *retary shall appoint within the Department of Health and*  
23 *Human Services a Medicare Provider Ombudsman. The*  
24 *Ombudsman shall—*



1           “(1) provide assistance, on a confidential basis,  
2           to providers of services and suppliers with respect to  
3           complaints, grievances, and requests for information  
4           concerning the programs under this title (including  
5           provisions of title XI insofar as they relate to this  
6           title and are not administered by the Office of the In-  
7           spector General of the Department of Health and  
8           Human Services) and in the resolution of unclear or  
9           conflicting guidance given by the Secretary and medi-  
10          care contractors to such providers of services and sup-  
11          pliers regarding such programs and provisions and  
12          requirements under this title and such provisions;  
13          and

14           “(2) submit recommendations to the Secretary  
15          for improvement in the administration of this title  
16          and such provisions, including—

17           “(A) recommendations to respond to recur-  
18          ring patterns of confusion in this title and such  
19          provisions (including recommendations regard-  
20          ing suspending imposition of sanctions where  
21          there is widespread confusion in program ad-  
22          ministration), and

23           “(B) recommendations to provide for an ap-  
24          propriate and consistent response (including not  
25          providing for audits) in cases of self-identified



1           *overpayments by providers of services and sup-*  
2           *pliers.*

3   *The Ombudsman shall not serve as an advocate for any in-*  
4   *creases in payments or new coverage of services, but may*  
5   *identify issues and problems in payment or coverage poli-*  
6   *cies.”.*

7           **(b) MEDICARE BENEFICIARY OMBUDSMAN.—***Title*  
8   *XVIII, as previously amended, is amended by inserting*  
9   *after section 1809 the following new section:*

10                   **“MEDICARE BENEFICIARY OMBUDSMAN**

11           **“SEC. 1810. (a) IN GENERAL.—***The Secretary shall*  
12   *appoint within the Department of Health and Human*  
13   *Services a Medicare Beneficiary Ombudsman who shall*  
14   *have expertise and experience in the fields of health care*  
15   *and education of (and assistance to) individuals entitled*  
16   *to benefits under this title.*

17           **“(b) DUTIES.—***The Medicare Beneficiary Ombudsman*  
18   *shall—*

19                   **“(1) receive complaints, grievances, and requests**  
20   *for information submitted by individuals entitled to*  
21   *benefits under part A or enrolled under part B, or*  
22   *both, with respect to any aspect of the medicare pro-*  
23   *gram;*

24                   **“(2) provide assistance with respect to com-**  
25   *plaints, grievances, and requests referred to in para-*  
26   *graph (1), including—*



1           “(A) assistance in collecting relevant infor-  
2 mation for such individuals, to seek an appeal of  
3 a decision or determination made by a fiscal  
4 intermediary, carrier, Medicare+Choice organi-  
5 zation, or the Secretary;

6           “(B) assistance to such individuals with  
7 any problems arising from disenrollment from a  
8 Medicare+Choice plan under part C; and

9           “(C) assistance to such individuals in pre-  
10 senting information under section 1860D-  
11 2(b)(4)(D)(v); and

12           “(3) submit annual reports to Congress and the  
13 Secretary that describe the activities of the Office and  
14 that include such recommendations for improvement  
15 in the administration of this title as the Ombudsman  
16 determines appropriate.

17 *The Ombudsman shall not serve as an advocate for any in-*  
18 *creases in payments or new coverage of services, but may*  
19 *identify issues and problems in payment or coverage poli-*  
20 *cies.*

21           “(c) *WORKING WITH HEALTH INSURANCE COUN-*  
22 *SELING PROGRAMS.—To the extent possible, the Ombuds-*  
23 *man shall work with health insurance counseling programs*  
24 *(receiving funding under section 4360 of Omnibus Budget*  
25 *Reconciliation Act of 1990) to facilitate the provision of in-*



1 *formation to individuals entitled to benefits under part A*  
2 *or enrolled under part B, or both regarding*  
3 *Medicare+Choice plans and changes to those plans. Noth-*  
4 *ing in this subsection shall preclude further collaboration*  
5 *between the Ombudsman and such programs.”.*

6 (c) *DEADLINE FOR APPOINTMENT.—The Secretary*  
7 *shall appoint the Medicare Provider Ombudsman and the*  
8 *Medicare Beneficiary Ombudsman, under the amendments*  
9 *made by subsections (a) and (b), respectively, by not later*  
10 *than 1 year after the date of the enactment of this Act.*

11 (d) *FUNDING.—There are authorized to be appro-*  
12 *priated to the Secretary (in appropriate part from the Fed-*  
13 *eral Hospital Insurance Trust Fund and the Federal Sup-*  
14 *plementary Medical Insurance Trust Fund) to carry out*  
15 *the provisions of subsection (b) of section 1868 of the Social*  
16 *Security Act (relating to the Medicare Provider Ombuds-*  
17 *man), as added by subsection (a)(5) and section 1807 of*  
18 *such Act (relating to the Medicare Beneficiary Ombuds-*  
19 *man), as added by subsection (b), such sums as are nec-*  
20 *essary for fiscal year 2004 and each succeeding fiscal year.*

21 (e) *USE OF CENTRAL, TOLL-FREE NUMBER (1-800-*  
22 *MEDICARE).—*

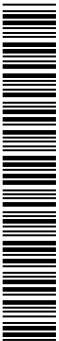
23 (1) *PHONE TRIAGE SYSTEM; LISTING IN MEDI-*  
24 *CARE HANDBOOK INSTEAD OF OTHER TOLL-FREE*  
25 *NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-2(b))*



1        *is amended by adding at the end the following: “The*  
2        *Secretary shall provide, through the toll-free number*  
3        *1-800-MEDICARE, for a means by which individ-*  
4        *uals seeking information about, or assistance with,*  
5        *such programs who phone such toll-free number are*  
6        *transferred (without charge) to appropriate entities*  
7        *for the provision of such information or assistance.*  
8        *Such toll-free number shall be the toll-free number*  
9        *listed for general information and assistance in the*  
10       *annual notice under subsection (a) instead of the list-*  
11       *ing of numbers of individual contractors.”.*

12                (2) *MONITORING ACCURACY.—*

13                        (A) *STUDY.—The Comptroller General of*  
14                        *the United States shall conduct a study to mon-*  
15                        *itor the accuracy and consistency of information*  
16                        *provided to individuals entitled to benefits under*  
17                        *part A or enrolled under part B, or both,*  
18                        *through the toll-free number 1-800-MEDICARE,*  
19                        *including an assessment of whether the informa-*  
20                        *tion provided is sufficient to answer questions of*  
21                        *such individuals. In conducting the study, the*  
22                        *Comptroller General shall examine the education*  
23                        *and training of the individuals providing infor-*  
24                        *mation through such number.*



1                   (B) *REPORT.*—Not later than 1 year after  
2                   the date of the enactment of this Act, the Comp-  
3                   troller General shall submit to Congress a report  
4                   on the study conducted under subparagraph (A).

5 **SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION PRO-**  
6                   **GRAM.**

7                   (a) *IN GENERAL.*—The Secretary shall establish a  
8                   demonstration program (in this section referred to as the  
9                   “demonstration program”) under which medicare special-  
10                  ists employed by the Department of Health and Human  
11                  Services provide advice and assistance to individuals enti-  
12                  tled to benefits under part A of title XVIII of the Social  
13                  Security Act, or enrolled under part B of such title, or both,  
14                  regarding the medicare program at the location of existing  
15                  local offices of the Social Security Administration.

16                  (b) *LOCATIONS.*—

17                   (1) *IN GENERAL.*—The demonstration program  
18                   shall be conducted in at least 6 offices or areas. Sub-  
19                   ject to paragraph (2), in selecting such offices and  
20                   areas, the Secretary shall provide preference for offices  
21                   with a high volume of visits by individuals referred  
22                   to in subsection (a).

23                   (2) *ASSISTANCE FOR RURAL BENEFICIARIES.*—  
24                   The Secretary shall provide for the selection of at  
25                   least 2 rural areas to participate in the demonstra-



1        *tion program. In conducting the demonstration pro-*  
2        *gram in such rural areas, the Secretary shall provide*  
3        *for medicare specialists to travel among local offices*  
4        *in a rural area on a scheduled basis.*

5        *(c) DURATION.—The demonstration program shall be*  
6        *conducted over a 3-year period.*

7        *(d) EVALUATION AND REPORT.—*

8                *(1) EVALUATION.—The Secretary shall provide*  
9                *for an evaluation of the demonstration program. Such*  
10               *evaluation shall include an analysis of—*

11                        *(A) utilization of, and satisfaction of those*  
12                        *individuals referred to in subsection (a) with, the*  
13                        *assistance provided under the program; and*

14                        *(B) the cost-effectiveness of providing bene-*  
15                        *ficiary assistance through out-stationing medi-*  
16                        *care specialists at local offices of the Social Secu-*  
17                        *rity Administration.*

18                *(2) REPORT.—The Secretary shall submit to*  
19        *Congress a report on such evaluation and shall in-*  
20        *clude in such report recommendations regarding the*  
21        *feasibility of permanently out-stationing medicare*  
22        *specialists at local offices of the Social Security Ad-*  
23        *ministration.*





1 **SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN NO-**  
2 **TICES TO BENEFICIARIES ABOUT SKILLED**  
3 **NURSING FACILITY BENEFITS.**

4 (a) *IN GENERAL.*—*The Secretary shall provide that in*  
5 *medicare beneficiary notices provided (under section*  
6 *1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a))*  
7 *with respect to the provision of post-hospital extended care*  
8 *services under part A of title XVIII of the Social Security*  
9 *Act, there shall be included information on the number of*  
10 *days of coverage of such services remaining under such part*  
11 *for the medicare beneficiary and spell of illness involved.*

12 (b) *EFFECTIVE DATE.*—*Subsection (a) shall apply to*  
13 *notices provided during calendar quarters beginning more*  
14 *than 6 months after the date of the enactment of this Act.*

15 **SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED**  
16 **NURSING FACILITIES IN HOSPITAL DIS-**  
17 **CHARGE PLANS.**

18 (a) *AVAILABILITY OF DATA.*—*The Secretary shall pub-*  
19 *licly provide information that enables hospital discharge*  
20 *planners, medicare beneficiaries, and the public to identify*  
21 *skilled nursing facilities that are participating in the medi-*  
22 *care program.*

23 (b) *INCLUSION OF INFORMATION IN CERTAIN HOS-*  
24 *PITAL DISCHARGE PLANS.*—

25 (1) *IN GENERAL.*—*Section 1861(ee)(2)(D) (42*  
26 *U.S.C. 1395x(ee)(2)(D)) is amended—*



1           (A) by striking “hospice services” and in-  
2           serting “hospice care and post-hospital extended  
3           care services”; and

4           (B) by inserting before the period at the end  
5           the following: “and, in the case of individuals  
6           who are likely to need post-hospital extended care  
7           services, the availability of such services through  
8           facilities that participate in the program under  
9           this title and that serve the area in which the  
10          patient resides”.

11          (2) *EFFECTIVE DATE.*—The amendments made  
12          by paragraph (1) shall apply to discharge plans made  
13          on or after such date as the Secretary shall specify,  
14          but not later than 6 months after the date the Sec-  
15          retary provides for availability of information under  
16          subsection (a).

## 17       ***Subtitle D—Appeals and Recovery***

### 18       ***SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE***

#### 19                       ***APPEALS.***

20          (a) *TRANSITION PLAN.*—

21               (1) *IN GENERAL.*—Not later than October 1,  
22               2004, the Commissioner of Social Security and the  
23               Secretary shall develop and transmit to Congress and  
24               the Comptroller General of the United States a plan  
25               under which the functions of administrative law



1 *judges responsible for hearing cases under title XVIII*  
2 *of the Social Security Act (and related provisions in*  
3 *title XI of such Act) are transferred from the responsi-*  
4 *bility of the Commissioner and the Social Security*  
5 *Administration to the Secretary and the Department*  
6 *of Health and Human Services.*

7 (2) *GAO EVALUATION.—The Comptroller Gen-*  
8 *eral of the United States shall evaluate the plan and,*  
9 *not later than the date that is 6 months after the date*  
10 *on which the plan is received by the Comptroller Gen-*  
11 *eral, shall submit to Congress a report on such eval-*  
12 *uation.*

13 (b) *TRANSFER OF ADJUDICATION AUTHORITY.—*

14 (1) *IN GENERAL.—Not earlier than July 1, 2005,*  
15 *and not later than October 1, 2005, the Commissioner*  
16 *of Social Security and the Secretary shall implement*  
17 *the transition plan under subsection (a) and transfer*  
18 *the administrative law judge functions described in*  
19 *such subsection from the Social Security Administra-*  
20 *tion to the Secretary.*

21 (2) *ASSURING INDEPENDENCE OF JUDGES.—The*  
22 *Secretary shall assure the independence of adminis-*  
23 *trative law judges performing the administrative law*  
24 *judge functions transferred under paragraph (1) from*  
25 *the Centers for Medicare & Medicaid Services and its*



1        *contractors. In order to assure such independence, the*  
2        *Secretary shall place such judges in an administra-*  
3        *tive office that is organizationally and functionally*  
4        *separate from such Centers. Such judges shall report*  
5        *to, and be under the general supervision of, the Sec-*  
6        *retary, but shall not report to, or be subject to super-*  
7        *vision by, another other officer of the Department.*

8            (3) *GEOGRAPHIC DISTRIBUTION.*—*The Secretary*  
9        *shall provide for an appropriate geographic distribu-*  
10       *tion of administrative law judges performing the ad-*  
11       *ministrative law judge functions transferred under*  
12       *paragraph (1) throughout the United States to ensure*  
13       *timely access to such judges.*

14           (4) *HIRING AUTHORITY.*—*Subject to the amounts*  
15       *provided in advance in appropriations Act, the Sec-*  
16       *retary shall have authority to hire administrative law*  
17       *judges to hear such cases, giving priority to those*  
18       *judges with prior experience in handling medicare*  
19       *appeals and in a manner consistent with paragraph*  
20       *(3), and to hire support staff for such judges.*

21           (5) *FINANCING.*—*Amounts payable under law to*  
22       *the Commissioner for administrative law judges per-*  
23       *forming the administrative law judge functions trans-*  
24       *ferred under paragraph (1) from the Federal Hospital*  
25       *Insurance Trust Fund and the Federal Supple-*



1        *mentary Medical Insurance Trust Fund shall become*  
2        *payable to the Secretary for the functions so trans-*  
3        *ferred.*

