107TH CONGRESS
1ST SESSION

S. 1135

To amend title XVIII of the Social Security Act to provide comprehensive reform of the medicare program, including the provision of coverage of outpatient prescription drugs under such program.

IN THE SENATE OF THE UNITED STATES

JUNE 28, 2001

Mr. GRAHAM (for himself, Mr. CHAFEE, Mr. CONRAD, Mrs. LINCOLN, Mr. MILLER, Mr. ROCKEFELLER, Mr. BINGAMAN, Mr. KERRY, and Mr. CARPER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide comprehensive reform of the medicare program, including the provision of coverage of outpatient prescription drugs under such program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Reform Act of 2001''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE MANAGEMENT AND ADMINISTRATION

Subtitle A—Transfer of Responsibility for National Coverage Determinations and Establishment of the Medicare Coverage Commission

SEC. 101. TRANSFER OF RESPONSIBILITY FOR NATIONAL COVERAGE DETERMINATIONS AND ESTABLISHMENT OF THE MEDICARE COVERAGE COMMISSION.

(a) RESPONSIBILITY AND ESTABLISHMENT.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1869 the following new sections:

''NATIONAL COVERAGE DETERMINATIONS

''SEC. 1869A. (a) RESPONSIBILITY.—

''(1) IN GENERAL.—

''(A) SOLE RESPONSIBILITY.—Beginning in 2003, the Medicare Coverage Commission established under section 1869B (in this section referred to as the 'Commission') shall have sole

responsibility for making national coverage determinations under this title.

''(B) LOCAL COVERAGE DETERMINATIONS.—The Secretary shall continue to have responsibility for local coverage determinations in accordance with section 1869(f).

''(2) PROCEDURES.—

''(A) IN GENERAL.—The Commission shall establish procedures for making national coverage determinations under this title.

''(B) REQUIREMENTS.—The procedures established under subparagraph (A) shall ensure that, in making national coverage determinations—

''(i) meetings of advisory committees established under section 1869B(f) with respect to the determination are made on the record;

''(ii) the Commission considers applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination;

''(iii) the Commission provides a clear statement of—

''(I) the basis for the determination (including responses to comments received from the public); and

''(II) the assumptions underlying that basis; and

''(iv) the Commission makes available to the public the data (other than proprietary data) considered in making the determination.

''(3) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Commission with respect to whether or not a particular item or service is covered nationally under this title, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered.

''(b) REVIEW OF NATIONAL COVERAGE DETERMINATIONS.—

''(1) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

"(A) Such a determination shall not be reviewed by any administrative law judge.

"(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

"(C) Upon the filing of a complaint by an aggrieved person (as described in paragraph (4)), such a determination shall be reviewed by the Appeals Board of the Commission. In conducting such a review, the Appeals Board—

"(i) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the Board determines that the record is incomplete or lacks adequate information to support the validity of the determination;

"(ii) may, as appropriate, consult with appropriate scientific and clinical experts; and

"(iii) shall defer only to the reasonable findings of fact, reasonable interpreta-

tions of law, and reasonable applications of fact to law by the Commission.

''(D) A decision of the Appeals Board constitutes a final agency action and is subject to judicial review.

''(2) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of a determination that may otherwise be subject to review under paragraph (1)(C), where the moving party alleges that—

''(A) there are no material issues of fact in dispute; and

''(B) the only issue of law is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Commission is invalid,

the moving party may seek review by a court of competent jurisdiction without filing a complaint under such paragraph and without otherwise exhausting other administrative remedies.

''(3) PENDING NATIONAL COVERAGE DETERMINATIONS.—

''(A) IN GENERAL.—In the event that the Commission has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an

aggrieved person (as described in paragraph (4)) may submit to the Commission a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period that begins on the date the Commission receives such a request (notwithstanding the receipt by the Commission of new evidence (if any) during such 90-day period), the Commission shall take 1 of the following actions:

''(i) Issue a national coverage determination, with or without limitations.

''(ii) Issue a national noncoverage determination.

''(iii) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

''(iv) Issue a notice that—

''(I) states that the Commission has not completed a review of the request for a national coverage determination; and

"(II) includes an identification of the remaining steps in the Commission's review process and a deadline by which the Commission will complete the review and take an action described in clause (i), (ii), or (iii).

"(B) DEEMED ACTION BY THE COMMISSION.—In the case of an action described in subparagraph (A)(iv), if the Commission fails to take an action referred to in such subparagraph by the deadline specified by the Commission under such subparagraph, then the Commission is deemed to have taken an action described in subparagraph (A)(iii) as of the deadline.

"(C) EXPLANATION OF DETERMINATION.—When issuing a determination under subparagraph (A), the Commission shall include an explanation of the basis for the determination. An action taken under such subparagraph (other than clause (iv) of such subparagraph) is deemed to be a national coverage determination for purposes of review under paragraph (1).

"(4) STANDING.—An action under this subsection seeking review of a national coverage determination may be initiated by—

"(A) an individual who is entitled to benefits under part A, or enrolled under part B, or both, and who is in need of the items or services that are the subject of the coverage determination; and

"(B) any other aggrieved party that has a financial interest in the coverage determination.

"(5) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE COMMISSION.—Each decision of a hearing by the Commission with respect to a national coverage determination shall be made public, and the Commission shall coordinate with the Secretary for the publication of each decision on the Medicare Internet site of the Department of Health and Human Services. The Commission shall remove from such decision any information that would identify any individual, provider of services, or supplier.

"(6) ANNUAL REPORT TO CONGRESS ON NATIONAL COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—Not later than December 1 of each year, beginning in 2003, the Commission shall submit to Congress a report that sets forth a detailed compilation of—

''(i) the actual time periods that were necessary to complete national coverage determinations that were made in the previous fiscal year for items or services not previously covered as a benefit under this title; and

''(ii) the basis for each such determination.

''(B) PUBLICATION OF REPORTS ON THE INTERNET.—The Commission shall coordinate with the Secretary for the publication of each report submitted under subparagraph (A) on the Medicare Internet site of the Department of Health and Human Services.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting administrative or judicial review pursuant to this section insofar as such review is explicitly prohibited or restricted under another provision of law.

''(c) COMMUNICATION BETWEEN COMMISSION AND SECRETARY.—

''(1) NOTIFICATION.—If the Commission or the Appeals Board of the Commission after a review of a determination makes a determination that a particular item or service is covered nationally under

this title, the Commission shall immediately notify the Secretary of such determination.

''(2) IMPLEMENTATION BY SECRETARY.—Upon being notified by the Commission that a determination has been made under this section that a particular item or service is covered nationally under this title, the Secretary shall implement such coverage in a timely manner.

''MEDICARE COVERAGE COMMISSION

''SEC. 1869B. (a) ESTABLISHMENT.—There is established a Medicare Coverage Commission (in this section referred to as the 'Commission'). The Commission shall be an independent establishment (as defined in section 104 of title 5, United States Code).

''(b) STRUCTURE AND MEMBERSHIP.—

''(1) STRUCTURE.—

''(A) IN GENERAL.—The Commission shall be composed of 7 members appointed by the President, by and with the advice and consent of the Senate.

''(B) RESTRICTION.—No member of the Commission may serve in any other office of the Federal Government while a member of the Commission.

''(2) MEMBERSHIP.—

"(A) IN GENERAL.—The members of the Commission shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and clinical, medical, technical, and scientific expertise, exceptionally qualified to perform the duties of the members of the Commission.

"(B) TERMS OF APPOINTMENT.—The terms of members of the Commission shall be for 3 years.

"(C) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office.

"(D) LIMITATION ON NUMBER OF TERMS.—Any person appointed as a member of the Commission shall not be eligible for reappointment to the Commission after having served 2 terms.

"(E) CHAIRPERSON.—The President shall designate a member of the Commission, at the

time of appointment of the member, as chairperson for that term of appointment, except that in the case of any vacancy of the chairperson, the President may designate another member for the remainder of that member's term.

''(c) DUTIES.—

''(1) IN GENERAL.—The Commission shall be responsible for making national coverage determinations (as defined in section 1869A(a)(3)) under this title, including at the request of medicare beneficiaries or their representatives, Federal Government agencies, including the Centers for Medicare & Medicaid Services, manufacturers and suppliers, and providers for such a determination.

''(2) ESTABLISHMENT OF APPEALS BOARD.—The Commission shall establish an Appeals Board for purposes of providing review of national coverage determinations under section 1869B(b).

''(3) OTHER SPECIFIC DUTIES.—In order to carry out the duties described in paragraph (1), the Commission may do the following if determined appropriate:

''(A) Commission technology assessments and studies.

''(B) Request that technology assessments and related studies be conducted by other Federal agencies pursuant to subsection (g).

''(C) Establish advisory committees pursuant to subsection (f) as appropriate to evaluate new procedures.

''(D) Review conflicting local coverage determinations (as defined in section 1869(f)(1)(B)) and determine whether a national coverage determination is necessary or desirable.

''(d) OPERATION OF THE COMMISSION.—

''(1) MEETINGS.—The Commission shall meet at the call of its chairperson not less often than quarterly.

''(2) QUORUM.—A quorum shall consist of 4 members of the Commission, except that the Commission may establish a lesser quorum to conduct hearings.

''(e) COMMISSION PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Membership on the Commission is not a full-time position. Each member of the Commission shall be compensated at a rate equal to the per diem equiva-

lent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of service for the Commission.

''(2) STAFF AND SUPPORT SERVICES.—

''(A) EXECUTIVE DIRECTOR.—The Chairperson shall appoint an executive director of the Commission who shall be paid at a rate specified by the Commission.

''(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

''(C) INAPPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be

paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(3) TRANSFER OF PERSONNEL, ASSETS, ETC.—For purposes of the Commission carrying out its duties, the Secretary and the Commission may provide for the transfer to the Commission of such civil service personnel employed by the Department of Health and Human Services, and such resources and assets of the Department used in carrying out this title, as the Commission requires.

''(f) APPOINTMENT OF ADVISORY COMMITTEES.—

''(1) IN GENERAL.—The Commission may appoint such advisory committees as the Commission determines appropriate to advise and consult the Commission in carrying out the duties of the Commission.

''(2) INAPPLICABILITY OF CIVIL SERVICE LAWS.—The advisory committees shall be appointed

without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

''(3) TRAVEL EXPENSES.—The members of the committees shall serve without compensation, except that such members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the committee.

''(4) REPORT ON ADVISORY COMMITTEES.—The Commission shall include in the annual report to Congress described in section 1869A(b)(6) the number of committees appointed under subsection (f) during the preceding year and the membership and activities of each such committee.

''(g) AUTHORITY TO REQUEST THAT FEDERAL AGENCIES CONDUCT ASSESSMENTS AND STUDIES.—The Commission may request any Federal department or agency to conduct a technology assessment or a related study that the Commission determines is necessary in order to carry out its duties under this section.

''(h) FUNDING OF COMMISSION.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) CONFORMING AMENDMENTS.—

(1) BIPA PROVISIONS.—

(A) Section 1869(c)(3)(B)(ii)(I) of the Social Security Act, as added by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–534), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ''If the Secretary has made a national coverage determination pursuant to the requirements established under the third sentence of section 1862(a)'' and inserting ''If the Medicare Coverage Commission has made a national coverage determination pursuant to the requirements established under section 1869A''.

(B) Section 1869(f) of the Social Security Act, as added by section 522(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–543), as so enacted into law, is amended to read as follows:

''(f) REVIEW OF LOCAL COVERAGE DETERMINATIONS.—

''(1) REVIEW.—

''(A) IN GENERAL.—Review of any local coverage determination shall be subject to the following limitations:

''(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge—

''(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the administrative law judge determines that the record is incomplete or lacks adequate information to support the validity of the determination;

''(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

''(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable

applications of fact to law by the Secretary.

''(ii) Upon the filing of a complaint by an aggrieved party, a decision of an administrative law judge under clause (i) shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) The Secretary shall implement a decision of the administrative law judge or the Departmental Appeals Board within 30 days of receipt of such decision.

''(iv) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(B) DEFINITION OF LOCAL COVERAGE DETERMINATION.—For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).

''(2) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of a determination that may otherwise be subject to review under paragraph (1)(A)(i), where the moving party alleges that—

''(A) there are no material issues of fact in dispute, and

''(B) the only issue of law is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid,

the moving party may seek review by a court of competent jurisdiction without filing a complaint under such paragraph and without otherwise exhausting other administrative remedies.

''(3) STANDING.—An action under this subsection seeking review of a local coverage determination may be initiated only by an individual who is entitled to benefits under part A, or enrolled under part B, or both, and who is in need of the items or services that are the subject of the coverage determination.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting administrative or judicial review pursuant to this section inso-

far as such review is explicitly prohibited or restricted under another provision of law.''.

(C) Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)), as amended by section 522(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–546), as so enacted into law, is amended by striking the third sentence.

(D) Section 1114 of the Social Security Act (42 U.S.C. 1314), as amended by section 522(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–546), as so enacted into law, is amended by striking subsection (i).

(2) MEDICARE+CHOICE.—Section 1853(c)(7) of the Social Security Act (42 U.S.C. 1395w–23(c)(7)) is amended by inserting ''or the Medicare Coverage Commission'' after ''If the Secretary''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to—

(1) the responsibility for making national coverage determinations;

(2) a review of any national or local coverage determination filed;

(3) a request to make such a determination made; and

(4) a national coverage determination made,

on or after January 1, 2003.