4            (6) *SHARED RESOURCES.*—*The Secretary shall*  
5        *enter into such arrangements with the Commissioner*  
6        *as may be appropriate with respect to transferred*  
7        *functions of administrative law judges to share office*  
8        *space, support staff, and other resources, with appro-*  
9        *prate reimbursement from the Trust Funds described*  
10       *in paragraph (5).*

11          (c) *INCREASED FINANCIAL SUPPORT.*—*In addition to*  
12       *any amounts otherwise appropriated, to ensure timely ac-*  
13       *tion on appeals before administrative law judges and the*  
14       *Departmental Appeals Board consistent with section 1869*  
15       *of the Social Security Act (as amended by section 521 of*  
16       *BIPA, 114 Stat. 2763A–534), there are authorized to be ap-*  
17       *propriated (in appropriate part from the Federal Hospital*  
18       *Insurance Trust Fund and the Federal Supplementary*  
19       *Medical Insurance Trust Fund) to the Secretary such sums*  
20       *as are necessary for fiscal year 2005 and each subsequent*  
21       *fiscal year to—*

22            (1) *increase the number of administrative law*  
23        *judges (and their staffs) under subsection (b)(4);*



1           (2) *improve education and training opportuni-*  
2           *ties for administrative law judges (and their staffs);*  
3           *and*

4           (3) *increase the staff of the Departmental Ap-*  
5           *peals Board.*

6           (d)           **CONFORMING            AMENDMENT.**—*Section*  
7           *1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by*  
8           *section 522(a) of BIPA (114 Stat. 2763A–543), is amended*  
9           *by striking “of the Social Security Administration”.*

10   **SEC. 932. PROCESS FOR EXPEDITED ACCESS TO REVIEW.**

11           (a) **EXPEDITED ACCESS TO JUDICIAL REVIEW.**—*Sec-*  
12           *tion 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA,*  
13           *is amended—*

14                   (1) *in paragraph (1)(A), by inserting “, subject*  
15                   *to paragraph (2),” before “to judicial review of the*  
16                   *Secretary’s final decision”;*

17                   (2) *in paragraph (1)(F)—*

18                           (A) *by striking clause (ii);*

19                           (B) *by striking “PROCEEDING” and all that*  
20                           *follows through “DETERMINATION” and inserting*  
21                           *“DETERMINATIONS AND RECONSIDERATIONS”;*

22                           *and*

23                           (C) *by redesignating subclauses (I) and (II)*  
24                           *as clauses (i) and (ii) and by moving the inden-*



1           *tation of such subclauses (and the matter that*  
2           *follows) 2 ems to the left; and*

3           *(3) by adding at the end the following new para-*  
4           *graph:*

5           “(2) *EXPEDITED ACCESS TO JUDICIAL RE-*  
6           *VIEW.—*

7                   “(A) *IN GENERAL.—The Secretary shall es-*  
8                   *tablish a process under which a provider of serv-*  
9                   *ices or supplier that furnishes an item or service*  
10                   *or an individual entitled to benefits under part*  
11                   *A or enrolled under part B, or both, who has*  
12                   *filed an appeal under paragraph (1) may obtain*  
13                   *access to judicial review when a review panel*  
14                   *(described in subparagraph (D)), on its own mo-*  
15                   *tion or at the request of the appellant, deter-*  
16                   *mines that no entity in the administrative ap-*  
17                   *peals process has the authority to decide the*  
18                   *question of law or regulation relevant to the mat-*  
19                   *ters in controversy and that there is no material*  
20                   *issue of fact in dispute. The appellant may make*  
21                   *such request only once with respect to a question*  
22                   *of law or regulation in a case of an appeal.*

23                   “(B) *PROMPT DETERMINATIONS.—If, after*  
24                   *or coincident with appropriately filing a request*  
25                   *for an administrative hearing, the appellant re-*



1           *quests a determination by the appropriate review*  
2           *panel that no review panel has the authority to*  
3           *decide the question of law or regulations relevant*  
4           *to the matters in controversy and that there is*  
5           *no material issue of fact in dispute and if such*  
6           *request is accompanied by the documents and*  
7           *materials as the appropriate review panel shall*  
8           *require for purposes of making such determina-*  
9           *tion, such review panel shall make a determina-*  
10          *tion on the request in writing within 60 days*  
11          *after the date such review panel receives the re-*  
12          *quest and such accompanying documents and*  
13          *materials. Such a determination by such review*  
14          *panel shall be considered a final decision and*  
15          *not subject to review by the Secretary.*

16                   “(C) ACCESS TO JUDICIAL REVIEW.—

17                           “(i) IN GENERAL.—If the appropriate  
18                   review panel—

19                                   “(I) determines that there are no  
20                                   material issues of fact in dispute and  
21                                   that the only issue is one of law or reg-  
22                                   ulation that no review panel has the  
23                                   authority to decide; or





1                   “(II) fails to make such deter-  
2                   mination within the period provided  
3                   under subparagraph (B);  
4                   then the appellant may bring a civil action  
5                   as described in this subparagraph.

6                   “(ii) DEADLINE FOR FILING.—Such  
7                   action shall be filed, in the case described  
8                   in—

9                   “(I) clause (i)(I), within 60 days  
10                  of date of the determination described  
11                  in such subparagraph; or

12                  “(II) clause (i)(II), within 60  
13                  days of the end of the period provided  
14                  under subparagraph (B) for the deter-  
15                  mination.

16                  “(iii) VENUE.—Such action shall be  
17                  brought in the district court of the United  
18                  States for the judicial district in which the  
19                  appellant is located (or, in the case of an  
20                  action brought jointly by more than one ap-  
21                  plicant, the judicial district in which the  
22                  greatest number of applicants are located)  
23                  or in the district court for the District of  
24                  Columbia.



1                   “(iv) *INTEREST ON AMOUNTS IN CON-*  
2                   *TROVERSY.—Where a provider of services or*  
3                   *supplier seeks judicial review pursuant to*  
4                   *this paragraph, the amount in controversy*  
5                   *shall be subject to annual interest beginning*  
6                   *on the first day of the first month beginning*  
7                   *after the 60-day period as determined pur-*  
8                   *suant to clause (ii) and equal to the rate of*  
9                   *interest on obligations issued for purchase*  
10                  *by the Federal Hospital Insurance Trust*  
11                  *Fund and by the Federal Supplementary*  
12                  *Medical Insurance Trust Fund for the*  
13                  *month in which the civil action authorized*  
14                  *under this paragraph is commenced, to be*  
15                  *awarded by the reviewing court in favor of*  
16                  *the prevailing party. No interest awarded*  
17                  *pursuant to the preceding sentence shall be*  
18                  *deemed income or cost for the purposes of*  
19                  *determining reimbursement due providers of*  
20                  *services or suppliers under this Act.*

21                  “(D) *REVIEW PANELS.—For purposes of*  
22                  *this subsection, a ‘review panel’ is a panel con-*  
23                  *sisting of 3 members (who shall be administra-*  
24                  *tive law judges, members of the Departmental*  
25                  *Appeals Board, or qualified individuals associ-*



1           *ated with a qualified independent contractor (as*  
2           *defined in subsection (c)(2)) or with another*  
3           *independent entity) designated by the Secretary*  
4           *for purposes of making determinations under*  
5           *this paragraph.”.*

6           *(b) APPLICATION TO PROVIDER AGREEMENT DETER-*  
7           *MINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1))*  
8           *is amended—*

9                     *(1) by inserting “(A)” after “(h)(1)”;* and

10                    *(2) by adding at the end the following new sub-*  
11            *paragraph:*

12            *“(B) An institution or agency described in subpara-*  
13            *graph (A) that has filed for a hearing under subparagraph*  
14            *(A) shall have expedited access to judicial review under this*  
15            *subparagraph in the same manner as providers of services,*  
16            *suppliers, and individuals entitled to benefits under part*  
17            *A or enrolled under part B, or both, may obtain expedited*  
18            *access to judicial review under the process established under*  
19            *section 1869(b)(2). Nothing in this subparagraph shall be*  
20            *construed to affect the application of any remedy imposed*  
21            *under section 1819 during the pendency of an appeal under*  
22            *this subparagraph.”.*

23            *(c) EFFECTIVE DATE.—The amendments made by this*  
24            *section shall apply to appeals filed on or after October 1,*  
25            *2004.*



1           (d) *EXPEDITED REVIEW OF CERTAIN PROVIDER*  
2 *AGREEMENT DETERMINATIONS.*—

3           (1) *TERMINATION AND CERTAIN OTHER IMME-*  
4 *DIATE REMEDIES.*—*The Secretary shall develop and*  
5 *implement a process to expedite proceedings under*  
6 *sections 1866(h) of the Social Security Act (42 U.S.C.*  
7 *1395cc(h)) in which the remedy of termination of*  
8 *participation, or a remedy described in clause (i) or*  
9 *(iii) of section 1819(h)(2)(B) of such Act (42 U.S.C.*  
10 *1395i-3(h)(2)(B)) which is applied on an immediate*  
11 *basis, has been imposed. Under such process priority*  
12 *shall be provided in cases of termination.*

13           (2) *INCREASED FINANCIAL SUPPORT.*—*In addi-*  
14 *tion to any amounts otherwise appropriated, to re-*  
15 *duce by 50 percent the average time for administra-*  
16 *tive determinations on appeals under section 1866(h)*  
17 *of the Social Security Act (42 U.S.C. 1395cc(h)),*  
18 *there are authorized to be appropriated (in appro-*  
19 *priate part from the Federal Hospital Insurance*  
20 *Trust Fund and the Federal Supplementary Medical*  
21 *Insurance Trust Fund) to the Secretary such addi-*  
22 *tional sums for fiscal year 2005 and each subsequent*  
23 *fiscal year as may be necessary. The purposes for*  
24 *which such amounts are available include increasing*  
25 *the number of administrative law judges (and their*



1        *staffs) and the appellate level staff at the Depart-*  
2        *mental Appeals Board of the Department of Health*  
3        *and Human Services and educating such judges and*  
4        *staffs on long-term care issues.*

5        **SEC. 933. REVISIONS TO MEDICARE APPEALS PROCESS.**

6        *(a) REQUIRING FULL AND EARLY PRESENTATION OF*  
7        *EVIDENCE.—*

8                *(1) IN GENERAL.—Section 1869(b) (42 U.S.C.*  
9                *1395ff(b)), as amended by BIPA and as amended by*  
10               *section 932(a), is further amended by adding at the*  
11               *end the following new paragraph:*

12                *“(3) REQUIRING FULL AND EARLY PRESEN-*  
13                *TATION OF EVIDENCE BY PROVIDERS.—A provider of*  
14                *services or supplier may not introduce evidence in*  
15                *any appeal under this section that was not presented*  
16                *at the reconsideration conducted by the qualified*  
17                *independent contractor under subsection (c), unless*  
18                *there is good cause which precluded the introduction*  
19                *of such evidence at or before that reconsideration.”.*

20                *(2) EFFECTIVE DATE.—The amendment made by*  
21                *paragraph (1) shall take effect on October 1, 2004.*

22                *(b) USE OF PATIENTS’ MEDICAL RECORDS.—Section*  
23                *1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended*  
24                *by BIPA, is amended by inserting “(including the medical*



1 *records of the individual involved)*” after “*clinical experi-*  
2 *ence*”.

3 (c) *NOTICE REQUIREMENTS FOR MEDICARE AP-*  
4 *PEALS.*—

5 (1) *INITIAL DETERMINATIONS AND REDETER-*  
6 *MINATIONS.*—*Section 1869(a) (42 U.S.C. 1395ff(a)),*  
7 *as amended by BIPA, is amended by adding at the*  
8 *end the following new paragraphs:*

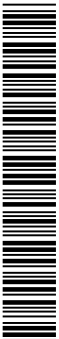
9 “(4) *REQUIREMENTS OF NOTICE OF DETERMINA-*  
10 *TIONS.*—*With respect to an initial determination in-*  
11 *sofar as it results in a denial of a claim for benefits—*

12 “(A) *the written notice on the determina-*  
13 *tion shall include—*

14 “(i) *the reasons for the determination,*  
15 *including whether a local medical review*  
16 *policy or a local coverage determination*  
17 *was used;*

18 “(ii) *the procedures for obtaining addi-*  
19 *tional information concerning the deter-*  
20 *mination, including the information de-*  
21 *scribed in subparagraph (B); and*

22 “(iii) *notification of the right to seek a*  
23 *redetermination or otherwise appeal the de-*  
24 *termination and instructions on how to ini-*



1           *tiate such a redetermination under this sec-*  
2           *tion; and*

3           “(B) *the person provided such notice may*  
4           *obtain, upon request, the specific provision of the*  
5           *policy, manual, or regulation used in making*  
6           *the determination.*

7           “(5) *REQUIREMENTS OF NOTICE OF REDETER-*  
8           *MINATIONS.—With respect to a redetermination inso-*  
9           *far as it results in a denial of a claim for benefits—*

10           “(A) *the written notice on the redetermina-*  
11           *tion shall include—*

12                   “(i) *the specific reasons for the redeter-*  
13                   *mination;*

14                   “(ii) *as appropriate, a summary of the*  
15                   *clinical or scientific evidence used in mak-*  
16                   *ing the redetermination;*

17                   “(iii) *a description of the procedures*  
18                   *for obtaining additional information con-*  
19                   *cerning the redetermination; and*

20                   “(iv) *notification of the right to appeal*  
21                   *the redetermination and instructions on*  
22                   *how to initiate such an appeal under this*  
23                   *section;*

24           “(B) *such written notice shall be provided*  
25           *in printed form and written in a manner cal-*



1           *culated to be understood by the individual enti-*  
2           *tled to benefits under part A or enrolled under*  
3           *part B, or both; and*

4           “(C) *the person provided such notice may*  
5           *obtain, upon request, information on the specific*  
6           *provision of the policy, manual, or regulation*  
7           *used in making the redetermination.”.*

8           (2) *RECONSIDERATIONS.—Section 1869(c)(3)(E)*  
9           *(42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is*  
10          *amended—*

11           (A) *by inserting “be written in a manner*  
12           *calculated to be understood by the individual en-*  
13           *titled to benefits under part A or enrolled under*  
14           *part B, or both, and shall include (to the extent*  
15           *appropriate)” after “in writing, ”; and*

16           (B) *by inserting “and a notification of the*  
17           *right to appeal such determination and instruc-*  
18           *tions on how to initiate such appeal under this*  
19           *section” after “such decision,”.*

20           (3) *APPEALS.—Section 1869(d) (42 U.S.C.*  
21           *1395ff(d)), as amended by BIPA, is amended—*

22           (A) *in the heading, by inserting “; NOTICE”*  
23           *after “SECRETARY”; and*

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





1           “(4) NOTICE.—Notice of the decision of an ad-  
2           ministrative law judge shall be in writing in a man-  
3           ner calculated to be understood by the individual en-  
4           titled to benefits under part A or enrolled under part  
5           B, or both, and shall include—

6                   “(A) the specific reasons for the determina-  
7                   tion (including, to the extent appropriate, a  
8                   summary of the clinical or scientific evidence  
9                   used in making the determination);

10                   “(B) the procedures for obtaining addi-  
11                   tional information concerning the decision; and

12                   “(C) notification of the right to appeal the  
13                   decision and instructions on how to initiate such  
14                   an appeal under this section.”.

15           (4) SUBMISSION OF RECORD FOR APPEAL.—Sec-  
16           tion 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by  
17           striking “prepare” and inserting “submit” and by  
18           striking “with respect to” and all that follows through  
19           “and relevant policies”.

20           (d) QUALIFIED INDEPENDENT CONTRACTORS.—

21                   (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED  
22                   INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42  
23                   U.S.C. 1395ff(c)(3)), as amended by BIPA, is  
24                   amended—



1           (A) in subparagraph (A), by striking “suffi-  
2           cient training and expertise in medical science  
3           and legal matters” and inserting “sufficient  
4           medical, legal, and other expertise (including  
5           knowledge of the program under this title) and  
6           sufficient staffing”; and

7           (B) by adding at the end the following new  
8           subparagraph:

9           “(K) INDEPENDENCE REQUIREMENTS.—

10           “(i) IN GENERAL.—Subject to clause  
11           (ii), a qualified independent contractor  
12           shall not conduct any activities in a case  
13           unless the entity—

14           “(I) is not a related party (as de-  
15           fined in subsection (g)(5));

16           “(II) does not have a material fa-  
17           miliar, financial, or professional rela-  
18           tionship with such a party in relation  
19           to such case; and

20           “(III) does not otherwise have a  
21           conflict of interest with such a party.

22           “(ii) EXCEPTION FOR REASONABLE  
23           COMPENSATION.—Nothing in clause (i) shall  
24           be construed to prohibit receipt by a quali-  
25           fied independent contractor of compensation



1                   *from the Secretary for the conduct of activi-*  
2                   *ties under this section if the compensation*  
3                   *is provided consistent with clause (iii).*

4                   “(iii) *LIMITATIONS ON ENTITY COM-*  
5                   *PENSATION.—Compensation provided by the*  
6                   *Secretary to a qualified independent con-*  
7                   *tractor in connection with reviews under*  
8                   *this section shall not be contingent on any*  
9                   *decision rendered by the contractor or by*  
10                  *any reviewing professional.”.*

11                  (2) *ELIGIBILITY REQUIREMENTS FOR REVIEW-*  
12                  *ERS.—Section 1869 (42 U.S.C. 1395ff), as amended*  
13                  *by BIPA, is amended—*

14                         (A) *by amending subsection (c)(3)(D) to*  
15                         *read as follows:*

16                                 “(D) *QUALIFICATIONS FOR REVIEWERS.—*  
17                                 *The requirements of subsection (g) shall be met*  
18                                 *(relating to qualifications of reviewing profes-*  
19                                 *sionals).”; and*

20                                 (B) *by adding at the end the following new*  
21                                 *subsection:*

22   “(g) *QUALIFICATIONS OF REVIEWERS.—*

23   “(1) *IN GENERAL.—In reviewing determinations*  
24   *under this section, a qualified independent contractor*  
25   *shall assure that—*



1           “(A) each individual conducting a review  
2 shall meet the qualifications of paragraph (2);

3           “(B) compensation provided by the con-  
4 tractor to each such reviewer is consistent with  
5 paragraph (3); and

6           “(C) in the case of a review by a panel de-  
7 scribed in subsection (c)(3)(B) composed of phy-  
8 sicians or other health care professionals (each in  
9 this subsection referred to as a ‘reviewing profes-  
10 sional’), a reviewing professional meets the  
11 qualifications described in paragraph (4) and,  
12 where a claim is regarding the furnishing of  
13 treatment by a physician (allopathic or osteo-  
14 pathic) or the provision of items or services by  
15 a physician (allopathic or osteopathic), a review-  
16 ing professional shall be a physician (allopathic  
17 or osteopathic).

18           “(2) INDEPENDENCE.—

19           “(A) IN GENERAL.—Subject to subpara-  
20 graph (B), each individual conducting a review  
21 in a case shall—

22                   “(i) not be a related party (as defined  
23                   in paragraph (5));



1           “(ii) not have a material familial, fi-  
2           nancial, or professional relationship with  
3           such a party in the case under review; and

4           “(iii) not otherwise have a conflict of  
5           interest with such a party.

6           “(B) *EXCEPTION.*—Nothing in subpara-  
7           graph (A) shall be construed to—

8           “(i) prohibit an individual, solely on  
9           the basis of a participation agreement with  
10          a fiscal intermediary, carrier, or other con-  
11          tractor, from serving as a reviewing profes-  
12          sional if—

13               “(I) the individual is not involved  
14               in the provision of items or services in  
15               the case under review;

16               “(II) the fact of such an agree-  
17               ment is disclosed to the Secretary and  
18               the individual entitled to benefits  
19               under part A or enrolled under part B,  
20               or both, (or authorized representative)  
21               and neither party objects; and

22               “(III) the individual is not an  
23               employee of the intermediary, carrier,  
24               or contractor and does not provide  
25               services exclusively or primarily to or



1                    *on behalf of such intermediary, carrier,*  
2                    *or contractor;*

3                    *“(ii) prohibit an individual who has*  
4                    *staff privileges at the institution where the*  
5                    *treatment involved takes place from serving*  
6                    *as a reviewer merely on the basis of having*  
7                    *such staff privileges if the existence of such*  
8                    *privileges is disclosed to the Secretary and*  
9                    *such individual (or authorized representa-*  
10                   *tive), and neither party objects; or*

11                   *“(iii) prohibit receipt of compensation*  
12                   *by a reviewing professional from a con-*  
13                   *tractor if the compensation is provided con-*  
14                   *sistent with paragraph (3).*

15                   *For purposes of this paragraph, the term ‘par-*  
16                   *ticipation agreement’ means an agreement relat-*  
17                   *ing to the provision of health care services by the*  
18                   *individual and does not include the provision of*  
19                   *services as a reviewer under this subsection.*

20                   *“(3) LIMITATIONS ON REVIEWER COMPENSA-*  
21                   *TION.—Compensation provided by a qualified inde-*  
22                   *pendent contractor to a reviewer in connection with*  
23                   *a review under this section shall not be contingent on*  
24                   *the decision rendered by the reviewer.*



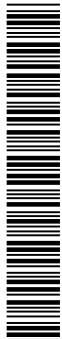
1           “(4) *LICENSURE AND EXPERTISE.*—*Each review-*  
2           *ing professional shall be—*

3                   “(A) *a physician (allopathic or osteopathic)*  
4                   *who is appropriately credentialed or licensed in*  
5                   *one or more States to deliver health care services*  
6                   *and has medical expertise in the field of practice*  
7                   *that is appropriate for the items or services at*  
8                   *issue; or*

9                   “(B) *a health care professional who is le-*  
10                   *gally authorized in one or more States (in ac-*  
11                   *cordance with State law or the State regulatory*  
12                   *mechanism provided by State law) to furnish the*  
13                   *health care items or services at issue and has*  
14                   *medical expertise in the field of practice that is*  
15                   *appropriate for such items or services.*

16           “(5) *RELATED PARTY DEFINED.*—*For purposes*  
17           *of this section, the term ‘related party’ means, with*  
18           *respect to a case under this title involving a specific*  
19           *individual entitled to benefits under part A or en-*  
20           *rolled under part B, or both, any of the following:*

21                   “(A) *The Secretary, the medicare adminis-*  
22                   *trative contractor involved, or any fiduciary, of-*  
23                   *ficer, director, or employee of the Department of*  
24                   *Health and Human Services, or of such con-*  
25                   *tractor.*



1           “(B) *The individual (or authorized rep-*  
2           *resentative).*”

3           “(C) *The health care professional that pro-*  
4           *vides the items or services involved in the case.*”

5           “(D) *The institution at which the items or*  
6           *services (or treatment) involved in the case are*  
7           *provided.*”

8           “(E) *The manufacturer of any drug or*  
9           *other item that is included in the items or serv-*  
10          *ices involved in the case.*”

11          “(F) *Any other party determined under any*  
12          *regulations to have a substantial interest in the*  
13          *case involved.*”.

14          (3) *REDUCING MINIMUM NUMBER OF QUALIFIED*  
15          *INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42*  
16          *U.S.C. 1395ff(c)(4)) is amended by striking “not*  
17          *fewer than 12 qualified independent contractors under*  
18          *this subsection” and inserting “with a sufficient num-*  
19          *ber of qualified independent contractors (but not*  
20          *fewer than 4 such contractors) to conduct reconsider-*  
21          *ations consistent with the timeframes applicable*  
22          *under this subsection”.*

23          (4) *EFFECTIVE DATE.—The amendments made*  
24          *by paragraphs (1) and (2) shall be effective as if in-*





1 *cluded in the enactment of the respective provisions of*  
2 *subtitle C of title V of BIPA, (114 Stat. 2763A–534).*

3 *(5) TRANSITION.—In applying section 1869(g) of*  
4 *the Social Security Act (as added by paragraph (2)),*  
5 *any reference to a medicare administrative contractor*  
6 *shall be deemed to include a reference to a fiscal*  
7 *intermediary under section 1816 of the Social Secu-*  
8 *rity Act (42 U.S.C. 1395h) and a carrier under sec-*  
9 *tion 1842 of such Act (42 U.S.C. 1395u).*

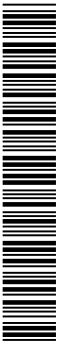
10 **SEC. 934. PREPAYMENT REVIEW.**

11 *(a) IN GENERAL.—Section 1874A, as added by section*  
12 *911(a)(1) and as amended by sections 912(b), 921(b)(1),*  
13 *and 921(c)(1), is further amended by adding at the end the*  
14 *following new subsection:*

15 *“(h) CONDUCT OF PREPAYMENT REVIEW.—*

16 *“(1) CONDUCT OF RANDOM PREPAYMENT RE-*  
17 *VIEW.—*

18 *“(A) IN GENERAL.—A medicare adminis-*  
19 *trative contractor may conduct random prepay-*  
20 *ment review only to develop a contractor-wide or*  
21 *program-wide claims payment error rates or*  
22 *under such additional circumstances as may be*  
23 *provided under regulations, developed in con-*  
24 *sultation with providers of services and sup-*  
25 *pliers.*



1           “(B) *USE OF STANDARD PROTOCOLS WHEN*  
2           *CONDUCTING PREPAYMENT REVIEWS.*—When a  
3           *medicare administrative contractor conducts a*  
4           *random prepayment review, the contractor may*  
5           *conduct such review only in accordance with a*  
6           *standard protocol for random prepayment audits*  
7           *developed by the Secretary.*

8           “(C) *CONSTRUCTION.*—Nothing in this  
9           *paragraph shall be construed as preventing the*  
10          *denial of payments for claims actually reviewed*  
11          *under a random prepayment review.*

12          “(D) *RANDOM PREPAYMENT REVIEW.*—For  
13          *purposes of this subsection, the term ‘random*  
14          *prepayment review’ means a demand for the*  
15          *production of records or documentation absent*  
16          *cause with respect to a claim.*

17          “(2) *LIMITATIONS ON NON-RANDOM PREPAYMENT*  
18          *REVIEW.*—

19                 “(A) *LIMITATIONS ON INITIATION OF NON-*  
20                 *RANDOM PREPAYMENT REVIEW.*—A *medicare ad-*  
21                 *ministrative contractor may not initiate non-*  
22                 *random prepayment review of a provider of serv-*  
23                 *ices or supplier based on the initial identifica-*  
24                 *tion by that provider of services or supplier of*  
25                 *an improper billing practice unless there is a*



1           *likelihood of sustained or high level of payment*  
2           *error (as defined in subsection (i)(3)(A)).*

3           “(B) *TERMINATION OF NON-RANDOM PRE-*  
4           *PAYMENT REVIEW.—The Secretary shall issue*  
5           *regulations relating to the termination, includ-*  
6           *ing termination dates, of non-random prepay-*  
7           *ment review. Such regulations may vary such a*  
8           *termination date based upon the differences in*  
9           *the circumstances triggering prepayment re-*  
10          *view.”.*

11          ***(b) EFFECTIVE DATE.—***

12           ***(1) IN GENERAL.—Except as provided in this***  
13           ***subsection, the amendment made by subsection (a)***  
14           ***shall take effect 1 year after the date of the enactment***  
15           ***of this Act.***

16           ***(2) DEADLINE FOR PROMULGATION OF CERTAIN***  
17           ***REGULATIONS.—The Secretary shall first issue regula-***  
18           ***tions under section 1874A(h) of the Social Security***  
19           ***Act, as added by subsection (a), by not later than 1***  
20           ***year after the date of the enactment of this Act.***

21           ***(3) APPLICATION OF STANDARD PROTOCOLS FOR***  
22           ***RANDOM           PREPAYMENT           REVIEW.—Section***  
23           ***1874A(h)(1)(B) of the Social Security Act, as added***  
24           ***by subsection (a), shall apply to random prepayment***  
25           ***reviews conducted on or after such date (not later***



1       *than 1 year after the date of the enactment of this*  
2       *Act) as the Secretary shall specify.*

3       (c) *APPLICATION TO FISCAL INTERMEDIARIES AND*  
4 *CARRIERS.—The provisions of section 1874A(h) of the So-*  
5 *cial Security Act, as added by subsection (a), shall apply*  
6 *to each fiscal intermediary under section 1816 of the Social*  
7 *Security Act (42 U.S.C. 1395h) and each carrier under sec-*  
8 *tion 1842 of such Act (42 U.S.C. 1395u) in the same man-*  
9 *ner as they apply to medicare administrative contractors*  
10 *under such provisions.*

11 **SEC. 935. RECOVERY OF OVERPAYMENTS.**

12       (a) *IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd)*  
13 *is amended by adding at the end the following new sub-*  
14 *section:*

15       “(f) *RECOVERY OF OVERPAYMENTS.—*

16               “(1) *USE OF REPAYMENT PLANS.—*

17                       “(A) *IN GENERAL.—If the repayment, with-*  
18 *in 30 days by a provider of services or supplier,*  
19 *of an overpayment under this title would con-*  
20 *stitute a hardship (as defined in subparagraph*  
21 *(B)), subject to subparagraph (C), upon request*  
22 *of the provider of services or supplier the Sec-*  
23 *retary shall enter into a plan with the provider*  
24 *of services or supplier for the repayment*  
25 *(through offset or otherwise) of such overpayment*



1           *over a period of at least 6 months but not longer*  
2           *than 3 years (or not longer than 5 years in the*  
3           *case of extreme hardship, as determined by the*  
4           *Secretary). Interest shall accrue on the balance*  
5           *through the period of repayment. Such plan shall*  
6           *meet terms and conditions determined to be ap-*  
7           *propriate by the Secretary.*

8                   “(B) *HARDSHIP.*—

9                           “(i) *IN GENERAL.*—*For purposes of*  
10                           *subparagraph (A), the repayment of an*  
11                           *overpayment (or overpayments) within 30*  
12                           *days is deemed to constitute a hardship if—*

13                                   “(I) *in the case of a provider of*  
14                                   *services that files cost reports, the ag-*  
15                                   *gregate amount of the overpayments*  
16                                   *exceeds 10 percent of the amount paid*  
17                                   *under this title to the provider of serv-*  
18                                   *ices for the cost reporting period cov-*  
19                                   *ered by the most recently submitted*  
20                                   *cost report; or*

21                                   “(II) *in the case of another pro-*  
22                                   *vider of services or supplier, the aggre-*  
23                                   *gate amount of the overpayments ex-*  
24                                   *ceeds 10 percent of the amount paid*  
25                                   *under this title to the provider of serv-*



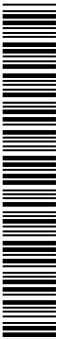
1                   ices or supplier for the previous cal-  
2                   endar year.