Subtitle B—Centers for Medicare & Medicaid Services Leadership

SEC. 111. SALARY INCREASE FOR THE CMS ADMINISTRATOR.

(a) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(b) CONFORMING AMENDMENT.—Section 5315 of title 5, United States Code, is amended by striking ''Administrator of the Health Care Financing Administration.''.

(c) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2002.

SEC. 112. ADDITION OF POLITICAL APPOINTEE POSITIONS.

(a) ESTABLISHMENT OF POSITIONS.—Section 1117 of the Social Security Act (42 U.S.C. 1317) is amended by adding at the end the following new subsection:

''(c) ADDITIONAL APPOINTEES.—

''(1) APPOINTMENT.—In addition to the Administrator of the Centers for Medicare & Medicaid Services, there shall be in such Centers 9 individuals who shall be appointed by the President.

''(2) DUTIES AND POWERS.—The individuals appointed under paragraph (1) shall perform such duties and exercise such powers as the Administrator of the Centers for Medicare & Medicaid Services shall from time to time assign or delegate.''.

(b) CONFORMING AMENDMENTS.—Section 1117 of the Social Security Act (42 U.S.C. 1317) is amended—

(1) in subsection (a), by striking ''The Administrator of the Health Care Financing Administration'' and inserting ''ADMINISTRATOR.—The Administrator of the Centers for Medicare & Medicaid Services'';

(2) in subsection (b)—

(A) by striking ''(b)(1) There is established in the Health Care Financing Administration'' and inserting ''(b) CHIEF ACTUARY.—

''(1) APPOINTMENT.—There is established in the Centers for Medicare & Medicaid Services'';

(B) in the second sentence of paragraph (1), by striking ''of such Administration'' and inserting ''of such Centers''; and

(C) in paragraph (2), by striking ''The Chief Actuary'' and inserting ''COMPENSATION.—The Chief Actuary''; and

(D) by realigning paragraph (2) so as to align the left margin of such paragraph with the left margin of paragraph (1); and

(3) by amending the heading to read as follows: ''ORGANIZATION OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES''.

SEC. 113. HIRING FLEXIBILITY FOR SCIENTIFIC AND CLINICAL EXPERTS.

Section 1117 of the Social Security Act (42 U.S.C. 1317), as amended by section 112(a), is amended by adding at the end the following new subsection:

''(d) HIRING FLEXIBILITY FOR SCIENTIFIC AND CLINICAL EXPERTS.—

''(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services may appoint such individuals with scientific or clinical expertise as the Administrator determines appropriate.

''(2) INAPPLICABILITY OF CIVIL SERVICE LAWS.—The Administrator may appoint an individual described in paragraph (1) without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may provide that such an individual is paid without

regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).''.

Subtitle C—Increased Funding for Improved Customer Service

SEC. 121. INCREASED FUNDING FOR IMPROVED CUSTOMER SERVICE.

(a) PURPOSES.—The purposes of this section are—

(1) to provide for an annual authorization of appropriation for the program management budget of the Centers for Medicare & Medicaid Services that is based on the growth in expenditures under the medicare program under title XVIII of the Social Security Act; and

(2) to provide sufficient funding to ensure that the Centers for Medicare & Medicaid Services has the resources to provide improved services to medicare beneficiaries and providers under the medicare program and build the analytical and institutional infrastructure necessary for a competitive health care delivery system through such measures as—

(A) placing representatives of the medicare program in social security field offices;

(B) establishing customer services positions at the regional offices of the Centers for

Medicare & Medicaid Services for providers under the medicare program;

(C) increasing the amount and availability of grants for health insurance information, counseling, and assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4);

(D) updating information technology systems;

(E) expanding the provider relations and training functions of fiscal intermediaries and carriers under the medicare program; and

(F) hiring staff to develop—

(i) improved mechanisms for risk adjusting payments under the medicare program;

(ii) improved mechanisms to measure the quality of entities with a contract under part C or D (as added by section 301) of the medicare program and plans offered by such entities;

(iii) improved systems for providing information regarding the medicare program to medicare beneficiaries and potential medicare beneficiaries; and

(iv) methods for determining which geographic cost differences are related to the quality of care provided and which are related to other factors.

(b) AUTHORIZATION OF APPROPRIATIONS.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''AUTHORIZATION OF APPROPRIATIONS FOR CMS PROGRAM MANAGEMENT

''SEC. 1897. There are authorized to be appropriated for carrying out part A, B, and C the following amounts:

''(1) For fiscal year 2002, $2,408,934,900; and

''(2) For each subsequent fiscal year, the amount appropriated under this section for the previous fiscal year increased by the percentage increase in outlays under this title (determined without regard to amounts appropriated under this section) for such subsequent year.

Subtitle D—Private Sector Purchasing and Quality Improvement Tools for Original Medicare

SEC. 131. CARE COORDINATION SERVICES.

(a) PROGRAM AUTHORIZED.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating section 1866B, as added by section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–509), as enacted into law by section 1(a)(6) of Public Law 106–554), as section 1866M; and

(2) by inserting after section 1866A (as added by such section 412) the following new section:

''CARE COORDINATION SERVICES

''SEC. 1866B. (a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2003, shall implement a care coordination services program in accordance with the provisions of this section under which, in appropriate circumstances, eligible individuals may elect to have health care services covered under this title managed and coordinated by a designated care coordinator.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program).

''(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

''(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The Secretary shall specify criteria to be used in making a determination as to whether an individual may appropriately be enrolled in the care coordination services program under this section, which shall include at least a finding by the Secretary that for each cohort of individuals with characteristics identified by the Secretary, professional management and coordination of care can reasonably be expected to improve processes or outcomes of health care.

''(2) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section.

''(c) ENROLLMENT OF INDIVIDUALS.—

''(1) SECRETARY'S DETERMINATION OF ELIGIBILITY.—The Secretary shall determine the eligibility for services under this section of individuals who are enrolled in the program under this section and who make application for such services in such form and manner as the Secretary may prescribe.

''(2) ENROLLMENT PERIOD.—

''(A) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall be effective as of the

first day of the month following the month in which the Secretary approves the individual's application under paragraph (1), shall remain in effect for 1 month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation.

''(B) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

''(d) PROGRAM.—The care coordination services program under this section shall include the following elements:

''(1) BASIC CARE COORDINATION SERVICES.—

''(A) IN GENERAL.—Except as otherwise provided in this section, each enrolled individual—

''(i) shall receive the case management-related services described in section 1905(t)(1), assessment services (as defined by the Secretary), and such other care co-

ordination services as the Secretary may specify; and

"(ii) may receive any additional item or service specified under subparagraph (B).

"(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to individuals enrolled in the program under this section (subject to an assessment by the care coordinator of an individual's circumstance and need for such benefits) in order to encourage enrollment in, or to improve the effectiveness of, such program.

"(2) AUTHORITY OF THE SECRETARY TO REQUIRE CARE COORDINATION.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section is entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the care coordinator, or coordinated through the care coordination services program. Under such provision, the Secretary shall prescribe exceptions for emergency medical services as described in section

1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

''(3) REDUCTION OR ELIMINATION OF COST SHARING.—Notwithstanding any other provision of law, the Secretary may provide for the reduction or elimination of beneficiary cost sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this title (other than the care coordination services and other benefits described in paragraph (1)) and may limit such reduction or elimination to particular service areas.

''(e) CARE COORDINATORS.—

''(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination services under this section, an individual or entity shall—

''(A) be—

''(i)(I) a physician; or

''(II) a health care professional (other than a physician) who meets such conditions as the Secretary may specify; or

''(ii) an entity (which may include physicians, physician group practices, and any other health care professional or entity that the Secretary determines is appro-

priate) that meets such conditions as the Secretary may specify;

''(B) have entered into a care coordination agreement; and

''(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

''(2) AGREEMENT TERM; PAYMENT.—

''(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall be for 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1).

''(B) PAYMENT FOR SERVICES.—The Secretary may negotiate or otherwise establish payment terms and rates for services described in subsection (d)(1).

''(C) TERMS.—In addition to such other terms as the Secretary may require, an agreement under this section shall include the terms specified in subparagraphs (A) through (C) of section 1905(t)(3).''.

(b) COVERAGE OF CARE COORDINATION SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(A) in the second sentence, by redesignating paragraphs (16) and (17) as clauses (i) and (ii), respectively; and

(B) in the first sentence—

(i) in paragraph (14), by striking ''and'' at the end;

(ii) in paragraph (15), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after paragraph (15) the following new paragraph:

''(16) care coordination services furnished in accordance with section 1866B.''.

(2) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO CARE COORDINATION SERVICES.—

(A) COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 223(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114

Stat. 2763A–489), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(i) by striking ''and (U)'' and inserting ''(U)''; and

(ii) by inserting before the semicolon at the end the following: '', and (V) with respect to care coordination services described in section 1861(s)(16), the amounts paid shall be 100 percent of the payment amount established under section 1866B''.

(B) DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(i) by striking ''and (6)'' and inserting ''(6)''; and

(ii) by inserting before the period at the end the following: '', and (7) such deductible shall not apply with respect to care coordination services (as described in section 1861(s)(16))''.

SEC. 132. DISEASE MANAGEMENT SERVICES.

(a) PROGRAM AUTHORIZED.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended

by section 131(a), is amended by inserting after section 1866B the following new section:

"DISEASE MANAGEMENT SERVICES

"SEC. 1866C. (a) IN GENERAL.—

"(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2003, may implement a program in accordance with the provisions of this section under which certain eligible individuals may, in appropriate circumstances, receive disease management services from entities designated by the Secretary with respect to diagnoses that the Secretary determines are amenable to such management.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program).

"(b) INDIVIDUALS WHO MAY RECEIVE DISEASE MANAGEMENT SERVICES.—No individual shall be eligible for enrollment in a disease management program under this section unless the Secretary finds the following with respect to the individual:

"(1) DIAGNOSIS AND RELATED CHARACTERISTICS.—

"(A) IN GENERAL.—The individual has been diagnosed with congestive heart failure, chronic obstructive pulmonary disease, diabetes, or any other diagnosis, if the Secretary has determined with respect to such diagnoses that there is evidence that the provision of disease management services, over clinically relevant time periods, to cohorts of individuals with such diagnoses can reasonably be expected to improve processes or outcomes of health care for the medicare population and to reduce aggregate costs to the programs under this title.

"(B) ADDITIONAL FACTORS.—Where required by the Secretary, the individual also has certain clinical characteristics or conditions, exhibits certain patterns of utilization, or manifests other factors indicating the need for and potential effectiveness of disease management.

"(2) REFERRAL BY QUALIFIED INDIVIDUAL OR ENTITY.—The individual has been referred for consideration for such services by an individual or entity furnishing health care items or services, or by an entity administering benefits under this title.

"(c) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures de-

signed to facilitate enrollment of eligible individuals in the program under this section.

''(d) ENROLLMENT OF INDIVIDUALS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

''(1) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall remain in effect for 1 month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation.

''(2) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

''(e) DISEASE MANAGEMENT REQUIREMENT.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section may be entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the disease management organization, or coordinated through the disease management services program. Under such

provision, the Secretary shall prescribe exceptions for emergency medical services as described in section 1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

''(f) DISEASE MANAGEMENT SERVICES.—

''(1) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection (b)(1), disease management services provided to an individual under this section may include—

''(A) initial and periodic health screening and assessment;

''(B) management (including coordination with other providers) of, and referral for, medical and other health services related to the managed diagnosis (which may include referral for provision of such services by the disease management organization);

''(C) monitoring and control of medications (including coordination with the entity managing benefits for the individual under part D);

''(D) patient education and counseling;

''(E) nursing or other health professional home visits, as appropriate;

''(F) providing access for consultations by telephone with physicians or other appropriate

medical professionals, including 24-hour availability for emergency consultations;

"(G) managing and facilitating the transition to other care arrangements in preparation for termination of the disease management enrollment; and

"(H) such other services for which payment would not otherwise be made under this title as the Secretary shall determine to be appropriate.

"(2) VARIATIONS IN SERVICE PACKAGES.—The types and combinations of disease management services furnished under agreements under this section may vary (as permitted or required by the Secretary) according to the types of diagnoses, conditions, patient profiles being managed, expertise of the disease management organization, and other factors the Secretary finds appropriate.

"(3) REDUCTION OR ELIMINATION OF COST-SHARING.—Notwithstanding any other provision of law, subject to the cost-effectiveness criteria specified in subsection (b)(1), the Secretary may provide for the reduction or elimination of beneficiary cost-sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services

furnished under this title (other than those furnished under a service package developed under paragraph (2)), and may limit such reduction or elimination to particular service areas.

''(g) AGREEMENTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

''(1) ENTITIES ELIGIBLE.—Entities qualified to enter into agreements with the Secretary for the provision of disease management services under this section include entities that have demonstrated the ability to meet the performance standards and other criteria established by the Secretary with respect to—

''(A) the management of each diagnosis and condition with respect to which the entity, if designated, would furnish disease management services under this section; and

''(B) the implementation of each disease management approach that the entity, if designated, would implement under this section.

''(2) CONDITIONS OF PARTICIPATION.—In order to be eligible to provide disease management services under this section, an entity shall—

''(A) have in effect an agreement with the Secretary setting forth such obligations of the

entity as a disease management organization under this section as the Secretary shall prescribe;

''(B) meet the standards established by the Secretary under subsection (h); and

''(C) meet such other conditions as the Secretary may establish.