3                   “(ii) *RULE OF APPLICATION.*—*The*  
4                   *Secretary shall establish rules for the appli-*  
5                   *cation of this subparagraph in the case of a*  
6                   *provider of services or supplier that was not*  
7                   *paid under this title during the previous*  
8                   *year or was paid under this title only dur-*  
9                   *ing a portion of that year.*

10                   “(iii) *TREATMENT OF PREVIOUS OVER-*  
11                   *PAYMENTS.*—*If a provider of services or*  
12                   *supplier has entered into a repayment plan*  
13                   *under subparagraph (A) with respect to a*  
14                   *specific overpayment amount, such payment*  
15                   *amount under the repayment plan shall not*  
16                   *be taken into account under clause (i) with*  
17                   *respect to subsequent overpayment amounts.*

18                   “(C) *EXCEPTIONS.*—*Subparagraph (A)*  
19                   *shall not apply if—*

20                   “(i) *the Secretary has reason to suspect*  
21                   *that the provider of services or supplier*  
22                   *may file for bankruptcy or otherwise cease*  
23                   *to do business or discontinue participation*  
24                   *in the program under this title; or*



1                   “(ii) there is an indication of fraud or  
2                   abuse committed against the program.

3                   “(D) IMMEDIATE COLLECTION IF VIOLATION  
4                   OF REPAYMENT PLAN.—If a provider of services  
5                   or supplier fails to make a payment in accord-  
6                   ance with a repayment plan under this para-  
7                   graph, the Secretary may immediately seek to  
8                   offset or otherwise recover the total balance out-  
9                   standing (including applicable interest) under  
10                  the repayment plan.

11                  “(E) RELATION TO NO FAULT PROVISION.—  
12                  Nothing in this paragraph shall be construed as  
13                  affecting the application of section 1870(c) (re-  
14                  lating to no adjustment in the cases of certain  
15                  overpayments).

16                  “(2) LIMITATION ON RECOUPMENT.—

17                  “(A) IN GENERAL.—In the case of a pro-  
18                  vider of services or supplier that is determined to  
19                  have received an overpayment under this title  
20                  and that seeks a reconsideration by a qualified  
21                  independent contractor on such determination  
22                  under section 1869(b)(1), the Secretary may not  
23                  take any action (or authorize any other person,  
24                  including any medicare contractor, as defined in  
25                  subparagraph (C)) to recoup the overpayment



1           *until the date the decision on the reconsideration*  
2           *has been rendered. If the provisions of section*  
3           *1869(b)(1) (providing for such a reconsideration*  
4           *by a qualified independent contractor) are not in*  
5           *effect, in applying the previous sentence any ref-*  
6           *erence to such a reconsideration shall be treated*  
7           *as a reference to a redetermination by the fiscal*  
8           *intermediary or carrier involved.*

9           “(B) *COLLECTION WITH INTEREST.—Inso-*  
10          *far as the determination on such appeal is*  
11          *against the provider of services or supplier, in-*  
12          *terest on the overpayment shall accrue on and*  
13          *after the date of the original notice of overpay-*  
14          *ment. Insofar as such determination against the*  
15          *provider of services or supplier is later reversed,*  
16          *the Secretary shall provide for repayment of the*  
17          *amount recouped plus interest at the same rate*  
18          *as would apply under the previous sentence for*  
19          *the period in which the amount was recouped.*

20          “(C) *MEDICARE CONTRACTOR DEFINED.—*  
21          *For purposes of this subsection, the term ‘medi-*  
22          *care contractor’ has the meaning given such term*  
23          *in section 1889(g).*

24          “(3) *LIMITATION ON USE OF EXTRAPOLATION.—*  
25          *A medicare contractor may not use extrapolation to*





1 *determine overpayment amounts to be recovered by*  
2 *recoupment, offset, or otherwise unless—*

3 *“(A) there is a sustained or high level of*  
4 *payment error (as defined by the Secretary by*  
5 *regulation); or*

6 *“(B) documented educational intervention*  
7 *has failed to correct the payment error (as deter-*  
8 *mined by the Secretary).*

9 *“(4) PROVISION OF SUPPORTING DOCUMENTA-*  
10 *TION.—In the case of a provider of services or sup-*  
11 *plier with respect to which amounts were previously*  
12 *overpaid, a medicare contractor may request the peri-*  
13 *odic production of records or supporting documenta-*  
14 *tion for a limited sample of submitted claims to en-*  
15 *sure that the previous practice is not continuing.*

16 *“(5) CONSENT SETTLEMENT REFORMS.—*

17 *“(A) IN GENERAL.—The Secretary may use*  
18 *a consent settlement (as defined in subparagraph*  
19 *(D)) to settle a projected overpayment.*

20 *“(B) OPPORTUNITY TO SUBMIT ADDITIONAL*  
21 *INFORMATION BEFORE CONSENT SETTLEMENT*  
22 *OFFER.—Before offering a provider of services or*  
23 *supplier a consent settlement, the Secretary*  
24 *shall—*



1                   “(i) communicate to the provider of  
2 services or supplier—

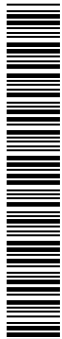
3                   “(I) that, based on a review of the  
4 medical records requested by the Sec-  
5 retary, a preliminary evaluation of  
6 those records indicates that there would  
7 be an overpayment;

8                   “(II) the nature of the problems  
9 identified in such evaluation; and

10                  “(III) the steps that the provider  
11 of services or supplier should take to  
12 address the problems; and

13                  “(ii) provide for a 45-day period dur-  
14 ing which the provider of services or sup-  
15 plier may furnish additional information  
16 concerning the medical records for the  
17 claims that had been reviewed.

18                  “(C) CONSENT SETTLEMENT OFFER.—The  
19 Secretary shall review any additional informa-  
20 tion furnished by the provider of services or sup-  
21 plier under subparagraph (B)(ii). Taking into  
22 consideration such information, the Secretary  
23 shall determine if there still appears to be an  
24 overpayment. If so, the Secretary—



1           “(i) shall provide notice of such deter-  
2           mination to the provider of services or sup-  
3           plier, including an explanation of the rea-  
4           son for such determination; and

5           “(ii) in order to resolve the overpay-  
6           ment, may offer the provider of services or  
7           supplier—

8                   “(I) the opportunity for a statis-  
9                   tically valid random sample; or

10                   “(II) a consent settlement.

11           *The opportunity provided under clause (ii)(I)*  
12           *does not waive any appeal rights with respect to*  
13           *the alleged overpayment involved.*

14           “(D) CONSENT SETTLEMENT DEFINED.—

15           *For purposes of this paragraph, the term ‘con-*  
16           *sent settlement’ means an agreement between the*  
17           *Secretary and a provider of services or supplier*  
18           *whereby both parties agree to settle a projected*  
19           *overpayment based on less than a statistically*  
20           *valid sample of claims and the provider of serv-*  
21           *ices or supplier agrees not to appeal the claims*  
22           *involved.*

23           “(6) NOTICE OF OVER-UTILIZATION OF CODES.—

24           *The Secretary shall establish, in consultation with or-*  
25           *ganizations representing the classes of providers of*



1        *services and suppliers, a process under which the Sec-*  
2        *retary provides for notice to classes of providers of*  
3        *services and suppliers served by the contractor in*  
4        *cases in which the contractor has identified that par-*  
5        *ticular billing codes may be overutilized by that class*  
6        *of providers of services or suppliers under the pro-*  
7        *grams under this title (or provisions of title XI inso-*  
8        *far as they relate to such programs).*

9                *“(7) PAYMENT AUDITS.—*

10                *“(A) WRITTEN NOTICE FOR POST-PAYMENT*  
11                *AUDITS.—Subject to subparagraph (C), if a*  
12                *medicare contractor decides to conduct a post-*  
13                *payment audit of a provider of services or sup-*  
14                *plier under this title, the contractor shall provide*  
15                *the provider of services or supplier with written*  
16                *notice (which may be in electronic form) of the*  
17                *intent to conduct such an audit.*

18                *“(B) EXPLANATION OF FINDINGS FOR ALL*  
19                *AUDITS.—Subject to subparagraph (C), if a*  
20                *medicare contractor audits a provider of services*  
21                *or supplier under this title, the contractor*  
22                *shall—*

23                *“(i) give the provider of services or*  
24                *supplier a full review and explanation of*  
25                *the findings of the audit in a manner that*



1           *is understandable to the provider of services*  
2           *or supplier and permits the development of*  
3           *an appropriate corrective action plan;*

4           “(ii) *inform the provider of services or*  
5           *supplier of the appeal rights under this title*  
6           *as well as consent settlement options (which*  
7           *are at the discretion of the Secretary);*

8           “(iii) *give the provider of services or*  
9           *supplier an opportunity to provide addi-*  
10          *tional information to the contractor; and*

11          “(iv) *take into account information*  
12          *provided, on a timely basis, by the provider*  
13          *of services or supplier under clause (iii).*

14          “(C) *EXCEPTION.—Subparagraphs (A) and*  
15          *(B) shall not apply if the provision of notice or*  
16          *findings would compromise pending law enforce-*  
17          *ment activities, whether civil or criminal, or re-*  
18          *veal findings of law enforcement-related audits.*

19          “(8) *STANDARD METHODOLOGY FOR PROBE SAM-*  
20          *PLING.—The Secretary shall establish a standard*  
21          *methodology for medicare contractors to use in select-*  
22          *ing a sample of claims for review in the case of an*  
23          *abnormal billing pattern.”.*

24          “(b) *EFFECTIVE DATES AND DEADLINES.—*



1           (1) *USE OF REPAYMENT PLANS.*—Section  
2           1893(f)(1) of the Social Security Act, as added by  
3           subsection (a), shall apply to requests for repayment  
4           plans made after the date of the enactment of this Act.

5           (2) *LIMITATION ON RECOUPMENT.*—Section  
6           1893(f)(2) of the Social Security Act, as added by  
7           subsection (a), shall apply to actions taken after the  
8           date of the enactment of this Act.

9           (3) *USE OF EXTRAPOLATION.*—Section  
10          1893(f)(3) of the Social Security Act, as added by  
11          subsection (a), shall apply to statistically valid ran-  
12          dom samples initiated after the date that is 1 year  
13          after the date of the enactment of this Act.

14          (4) *PROVISION OF SUPPORTING DOCUMENTA-*  
15          *TION.*—Section 1893(f)(4) of the Social Security Act,  
16          as added by subsection (a), shall take effect on the  
17          date of the enactment of this Act.

18          (5) *CONSENT SETTLEMENT.*—Section 1893(f)(5)  
19          of the Social Security Act, as added by subsection (a),  
20          shall apply to consent settlements entered into after  
21          the date of the enactment of this Act.

22          (6) *NOTICE OF OVERUTILIZATION.*—Not later  
23          than 1 year after the date of the enactment of this  
24          Act, the Secretary shall first establish the process for  
25          notice of overutilization of billing codes under section



1       1893A(f)(6) of the Social Security Act, as added by  
2       subsection (a).

3               (7) *PAYMENT AUDITS.*—Section 1893A(f)(7) of  
4       the Social Security Act, as added by subsection (a),  
5       shall apply to audits initiated after the date of the  
6       enactment of this Act.

7               (8) *STANDARD FOR ABNORMAL BILLING PAT-*  
8       *TERNS.*—Not later than 1 year after the date of the  
9       enactment of this Act, the Secretary shall first estab-  
10      lish a standard methodology for selection of sample  
11      claims for abnormal billing patterns under section  
12      1893(f)(8) of the Social Security Act, as added by  
13      subsection (a).

14   **SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF AP-**  
15                                    **PEAL.**

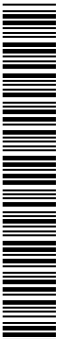
16       (a) *IN GENERAL.*—Section 1866 (42 U.S.C. 1395cc)  
17      is amended—

18               (1) by adding at the end of the heading the fol-  
19      lowing: “; *ENROLLMENT PROCESSES*”; and

20               (2) by adding at the end the following new sub-  
21      section:

22               “(j) *ENROLLMENT PROCESS FOR PROVIDERS OF SERV-*  
23      *ICES AND SUPPLIERS.*—

24               “(1) *ENROLLMENT PROCESS.*—



1           “(A) *IN GENERAL.*—*The Secretary shall es-*  
2           *tablish by regulation a process for the enrollment*  
3           *of providers of services and suppliers under this*  
4           *title.*

5           “(B) *DEADLINES.*—*The Secretary shall es-*  
6           *tablish by regulation procedures under which*  
7           *there are deadlines for actions on applications*  
8           *for enrollment (and, if applicable, renewal of en-*  
9           *rollment). The Secretary shall monitor the per-*  
10          *formance of medicare administrative contractors*  
11          *in meeting the deadlines established under this*  
12          *subparagraph.*

13          “(C) *CONSULTATION BEFORE CHANGING*  
14          *PROVIDER ENROLLMENT FORMS.*—*The Secretary*  
15          *shall consult with providers of services and sup-*  
16          *pliers before making changes in the provider en-*  
17          *rollment forms required of such providers and*  
18          *suppliers to be eligible to submit claims for*  
19          *which payment may be made under this title.*

20          “(2) *HEARING RIGHTS IN CASES OF DENIAL OR*  
21          *NON-RENEWAL.*—*A provider of services or supplier*  
22          *whose application to enroll (or, if applicable, to renew*  
23          *enrollment) under this title is denied may have a*  
24          *hearing and judicial review of such denial under the*  
25          *procedures that apply under subsection (h)(1)(A) to a*





1        *provider of services that is dissatisfied with a deter-*  
2        *mination by the Secretary.”.*

3        *(b) EFFECTIVE DATES.—*

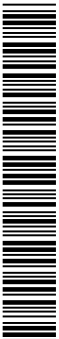
4            *(1) ENROLLMENT PROCESS.—The Secretary shall*  
5        *provide for the establishment of the enrollment process*  
6        *under section 1866(j)(1) of the Social Security Act, as*  
7        *added by subsection (a)(2), within 6 months after the*  
8        *date of the enactment of this Act.*

9            *(2) CONSULTATION.—Section 1866(j)(1)(C) of*  
10        *the Social Security Act, as added by subsection*  
11        *(a)(2), shall apply with respect to changes in provider*  
12        *enrollment forms made on or after January 1, 2004.*

13            *(3) HEARING RIGHTS.—Section 1866(j)(2) of the*  
14        *Social Security Act, as added by subsection (a)(2),*  
15        *shall apply to denials occurring on or after such date*  
16        *(not later than 1 year after the date of the enactment*  
17        *of this Act) as the Secretary specifies.*

18        **SEC. 937. PROCESS FOR CORRECTION OF MINOR ERRORS**  
19                            **AND OMISSIONS WITHOUT PURSUING AP-**  
20                            **PEALS PROCESS.**

21            *(a) CLAIMS.—The Secretary shall develop, in consulta-*  
22        *tion with appropriate medicare contractors (as defined in*  
23        *section 1889(g) of the Social Security Act, as inserted by*  
24        *section 301(a)(1)) and representatives of providers of serv-*  
25        *ices and suppliers, a process whereby, in the case of minor*



1 *errors or omissions (as defined by the Secretary) that are*  
2 *detected in the submission of claims under the programs*  
3 *under title XVIII of such Act, a provider of services or sup-*  
4 *plier is given an opportunity to correct such an error or*  
5 *omission without the need to initiate an appeal. Such proc-*  
6 *ess shall include the ability to resubmit corrected claims.*

7 (b) *PERMITTING USE OF CORRECTED AND SUPPLE-*  
8 *MENTARY DATA.—*

9 (1) *IN GENERAL.—Section 1886(d)(10)(D)(vi)*  
10 *(42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by*  
11 *adding after subclause (II) at the end the following:*  
12 *“Notwithstanding subclause (I), a hospital may submit,*  
13 *and the Secretary may accept upon verification, data that*  
14 *corrects or supplements the data described in such subclause*  
15 *without regard to whether the corrected or supplementary*  
16 *data relate to a cost report that has been settled.”.*

17 (2) *EFFECTIVE DATE.—The amendment made by*  
18 *paragraph (1) shall apply to fiscal years beginning*  
19 *with fiscal year 2004.*

20 (3) *SUBMITTAL AND RESUBMITTAL OF APPLICA-*  
21 *TIONS PERMITTED FOR FISCAL YEAR 2004.—*

22 (A) *IN GENERAL.—Notwithstanding any*  
23 *other provision of law, a hospital may submit*  
24 *(or resubmit) an application for a change de-*  
25 *scribed in section 1886(d)(10)(C)(i)(II) of the*



1           *Social Security Act for fiscal year 2004 if the*  
2           *hospital demonstrates on a timely basis to the*  
3           *satisfaction of the Secretary that the use of cor-*  
4           *rected or supplementary data under the amend-*  
5           *ment made by paragraph (1) would materially*  
6           *affect the approval of such an application.*

7                   (B) *APPLICATION OF BUDGET NEU-*  
8           *TRALITY.—If one or more hospital’s applications*  
9           *are approved as a result of paragraph (1) and*  
10          *subparagraph (A) for fiscal year 2004, the Sec-*  
11          *retary shall make a proportional adjustment in*  
12          *the standardized amounts determined under sec-*  
13          *tion 1886(d)(3) of the Social Security Act (42*  
14          *U.S.C. 1395ww(d)(3)) for fiscal year 2004 to as-*  
15          *sure that approval of such applications does not*  
16          *result in aggregate payments under section*  
17          *1886(d) of such Act that are greater or less than*  
18          *those that would otherwise be made if paragraph*  
19          *(1) and subparagraph (A) did not apply.*

20 **SEC. 938. PRIOR DETERMINATION PROCESS FOR CERTAIN**  
21                   **ITEMS AND SERVICES; ADVANCE BENE-**  
22                   **FICIARY NOTICES.**

23           (a) *IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)),*  
24           *as amended by sections 521 and 522 of BIPA and section*



1 933(d)(2)(B), is further amended by adding at the end the  
2 following new subsection:

3 “(h) *PRIOR DETERMINATION PROCESS FOR CERTAIN*  
4 *ITEMS AND SERVICES.*—

5 “(1) *ESTABLISHMENT OF PROCESS.*—

6 “(A) *IN GENERAL.*—With respect to a medi-  
7 care administrative contractor that has a con-  
8 tract under section 1874A that provides for mak-  
9 ing payments under this title with respect to eli-  
10 gible items and services described in subpara-  
11 graph (C), the Secretary shall establish a prior  
12 determination process that meets the require-  
13 ments of this subsection and that shall be applied  
14 by such contractor in the case of eligible request-  
15 ers.

16 “(B) *ELIGIBLE REQUESTER.*—For purposes  
17 of this subsection, each of the following shall be  
18 an eligible requester:

19 “(i) *A physician, but only with respect*  
20 *to eligible items and services for which the*  
21 *physician may be paid directly.*

22 “(ii) *An individual entitled to benefits*  
23 *under this title, but only with respect to an*  
24 *item or service for which the individual re-*  
25 *ceives, from the physician who may be paid*



1                   *directly for the item or service, an advance*  
2                   *beneficiary notice under section 1879(a)*  
3                   *that payment may not be made (or may no*  
4                   *longer be made) for the item or service*  
5                   *under this title.*

6                   “(C) *ELIGIBLE ITEMS AND SERVICES.*—*For*  
7                   *purposes of this subsection and subject to para-*  
8                   *graph (2), eligible items and services are items*  
9                   *and services which are physicians’ services (as*  
10                   *defined in paragraph (4)(A) of section 1848(f)*  
11                   *for purposes of calculating the sustainable*  
12                   *growth rate under such section).*

13                   “(2) *SECRETARIAL FLEXIBILITY.*—*The Secretary*  
14                   *shall establish by regulation reasonable limits on the*  
15                   *categories of eligible items and services for which a*  
16                   *prior determination of coverage may be requested*  
17                   *under this subsection. In establishing such limits, the*  
18                   *Secretary may consider the dollar amount involved*  
19                   *with respect to the item or service, administrative*  
20                   *costs and burdens, and other relevant factors.*

21                   “(3) *REQUEST FOR PRIOR DETERMINATION.*—

22                   “(A) *IN GENERAL.*—*Subject to paragraph*  
23                   *(2), under the process established under this sub-*  
24                   *section an eligible requester may submit to the*  
25                   *contractor a request for a determination, before*



1           *the furnishing of an eligible item or service in-*  
2           *volved as to whether the item or service is cov-*  
3           *ered under this title consistent with the applica-*  
4           *ble requirements of section 1862(a)(1)(A) (relat-*  
5           *ing to medical necessity).*

6           “(B) *ACCOMPANYING DOCUMENTATION.*—  
7           *The Secretary may require that the request be*  
8           *accompanied by a description of the item or*  
9           *service, supporting documentation relating to the*  
10           *medical necessity for the item or service, and*  
11           *any other appropriate documentation. In the*  
12           *case of a request submitted by an eligible re-*  
13           *quester who is described in paragraph (1)(B)(ii),*  
14           *the Secretary may require that the request also*  
15           *be accompanied by a copy of the advance bene-*  
16           *ficiary notice involved.*

17           “(4) *RESPONSE TO REQUEST.*—

18           “(A) *IN GENERAL.*—*Under such process, the*  
19           *contractor shall provide the eligible requester*  
20           *with written notice of a determination as to*  
21           *whether—*

22                           “(i) *the item or service is so covered;*

23                           “(ii) *the item or service is not so cov-*  
24                           *ered; or*



1                   “(iii) the contractor lacks sufficient in-  
2                   formation to make a coverage determina-  
3                   tion.

4                   If the contractor makes the determination de-  
5                   scribed in clause (iii), the contractor shall in-  
6                   clude in the notice a description of the addi-  
7                   tional information required to make the coverage  
8                   determination.

9                   “(B) DEADLINE TO RESPOND.—Such notice  
10                  shall be provided within the same time period as  
11                  the time period applicable to the contractor pro-  
12                  viding notice of initial determinations on a  
13                  claim for benefits under subsection (a)(2)(A).

14                  “(C) INFORMING BENEFICIARY IN CASE OF  
15                  PHYSICIAN REQUEST.—In the case of a request  
16                  in which an eligible requester is not the indi-  
17                  vidual described in paragraph (1)(B)(ii), the  
18                  process shall provide that the individual to  
19                  whom the item or service is proposed to be fur-  
20                  nished shall be informed of any determination  
21                  described in clause (ii) (relating to a determina-  
22                  tion of non-coverage) and the right (referred to  
23                  in paragraph (6)(B)) to obtain the item or serv-  
24                  ice and have a claim submitted for the item or  
25                  service.



1           “(5) *EFFECT OF DETERMINATIONS.*—

2                   “(A) *BINDING NATURE OF POSITIVE DETER-*  
3                   *MINATION.*—*If the contractor makes the deter-*  
4                   *mination described in paragraph (4)(A)(i), such*  
5                   *determination shall be binding on the contractor*  
6                   *in the absence of fraud or evidence of misrepre-*  
7                   *sentation of facts presented to the contractor.*

8                   “(B) *NOTICE AND RIGHT TO REDETERMINA-*  
9                   *TION IN CASE OF A DENIAL.*—

10                   “(i) *IN GENERAL.*—*If the contractor*  
11                   *makes the determination described in para-*  
12                   *graph (4)(A)(ii)—*

13                           “(I) *the eligible requester has the*  
14                           *right to a redetermination by the con-*  
15                           *tractor on the determination that the*  
16                           *item or service is not so covered; and*

17                           “(II) *the contractor shall include*  
18                           *in notice under paragraph (4)(A) a*  
19                           *brief explanation of the basis for the*  
20                           *determination, including on what na-*  
21                           *tional or local coverage or noncoverage*  
22                           *determination (if any) the determina-*  
23                           *tion is based, and the right to such a*  
24                           *redetermination.*





1                   “(i) *DEADLINE FOR REDETERMINA-*  
2                   *TIONS.—The contractor shall complete and*  
3                   *provide notice of such redetermination with-*  
4                   *in the same time period as the time period*  
5                   *applicable to the contractor providing notice*  
6                   *of redeterminations relating to a claim for*  
7                   *benefits under subsection (a)(3)(C)(ii).*

8                   “(6) *LIMITATION ON FURTHER REVIEW.—*

9                   “(A) *IN GENERAL.—Contractor determina-*  
10                   *tions described in paragraph (4)(A)(ii) or*  
11                   *(4)(A)(iii) (and redeterminations made under*  
12                   *paragraph (5)(B)), relating to pre-service claims*  
13                   *are not subject to further administrative appeal*  
14                   *or judicial review under this section or other-*  
15                   *wise.*

16                   “(B) *DECISION NOT TO SEEK PRIOR DETER-*  
17                   *MINATION OR NEGATIVE DETERMINATION DOES*  
18                   *NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK*  
19                   *REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing*  
20                   *in this subsection shall be construed as affecting*  
21                   *the right of an individual who—*

22                   “(i) *decides not to seek a prior deter-*  
23                   *mination under this subsection with respect*  
24                   *to items or services; or*



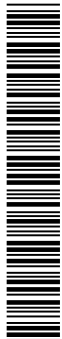
1                   “(i) seeks such a determination and  
2                   has received a determination described in  
3                   paragraph (4)(A)(i),  
4                   from receiving (and submitting a claim for) such  
5                   items services and from obtaining administrative  
6                   or judicial review respecting such claim under  
7                   the other applicable provisions of this section.  
8                   Failure to seek a prior determination under this  
9                   subsection with respect to items and services  
10                  shall not be taken into account in such adminis-  
11                  trative or judicial review.

12                  “(C) NO PRIOR DETERMINATION AFTER RE-  
13                  CEIPT OF SERVICES.—Once an individual is pro-  
14                  vided items and services, there shall be no prior  
15                  determination under this subsection with respect  
16                  to such items or services.”.

17                  (b) EFFECTIVE DATE; TRANSITION.—

18                  (1) EFFECTIVE DATE.—The Secretary shall es-  
19                  tablish the prior determination process under the  
20                  amendment made by subsection (a) in such a manner  
21                  as to provide for the acceptance of requests for deter-  
22                  minations under such process filed not later than 18  
23                  months after the date of the enactment of this Act.