''(3) SECRETARY'S OPTION FOR NONCOMPETITIVE DESIGNATION.—The Secretary may designate an entity to provide disease management services under this section without regard to the requirements of section 5 of title 41, United States Code.

''(h) STANDARDS.—

''(1) QUALITY.—The Secretary shall establish standards for, and procedures for assessing, the quality of care provided by disease management organizations under this section, which shall include—

''(A) performance standards with respect to the processes or outcomes of health care or the health status of enrolled individuals, including procedures for establishing a baseline and measuring changes in health care processes or health outcomes with respect to managed diseases or health conditions;

''(B) a requirement that the organization meet such licensure and other accreditation standards as the Secretary may find appropriate; and

''(C) such other quality standards, including patient satisfaction, as the Secretary may find appropriate.

''(2) COST MANAGEMENT.—The Secretary shall establish a performance standard with respect to management or reduction of the aggregate costs of health care items and services related to managed health conditions furnished to enrolled individuals, including procedures for establishing a baseline and measuring changes in costs for such items and services.

''(i) PAYMENT.—

''(1) TERMS OF PAYMENT.—The Secretary may negotiate or otherwise establish payment terms and rates for service packages developed under subsection (f)(2).

''(2) WITHHOLDING OF PAYMENTS.—An agreement under subsection (g) may provide that the Secretary may withhold up to 10 percent of the amount due a disease management organization under the basis of payment established under paragraph (1)

until such time as such organization meets a standard or standards specified in such agreement.''.

(b) COVERAGE OF DISEASE MANAGEMENT SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)), as amended by section 131(b)(1), is amended—

(A) by striking ''and'' at the end of paragraph (15);

(B) by striking the period at the end of paragraph (16) and inserting ''; and''; and

(C) by inserting after paragraph (16) the following new paragraph:

''(17) disease management services furnished in accordance with section 1866C.''.

(2) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO DISEASE MANAGEMENT SERVICES.—

(A) COINSURANCE.—Section 1833(a)(1)(V) of the Social Security Act (42 U.S.C. 1395l(a)(1)(V)), as added by section 131(b)(2)(A), is amended to read as follows: ''(V) with respect to care coordination services described in section 1861(s)(16) and disease management services described in section

1861(s)(17), the amounts paid shall be 100 percent of the payment amounts established under sections 1866B and 1866C, respectively;''.

(B) DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 131(b)(2)(B), is amended by inserting before the period at the end the following: ''or to disease management services (as described in section 1861(s)(17))''.

SEC. 133. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

(a) PROGRAM AUTHORIZED.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 132, is amended by inserting after section 1866C the following new section:

''COMPETITIVE ACQUISITION OF ITEMS AND SERVICES

''SEC. 1866D. (a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary shall implement a program to purchase, on behalf of individuals enrolled under this part certain competitively priced items and services for which payment may be made under part B.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may

administer the program under this section in accordance with section 1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program).

''(b) ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for agreement award purposes for the furnishing under part B of the items and services described in subsection (d) after 2003. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of individuals and entities able to furnish items and services, and the estimated savings to be realized by the use of competitive acquisition in the furnishing of items and services in the area.

''(c) AWARDING OF AGREEMENTS IN COMPETITIVE ACQUISITION AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities

supplying items and services described in subsection (d) for each competitive acquisition area established under subsection (b) for each class of items and services.

''(2) CONDITIONS FOR AWARDING AGREEMENT.—The Secretary may not enter an agreement with any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and that the aggregate amounts to be paid under the agreement are expected to be less than the aggregate amounts that would otherwise be paid.

''(3) TERMS OF AGREEMENT.—An agreement entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services described in paragraphs (3) and (5) through (9) of section 1861(s) (other than custom fabricated prostheses, as defined by the Secretary), and such other items or services as the Secretary may specify.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)

of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (20);

(2) by striking the period at the end of paragraph (21) and inserting ''; or''; and

(3) by inserting after paragraph (21) the following new paragraph:

''(22) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1866D(a)) by an entity other than an entity with which the Secretary has entered into an agreement under section 1866D(c) for the furnishing of such an item or service in that area, except in such cases of emergency or urgent need as the Secretary shall prescribe.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished after 2003.

SEC. 134. PROVIDER AND PHYSICIAN COLLABORATIONS.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 133, is amended by inserting after section 1866D the following new section:

''PROVIDER AND PHYSICIAN COLLABORATIONS

''SEC. 1866E. (a) IN GENERAL.—

''(1) PROGRAM AUTHORITY.—The Secretary may enter into agreements with specific providers, suppliers, or other individuals or entities for the furnishing of bundled items and services in selected sites of service or related to specific medical conditions or needs for an episode of care. The services may include any items or services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program).

''(b) BASIS OF SELECTION.—The Secretary shall select entities for agreements under this section on the basis of ability to provide services more efficiently, to provide improved coordination of care, to offer additional benefits, and to meet quality and other standards and beneficiary protections and other requirements set by the Secretary.

''(c) PAYMENT.—Payment under this section shall be made on the basis of all-inclusive rates. The all-inclusive rate paid to an entity for bundled items and services furnished during an episode of care under this section shall

be less than the estimated amount of the payments that the Secretary would have otherwise made for the items and services.

''(d) TERM OF AGREEMENT.—Agreements under this section shall be for periods that the Secretary may determine.

''(e) INCENTIVES TO BENEFICIARIES FOR USE OF CONTRACTING ENTITIES.—Notwithstanding any other provision of law, entities under a contract under this section may furnish additional services or waive part or all beneficiary cost-sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this section.

''(f) BENEFICIARY ELECTION.—An individual entitled to benefits under this title who elects to obtain services under an agreement under this section shall agree to receive under such agreement all benefits related to the episode of care covered by the agreement (subject to such exceptions for emergency services and as the Secretary otherwise may specify).''.

SEC. 135. PREFERRED PARTICIPANTS.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 134, is amended by inserting after section 1866E the following new section:

''PREFERRED PARTICIPANTS

''SEC. 1866F. (a) PROGRAM AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall implement beginning in 2003, a preferred participant program, under which the Secretary enters into agreements for the furnishing of health care items and services by individuals and entities participating in the program under part A or B of this title that provide high-quality, efficient health care.

''(2) LIMITATION.—The Secretary shall not implement the program under this section with respect to a service area, or with respect to a category of individuals and entities furnishing items and services in such service area, unless the Secretary estimates that to do so will reduce the cost and improve the quality of the programs under this title.

''(3) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary shall administer the program under this section in accordance with section 1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program).

''(b) PREFERRED PARTICIPANT AGREEMENT.—

''(1) CRITERIA AND TERMS.—In order to be eligible to participate in the program under part A or

B as a preferred participant, an individual or entity shall meet the following conditions:

''(A) PARTICIPATION CRITERIA.—The individual or entity shall meet the criteria established by the Secretary under section 1866M(b)(5) (relating to quality, cost-effectiveness, categories of participants in each service area, and such other standards or criteria as the Secretary may establish).

''(B) PAYMENT RATE.—The individual or entity shall agree to accept payment, for covered health care items and services furnished during the term of the agreement, at the rates established under this section (which may include rates in effect under part A or B, discounted rates, or such other rates as the Secretary may find appropriate).

''(2) DURATION.—A preferred participant agreement under this section shall be for a calendar year (or, in the case of an agreement commencing after the first day of January (or such later date as the Secretary may specify), for the remainder of such calendar year), and shall be annually renewable, at the option of the participant, while the par-

ticipant continues to meet all applicable conditions of participation.

''(c) OPTION TO REDUCE COST-SHARING.—Notwithstanding any other provision of law, subject to the cost-effectiveness criteria specified in subsection (a)(2), the Secretary may—

''(1) provide for the reduction or elimination of beneficiary cost-sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this section, and may limit such reduction or elimination to particular service areas; and

''(2) permit individuals or entities under an agreement under this section to waive part or all of such beneficiary cost-sharing.''.

(b) DEFINITIONS.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–471), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by adding at the end the following new subsection:

''(ww) PREFERRED PARTICIPANT.—The term 'preferred participant' means an individual or entity that furnishes health care items or services under part A or B

and that has in effect an agreement under section 1866F(b).''.

SEC. 136. SIMPLIFIED CENTER PAYMENTS.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 135, is amended by inserting after section 1866F the following new section:

'SIMPLIFIED CENTER PAYMENTS

''SEC. 1866G. (a) IN GENERAL.—

''(1) COMPETITION TO FURNISH BUNDLED ITEMS AND SERVICES.—The Secretary, beginning in 2003, shall use a competitive process to enter into agreements with specific hospitals or other entities for the furnishing of bundled groups of items and services related to certain surgical procedures, and of other bundled groups of items and services (unrelated to surgical procedures) specified by the Secretary furnished during an episode of care (as defined by the Secretary). Such items and services may include any items or services covered under this title that the Secretary determines to be appropriate.

''(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program).

''(b) ELIGIBILITY CRITERIA.—In order to be eligible for an agreement under this section, an entity shall—

''(1) meet quality standards established by the Secretary;

''(2) implement an ongoing quality assurance program approved by the Secretary; and

''(3) meet such other requirements as the Secretary may establish.

''(c) PAYMENT.—

''(1) IN GENERAL.—The Secretary shall establish criteria for identifying the health care items and services furnished by a center with an agreement under this section during an episode of care that are to be bundled together and for which payment shall be made on the basis of an all-inclusive rate.

''(2) PAYMENT LIMITATION.—

''(A) LIMITATION ON AGGREGATE PAYMENTS TO ENTITIES.—The estimated amount of aggregate payments to all entities under this section for a year shall be less than the estimated amount of aggregate payments that the Secretary would otherwise have made for such year, adjusted for changes in the number of individuals receiving services.

"(B) LIMITATION ON PAYMENTS TO PARTICULAR ENTITIES.—In no case shall the all-inclusive rate paid to an entity for items and services furnished during an episode of care under this section exceed the estimated amount of the payments that the Secretary would otherwise have made for such items and services.

"(d) AGREEMENT PERIOD.—An agreement period shall be for up to 3 years (subject to renewal).

"(e) INCENTIVES FOR USE OF CENTERS.—Notwithstanding any other provision of law, the Secretary may permit entities under an agreement under this section to furnish additional services or to waive part or all beneficiary cost-sharing (such as deductibles, copayments, and coinsurance) with respect to any of the items or services furnished under this section.

"(f) BENEFICIARY ELECTION.—Notwithstanding any other provision of this title, an individual who voluntarily elects to receive items and services under an arrangement described in subsection (a)(1) with respect to an episode of care shall not be entitled to payment under this title for any such item or service furnished with respect to such episode of care other than through such arrangement, subject to such exceptions as the Secretary may prescribe for

emergency medical services as described in section 1852(d)(3) and other cases of urgent need.''.

SEC. 137. CONFORMING CHANGES TO PHYSICIAN GROUP PRACTICE DEMONSTRATION AND ADMINISTRATIVE PROVISIONS.

(a) CONFORMING CHANGE TO PHYSICIAN GROUP PRACTICE DEMONSTRATION.—Section 1866A(a)(2), as added by section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–509), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ''1866B'' and inserting ''1866M, including subsection (b)(2) of such section (relating to the discretion of the Secretary as to the scope of the program)''.

(b) CONFORMING CHANGES TO ADMINISTRATIVE PROVISIONS.—Section 1866M (as redesignated by section 131(a)(1)) is amended to read as follows:

''GENERAL PROVISIONS FOR ADMINISTRATION OF CERTAIN PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT PROGRAMS

''SEC. 1866M. (a) IN GENERAL.—Except as otherwise specifically provided, the provisions of this section apply to the programs under the following provisions of this title:

''(1) Section 1866A (demonstration of application of physician volume increases to group practices).

''(2) Section 1866B (care coordination services).

''(3) Section 1866C (disease management services).

''(4) Section 1866D (competitive acquisition of items and services).

''(5) Section 1866E (provider and physician collaborations).

''(6) Section 1866F (preferred participants).

''(7) Section 1866G (simplified center payments).

''(b) PROVISIONS GENERALLY APPLICABLE TO DESIGNATED PROGRAMS.—The following provisions apply to programs specified in subsection (a), except as otherwise specifically provided:

''(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under a program specified in subsection (a) if such individual—

''(A) is enrolled in under the program under part B;

''(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1833(a)(1)(A), or a PACE program under section 1894; and

''(C) in the case of the programs specified in paragraphs (1), (2), (3), (5), and (7) of subsection (a), is entitled to benefits under part A.

''(2) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary may limit the implementation of a program specified in subsection (a) to—

''(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

''(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

"(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

"(D) any combination of any of the limits described in subparagraphs (A) through (C).

"(3) VOLUNTARY RECEIPT OF ITEMS AND SERVICES.—Except as provided in the authority for the program specified in subsection (a)(4), items and services shall be furnished to an individual under the programs specified in subsection (a) only at the individual's election.

"(4) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the programs specified in subsection (a).

"(5) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the programs specified in subsection (a) including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care

items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

''(6) ADMINISTRATIVE REVIEW OF ADVERSE DECISION.—

''(A) DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES UNDER PROGRAMS.—An individual or entity furnishing services under a program specified in subsection (a) shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the individual or entity to provide health care items or services under such program.

''(B) DECISIONS AFFECTING BENEFICIARIES UNDER CARE COORDINATION SERVICES OR DISEASE MANAGEMENT SERVICES PROGRAMS.—

''(i) DETERMINATION OF INELIGIBILITY.—An individual shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary)

of a determination that the individual does not meet the criteria for eligibility to participate in a program specified in paragraph (2) or (3) of subsection (a).