24                  (2) TRANSITION.—During the period in which  
25                  the amendment made by subsection (a) has become ef-



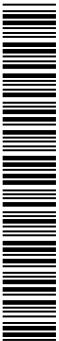
1        *fective but contracts are not provided under section*  
2        *1874A of the Social Security Act with medicare ad-*  
3        *ministrative contractors, any reference in section*  
4        *1869(g) of such Act (as added by such amendment) to*  
5        *such a contractor is deemed a reference to a fiscal*  
6        *intermediary or carrier with an agreement under sec-*  
7        *tion 1816, or contract under section 1842, respec-*  
8        *tively, of such Act.*

9                (3) *LIMITATION ON APPLICATION TO SGR.—For*  
10        *purposes of applying section 1848(f)(2)(D) of the So-*  
11        *cial Security Act (42 U.S.C. 1395w-4(f)(2)(D)), the*  
12        *amendment made by subsection (a) shall not be con-*  
13        *sidered to be a change in law or regulation.*

14        (c) *PROVISIONS RELATING TO ADVANCE BENEFICIARY*  
15        *NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—*

16                (1) *DATA COLLECTION.—The Secretary shall es-*  
17        *tablish a process for the collection of information on*  
18        *the instances in which an advance beneficiary notice*  
19        *(as defined in paragraph (5)) has been provided and*  
20        *on instances in which a beneficiary indicates on such*  
21        *a notice that the beneficiary does not intend to seek*  
22        *to have the item or service that is the subject of the*  
23        *notice furnished.*

24                (2) *OUTREACH AND EDUCATION.—The Secretary*  
25        *shall establish a program of outreach and education*



1       *for beneficiaries and providers of services and other*  
2       *persons on the appropriate use of advance beneficiary*  
3       *notices and coverage policies under the medicare pro-*  
4       *gram.*

5               (3) *GAO REPORT REPORT ON USE OF ADVANCE*  
6       *BENEFICIARY NOTICES.—Not later than 18 months*  
7       *after the date on which section 1869(g) of the Social*  
8       *Security Act (as added by subsection (a)) takes effect,*  
9       *the Comptroller General of the United States shall*  
10       *submit to Congress a report on the use of advance*  
11       *beneficiary notices under title XVIII of such Act.*  
12       *Such report shall include information concerning the*  
13       *providers of services and other persons that have pro-*  
14       *vided such notices and the response of beneficiaries to*  
15       *such notices.*

16               (4) *GAO REPORT ON USE OF PRIOR DETERMINA-*  
17       *TION PROCESS.—Not later than 18 months after the*  
18       *date on which section 1869(g) of the Social Security*  
19       *Act (as added by subsection (a)) takes effect, the*  
20       *Comptroller General of the United States shall submit*  
21       *to Congress a report on the use of the prior deter-*  
22       *mination process under such section. Such report*  
23       *shall include—*

24                       (A) *information concerning the types of*  
25       *procedures for which a prior determination has*



1           *been sought, determinations made under the*  
2           *process, and changes in receipt of services result-*  
3           *ing from the application of such process; and*

4                   *(B) an evaluation of whether the process*  
5           *was useful for physicians (and other suppliers)*  
6           *and beneficiaries, whether it was timely, and*  
7           *whether the amount of information required was*  
8           *burdensome to physicians and beneficiaries.*

9           (5) *ADVANCE BENEFICIARY NOTICE DEFINED.—*

10           *In this subsection, the term “advance beneficiary no-*  
11           *tice” means a written notice provided under section*  
12           *1879(a) of the Social Security Act (42 U.S.C.*  
13           *1395pp(a)) to an individual entitled to benefits under*  
14           *part A or B of title XVIII of such Act before items*  
15           *or services are furnished under such part in cases*  
16           *where a provider of services or other person that*  
17           *would furnish the item or service believes that pay-*  
18           *ment will not be made for some or all of such items*  
19           *or services under such title.*



1                   ***Subtitle V—Miscellaneous***  
2                                   ***Provisions***

3   ***SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION***  
4                                   ***AND MANAGEMENT (E & M) DOCUMENTATION***  
5                                   ***GUIDELINES.***

6           (a) *IN GENERAL.*—*The Secretary may not implement*  
7 *any new documentation guidelines for, or clinical examples*  
8 *of, evaluation and management physician services under*  
9 *the title XVIII of the Social Security Act on or after the*  
10 *date of the enactment of this Act unless the Secretary—*

11                   (1) *has developed the guidelines in collaboration*  
12 *with practicing physicians (including both generalists*  
13 *and specialists) and provided for an assessment of the*  
14 *proposed guidelines by the physician community;*

15                   (2) *has established a plan that contains specific*  
16 *goals, including a schedule, for improving the use of*  
17 *such guidelines;*

18                   (3) *has conducted appropriate and representative*  
19 *pilot projects under subsection (b) to test modifica-*  
20 *tions to the evaluation and management documenta-*  
21 *tion guidelines;*

22                   (4) *finds that the objectives described in sub-*  
23 *section (c) will be met in the implementation of such*  
24 *guidelines; and*



1           (5) *has established, and is implementing, a pro-*  
2           *gram to educate physicians on the use of such guide-*  
3           *lines and that includes appropriate outreach.*

4 *The Secretary shall make changes to the manner in which*  
5 *existing evaluation and management documentation guide-*  
6 *lines are implemented to reduce paperwork burdens on phy-*  
7 *sicians.*

8           **(b) PILOT PROJECTS TO TEST EVALUATION AND MAN-**  
9 **AGEMENT DOCUMENTATION GUIDELINES.—**

10           **(1) IN GENERAL.—***The Secretary shall conduct*  
11 *under this subsection appropriate and representative*  
12 *pilot projects to test new evaluation and management*  
13 *documentation guidelines referred to in subsection*  
14 *(a).*

15           **(2) LENGTH AND CONSULTATION.—***Each pilot*  
16 *project under this subsection shall—*

17                   **(A)** *be voluntary;*

18                   **(B)** *be of sufficient length as determined by*  
19 *the Secretary to allow for preparatory physician*  
20 *and medicare contractor education, analysis,*  
21 *and use and assessment of potential evaluation*  
22 *and management guidelines; and*

23                   **(C)** *be conducted, in development and*  
24 *throughout the planning and operational stages*  
25 *of the project, in consultation with practicing*



1           *physicians (including both generalists and spe-*  
2           *cialists).*

3           (3) *RANGE OF PILOT PROJECTS.—Of the pilot*  
4           *projects conducted under this subsection—*

5                   (A) *at least one shall focus on a peer review*  
6                   *method by physicians (not employed by a medi-*  
7                   *care contractor) which evaluates medical record*  
8                   *information for claims submitted by physicians*  
9                   *identified as statistical outliers relative to defini-*  
10                  *tions published in the Current Procedures Ter-*  
11                  *minology (CPT) code book of the American Med-*  
12                  *ical Association;*

13                  (B) *at least one shall focus on an alter-*  
14                  *native method to detailed guidelines based on*  
15                  *physician documentation of face to face encoun-*  
16                  *ter time with a patient;*

17                  (C) *at least one shall be conducted for serv-*  
18                  *ices furnished in a rural area and at least one*  
19                  *for services furnished outside such an area; and*

20                  (D) *at least one shall be conducted in a set-*  
21                  *ting where physicians bill under physicians'*  
22                  *services in teaching settings and at least one*  
23                  *shall be conducted in a setting other than a*  
24                  *teaching setting.*





1           (4) *BANNING OF TARGETING OF PILOT PROJECT*  
2           *PARTICIPANTS.*—Data collected under this subsection  
3           shall not be used as the basis for overpayment de-  
4           mands or post-payment audits. Such limitation ap-  
5           plies only to claims filed as part of the pilot project  
6           and lasts only for the duration of the pilot project  
7           and only as long as the provider is a participant in  
8           the pilot project.

9           (5) *STUDY OF IMPACT.*—Each pilot project shall  
10          examine the effect of the new evaluation and manage-  
11          ment documentation guidelines on—

12                 (A) different types of physician practices,  
13                 including those with fewer than 10 full-time-  
14                 equivalent employees (including physicians); and

15                 (B) the costs of physician compliance, in-  
16                 cluding education, implementation, auditing,  
17                 and monitoring.

18          (6) *PERIODIC REPORTS.*—The Secretary shall  
19          submit to Congress periodic reports on the pilot  
20          projects under this subsection.

21          (c) *OBJECTIVES FOR EVALUATION AND MANAGEMENT*  
22          *GUIDELINES.*—The objectives for modified evaluation and  
23          management documentation guidelines developed by the  
24          Secretary shall be to—



1           (1) *identify clinically relevant documentation*  
2           *needed to code accurately and assess coding levels ac-*  
3           *curately;*

4           (2) *decrease the level of non-clinically pertinent*  
5           *and burdensome documentation time and content in*  
6           *the physician's medical record;*

7           (3) *increase accuracy by reviewers; and*

8           (4) *educate both physicians and reviewers.*

9           (d) *STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF*  
10 *DOCUMENTATION FOR PHYSICIAN CLAIMS.—*

11           (1) *STUDY.—The Secretary shall carry out a*  
12 *study of the matters described in paragraph (2).*

13           (2) *MATTERS DESCRIBED.—The matters referred*  
14 *to in paragraph (1) are—*

15           (A) *the development of a simpler, alter-*  
16 *native system of requirements for documentation*  
17 *accompanying claims for evaluation and man-*  
18 *agement physician services for which payment is*  
19 *made under title XVIII of the Social Security*  
20 *Act; and*

21           (B) *consideration of systems other than cur-*  
22 *rent coding and documentation requirements for*  
23 *payment for such physician services.*

24           (3) *CONSULTATION WITH PRACTICING PHYSI-*  
25 *CIANS.—In designing and carrying out the study*



1        *under paragraph (1), the Secretary shall consult with*  
2        *practicing physicians, including physicians who are*  
3        *part of group practices and including both generalists*  
4        *and specialists.*

5                *(4) APPLICATION OF HIPAA UNIFORM CODING RE-*  
6        *QUIREMENTS.—In developing an alternative system*  
7        *under paragraph (2), the Secretary shall consider re-*  
8        *quirements of administrative simplification under*  
9        *part C of title XI of the Social Security Act.*

10               *(5) REPORT TO CONGRESS.—(A) Not later than*  
11        *October 1, 2005, the Secretary shall submit to Con-*  
12        *gress a report on the results of the study conducted*  
13        *under paragraph (1).*

14               *(B) The Medicare Payment Advisory Commis-*  
15        *sion shall conduct an analysis of the results of the*  
16        *study included in the report under subparagraph (A)*  
17        *and shall submit a report on such analysis to Con-*  
18        *gress.*

19               *(e) STUDY ON APPROPRIATE CODING OF CERTAIN EX-*  
20        *TENDED OFFICE VISITS.—The Secretary shall conduct a*  
21        *study of the appropriateness of coding in cases of extended*  
22        *office visits in which there is no diagnosis made. Not later*  
23        *than October 1, 2005, the Secretary shall submit a report*  
24        *to Congress on such study and shall include recommenda-*  
25        *tions on how to code appropriately for such visits in a man-*



1 *ner that takes into account the amount of time the physi-*  
2 *cian spent with the patient.*

3 *(f) DEFINITIONS.—In this section—*

4 *(1) the term “rural area” has the meaning given*  
5 *that term in section 1886(d)(2)(D) of the Social Secu-*  
6 *rity Act, 42 U.S.C. 1395ww(d)(2)(D); and*

7 *(2) the term “teaching settings” are those set-*  
8 *tings described in section 415.150 of title 42, Code of*  
9 *Federal Regulations.*

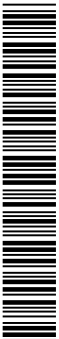
10 **SEC. 942. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY**  
11 **AND COVERAGE.**

12 *(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—*  
13 *Section 1868 (42 U.S.C. 1395ee), as amended by section*  
14 *921(a), is amended by adding at the end the following new*  
15 *subsection:*

16 *“(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—*

17 *“(1) ESTABLISHMENT.—The Secretary shall es-*  
18 *tablish a Council for Technology and Innovation*  
19 *within the Centers for Medicare & Medicaid Services*  
20 *(in this section referred to as ‘CMS’).*

21 *“(2) COMPOSITION.—The Council shall be com-*  
22 *posed of senior CMS staff and clinicians and shall be*  
23 *chaired by the Executive Coordinator for Technology*  
24 *and Innovation (appointed or designated under para-*  
25 *graph (4)).*

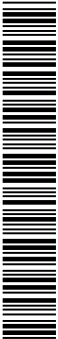


1           “(3) *DUTIES.*—*The Council shall coordinate the*  
2           *activities of coverage, coding, and payment processes*  
3           *under this title with respect to new technologies and*  
4           *procedures, including new drug therapies, and shall*  
5           *coordinate the exchange of information on new tech-*  
6           *nologies between CMS and other entities that make*  
7           *similar decisions.*

8           “(4) *EXECUTIVE COORDINATOR FOR TECH-*  
9           *NOLOGY AND INNOVATION.*—*The Secretary shall ap-*  
10          *point (or designate) a noncareer appointee (as defined*  
11          *in section 3132(a)(7) of title 5, United States Code)*  
12          *who shall serve as the Executive Coordinator for Tech-*  
13          *nology and Innovation. Such executive coordinator*  
14          *shall report to the Administrator of CMS, shall chair*  
15          *the Council, shall oversee the execution of its duties,*  
16          *and shall serve as a single point of contact for outside*  
17          *groups and entities regarding the coverage, coding,*  
18          *and payment processes under this title.”.*

19          “(b) *METHODS FOR DETERMINING PAYMENT BASIS*  
20          *FOR NEW LAB TESTS.*—*Section 1833(h) (42 U.S.C.*  
21          *1395l(h)) is amended by adding at the end the following:*

22          “(8)(A) *The Secretary shall establish by regulation*  
23          *procedures for determining the basis for, and amount of,*  
24          *payment under this subsection for any clinical diagnostic*  
25          *laboratory test with respect to which a new or substantially*



1 *revised HCPCS code is assigned on or after January 1,*  
2 *2005 (in this paragraph referred to as ‘new tests’).*

3 “(B) *Determinations under subparagraph (A) shall be*  
4 *made only after the Secretary—*

5 “(i) *makes available to the public (through an*  
6 *Internet site and other appropriate mechanisms) a*  
7 *list that includes any such test for which establish-*  
8 *ment of a payment amount under this subsection is*  
9 *being considered for a year;*

10 “(ii) *on the same day such list is made avail-*  
11 *able, causes to have published in the Federal Register*  
12 *notice of a meeting to receive comments and rec-*  
13 *ommendations (and data on which recommendations*  
14 *are based) from the public on the appropriate basis*  
15 *under this subsection for establishing payment*  
16 *amounts for the tests on such list;*

17 “(iii) *not less than 30 days after publication of*  
18 *such notice convenes a meeting, that includes rep-*  
19 *resentatives of officials of the Centers for Medicare &*  
20 *Medicaid Services involved in determining payment*  
21 *amounts, to receive such comments and recommenda-*  
22 *tions (and data on which the recommendations are*  
23 *based);*