''(ii) DENIAL OF PAYMENT FOR ITEMS OR SERVICES.—A beneficiary shall be entitled to a reconsideration or appeal of a denial of payment under section 1866B(d)(2) or 1866C(e)(2) in accordance with the provisions of section 1852(g), as if such section applied to this clause. In applying such section 1852(g), any reference to a Medicare+Choice organization is construed to refer to the program administrator or, if the Secretary has not contracted with a program administrator, to the Secretary.

''(7) SECRETARY'S REVIEW OF MARKETING MATERIALS.—An agreement with an individual or entity furnishing services under a program specified in subsection (a) shall require the individual or entity to guarantee that it will not distribute materials marketing items or services under such program without the Secretary's prior review and approval;

''(8) PAYMENT IN FULL.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under a program specified in subsection (a) shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this title.

''(B) COLLECTION OF DEDUCTIBLES AND COINSURANCE.—Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

''(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary may administer a program specified in subsection (a) through a contract with a program administrator in accordance with the provisions of this subsection.

''(2) SCOPE OF PROGRAM ADMINISTRATOR CONTRACTS.—A contract under this subsection may, at the Secretary's discretion, relate to administration of any or all of the programs specified in subsection (a). The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

''(3) ELIGIBLE CONTRACTORS.—The Secretary may contract for the administration of the program with—

''(A) an entity that, under a contract under section 1816 or 1842, determines the amount of and makes payments for health care items and services furnished under this title; or

''(B) any other entity with substantial experience in managing the type of program concerned.

''(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

''(A) IN GENERAL.—A contract under this subsection shall be for an initial term of up to 3 years, renewable for additional terms of up to 3 years.

''(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 5 of title 41, United States Code.

''(5) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation

shall apply to program administration contracts under this subsection.

''(6) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

''(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

''(A) AGREEMENTS WITH INDIVIDUALS OR ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of individuals or entities seeking to enter or renew agreements to provide services under a program specified in subsection (a), and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

"(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

"(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under any such program.

"(D) PAYMENT OF BONUSES.—Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (d)(2)(A)(ii) to individuals and entities furnishing items or services for which payment may be made under any such program.

"(E) LIST OF PROGRAM PARTICIPANTS.—Maintain and regularly update a list of individuals or entities with agreements to provide health care items and services under any such program, and ensure that such list, in electronic and hard copy formats, is readily available, as applicable, to—

"(i) individuals residing in the service area who are entitled to benefits under part A or enrolled in the program under part B;

"(ii) the entities responsible under sections 1816 and 1842 for administering payments for health care items and services furnished; and

"(iii) individuals and entities providing health care items and services in the service area.

"(F) BENEFICIARY ENROLLMENT.—Determine eligibility of individuals to enroll under a program specified in subsection (a) and provide enrollment-related services (but only if the Secretary finds that the program administrator has no conflict of interest caused by a financial relationship with any individual or entity furnishing items or services for which payment may be made under any such program, or any other conflict of interest with respect to such function).

"(G) OVERSIGHT.—Monitor the compliance of individuals and entities with agreements under any such program with the conditions of participation.

"(H) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subparagraph (A) and in subsection (b)(6).

"(I) REVIEW OF MARKETING MATERIALS.—Conduct a review of marketing materials proposed by an individual or entity furnishing services under any such program.

"(J) ADDITIONAL FUNCTIONS.—Perform such other functions as the Secretary may specify.

"(8) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

"(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

"(d) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

''(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to require individuals and entities with agreements to provide health care items or services under programs specified under subsection (a), and entities with program administration contracts under subsection (c), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of such program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

''(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under a program specified in subsection (a) from the Health Insurance and Supplementary Medical Insurance Trust Funds in amounts that do not exceed 50 percent of the savings to such Trust Funds attributable to such programs (or in the case of the program specified in subsection (a)(1), in amounts authorized under such program), in accordance with the following:

"(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—The Secretary may make bonus payments under each program specified in subsection (a) to program administrators.

"(B) PAYMENTS TO INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the programs specified in paragraphs (1), (2), (3), and (6) of subsection (a), or may authorize a program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

"(ii) LIMITATIONS.—The Secretary may limit bonus payments under clause (i) to particular service areas, types of individuals or entities furnishing items or services under a program, or kinds of items or services, and may condition such payments on the achievement of such standards related to efficiency, improvement in proc-

esses or outcomes of care, or such other factors as the Secretary determines to be appropriate.

''(3) ANTIDISCRIMINATION LIMITATION.—

''(A) IN GENERAL.—The Secretary shall not enter into an agreement with an individual or entity to provide health care items or services under a program specified under subsection (a), or with an entity to administer such a program, unless such individual or entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under such program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed to prohibit such individual or entity from taking any action explicitly authorized by the provisions of section 1866B (care coordination services) or section 1866C (disease management services).

''(e) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to a pro-

gram specified in subsection (a) shall not be subject to review by a judicial or administrative tribunal:

''(1) Limiting the implementation of a program under subsection (b)(2).

''(2) The establishment of program participation standards under subsection (b)(5); or the denial or termination of, or refusal to renew, an agreement with an individual or entity to provide health care items and services under the program.

''(3) The determination of a beneficiary's eligibility under subsection (b)(6)(B).

''(4) The establishment of program administration contract performance standards under subsection (c)(6); or the refusal to renew a program administration contract; or the noncompetitive award or renewal of a program administration contract under subsection (c)(4)(B).

''(5) The establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

''(6) A determination with respect to a program (where specifically authorized by the program authority or by subsection (d)(2))—

''(A) as to whether cost savings have been achieved, and the amount of savings;

"(B) as to whether, to whom, and in what amounts bonuses will be paid; or

"(C) as to whether to reduce or eliminate beneficiary cost-sharing.

"(f) APPLICATION LIMITED TO PARTS A AND B.—None of the provisions of this section or of the programs specified in subsection (a) shall apply to the programs under parts C and D.

"(g) REPORTS TO CONGRESS.—Not later than 2 years after the date of enactment of this section, and biennially thereafter for 6 years, the Secretary shall report to Congress on the use of authorities under each of sections 1866A through 1866G. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this title.".

(b) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

"(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDI-

CARE.—In the case of a designated health service, if the designated health service is—

''(A) included in the services under section 1866B, 1866C, 1866E, or 1866G; and

''(B) provided by an individual or entity meeting such criteria related to quality assurance, financial disclosure, and other factors as the Secretary may find appropriate.''.

SEC. 138. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

(a) CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE COMPANIES.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''with carriers'' and inserting ''with agencies and organizations (in this section referred to as 'carriers')''; and

(2) by repealing subsection (f).

(b) SECRETARIAL FLEXIBILITY IN CONTRACTING FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CARRIER FUNCTIONS.—

(1) AUTHORITY TO ENTER INTO CONTRACTS.—

(A) IN GENERAL.—Section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a)) is amended to read as follows:

''(a)(1) The Secretary may enter into contracts with agencies or organizations to perform any or all of the following functions, or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other organizations) to—

''(A) determine (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this part to be made to providers of services;

''(B) make payments described in subparagraph (A);

''(C) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as providers of services;

''(D) serve as a center for, and communicate to individuals entitled to benefits under this part and to providers of services, any information or instructions furnished to the agency or organization by the Secretary, and serve as a channel of communication from individuals entitled to benefits under this part and from providers of services to the Secretary;

''(E) make such audits of the records of providers of services as may be necessary to ensure that proper payments are made under this part;

''(F) perform the functions described by subsection (d); and

''(G) perform such other functions as are necessary to carry out the purposes of this part.

''(2) In this title and title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section.''.

(B) PREREQUISITES FOR CONTRACTS.—Section 1816(b)(1)(A) of the Social Security Act (42 U.S.C. 1395h(b)(1)(A)) is amended by striking ''after applying the standards, criteria, and procedures'' and inserting ''after evaluating the ability of the agency or organization to fulfill the contract performance requirements''.

(C) DUTIES OF FISCAL INTERMEDIARIES; RIGHTS OF PROVIDERS.—Section 1816(d) of the Social Security Act (42 U.S.C. 1395h(d)) is amended to read as follows:

''(d) Each provider of services shall have a fiscal intermediary that—

''(1) acts as a single point of contact for the provider of services under this part;

''(2) makes its services sufficiently available to meet the needs of the provider of services; and

''(3) is responsible and accountable for arranging the resolution of issues raised under this part by the provider of services.''.

(D) SOLICITATION OF COMMENTS FOR PERFORMANCE EVALUATIONS.—Section 1816(e) of the Social Security Act (42 U.S.C. 1395h(e)) is amended to read as follows:

''(e) The Secretary, in evaluating the performance of a fiscal intermediary, may solicit comments from providers of services.''.

(E) CONSULTATION WITH RESPECT TO PERFORMANCE REQUIREMENTS FOR FISCAL INTERMEDIARIES.—Section 1816(f)(1) of the Social Security Act (42 U.S.C. 1395h(f)) is amended to read as follows:

''(f)(1) With respect to the establishment of contract performance requirements, the Secretary may consult with—

''(A) Medicare+Choice organizations under part C of this title;

''(B) providers of services and other persons who furnish items or services for which payment may be made under this title; and

''(C) organizations and agencies performing functions necessary to carry out the purposes of this part.''.

(F) CONSULTATION WITH RESPECT TO PERFORMANCE REQUIREMENTS FOR CARRIERS.—Section 1842(b)(2) of the Social Security Act (42 U.S.C. 1395u(b)(2)) is amended—

(i) in subparagraph (A)—

(I) by inserting ''(i)'' before ''No such contract'';

(II) by striking the second sentence and inserting the following new clause:

''(ii) With respect to the establishment of contract performance requirements, the Secretary may consult with—

''(I) Medicare+Choice organizations under part C of this title;

''(II) providers of services and other persons who furnish items or services for which payment may be made under this title; and

''(III) organizations and agencies performing functions necessary to carry out the purposes of this part.'';

(III) by striking the third sentence; and

(IV) by striking the fourth sentence and inserting the following new clause:

''(iii) The Secretary may not require, as a condition of entering into a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.'';

(ii) in subparagraph (B), in the matter preceding clause (i), by striking ''establish standards'' and inserting ''develop contract performance requirements''; and

(iii) in subparagraph (D), by striking ''standards and criteria'' each place it appears and inserting ''contract performance requirements''.

(2) CONFORMING AMENDMENTS.—

(A) PREREQUISITES FOR CONTRACTS.—Section 1816(b) of the Social Security Act (42 U.S.C. 1395h(b)) is amended—

(i) in the matter preceding paragraph (1), by striking ''an agreement'' and inserting ''a contract'';

(ii) in paragraph (1)(B), by striking ''agreement'' and inserting ''contract''; and

(iii) in paragraph (2)(A), by striking ''agreement'' and inserting ''contract''.

(B) TERMS AND CONDITIONS OF CONTRACTS; PROMPT PAYMENT OF CLAIMS.—Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended—

(i) in paragraph (1)—

(I) in the first sentence, by striking ''An agreement'' and inserting ''A contract''; and

(II) in the last sentence, by striking ''an agreement'' and inserting ''a contract'';

(ii) in paragraph (2)—

(I) in subparagraph (A), in the matter preceding clause (i), by striking ''Each agreement under this section'' and inserting ''Each contract under this section that provides for

making payments under this part''; and

(II) in subparagraph (C), by striking ''hospital, rural primary care hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency'' and inserting ''provider of services (as defined in section 1861(u))''; and

(iii) in paragraph (3)(A), by striking ''agreement under this section'' and inserting ''contract under this section that provides for making payments under this part''.

(C) SURETY BONDS.—Section 1816(h) of the Social Security Act (42 U.S.C. 1395h(h)) is amended—

(i) by striking ''An agreement'' and inserting ''A contract''; and

(ii) by striking ''the agreement'' each place it appears and inserting ''the contract''.

(D) LIMITATION ON LIABILITY FOR CERTIFYING AND DISBURSING OFFICERS.—Section

1816(i)(1) of the Social Security Act (42 U.S.C. 1395h(i)(1)) is amended by striking ''an agreement'' and inserting ''a contract''.

(E) DENIAL OF CLAIM; NOTIFICATION AND RECONSIDERATION.—Section 1816(j) of the Social Security Act (42 U.S.C. 1395h(j)) is amended in the matter preceding paragraph (1)—

(i) by striking ''An agreement'' and inserting ''A contract''; and

(ii) by striking ''for home health services, extended care services, or post-hospital extended care services''.

(F) ANNUAL REPORTING REQUIREMENT ON ERRONEOUS PAYMENT RECOVERY.—Section 1816(k) of the Social Security Act (42 U.S.C. 1395h(k)) is amended—

(i) by striking ''An agreement'' and inserting ''A contract''; and

(ii) by inserting ''(as appropriate)'' after ''submit''.

(G) COORDINATION WITH MEDICARE INTEGRITY PROGRAM.—Section 1816(l) of the Social Security Act (42 U.S.C. 1395h(l)) is

amended by striking ''an agreement'' and inserting ''a contract''.