24 “(iv) *taking into account the comments and rec-*  
25 *ommendations (and accompanying data) received at*



1        *such meeting, develops and makes available to the*  
2        *public (through an Internet site and other appro-*  
3        *prate mechanisms) a list of proposed determinations*  
4        *with respect to the appropriate basis for establishing*  
5        *a payment amount under this subsection for each*  
6        *such code, together with an explanation of the reasons*  
7        *for each such determination, the data on which the*  
8        *determinations are based, and a request for public*  
9        *written comments on the proposed determination; and*

10        *“(v) taking into account the comments received*  
11        *during the public comment period, develops and*  
12        *makes available to the public (through an Internet*  
13        *site and other appropriate mechanisms) a list of final*  
14        *determinations of the payment amounts for such tests*  
15        *under this subsection, together with the rationale for*  
16        *each such determination, the data on which the deter-*  
17        *minations are based, and responses to comments and*  
18        *suggestions received from the public.*

19        *“(C) Under the procedures established pursuant to sub-*  
20        *paragraph (A), the Secretary shall—*

21        *“(i) set forth the criteria for making determina-*  
22        *tions under subparagraph (A); and*

23        *“(ii) make available to the public the data (other*  
24        *than proprietary data) considered in making such de-*  
25        *terminations.*



1       “(D) *The Secretary may convene such further public*  
2 *meetings to receive public comments on payment amounts*  
3 *for new tests under this subsection as the Secretary deems*  
4 *appropriate.*

5       “(E) *For purposes of this paragraph:*

6           “(i) *The term ‘HCPCS’ refers to the Health Care*  
7 *Procedure Coding System.*

8           “(ii) *A code shall be considered to be ‘substan-*  
9 *tially revised’ if there is a substantive change to the*  
10 *definition of the test or procedure to which the code*  
11 *applies (such as a new analyte or a new methodology*  
12 *for measuring an existing analyte-specific test).’.*

13       (c) *GAO STUDY ON IMPROVEMENTS IN EXTERNAL*  
14 *DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT*  
15 *PAYMENT SYSTEM.—*

16           (1) *STUDY.—The Comptroller General of the*  
17 *United States shall conduct a study that analyzes*  
18 *which external data can be collected in a shorter time*  
19 *frame by the Centers for Medicare & Medicaid Serv-*  
20 *ices for use in computing payments for inpatient hos-*  
21 *pital services. The study may include an evaluation*  
22 *of the feasibility and appropriateness of using of*  
23 *quarterly samples or special surveys or any other*  
24 *methods. The study shall include an analysis of*  
25 *whether other executive agencies, such as the Bureau*





1 *of Labor Statistics in the Department of Commerce,*  
2 *are best suited to collect this information.*

3 (2) *REPORT.—By not later than October 1,*  
4 *2004, the Comptroller General shall submit a report*  
5 *to Congress on the study under paragraph (1).*

6 (d) *PROCESS FOR ADOPTION OF ICD CODES AS DATA*  
7 *STANDARD.—Section 1172(f) (42 U.S.C. 1320d–1(f)) is*  
8 *amended by inserting after the first sentence the following:*  
9 *“Notwithstanding the preceding sentence, if the National*  
10 *Committee on Vital and Health Statistics has not made a*  
11 *recommendation to the Secretary before the date of the en-*  
12 *actment of this sentence, with respect to the adoption of the*  
13 *International Classification of Diseases, 10th Revision,*  
14 *Procedure Coding System (‘ICD–10–PCS’) and the Inter-*  
15 *national Classification of Diseases, 10th Revision, Clinical*  
16 *Modification (‘ICD–10–CM’) as a standard under this part*  
17 *for the reporting of diagnoses, the Secretary may adopt*  
18 *ICD–10–PCS and ICD–10–CM as such a standard on or*  
19 *after 1 year after such date without receiving such a rec-*  
20 *ommendation.”.*

21 **SEC. 943. TREATMENT OF HOSPITALS FOR CERTAIN SERV-**  
22 **ICES UNDER MEDICARE SECONDARY PAYOR**  
23 **(MSP) PROVISIONS.**

24 (a) *IN GENERAL.—The Secretary shall not require a*  
25 *hospital (including a critical access hospital) to ask ques-*



1 *tions (or obtain information) relating to the application of*  
2 *section 1862(b) of the Social Security Act (relating to medi-*  
3 *care secondary payor provisions) in the case of reference*  
4 *laboratory services described in subsection (b), if the Sec-*  
5 *retary does not impose such requirement in the case of such*  
6 *services furnished by an independent laboratory.*

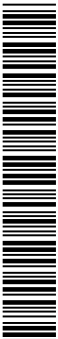
7       **(b) REFERENCE LABORATORY SERVICES DE-**  
8 *SCRIBED.—Reference laboratory services described in this*  
9 *subsection are clinical laboratory diagnostic tests (or the*  
10 *interpretation of such tests, or both) furnished without a*  
11 *face-to-face encounter between the individual entitled to*  
12 *benefits under part A or enrolled under part B, or both,*  
13 *and the hospital involved and in which the hospital submits*  
14 *a claim only for such test or interpretation.*

15 **SEC. 944. EMTALA IMPROVEMENTS.**

16       **(a) PAYMENT FOR EMTALA-MANDATED SCREENING**  
17 **AND STABILIZATION SERVICES.—**

18           **(1) IN GENERAL.—***Section 1862 (42 U.S.C.*  
19 *1395y) is amended by inserting after subsection (c)*  
20 *the following new subsection:*

21       **“(d) For purposes of subsection (a)(1)(A), in the case**  
22 *of any item or service that is required to be provided pursu-*  
23 *ant to section 1867 to an individual who is entitled to bene-*  
24 *fits under this title, determinations as to whether the item*  
25 *or service is reasonable and necessary shall be made on the*



1 *basis of the information available to the treating physician*  
2 *or practitioner (including the patient's presenting symp-*  
3 *toms or complaint) at the time the item or service was or-*  
4 *dered or furnished by the physician or practitioner (and*  
5 *not on the patient's principal diagnosis). When making*  
6 *such determinations with respect to such an item or service,*  
7 *the Secretary shall not consider the frequency with which*  
8 *the item or service was provided to the patient before or*  
9 *after the time of the admission or visit.”.*

10           (2) *EFFECTIVE DATE.—The amendment made by*  
11 *paragraph (1) shall apply to items and services fur-*  
12 *nished on or after January 1, 2004.*

13           (b) *NOTIFICATION OF PROVIDERS WHEN EMTALA IN-*  
14 *VESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42*  
15 *U.S.C. 1395dd(d)) is amended by adding at the end the*  
16 *following new paragraph:*

17           “(4) *NOTICE UPON CLOSING AN INVESTIGA-*  
18 *TION.—The Secretary shall establish a procedure to*  
19 *notify hospitals and physicians when an investigation*  
20 *under this section is closed.”.*

21           (c) *PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS*  
22 *IN EMTALA CASES INVOLVING TERMINATION OF PARTICI-*  
23 *PATION.—*

24           (1) *IN GENERAL.—Section 1867(d)(3) (42 U.S.C.*  
25 *1395dd(d)(3)) is amended—*



1           (A) *in the first sentence, by inserting “or in*  
2           *terminating a hospital’s participation under this*  
3           *title” after “in imposing sanctions under para-*  
4           *graph (1)”*; and

5           (B) *by adding at the end the following new*  
6           *sentences: “Except in the case in which a delay*  
7           *would jeopardize the health or safety of individ-*  
8           *uals, the Secretary shall also request such a re-*  
9           *view before making a compliance determination*  
10          *as part of the process of terminating a hospital’s*  
11          *participation under this title for violations re-*  
12          *lated to the appropriateness of a medical screen-*  
13          *ing examination, stabilizing treatment, or an*  
14          *appropriate transfer as required by this section,*  
15          *and shall provide a period of 5 days for such re-*  
16          *view. The Secretary shall provide a copy of the*  
17          *organization’s report to the hospital or physician*  
18          *consistent with confidentiality requirements im-*  
19          *posed on the organization under such part B.”.*

20          (2) *EFFECTIVE DATE.—The amendments made*  
21          *by paragraph (1) shall apply to terminations of par-*  
22          *ticipation initiated on or after the date of the enact-*  
23          *ment of this Act.*



1           (d) *MODIFICATION OF REQUIRMENT FOR MEDICAL*  
2 *SCREENING EXAMINATIONS FOR PATIENTS NOT REQUEST-*  
3 *ING EMERGENCY DEPARTMENT SERVICES.—*

4           (1) *IN GENERAL.—Section 1867(a) (42 U.S.C.*  
5 *1395dd(a)) is amended—*

6           (A) *by designating all that follows “(a)*  
7 *MEDICAL SCREENING REQUIREMENT.—” as*  
8 *paragraph (1) with the heading “IN GENERAL.—*  
9 *”;*

10           (B) *by aligning such paragraph with the*  
11 *paragraph added by paragraph (3); and*

12           (C) *by adding at the end the following new*  
13 *paragraph:*

14           “(2) *EXCEPTION FOR CERTAIN CASES.—The re-*  
15 *quirement for an appropriate medical screening ex-*  
16 *amination under paragraph (1) shall not apply in*  
17 *the case of an individual who comes to the emergency*  
18 *department and does not request examination or*  
19 *treatment for an emergency medical condition (such*  
20 *as a request solely for prescription refills, blood pres-*  
21 *sure screening, and non-emergency laboratory and di-*  
22 *agnostic tests).”.*

23           (2) *EFFECTIVE DATE.—The amendments made*  
24 *by paragraph (1) shall apply to terminations of par-*



1        *icipation initiated on or after the date of the enact-*  
2        *ment of this Act.*

3    **SEC. 945. EMERGENCY MEDICAL TREATMENT AND ACTIVE**  
4                    **LABOR ACT (EMTALA) TECHNICAL ADVISORY**  
5                    **GROUP.**

6        (a) *ESTABLISHMENT.*—*The Secretary shall establish a*  
7        *Technical Advisory Group (in this section referred to as the*  
8        *“Advisory Group”) to review issues related to the Emer-*  
9        *gency Medical Treatment and Labor Act (EMTALA) and*  
10       *its implementation. In this section, the term “EMTALA”*  
11       *refers to the provisions of section 1867 of the Social Security*  
12       *Act (42 U.S.C. 1395dd).*

13       (b) *MEMBERSHIP.*—*The Advisory Group shall be com-*  
14       *posed of 19 members, including the Administrator of the*  
15       *Centers for Medicare & Medicaid Services and the Inspector*  
16       *General of the Department of Health and Human Services*  
17       *and of which—*

18                (1) *4 shall be representatives of hospitals, includ-*  
19                *ing at least one public hospital, that have experience*  
20                *with the application of EMTALA and at least 2 of*  
21                *which have not been cited for EMTALA violations;*

22                (2) *7 shall be practicing physicians drawn from*  
23                *the fields of emergency medicine, cardiology or*  
24                *cardiothoracic surgery, orthopedic surgery, neuro-*  
25                *surgery, pediatrics or a pediatric subspecialty, obstet-*



1 *rics-gynecology, and psychiatry, with not more than*  
2 *one physician from any particular field;*

3 *(3) 2 shall represent patients;*

4 *(4) 2 shall be staff involved in EMTALA inves-*  
5 *tigations from different regional offices of the Centers*  
6 *for Medicare & Medicaid Services; and*

7 *(5) 1 shall be from a State survey office involved*  
8 *in EMTALA investigations and 1 shall be from a*  
9 *peer review organization, both of whom shall be from*  
10 *areas other than the regions represented under para-*  
11 *graph (4).*

12 *In selecting members described in paragraphs (1) through*  
13 *(3), the Secretary shall consider qualified individuals nomi-*  
14 *nated by organizations representing providers and patients.*

15 *(c) GENERAL RESPONSIBILITIES.—The Advisory*  
16 *Group—*

17 *(1) shall review EMTALA regulations;*

18 *(2) may provide advice and recommendations to*  
19 *the Secretary with respect to those regulations and*  
20 *their application to hospitals and physicians;*

21 *(3) shall solicit comments and recommendations*  
22 *from hospitals, physicians, and the public regarding*  
23 *the implementation of such regulations; and*





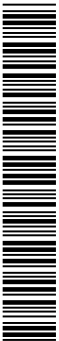


1           “(D) *In extraordinary, exigent, or other non-routine*  
2 *circumstances, such as unanticipated periods of high pa-*  
3 *tient loads, staffing shortages due to illness or other events,*  
4 *or temporary travel of a patient outside a hospice pro-*  
5 *gram’s service area, a hospice program may enter into ar-*  
6 *rangements with another hospice program for the provision*  
7 *by that other program of services described in paragraph*  
8 *(2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II)*  
9 *shall apply with respect to the services provided under such*  
10 *arrangements.*

11           “(E) *A hospice program may provide services de-*  
12 *scribed in paragraph (1)(A) other than directly by the pro-*  
13 *gram if the services are highly specialized services of a reg-*  
14 *istered professional nurse and are provided non-routinely*  
15 *and so infrequently so that the provision of such services*  
16 *directly would be impracticable and prohibitively expen-*  
17 *sive.”.*

18           (b) *CONFORMING PAYMENT PROVISION.—Section*  
19 *1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the*  
20 *end the following new paragraph:*

21           “(4) *In the case of hospice care provided by a hospice*  
22 *program under arrangements under section 1861(dd)(5)(D)*  
23 *made by another hospice program, the hospice program that*  
24 *made the arrangements shall bill and be paid for the hospice*  
25 *care.”.*



1           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
2 *section shall apply to hospice care provided on or after the*  
3 *date of the enactment of this Act.*

4 **SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHO-**  
5 **GENS STANDARD TO CERTAIN HOSPITALS.**

6           (a) *IN GENERAL.*—*Section 1866 (42 U.S.C. 1395cc)*  
7 *is amended—*

8                 (1) *in subsection (a)(1)—*

9                         (A) *in subparagraph (R), by striking “and”*  
10 *at the end;*

11                        (B) *in subparagraph (S), by striking the*  
12 *period at the end and inserting “, and”; and*

13                        (C) *by inserting after subparagraph (S) the*  
14 *following new subparagraph:*

15                                 “(T) *in the case of hospitals that are not other-*  
16 *wise subject to the Occupational Safety and Health*  
17 *Act of 1970, to comply with the Bloodborne Pathogens*  
18 *standard under section 1910.1030 of title 29 of the*  
19 *Code of Federal Regulations (or as subsequently redес-*  
20 *ignated).”;* and