(H) AUTHORITY TO ENTER INTO CONTRACTS WITH CARRIERS.—Section 1842(a) of the Social Security Act (42 U.S.C. 1395u(a)) is amended—

(i) in the matter preceding paragraph (1)—

(I) by striking ''carriers with which agreements'' and inserting ''single contracts under section 1816 and this section together, or separate contracts with eligible agencies and organizations with which contracts''; and

(II) by striking ''some or all of the following functions'' and inserting ''any or all of the following functions, or parts of those functions''; and

(ii) in paragraph (3), by inserting ''(to and from individuals enrolled under this part and to and from physicians and other entities that furnish items and services)'' after ''communication''.

(I) APPLICABILITY OF COMPETITIVE BIDDING PROVISIONS; FINDINGS AS TO FINANCIAL

RESPONSIBILITIES; CONTRACTUAL DUTIES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended—

(i) in paragraph (2)(C), in the first sentence, by inserting ''(as appropriate)'' after ''carriers'';

(ii) in paragraph (3), in the matter preceding subparagraph (A), by inserting ''(as appropriate)'' after ''contract'';

(iii) in paragraph (7)(A), in the matter preceding clause (i), by striking ''the carrier'' and inserting ''a carrier''; and

(iv) in paragraph (11)(A), in the matter preceding clause (i), by inserting ''(as appropriate)'' after ''each carrier''.

(J) PARTICIPATING PHYSICIAN OR SUPPLIER; CONTRACTS WITH THE SECRETARY; PAYMENT OF CLAIMS ON ASSIGNMENT.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended—

(i) in paragraph (2), in the first sentence—

(I) by striking ''an agreement'' and inserting ''a contract''; and

(II) by inserting ''(as appropriate)'' after ''shall'';

(ii) in paragraph (3)(A), by striking ''an agreement'' and inserting ''a contract'';

(iii) in paragraph (3)(B), in the third sentence, by striking ''agreements'' and inserting ''contracts'';

(iv) in paragraph (5)(A), by inserting ''(as appropriate)'' after ''carriers''; and

(v) in paragraph (8)—

(I) by striking ''an agreement'' and inserting ''a contract''; and

(II) by striking ''such agreement'' and inserting ''such contract''.

(c) ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS.—

(1) FISCAL INTERMEDIARIES.—Section 1816 of the Social Security Act (42 U.S.C. 1395h) is amended—

(A) in subsection (b), in the matter preceding paragraph (1), by striking ''or renew'';

(B) in subsection (c)(1), in the last sentence, by striking ''or renewing''; and

(C) by repealing subsection (g).

(2) CARRIERS.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by repealing paragraph (5).

(d) REPEAL OF FISCAL INTERMEDIARY REQUIREMENTS THAT ARE NOT COST-EFFECTIVE.—Section 1816(f)(2) of the Social Security Act (42 U.S.C. 1395h(f)(2)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''standards and criteria established under'' and inserting ''contract performance requirements described in''; and

(2) by striking subparagraph (A) and inserting the following new subparagraph:

''(A) with respect to claims for services furnished under this part by any provider of services (as defined in section 1861(u)) other than a hospital, whether such agency or organization is able to process 75 percent of reconsiderations within 60 days and 90 percent of reconsiderations within 90 days; and''.

(e) REPEAL OF COST REIMBURSEMENT REQUIREMENTS.—

(1) FISCAL INTERMEDIARIES.—Section 1816(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended—

(A) in the first sentence—

(i) by striking the comma after ''appropriate'' and inserting ''and''; and

(ii) by striking '', and shall provide for payment'' and all that follows before the period; and

(B) by striking the second and third sentences.

(2) CARRIERS.—Section 1842(c)(1) of the Social Security Act (42 U.S.C. 1395u(c)(1)) is amended—

(A) in the first sentence—

(i) by striking ''section shall provide'' and inserting ''section may provide''; and

(ii) by striking '', and shall provide'' and all that follows before the period; and

(B) by striking the second and third sentences.

(3) CONFORMING AMENDMENT TO DEFICIT REDUCTION ACT.—Subsection (a) of section 2326 of the Deficit Reduction Act of 1984 (42 U.S.C. 1395h note) is repealed.

(f) SECRETARIAL FLEXIBILITY WITH RESPECT TO RENEWING CONTRACTS AND TRANSFER OF FUNCTIONS.—

(1) FISCAL INTERMEDIARIES.—Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended by adding at the end the following:

''(4)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

''(B)(i) The Secretary may renew a contract with a fiscal intermediary under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the fiscal intermediary has met or exceeded the performance requirements established in the current contract.

''(ii) Functions may be transferred among fiscal intermediaries without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.''.

(2) CARRIERS.—Section 1842(b)(1) of the Social Security Act (42 U.S.C. 1395u(b)(1)) is amended to read as follows:

''(b)(1)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

''(B)(i) The Secretary may renew a contract with a carrier under subsection (a) from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the carrier has met or exceeded the performance requirements established in the current contract.

''(ii) Functions may be transferred among carriers without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.''.

(g) WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS.—Contracts that have periods that begin before or during the 1-year period that begins on the first day of the fourth calendar month that begins after the date of enactment of this Act may be entered into under section 1816(a) or 1842(a) of the Social Security Act (42 U.S.C. 1395h(a) and 1395u(a)) without regard to any provision of law requiring the use of competitive procedures.

(h) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section apply to contracts that have periods beginning after the third calendar month that begins after the date of enactment of this Act.

(2) ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS.—The amendments made by subsection (c) apply to contracts that have periods ending on or after the end of the third calendar month that begins after the date of enactment of this Act.

(3) SECRETARIAL FLEXIBILITY WITH RESPECT TO RENEWING CONTRACTS AND TRANSFER OF FUNCTIONS.—The amendments made by subsection (f) apply to contracts that have periods that begin after the end of the 1-year period specified in subsection (g).

TITLE II—MEDICARE+CHOICE COMPETITION

SEC. 201. REVISION OF MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

(a) AREAS IN FLORIDA.—Section 4011 of the Balanced Budget Act of 1997 (42 U.S.C. 1395w–23 note) is amended—

(1) by striking subsection (b)(2)(B) and inserting the following:

''(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A)—

''(i) 2 shall be in Florida; and

''(ii) 3 shall be in urban areas and 1 shall be in a rural area.''; and

(2) in subsection (c), by adding at the end the following new paragraph:

''(3) IMPLEMENTATION OF PROJECT IN AREAS IN FLORIDA.—The Secretary shall ensure that the areas in Florida designated pursuant to subsection (b)(2)(B)(i) be the first 2 areas in which the project is implemented.''.

(b) BUDGET NEUTRALITY DURING 5-FISCAL-YEAR PERIOD.—Section 4011(g) of the Balanced Budget Act of 1997 (42 U.S.C. 1395w–23 note) is amended—

(1) by striking ''for a fiscal year'' and inserting ''for any 5-fiscal-year period''; and

(2) by inserting ''for such period'' after ''4001,''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 533 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–389), as enacted into law by section 1000(a)(6) of Public Law 106–113.

TITLE III—MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 301. MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM.

(a) ESTABLISHMENT.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered outpatient drug' means any of the following products:

''(i) A drug which may be dispensed only upon prescription, and—

''(I) which is approved for safety and effectiveness as a prescription drug under section 505 of the Federal Food, Drug, and Cosmetic Act;

''(II)(aa) which was commercially used or sold in the United States be-

fore the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

''(III)(aa) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) for which the Secretary has

not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(ii) A biological product which—

''(I) may only be dispensed upon prescription;

''(II) is licensed under section 351 of the Public Health Service Act; and

''(III) is produced at an establishment licensed under such section to produce such product.

''(iii) Insulin approved under appropriate Federal law, including needles, syringes, and disposable pumps for the administration of such insulin.

''(iv) A prescribed drug or biological product that would meet the requirements of clause (i) or (ii) except that it is available over-the-counter in addition to being available upon prescription.

''(B) EXCLUSION.—The term 'covered outpatient drug' does not include any product—

''(i) except as provided in subparagraph (A)(iv), which may be distributed to individuals without a prescription;

''(ii) for which payment is available under part A or B or would be available under part B but for the application of a deductible under such part (unless payment for such product is not available because benefits under part A or B have been exhausted), determined without regard to whether the beneficiary involved is entitled to benefits under part A or enrolled under part B; or

''(iii) except for agents used to promote smoking cessation, for which coverage may be excluded or restricted under section 1927(d)(2).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A or enrolled under part B.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate to provide eligible beneficiaries with covered outpatient drugs under a plan under this part, including—

''(A) a pharmacy benefit management company;

''(B) a retail pharmacy delivery system;

''(C) a health plan or insurer;

''(D) a State (through mechanisms established under a State plan under title XIX);

''(E) any other entity approved by the Secretary; or

''(F) any combination of the entities described in subparagraphs (A) through (E) if the Secretary determines that such combination—

''(i) increases the scope or efficiency of the provision of benefits under this part; and

''(ii) is not anticompetitive.

''(4) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms

'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to Medicare+Choice organizations).

''(5) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860J) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—Beginning in 2004, the Secretary shall provide for and administer an outpatient prescription drug benefit program under which each eligible beneficiary enrolled under this part shall be provided with coverage of covered outpatient drugs as follows:

''(A) MEDICARE+CHOICE PLAN.—If the eligible beneficiary is eligible to enroll in a Medicare+Choice plan, the beneficiary may enroll in such a plan and obtain coverage of covered outpatient drugs through such plan.

''(B) MEDICARE PRESCRIPTION DRUG PLAN.—If the eligible beneficiary is not enrolled

in a Medicare+Choice plan, the beneficiary shall obtain coverage of covered outpatient drugs through enrollment in a plan offered by an eligible entity with a contract under this part.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program established under this part.

''(3) SCOPE OF BENEFITS.—The program established under this part shall provide for coverage of all therapeutic classes of covered outpatient drugs.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860B(a)(2)(A)(vi)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860B(a)(2)(A)(iii), is permitted to subsequently enroll under this part without any penalty and obtain coverage of covered outpatient drugs in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT

''SEC. 1860B. (a) ENROLLMENT UNDER THIS PART.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive covered outpatient drugs under this title.

''(2) ENROLLMENT PROCEDURES.—

''(A) LATE ENROLLMENT PENALTY.—

''(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, in the case of an eligible beneficiary whose coverage period under this part began pur-

suant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in subparagraph (B), the Secretary shall establish procedures for increasing the amount of the monthly part D premium under section 1860D applicable to such beneficiary—

"(I) by an amount that is equal to 10 percent of such premium for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled; or

"(II) if determined appropriate by the Secretary, by an amount that the Secretary determines is actuarially sound for each such period.

"(ii) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under clause (i), there shall be taken into account—

''(I) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(II) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(iii) PERIODS NOT TAKEN INTO ACCOUNT.—

''(I) IN GENERAL.—For purposes of calculating any 12-month period under clause (i), subject to subclause (II), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (vi)).

''(II) APPLICATION.—This clause shall only apply with respect to a cov-

erage period the enrollment for which occurs before the end of the 60-day period that begins on the first day of the month which includes—

"(aa) in the case of a beneficiary with coverage described in subclause (II) of clause (vi), the date on which the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of the coverage provided under the program under this part; or

"(bb) in the case of a beneficiary with coverage described in subclause (I), (III), or (IV) of clause (vi), the date on which the beneficiary loses eligibility for such coverage.

"(iv) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly part D premium under clause (i) with respect to a particular continuous period of eligibility shall not be ap-

plicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(v) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(I) IN GENERAL.—Subject to subclause (II), for purposes of this subparagraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(II) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for pur-

poses of subsequently applying this subparagraph).

"(vi) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

"(I) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934 and through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997).

"(II) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, and a qualified retiree

prescription drug plan as defined in section 1860I(e)(3), that provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(III) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(IV) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

''(B) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—The Secretary shall establish an applicable period, which shall begin on the date on which the Sec-

retary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may enroll under this part without the application of the late enrollment procedures established under subparagraph (A)(i).

''(3) PERIOD OF COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(B) OPEN ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part pursuant to paragraph (2)(B) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(C) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2004.

''(4) TERMINATION.—

''(A) IN GENERAL.—The causes of termination specified in section 1838 shall apply to

this part in the same manner as such causes apply to part B.

''(B) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—

''(i) IN GENERAL.—In addition to the causes of termination specified in subparagraph (A), the Secretary shall terminate an individual's coverage under this part if the individual is no longer enrolled in either part A or B.

''(ii) EFFECTIVE DATE.—The termination described in clause (i) shall be effective on the effective date of termination of coverage under part A or (if later) under part B.

''(C) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Secretary shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Secretary under subsection (b)(1)).

''(b) ENROLLMENT IN A PLAN.—

''(1) PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall make an annual election to enroll in any plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(B) RULES.—In establishing the process under subparagraph (A), the Secretary shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a Medicare+Choice plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than paragraph (3)(C)(i), relating to default enrollment); and

"(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

"(2) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of covered outpatient drugs under this part through such plan.

"(c) FIRST ENROLLMENT PERIOD.—The processes developed under subsections (a) and (b) shall ensure that eligible beneficiaries are permitted to enroll under this part and with an eligible entity prior to January 1, 2004, in order to ensure that coverage under this part is effective as of such date.

"(d) ENROLLMENT IN A MEDICARE+CHOICE PLAN.—Enrollment in a Medicare+Choice plan is subject to the rules for enrollment in such plan under section 1851.

"PROVIDING INFORMATION TO BENEFICIARIES

"SEC. 1860C. (a) ACTIVITIES.—

"(1) IN GENERAL.—The Secretary shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and pro-

spective eligible beneficiaries) regarding the coverage provided under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860B(c).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Secretary under section 1851(d);

''(B) be coordinated with the activities performed by the Secretary under such section and under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan, including the prices bene-

ficiaries will be charged for covered outpatient drugs, any preferred pharmacy networks used by the eligible entity under the plan, and the formularies and appeals processes under the plan.

''(B) QUALITY AND PERFORMANCE.—To the extent available, the quality and performance of the eligible entity offering the plan.

''(C) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(D) CONSUMER SATISFACTION SURVEYS.—To the extent available, the results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Secretary may prescribe.

''(3) INFORMATION STANDARDS.—The Secretary shall develop standards to ensure that the information provided to eligible beneficiaries under this part is complete, accurate, and uniform.

''(c) USE OF MEDICARE CONSUMER COALITIONS TO PROVIDE INFORMATION.—

"(1) IN GENERAL.—The Secretary may contract with Medicare Consumer Coalitions to conduct the informational activities—

"(A) under this section;

"(B) under section 1851(d); and

"(C) under section 1804.

"(2) SELECTION OF COALITIONS.—If the Secretary determines the use of Medicare Consumer Coalitions to be appropriate, the Secretary shall—

"(A) develop and disseminate, in such areas as the Secretary determines appropriate, a request for proposals for Medicare Consumer Coalitions to contract with the Secretary in order to conduct any of the informational activities described in paragraph (1); and

"(B) select a proposal of a Medicare Consumer Coalition to conduct the informational activities in each such area, with a preference for broad participation by organizations with experience in providing information to beneficiaries under this title.

"(3) PAYMENT TO MEDICARE CONSUMER COALITIONS.—The Secretary shall make payments to Medicare Consumer Coalitions contracting under

this subsection in such amounts and in such manner as the Secretary determines appropriate.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to contract with Medicare Consumer Coalitions under this section.

''(5) MEDICARE CONSUMER COALITION DEFINED.—In this subsection, the term 'Medicare Consumer Coalition' means an entity that is a nonprofit organization operated under the direction of a board of directors that is primarily composed of beneficiaries under this title.

''PREMIUMS

''SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF MONTHLY PART D PREMIUM RATES.—

''(1) IN GENERAL.—The Secretary shall, during September of each year (beginning in 2003), determine and promulgate a monthly part D premium rate for the succeeding year in accordance with the provisions of this subsection.

''(2) ACTUARIAL DETERMINATIONS.—

''(A) DETERMINATION OF ANNUAL BENEFIT AND ADMINISTRATIVE COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of

the benefits and administrative costs that will be payable from the Prescription Drug Account for providing covered outpatient drugs in such calendar year with respect to enrollees in the program under this part.

''(B) DETERMINATION OF MONTHLY PART D PREMIUM RATES.—

''(i) IN GENERAL.—The Secretary shall determine the monthly part D premium rate for such succeeding year, which shall be 1/12 of the applicable share of—

''(I) the amount determined under subparagraph (A); divided by

''(II) the total number of enrollees under this part,

rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) DEFINITION OF APPLICABLE SHARE.—For purposes of clause (i), the term 'applicable share' means—

''(I) one-half, in the case of premiums paid by an eligible beneficiary enrolled in the program under this part; and

"(II) two-thirds, in the case of premiums paid for such a beneficiary by an employer (as defined in section 1860I(e)(2)) with which the beneficiary was formerly employed.

"(3) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly part D premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under paragraphs (1) and (2).

"(4) COLLECTION OF PART D PREMIUM.—The monthly part D premium applicable to an eligible beneficiary under this part (after application of any increase under subsection (b) or under section 1860B(a)(2)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

"(b) SLIDING SCALE PREMIUM.—

"(1) INCREASE.—

"(A) AMOUNT.—

"(i) IN GENERAL.—Except as provided in paragraph (4), in the case of an eligible beneficiary whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the Secretary shall increase the amount of the monthly part D premium for such individual established under subsection (a) by an amount which bears the same ratio to such premium as such excess bears to an amount equal to ⅓ of the applicable threshold amount under subparagraph (B).

"(ii) LIMITATION.—In no event shall the increase described in clause (i) exceed an amount equal to 50 percent of the monthly part D premium established under subsection (a).

"(B) DEFINITION OF THRESHOLD AMOUNT.—For purposes of this subsection, the term 'threshold amount' means—

"(i) except as otherwise provided in this subparagraph, $75,000;

"(ii) $150,000 in the case of a joint return; and

"(iii) zero in the case of a taxpayer who—

"(I) is married at the close of the taxable year but does not file a joint return for such year; and

"(II) does not live apart from his spouse at all times during the taxable year.

"(C) INFLATION ADJUSTMENT FOR THRESHOLD AMOUNT.—

"(i) IN GENERAL.—In the case of any calendar year beginning after 2004, each of the dollar amounts in clauses (i) and (ii) of subparagraph (B) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year, exceeds

such average for the 12-month period ending with June 2003.

''(ii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $5, such dollar amount shall be rounded to the nearest multiple of $5.

''(D) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(E) DEFINITION OF JOINT RETURN.—For purposes of this subsection, the term 'joint return' has the meaning given the term in section 7701(a)(38) of the Internal Revenue Code of 1986.

''(2) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—The Secretary shall make an initial determination of the amount of an eligible beneficiary's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) NOTICE.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each eligible beneficiary whom the Secretary finds (on the basis of the beneficiary's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the beneficiary will be subject to such an increase, and shall include in such notice the Secretary's estimate of the beneficiary's modified adjusted gross income for the year.

''(B) CALCULATION BASED ON INFORMATION PROVIDED BY BENEFICIARY.—If, during the 60-day period beginning on the date notice is provided to an eligible beneficiary under subparagraph (A), the beneficiary provides the Sec-

retary with appropriate information (as determined by the Secretary) on the beneficiary's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the beneficiary shall be based on the information provided by the beneficiary.

''(C) CALCULATION BASED ON NOTICE AMOUNT IF NO INFORMATION IS PROVIDED BY THE BENEFICIARY OR IF THE SECRETARY DETERMINES THAT THE PROVIDED INFORMATION IS NOT APPROPRIATE.—The amount initially determined by the Secretary under this paragraph with respect to an eligible beneficiary shall be the amount included in the notice provided to the beneficiary under subparagraph (A) if—

''(i) the beneficiary does not provide the Secretary with information under subparagraph (B); or

''(ii) the Secretary determines that the information provided by the beneficiary to the Secretary under such subparagraph is not appropriate.

''(3) ADJUSTMENTS.—

''(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an eligible beneficiary's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the beneficiary's monthly part D premium under this part (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly part D premiums paid by the beneficiary under this part during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the beneficiary during the previous calendar year if the amount of the beneficiary's modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the beneficiary's

modified adjusted gross income determined under this paragraph.

''(B) INTEREST.—

''(i) INCREASE.—In the case of an eligible beneficiary for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the beneficiary under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the beneficiary's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under clause (ii) for each of the months described in such clause.

''(ii) COMPUTATION.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (com-

pounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the eligible beneficiary provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the beneficiary's monthly part D premium is increased under this paragraph.

''(iii) EXCEPTION.—Interest shall not be imposed under this subparagraph if the amount of the eligible beneficiary's modified adjusted gross income provided by the beneficiary under subparagraph (B) of paragraph (2) was not less than the beneficiary's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) STEPS TO RECOVER AMOUNTS DUE FROM PREVIOUSLY ENROLLED BENE-

FICIARIES.—In the case of an eligible beneficiary who is not enrolled under this part for any calendar year for which the beneficiary's monthly part D premium under this part for months during the year would be increased pursuant to subparagraph (A) if the beneficiary were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the beneficiary the total amount by which the beneficiary's monthly part D premium under this part for months during the year would have been increased under subparagraph (A) if the beneficiary were enrolled under this part for the year.

''(D) DECEASED BENEFICIARY.—In the case of a deceased eligible beneficiary for whom the amount of the monthly part D premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the beneficiary were not deceased, the Secretary shall make a payment to the beneficiary's surviving spouse (or, in the case of an eligible beneficiary who does not have a surviving spouse,

to the beneficiary's estate) in an amount equal to the difference between—

"(i) the total amount by which the beneficiary's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

"(ii) the amount (if any) by which the beneficiary's premium was decreased for months during the year pursuant to subparagraph (A).

"(4) WAIVER BY SECRETARY.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

"(5) TRANSFER TO PRESCRIPTION DRUG ACCOUNT.—The Secretary shall transfer amounts received pursuant to this subsection to the Prescription Drug Account.

"OUTPATIENT PRESCRIPTION DRUG BENEFITS

"SEC. 1860E. (a) REQUIREMENT.—A plan offered by an eligible entity under this part shall provide eligible beneficiaries enrolled in such plan with—

''(1) coverage of covered outpatient prescription drugs with the cost-sharing described in subsection (b); and

''(2) access to negotiated prices for such drugs under subsection (c).

''(b) COST-SHARING.—

''(1) DEDUCTIBLE.—

''(A) IN GENERAL.—Subject to subparagraph (B), there is an annual deductible that is equal to $250.

''(B) WAIVER OF DEDUCTIBLE FOR GENERIC DRUGS.—

''(i) IN GENERAL.—An eligible entity offering a plan under this part may provide, with respect to such plan, that generic drugs are not subject to the deductible described in subparagraph (A) if the Secretary determines that the waiver of the deductible—

''(I) is tied to the performance goals described in section 1860H(b)(1)(C); and

''(II) will not result in an increase in the expenditures made from the Prescription Drug Account.

''(ii) CREDIT FOR AMOUNTS PAID.—If the deductible is waived pursuant to clause (i), any coinsurance paid by an eligible beneficiary for the generic drug shall be credited toward the annual deductible.

''(2) COINSURANCE.—

''(A) ESTABLISHMENT.—

''(i) IN GENERAL.—Subject to subparagraph (B) and subparagraphs (A)(i) and (B) of section 1860G(b)(4), if any covered outpatient drug is provided to an eligible beneficiary in a year after the beneficiary has met any deductible requirement under paragraph (1) for the year, the beneficiary shall be responsible for making payments for the drug in an amount equal to the applicable percentage of the cost of the drug.

''(ii) APPLICABLE PERCENTAGE DEFINED.—For purposes of clause (i), the 'applicable percentage' means, with respect to any covered outpatient drug provided to an eligible beneficiary in a year—

''(I) 50 percent to the extent the out-of-pocket expenses of the bene-

ficiary for such drug, when added to the out-of-pocket expenses of the beneficiary for covered outpatient drugs previously provided in the year, do not exceed $3,500;

"(II) 25 percent to the extent such expenses, when so added, exceed $3,500 but do not exceed $4,000; and

"(III) 0 percent to the extent such expenses, when so added, would exceed $4,000.

"(iii) OUT-OF-POCKET EXPENSES DEFINED.—For purposes of clause (ii), the term 'out-of-pocket expenses' means expenses incurred as a result of the application of the deductible under paragraph (1) and the coinsurance required under this subsection.

"(B) REDUCTION BY ELIGIBLE ENTITY.—An eligible entity offering a plan under this part may reduce the applicable percentage that an eligible beneficiary enrolled in the plan is subject to under subparagraph (A) if the Secretary determines that such reduction—

"(i) is tied to the performance goals described in section 1860H(b)(1)(C); and

"(ii) will not result in an increase in the expenditures made from the Prescription Drug Account.

"(3) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any calendar year beginning after 2004, each of the dollar amounts in paragraphs (1)(A) and (2)(A)(ii) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the percentage (if any) by which the amount of average per capita expenditures under this part in the preceding calendar year exceeds the amount of such expenditures in 2004.

"(B) ROUNDING.—If any dollar amount after being increased under subparagraph (A) is not a multiple of $5, such dollar amount shall be rounded to the nearest multiple of $5.

"(c) ACCESS TO NEGOTIATED PRICES.—Under a plan offered by an eligible entity with a contract under this part, the eligible entity offering such plan shall provide eligible beneficiaries enrolled in such plan with access

to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits or only partial benefits may be payable under the coverage with respect to such drugs because of the application of the deductible under subsection (b)(1) or the coinsurance under subsection (b)(2).

''ENTITIES ELIGIBLE TO PROVIDE OUTPATIENT DRUG BENEFIT

''SEC. 1860F. (a) ESTABLISHMENT OF PANELS OF PLANS AVAILABLE IN AN AREA.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which the Secretary—

''(A) accepts bids submitted by eligible entities for the plans which such entities intend to offer in an area established under subsection (b); and

''(B) awards contracts to such entities to provide such plans to eligible beneficiaries in the area.

''(2) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

''(b) AREA FOR CONTRACTS.—

''(1) REGIONAL BASIS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to paragraph (2), the contract entered into between the Secretary and an eligible entity with respect to a plan shall require the eligible entity to provide coverage of covered outpatient drugs under the plan in a region determined by the Secretary under paragraph (2).

''(B) PARTIAL REGIONAL BASIS.—

''(i) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the coverage described in subparagraph (A) to be provided in a partial region determined appropriate by the Secretary.

''(ii) REQUIREMENTS.—If the Secretary permits coverage pursuant to clause (i), the Secretary shall ensure that the partial region in which coverage is provided is—

''(I) at least the size of the commercial service area of the eligible entity for that area; and

''(II) not smaller than a State.

''(2) DETERMINATION.—

"(A) IN GENERAL.—In determining regions for contracts under this part, the Secretary shall—

"(i) take into account the number of eligible beneficiaries in an area in order to encourage participation by eligible entities; and

"(ii) ensure that there are at least 10 different regions in the United States.