21                         (2) *by adding at the end of subsection (b) the fol-*  
22 *lowing new paragraph:*

23                                 “(4)(A) *A hospital that fails to comply with the re-*  
24 *quirement of subsection (a)(1)(T) (relating to the*  
25 *Bloodborne Pathogens standard) is subject to a civil money*



1 *penalty in an amount described in subparagraph (B), but*  
2 *is not subject to termination of an agreement under this*  
3 *section.*

4       “(B) *The amount referred to in subparagraph (A) is*  
5 *an amount that is similar to the amount of civil penalties*  
6 *that may be imposed under section 17 of the Occupational*  
7 *Safety and Health Act of 1970 for a violation of the*  
8 *Bloodborne Pathogens standard referred to in subsection*  
9 *(a)(1)(T) by a hospital that is subject to the provisions of*  
10 *such Act.*

11       “(C) *A civil money penalty under this paragraph shall*  
12 *be imposed and collected in the same manner as civil money*  
13 *penalties under subsection (a) of section 1128A are imposed*  
14 *and collected under that section.”.*

15       (b) *EFFECTIVE DATE.*—*The amendments made by this*  
16 *subsection (a) shall apply to hospitals as of July 1, 2004.*

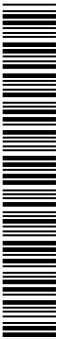
17 **SEC. 948. BIPA-RELATED TECHNICAL AMENDMENTS AND**  
18 **CORRECTIONS.**

19       (a) *TECHNICAL AMENDMENTS RELATING TO ADVISORY*  
20 *COMMITTEE UNDER BIPA SECTION 522.*—(1) *Subsection*  
21 *(i) of section 1114 (42 U.S.C. 1314)—*

22               (A) *is transferred to section 1862 and added at*  
23 *the end of such section; and*

24               (B) *is redesignated as subsection (j).*

25       (2) *Section 1862 (42 U.S.C. 1395y) is amended—*



1           (A) *in the last sentence of subsection (a), by*  
2           *striking “established under section 1114(f)”*; and

3           (B) *in subsection (j), as so transferred and*  
4           *redesignated—*

5                 (i) *by striking “under subsection (f)”*; and

6                 (ii) *by striking “section 1862(a)(1)” and*  
7                 *inserting “subsection (a)(1)”*.

8           (b) *TERMINOLOGY CORRECTIONS.—(1) Section*  
9           *1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amend-*  
10           *ed by section 521 of BIPA, is amended—*

11                 (A) *in subclause (III), by striking “policy” and*  
12                 *inserting “determination”*; and

13                 (B) *in subclause (IV), by striking “medical re-*  
14                 *view policies” and inserting “coverage determina-*  
15                 *tions”*.

16           (2) *Section 1852(a)(2)(C) (42 U.S.C. 1395w-*  
17           *22(a)(2)(C)) is amended by striking “policy” and “POLICY”*  
18           *and inserting “determination” each place it appears and*  
19           *“DETERMINATION”, respectively*.

20           (c) *REFERENCE CORRECTIONS.—Section 1869(f)(4)*  
21           *(42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA,*  
22           *is amended—*

23                 (1) *in subparagraph (A)(iv), by striking “sub-*  
24                 *clause (I), (II), or (III)” and inserting “clause (i),*  
25                 *(ii), or (iii)”*;



1           (2) *in subparagraph (B), by striking “clause*  
2 *(i)(IV)” and “clause (i)(III)” and inserting “sub-*  
3 *paragraph (A)(iv)” and “subparagraph (A)(iii)”, re-*  
4 *spectively; and*

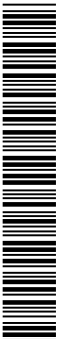
5           (3) *in subparagraph (C), by striking “clause*  
6 *(i)”, “subclause (IV)” and “subparagraph (A)” and*  
7 *inserting “subparagraph (A)”, “clause (iv)” and*  
8 *“paragraph (1)(A)”, respectively each place it ap-*  
9 *pears.*

10          (d) *OTHER CORRECTIONS.—Effective as if included in*  
11 *the enactment of section 521(c) of BIPA, section 1154(e)*  
12 *(42 U.S.C. 1320c–3(e)) is amended by striking paragraph*  
13 *(5).*

14          (e) *EFFECTIVE DATE.—Except as otherwise provided,*  
15 *the amendments made by this section shall be effective as*  
16 *if included in the enactment of BIPA.*

17 **SEC. 949. CONFORMING AUTHORITY TO WAIVE A PROGRAM**  
18 **EXCLUSION.**

19          *The first sentence of section 1128(c)(3)(B) (42 U.S.C.*  
20 *1320a–7(c)(3)(B)) is amended to read as follows: “Subject*  
21 *to subparagraph (G), in the case of an exclusion under sub-*  
22 *section (a), the minimum period of exclusion shall be not*  
23 *less than five years, except that, upon the request of the ad-*  
24 *ministrator of a Federal health care program (as defined*  
25 *in section 1128B(f)) who determines that the exclusion*



1 *would impose a hardship on individuals entitled to benefits*  
2 *under part A of title XVIII or enrolled under part B of*  
3 *such title, or both, the Secretary may waive the exclusion*  
4 *under subsection (a)(1), (a)(3), or (a)(4) with respect to*  
5 *that program in the case of an individual or entity that*  
6 *is the sole community physician or sole source of essential*  
7 *specialized services in a community.”.*

8 **SEC. 950. TREATMENT OF CERTAIN DENTAL CLAIMS.**

9 *(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is*  
10 *amended by adding after subsection (g) the following new*  
11 *subsection:*

12 *“(h)(1) Subject to paragraph (2), a group health plan*  
13 *(as defined in subsection (a)(1)(A)(v)) providing supple-*  
14 *mental or secondary coverage to individuals also entitled*  
15 *to services under this title shall not require a medicare*  
16 *claims determination under this title for dental benefits spe-*  
17 *cifically excluded under subsection (a)(12) as a condition*  
18 *of making a claims determination for such benefits under*  
19 *the group health plan.*

20 *“(2) A group health plan may require a claims deter-*  
21 *mination under this title in cases involving or appearing*  
22 *to involve inpatient dental hospital services or dental serv-*  
23 *ices expressly covered under this title pursuant to actions*  
24 *taken by the Secretary.”.*



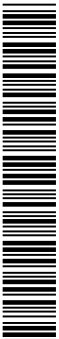
1           (b) *EFFECTIVE DATE.*—*The amendment made by sub-*  
2 *section (a) shall take effect on the date that is 60 days after*  
3 *the date of the enactment of this Act.*

4 **SEC. 951. FURNISHING HOSPITALS WITH INFORMATION TO**  
5 **COMPUTE DSH FORMULA.**

6           *Beginning not later than 1 year after the date of the*  
7 *enactment of this Act, the Secretary shall furnish to sub-*  
8 *section (d) hospitals (as defined in section 1886(d)(1)(B)*  
9 *of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the*  
10 *data necessary for such hospitals to compute the number*  
11 *of patient days described in subclause (II) of section*  
12 *1886(d)(5)(F)(vi) of the Social Security Act (42 U.S.C.*  
13 *1395ww(d)(5)(F)(vi)) used in computing the dispropor-*  
14 *tionate patient percentage under such section for that hos-*  
15 *pital. Such data shall also be furnished to other hospitals*  
16 *which would qualify for additional payments under part*  
17 *A of title XVIII of the Social Security Act on the basis of*  
18 *such data.*

19 **SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.**

20           (a) *IN GENERAL.*—*Section 1842(b)(6)(A) (42 U.S.C.*  
21 *1395u(b)(6)(A)) is amended by striking “or (ii) (where the*  
22 *service was provided in a hospital, critical access hospital,*  
23 *clinic, or other facility) to the facility in which the service*  
24 *was provided if there is a contractual arrangement between*  
25 *such physician or other person and such facility under*



1 *which such facility submits the bill for such service,” and*  
2 *inserting “or (ii) where the service was provided under a*  
3 *contractual arrangement between such physician or other*  
4 *person and an entity (as defined by the Secretary), to the*  
5 *entity if, under the contractual arrangement, the entity sub-*  
6 *mits the bill for the service and the contractual arrangement*  
7 *meets such other program integrity and other safeguards*  
8 *as the Secretary may determine to be appropriate,”.*

9 (b) *CONFORMING AMENDMENT.*—*The second sentence*  
10 *of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended*  
11 *by striking “except to an employer or facility” and insert-*  
12 *ing “except to an employer, entity, or other person”.*

13 (c) *EFFECTIVE DATE.*—*The amendments made by sec-*  
14 *tion shall apply to payments made on or after the date that*  
15 *is one year after the date of the enactment of this Act.*

16 **SEC. 953. OTHER PROVISIONS.**

17 (a) *GAO REPORTS ON THE PHYSICIAN COMPENSA-*  
18 *TION.*—

19 (1) *SUSTAINABLE GROWTH RATE AND UP-*  
20 *DATES.*—*Not later than 6 months after the date of the*  
21 *enactment of this Act, the Comptroller General of the*  
22 *United States shall submit to Congress a report on*  
23 *the appropriateness of the updates in the conversion*  
24 *factor under subsection (d)(3) of section 1848 of the*  
25 *Social Security Act (42 U.S.C. 1395w-4), including*



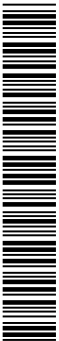


1        *the appropriateness of the sustainable growth rate for-*  
2        *mula under subsection (f) of such section for 2002*  
3        *and succeeding years. Such report shall examine the*  
4        *stability and predictability of such updates and rate*  
5        *and alternatives for the use of such rate in the up-*  
6        *dates.*

7                (2) *PHYSICIAN COMPENSATION GENERALLY.—Not*  
8        *later than 12 months after the date of the enactment*  
9        *of this Act, the Comptroller General shall submit to*  
10        *Congress a report on all aspects of physician com-*  
11        *penetration for services furnished under title XVIII of*  
12        *the Social Security Act, and how those aspects inter-*  
13        *act and the effect on appropriate compensation for*  
14        *physician services. Such report shall review alter-*  
15        *natives for the physician fee schedule under section*  
16        *1848 of such title (42 U.S.C. 1395w-4).*

17                (b) *ANNUAL PUBLICATION OF LIST OF NATIONAL COV-*  
18        *ERAGE DETERMINATIONS.—The Secretary shall provide, in*  
19        *an appropriate annual publication available to the public,*  
20        *a list of national coverage determinations made under title*  
21        *XVIII of the Social Security Act in the previous year and*  
22        *information on how to get more information with respect*  
23        *to such determinations.*

24                (c) *GAO REPORT ON FLEXIBILITY IN APPLYING HOME*  
25        *HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS*



1 *WHO ARE NOT MEDICARE BENEFICIARIES.*—Not later than  
2 6 months after the date of the enactment of this Act, the  
3 Comptroller General of the United States shall submit to  
4 Congress a report on the implications if there were flexi-  
5 bility in the application of the medicare conditions of par-  
6 ticipation for home health agencies with respect to groups  
7 or types of patients who are not medicare beneficiaries. The  
8 report shall include an analysis of the potential impact of  
9 such flexible application on clinical operations and the re-  
10 cipients of such services and an analysis of methods for  
11 monitoring the quality of care provided to such recipients.

12 *(d) OIG REPORT ON NOTICES RELATING TO USE OF*  
13 *HOSPITAL LIFETIME RESERVE DAYS.*—Not later than 1  
14 year after the date of the enactment of this Act, the Inspec-  
15 tor General of the Department of Health and Human Serv-  
16 ices shall submit a report to Congress on—

17 *(1) the extent to which hospitals provide notice*  
18 *to medicare beneficiaries in accordance with applica-*  
19 *ble requirements before they use the 60 lifetime reserve*  
20 *days described in section 1812(a)(1) of the Social Se-*  
21 *curity Act (42 U.S.C. 1395d(a)(1)); and*

22 *(2) the appropriateness and feasibility of hos-*  
23 *pitals providing a notice to such beneficiaries before*  
24 *they completely exhaust such lifetime reserve days.*



1 **SEC. 954. TEMPORARY SUSPENSION OF OASIS REQUIRE-**  
2 **MENT FOR COLLECTION OF DATA ON NON-**  
3 **MEDICARE AND NON-MEDICAID PATIENTS.**

4 (a) *IN GENERAL.*—During the period described in sub-  
5 section (b), the Secretary may not require, under section  
6 4602(e) of the Balanced Budget Act of 1997 or otherwise  
7 under OASIS, a home health agency to gather or submit  
8 information that relates to an individual who is not eligible  
9 for benefits under either title XVIII or title XIX of the So-  
10 cial Security Act (such information in this section referred  
11 to as “non-medicare/medicaid OASIS information”).

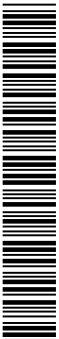
12 (b) *PERIOD OF SUSPENSION.*—The period described in  
13 this subsection—

14 (1) begins on the date of the enactment of this  
15 Act; and

16 (2) ends on the last day of the 2nd month begin-  
17 ning after the date as of which the Secretary has pub-  
18 lished final regulations regarding the collection and  
19 use by the Centers for Medicare & Medicaid Services  
20 of non-medicare/medicaid OASIS information fol-  
21 lowing the submission of the report required under  
22 subsection (c).

23 (c) *REPORT.*—

24 (1) *STUDY.*—The Secretary shall conduct a study  
25 on how non-medicare/medicaid OASIS information is



1        *and can be used by large home health agencies. Such*  
2        *study shall examine—*

3                *(A) whether there are unique benefits from*  
4                *the analysis of such information that cannot be*  
5                *derived from other information available to, or*  
6                *collected by, such agencies; and*

7                *(B) the value of collecting such information*  
8                *by small home health agencies compared to the*  
9                *administrative burden related to such collection.*

10        *In conducting the study the Secretary shall obtain*  
11        *recommendations from quality assessment experts in*  
12        *the use of such information and the necessity of small,*  
13        *as well as large, home health agencies collecting such*  
14        *information.*

15                *(2) REPORT.—The Secretary shall submit to*  
16        *Congress a report on the study conducted under para-*  
17        *graph (1) by not later than 18 months after the date*  
18        *of the enactment of this Act.*

19                *(d) CONSTRUCTION.—Nothing in this section shall be*  
20        *construed as preventing home health agencies from col-*  
21        *lecting non-medicare/medicaid OASIS information for*  
22        *their own use.*