"(B) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of coverage areas under this part shall not be subject to administrative or judicial review.

"(c) SUBMISSION OF BIDS.—

"(1) SUBMISSION.—

"(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity desiring to offer a plan under this part in an area shall submit a bid with respect to such plan to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

"(B) BID THAT COVERS MULTIPLE AREAS.—The Secretary shall permit an eligible

entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

''(2) REQUIRED INFORMATION.—The bids described in paragraph (1) shall include—

''(A) a proposal for the estimated prices of covered outpatient drugs and the projected annual increases in such prices, including differentials between formulary and nonformulary prices, if applicable;

''(B) a statement regarding the amount that the entity will charge the Secretary for administering and delivering the benefits under the contract;

''(C) a statement regarding whether the entity will waive the deductible for generic drugs pursuant to section 1860E(b)(1)(B), and if so, how such waiver is tied to the performance goals described in section 1860H(b)(1)(C);

''(D) a statement regarding whether the entity will reduce the applicable coinsurance percentage pursuant to section 1860E(b)(2)(B) and if so, the amount of such reduction and how such reduction is tied to the performance goals described in section 1860H(b)(1)(C);

''(E) a detailed description of the performance goals for which the administrative fee of the entity will be subject to risk pursuant to section 1860H(b)(1)(C);

''(F) a detailed description of access to pharmacy services provided under the plan, including information regarding—

''(i) whether the entity will use a preferred pharmacy network under the plan;

''(ii) if a preferred pharmacy network is used, whether the entity will offer access to pharmacies that are outside such network, and if such access is provided, the increased coinsurance that beneficiaries will be subject to if they obtain drugs at such pharmacies;

''(G) if the entity utilizes a formulary, a detailed description of the procedures and standards the entity will use for—

''(i) adding new drugs to a therapeutic class within the formulary; and

''(ii) determining when and how often the formulary should be modified;

''(H) a detailed description of any ownership or shared financial interests with other en-

tities involved in the delivery of the benefit as proposed under the plan;

''(I) a detailed description of the entity's estimated marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries; and

''(J) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

''(d) ACCESS TO BENEFITS IN CERTAIN AREAS.—

''(1) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient drugs under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

''(2) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

''(e) AWARDING OF CONTRACTS.—

''(1) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goal of containing costs under this title, award in a competitive manner at least 2 contracts to offer a plan in an area, unless only 1 bidding entity (and the plan offered by the entity) meet the minimum standards specified under this part and by the Secretary.

''(2) DETERMINATION.—In determining which of the eligible entities that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of the past performance of the entity and other relevant factors, with respect to—

''(A) how well the entity (and the plan offered by the entity) meet such minimum standards;

''(B) the amount that the entity will charge the Secretary for administering and delivering the benefits under the contract;

''(C) the performance goals for which the administrative fee of the entity will be subject to risk pursuant to section 1860H(b)(1)(C);

"(D) the proposed negotiated prices of covered outpatient drugs and annual increases in such prices;

"(E) the factors described in section 1860C(b)(2);

"(F) prior experience of the entity in administering a prescription drug benefit program;

"(G) effectiveness of the entity and plan in containing costs through pricing incentives and utilization management; and

"(H) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

"(3) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

"(A) is not inconsistent with the—

"(i) purposes of the programs under this title; or

"(ii) best interests of beneficiaries enrolled under this part; and

"(B) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

"(4) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to an eligible entity with respect to a plan under this part shall not be subject to administrative or judicial review.

"(f) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

"(g) DURATION OF CONTRACTS.—Each contract awarded under this part shall be for a term of at least 2 years but not more than 5 years, as determined by the Secretary.

"MINIMUM STANDARDS FOR ELIGIBLE ENTITIES

"SEC. 1860G. (a) IN GENERAL.—The Secretary shall not award a contract to an eligible entity under this part unless the Secretary finds that the eligible entity agrees

to comply with such terms and conditions as the Secretary shall specify, including the following:

''(1) QUALITY AND FINANCIAL STANDARDS.—The eligible entity meets the quality and financial standards specified by the Secretary.

''(2) PROCEDURES TO ENSURE PROPER UTILIZATION, COMPLIANCE, AND AVOIDANCE OF ADVERSE DRUG REACTIONS.—The eligible entity has in place drug utilization review procedures to ensure—

''(A) the appropriate utilization by eligible beneficiaries enrolled in the plan covered by the contract of the benefits to be provided under the plan; and

''(B) the avoidance of adverse drug reactions among such beneficiaries, including problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse and misuse.

''(3) PATIENT PROTECTIONS.—

''(A) ACCESS.—

''(i) IN GENERAL.—The eligible entity ensures that the covered outpatient drugs are accessible and convenient to eligible beneficiaries enrolled in the plan covered by the contract, including by offering the services 24 hours a day and 7 days a week for emergencies.

''(ii) PREFERRED PHARMACY NETWORKS.—If the eligible entity utilizes a preferred pharmacy network, the network complies with the standards under subsection (b)(3).

''(B) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—The eligible entity has procedures in place to ensure that—

''(i) the total charge for each covered outpatient drug dispensed to an eligible beneficiary enrolled in the plan covered by the contract does not exceed the negotiated price for the drug (as reported to the Secretary pursuant to paragraph (5)(A)); and

''(ii) the retail pharmacy dispensing the drug does not charge (or collect from) such beneficiary an amount that exceeds the beneficiary's obligation (as determined

in accordance with the provisions of this part) of the negotiated price.

''(C) RETAIL PHARMACY MEETS MINIMUM QUALITY AND TECHNOLOGY STANDARDS.—The eligible entity ensures that any retail pharmacy that it contracts with to deliver benefits under this part meets minimum quality and technology standards (as established by the Secretary).

''(D) CONTINUITY OF CARE.—

''(i) IN GENERAL.—The eligible entity ensures that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1860B(b)(1)), the entity will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another eligible entity under this part or, if eligible, with a Medicare+Choice organization.

''(ii) LIMITED PERIOD.—In no event shall an eligible entity be required to provide the extended coverage required under

clause (i) beyond the date which is 30 days after the coverage with such entity would have terminated but for this subparagraph.

''(E) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—The eligible entity has in place procedures to determine if a drug is medically necessary to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary enrolled in the plan that is covered by the contract. Such procedures shall require that such determinations are based on professional medical judgment, the medical condition of the beneficiary, and other medical evidence.

''(F) PROCEDURES REGARDING DENIALS OF CARE.—The eligible entity has in place procedures to ensure—

''(i) a timely internal and external review and resolution of denials of coverage (in whole or in part) and complaints (including those regarding the use of formularies under subsection (b)) by eligible beneficiaries enrolled in the plan that is covered by the contract, or by providers,

pharmacists, and other individuals acting on behalf of each such beneficiary (with the beneficiary's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C; and

''(ii) that eligible beneficiaries are provided with information regarding the appeals procedures under this part at the time of enrollment with the entity.

''(G) PROCEDURES REGARDING PATIENT CONFIDENTIALITY.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the plan that is covered by the contract, the entity has in place procedures to—

''(i) safeguard the privacy of any individually identifiable beneficiary information;

''(ii) maintain such records and information in a manner that is accurate and timely;

"(iii) ensure timely access by such beneficiaries to such records and information; and

"(iv) otherwise comply with applicable laws relating to patient confidentiality.

"(H) PROCEDURES REGARDING TRANSFER OF MEDICAL RECORDS.—

"(i) IN GENERAL.—The eligible entity has in place procedures for the timely transfer of records and information described in subparagraph (G) (with respect to a beneficiary who loses coverage under this part with the entity and enrolls with another entity (including a Medicare+Choice organization) under this part) to such other entity.

"(ii) PATIENT CONFIDENTIALITY.—The procedures described in clause (i) shall comply with the patient confidentiality procedures described in subparagraph (G).

"(I) PROCEDURES REGARDING MEDICAL ERRORS.—The eligible entity has in place procedures for working with the Secretary to deter medical errors related to the provision of covered outpatient drugs.

''(4) PROCEDURES TO CONTROL FRAUD, ABUSE, AND WASTE.—The eligible entity has in place procedures to control fraud, abuse, and waste.

''(5) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The eligible entity provides the Secretary with reports containing information regarding the following:

''(i) The prices that the eligible entity is paying for covered outpatient drugs.

''(ii) The prices that eligible beneficiaries enrolled in the plan that is covered by the contract will be charged for covered outpatient drugs.

''(iii) The administrative costs of providing such benefits.

''(iv) Utilization of such benefits.

''(v) Marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries.

''(B) TIMEFRAME FOR SUBMITTING REPORTS.—

''(i) IN GENERAL.—The eligible entity shall submit a report described in subparagraph (A) to the Secretary within 3 months after the end of each 12-month pe-

riod in which the eligible entity has a contract under this part. Such report shall contain information concerning the benefits provided during such 12-month period.

"(ii) LAST YEAR OF CONTRACT.—In the case of the last year of a contract under this part, the Secretary may require that a report described in subparagraph (A) be submitted 3 months prior to the end of the contract. Such report shall contain information concerning the benefits provided between the period covered by the most recent report under this subparagraph and the date that a report is submitted under this clause.

"(C) CONFIDENTIALITY OF INFORMATION.—

"(i) IN GENERAL.—Notwithstanding any other provision of law and subject to clause (ii), information disclosed by an eligible entity pursuant to subparagraph (A) (except for information described in clause (ii) of such subparagraph) is confidential and shall only be used by the Secretary for

the purposes of, and to the extent necessary, to carry out this part.

''(ii) UTILIZATION DATA.—Subject to patient confidentiality laws, the Secretary shall make information disclosed by an eligible entity pursuant to subparagraph (A)(iv) (regarding utilization data) available for research purposes. The Secretary may charge a reasonable fee for making such information available.

''(6) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The eligible entity complies with the requirements described in section 1860F(f).

''(7) RECORDS AND AUDITS.—The eligible entity maintains adequate records related to the administration of the benefit under this part and affords the Secretary access to such records for auditing purposes.

''(b) SPECIAL RULES REGARDING COST-EFFECTIVE PROVISION OF BENEFITS.—

''(1) IN GENERAL.—In providing the benefits under a contract under this part, an eligible entity may—

''(A) employ mechanisms to provide the benefits economically, including the use of—

"(i) formularies (pursuant to paragraph (2));

"(ii) alternative methods of distribution;

"(iii) preferred pharmacy networks (pursuant to paragraph (3)); and

"(iv) generic drug substitution;

"(B) use mechanisms to encourage eligible beneficiaries to select cost-effective drugs or less costly means of receiving drugs, including the use of pharmacy incentive programs, therapeutic interchange programs, and disease management programs; and

"(C) encourage pharmacy providers to—

"(i) inform beneficiaries of the differentials in price between generic and nongeneric drug equivalents; and

"(ii) provide medication therapy management programs in order to enhance beneficiaries' understanding of the appropriate use of medications and to reduce the risk of potential adverse events associated with medications.

"(2) FORMULARIES.—If an eligible entity uses a formulary under this part, such formulary shall

comply with standards established by the Secretary in consultation with the Medicare Prescription Drug Advisory Committee established under section 1860K. Such standards shall require that the eligible entity—

"(A) use a pharmacy and therapeutic committee (that meets the standards for a pharmacy and therapeutic committee established by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) to develop and implement the formulary;

"(B) include in the formulary—

"(i) at least 1 drug from each therapeutic class (as defined by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee);

"(ii) if there is more than 1 drug available in a therapeutic class, at least 2 drugs from such class unless determined clinically inappropriate in accordance with standards established by the Secretary; and

"(iii) if there are more than 2 drugs available in a therapeutic class, at least 2 drugs from such class and a generic drug

substitute if available unless determined clinically inappropriate in accordance with standards established by the Secretary;

''(C) develop procedures for the modification of the formulary, including for the addition of new drugs to an existing therapeutic class;

''(D) provide for coverage of nonformulary drugs when determined (pursuant to subparagraph (E) or (F)(i) of subsection (a)(3)) to be medically necessary to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary;

''(E) disclose to current and prospective beneficiaries and to providers in the service area the nature of the formulary restrictions, including information regarding the drugs included in the formulary, coinsurance, and any difference in the cost-sharing for different types of drugs; and

''(F) provide a reasonable amount of notice to beneficiaries enrolled in the plan that is covered by the contract under this part of any change in the formulary.

''(3) PREFERRED PHARMACY NETWORKS.—

''(A) IN GENERAL.—If an eligible entity uses a preferred pharmacy network to deliver benefits under this part, such network shall meet minimum access standards established by the Secretary.

''(B) STANDARDS.—In establishing standards under subparagraph (A), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(4) CONSTRUCTION.—

''(A) FORMULARIES.—Nothing in this part shall be construed as precluding an eligible entity from—

''(i) requiring cost-sharing for nonformulary drugs that is higher than the cost-sharing established in section 1860E(b)(2), except that such entity shall provide for coverage of a nonformulary drug at the same cost-sharing level as a drug within the formulary if such nonformulary drug is determined (pursuant to subparagraph (E) or (F)(i) of subsection (a)(3)) to be medically necessary to prevent or slow the dete-

rioration of, or improve or maintain, the health of an eligible beneficiary;

''(ii) educating prescribing providers, pharmacists, and beneficiaries about the medical and cost benefits of formulary drugs (including generic drugs); or

''(iii) requesting prescribing providers to consider a formulary drug prior to dispensing of a nonformulary drug, as long as such request does not unduly delay the provision of the drug.

''(B) PREFERRED PHARMACY NETWORKS.—Nothing in this part shall be construed as precluding the entity from requiring cost-sharing for a covered outpatient drug that is higher than the cost-sharing established in section 1860E(b)(2) if the drug was obtained at a pharmacy that is not in such network.

''PAYMENTS

''SEC. 1860H. (a) PROCEDURES FOR PAYMENTS TO ELIGIBLE ENTITIES.—The Secretary shall establish procedures for making payments to each eligible entity with a contract under this part for the administration and delivery of the benefits under this part.

''(b) REQUIREMENTS FOR PROCEDURES.—

''(1) IN GENERAL.—The procedures established under subsection (a) shall provide for the following:

''(A) ADMINISTRATIVE PAYMENT.—Payment of administrative fees for such administration and delivery.

''(B) REIMBURSEMENT FOR COSTS OF DRUGS PROVIDED.—Payments for the costs of covered outpatient drugs provided to eligible beneficiaries enrolled under this part and in a plan offered by the eligible entity.

''(C) RISK REQUIREMENT.—An adjustment of a percentage (determined under paragraph (2)) of the administrative fee payments made to an eligible entity to ensure that the entity, in administering and delivering the benefits under this part, pursues performance goals established by the Secretary, including the following:

''(i) QUALITY SERVICE.—The entity provides eligible beneficiaries enrolled in the plan that is covered by the contract under this part with quality services, as measured by such factors as sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and

member service support access, response time in mail delivery service, and timely action with regard to appeals and current beneficiary service surveys.

''(ii) QUALITY CLINICAL CARE.—The entity provides such beneficiaries with quality clinical care, as measured by such factors as providing—

''(I) notification to such beneficiaries and to providers in order to prevent adverse drug reactions; and

''(II) specific clinical suggestions to improve health and patient and prescriber education as appropriate.

''(iii) CONTROL OF MEDICARE COSTS.—The entity contains costs to the Prescription Drug Account, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of beneficiaries to medically necessary covered outpatient drugs.

''(2) PERCENTAGE OF PAYMENT TIED TO RISK.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the percentage of the administrative payments to an eligible entity that will be tied to the performance goals described in paragraph (1)(C).

"(B) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this subsection at a level that jeopardizes the ability of an eligible entity to administer and deliver the benefits under this part or administer and deliver such benefits in a quality manner.

"(3) RISK ADJUSTMENT OF PAYMENTS BASED ON ENROLLEES IN PLAN.—To the extent that an eligible entity is at risk under this subsection, the procedures established under subsection (a) may include a methodology for risk adjusting the payments made to such entity based on the differences in actuarial risk of different enrollees being served if the Secretary determines such adjustments to be necessary and appropriate.

"(c) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—For provisions related to payments to Medicare+Choice organizations for the administration

and delivery of benefits under this part to eligible beneficiaries enrolled in a Medicare+Choice plan offered by the organization, see section 1853(c)(8).

''(d) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860I. (a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section to be known as the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (e)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain

such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the outpatient prescription drug benefit under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the Secretary, for each calendar quarter for which it seeks an incentive payment under this section, the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of

audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and comply with such other requirements, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made by the Secretary on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined in paragraph (2), for each retired individual (or spouse) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for but was not enrolled in the outpatient prescription drug benefit program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to ⅔ of the monthly part D premium amount payable by an eligible beneficiary enrolled under this part, as set for the calendar year pursuant to section 1860D(a)(2).

''(3) PAYMENT DATE.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals

(or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(2) EMPLOYER.—The term 'employer' has the meaning given the term in section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs whose actuarial value (as defined by the Secretary) to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' in section 3(16)(B) of the Employer Retirement Income Security Act of 1974.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, such sums as may be necessary to carry out the program under this section.

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860J. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the

Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including payments to eligible entities under section 1860H and payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFER TO PART A AND B TRUST FUNDS FOR MEDICARE+CHOICE PAYMENTS.—The Managing Trustee shall establish procedures for the transfer of funds from the Account, in an amount determined appropriate by the Secretary, to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in order to reimburse such trust funds for payments to Medicare+Choice organizations for the provision of covered outpatient drugs pursuant to section 1853(c)(8).

''(3) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not

be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part in the year exceed the premiums collected under section 1860D(a)(4) for the year.

''MEDICARE PRESCRIPTION DRUG ADVISORY COMMITTEE

''SEC. 1860K. (a) ESTABLISHMENT OF COMMITTEE.—There is established a Medicare Prescription Drug Advisory Committee (in this section referred to as the 'Committee').

''(b) FUNCTIONS OF COMMITTEE.—On and after March 1, 2002, the Committee shall advise the Secretary on policies related to—

''(1) the development of guidelines for the implementation and administration of the outpatient prescription drug benefit program under this part; and

''(2) the development of—

''(A) standards for a pharmacy and therapeutics committee required of eligible entities under section 1860G(b)(2)(A);

''(B) standards required of eligible entities under subparagraphs (E) and (F) of section 1860G(a)(3) for determining if a drug is medically necessary to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary;

''(C) standards for—

''(i) defining therapeutic classes; and

''(ii) adding new therapeutic classes to a formulary;

''(D) procedures to evaluate the bids submitted by eligible entities under this part; and

''(E) procedures to ensure that eligible entities with a contract under this part are in compliance with the requirements under this part.

''(c) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

''(1) STRUCTURE.—The Committee shall be composed of 19 members who shall be appointed by the Secretary.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and

shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Committee.

''(B) SPECIFIC MEMBERS.—Of the members appointed under paragraph (1)—

''(i) nine shall be chosen to represent physicians;

''(ii) four shall be chosen to represent pharmacists;

''(iii) one shall be chosen to represent the Centers for Medicare & Medicaid Services;

''(iv) four shall be chosen to represent actuaries, pharmacoeconomists, researchers, and other appropriate experts; and

''(v) one shall be chosen to represent emerging drug technologies.

''(d) TERMS OF APPOINTMENT.—Each member of the Committee shall serve for a term determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on January 1, 2002.

''(e) CHAIRPERSON.—The Secretary shall designate a member of the Committee as Chairperson. The term as Chairperson shall be for a 1-year period.

''(f) COMMITTEE PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

''(2) STAFF.—The Committee may appoint such personnel as the Committee considers appropriate.

''(g) OPERATION OF THE COMMITTEE.—

''(1) MEETINGS.—The Committee shall meet at the call of the Chairperson (after consultation with the other members of the Committee) not less often than quarterly to consider a specific agenda of issues, as determined by the Chairperson after such consultation.

''(2) QUORUM.—Ten members of the Committee shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(i) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) EXCLUSIONS FROM COVERAGE.—

(1) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(2) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF REASONABLE AND NECESSARY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking ''and'' at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

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

''(J) in the case of prescription drugs covered under part D, which are not reasonable and necessary to prevent or slow the deterioration of, or improve or maintain, the health of eligible beneficiaries;''.

(c) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860J'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and section 1860D(a)(4) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1860D(a)(4) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(d) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title.

SEC. 302. PART D BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(2) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(b) VOLUNTARY BENEFICIARY ENROLLMENT FOR DRUG COVERAGE.—Section 1852(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(c) ACCESS TO SERVICES.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(1) in subparagraph (D), by striking ''and'' at the end;

(2) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) in the case of covered outpatient drugs (as defined in section 1860(1)) provided to individuals enrolled under part D, the organization complies with the access requirements applicable under part D.''.

(d) PAYMENTS TO ORGANIZATIONS.—Section 1853(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(1) by inserting ''determined separately for the benefits under parts A and B and under part D (for

individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(2) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for the benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(3) by inserting before the last sentence the following: ''In the case of the payments for the benefits under part D, such payment shall be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate to ensure actuarial equivalence.''.

(e) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate''; and

(2) by adding at the end the following new paragraph:

''(8) PAYMENT FOR PART D BENEFITS.—The Secretary shall determine a capitation rate for part D benefits (for individuals enrolled under such part) as follows:

''(A) DRUGS DISPENSED IN 2004.—In the case of prescription drugs dispensed in 2004, the capitation rate shall be based on the projected national per capita costs for prescription drug benefits under part D and associated claims processing costs for beneficiaries enrolled under part D and not enrolled with a Medicare+Choice organization under this part.

''(B) DRUGS DISPENSED IN SUBSEQUENT YEARS.—In the case of prescription drugs dispensed in a subsequent year, the capitation rate shall be equal to the capitation rate for the preceding year increased by the Secretary's estimate of the projected per capita rate of annual growth in expenditures under this title for an individual enrolled under part D for such subsequent year.''.

(f) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of the Social Security Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PART D BENEFITS.—With respect to outpatient prescription drug benefits under part D, a Medicare+Choice organization may not require that an enrollee pay a deductible or a co-

insurance percentage that exceeds the deductible or coinsurance percentage applicable for such benefits for an eligible beneficiary under part D.''.

(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of the Social Security Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for the benefits under parts A and B and for prescription drug benefits under part D.''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services provided under a Medicare+Choice plan on or after January 1, 2004.

SEC. 303. REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY REGARDING SLIDING SCALE PART D PREMIUM.

(a) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

''(18) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT SLIDING SCALE MEDICARE PART D PREMIUM.—

"(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Department of Health and Human Services return information with respect to a taxpayer who is required to pay a monthly part D premium under part D of the medicare program. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the adjusted gross income of such taxpayer,

"(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

"(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

"(vi) the amounts excluded from such taxpayer's gross income under sections 931

and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly part D premium under part D of the medicare program.''.

(b) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking ''or (17)'' each place it appears and inserting ''(17), or (18)''.

SEC. 304. ADDITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) INCLUSION IN MEDICARE COST-SHARING.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

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

"(iii) premiums under section 1860D(a).";

(2) in subparagraph (B), by striking "section 1813" and inserting "sections 1813 and 1860E(b)(2)"; and

(3) in subparagraph (C), by striking "section 1813 and section 1833(b)" and inserting "sections 1813, 1833(b), and 1860E(b)(1)".

(b) EXPANSION OF MEDICAL ASSISTANCE.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) in clause (iii)—

(A) by striking "section 1905(p)(3)(A)(ii)" and inserting "clauses (ii) and (iii) of section 1905(p)(3)(A), for the coinsurance described in section 1860E(b)(2), and for the deductible described in section 1860E(b)(1)"; and

(B) by striking "and" at the end;

(2) by redesignating clause (iv) as clause (vi); and

(3) by inserting after clause (iii) the following new clauses:

"(iv) for making medical assistance available for medicare cost-sharing described in sec-

tion 1905(p)(3)(A)(iii), for the coinsurance described in section 1860E(b)(2), and for the deductible described in section 1860E(b)(1) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 120 percent but does not exceed 135 percent of such official poverty line for a family of the size involved;

''(v) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) on a linear sliding scale based on the income of such individuals for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 135 percent but does not exceed 150 percent of such official poverty line for a family of the size involved; and''.

(c) NONAPPLICABILITY OF PAYMENT DIFFERENTIAL REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1902(n)(2) of the Social Security Act (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following new sentence: ''The preceding sentence shall not

apply to coinsurance described in section 1860E(b)(2) or deductibles described in section 1860E(b)(1).''.

(d) 100 PERCENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking ''and'' before ''(4)''; and

(2) by inserting before the period at the end the following: '', and (5) the Federal medical assistance percentage shall be 100 percent with respect to medical assistance provided under clauses (iv) and (v) of section 1902(a)(10)(E)''.

(e) TREATMENT OF TERRITORIES.—Section 1108(g) of such Act (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(3) Notwithstanding the preceding provisions of this subsection, with respect to fiscal year 2004 and any fiscal year thereafter, the amount otherwise determined under this subsection (and subsection (f)) for the fiscal year for a Commonwealth or territory shall be increased by the ratio (as estimated by the Secretary) of—

''(A) the aggregate amount of payments made to the 50 States and the District of Columbia for the fiscal year under title XIX that are attributable to making medical assistance available for individ-

uals described in clauses (i), (iii), (iv), and (v) of section 1902(a)(10)(E) for payment of medicare cost-sharing that consists of premiums under section 1860D(a), coinsurance described in section 1860E(b)(2), or deductibles described in section 1860E(b)(1); to

''(B) the aggregate amount of total payments made to such States and District for the fiscal year under such title.''.

(f) CONFORMING AMENDMENTS.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended—

(1) in subsection (a), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)'';

(2) in subsection (c)(2)(A)—

(A) in clause (i), by striking ''section 1902(a)(10)(E)(iv)(I)'' and inserting ''section 1902(a)(10)(E)(vi)(I)''; and

(B) in clause (ii), by striking ''section 1902(a)(10)(E)(iv)(II)'' and inserting ''section 1902(a)(10)(E)(vi)(II)'';

(3) in subsection (d), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)''; and

(4) in subsection (e), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply for medical assistance provided under section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) on and after January 1, 2004.

SEC. 305. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZED BENEFIT PACKAGES FOR MEDICARE SUPPLEMENTAL POLICIES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages classified as 'H', 'I', and 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) shall be revised so that—

''(i) the coverage of outpatient prescription drugs available under such benefit packages is replaced with coverage of

outpatient prescription drugs that complements but does not duplicate the coverage of outpatient prescription drugs that is otherwise available under this title;

"(ii) the revised benefit packages provide a range of coverage options for outpatient prescription drugs for beneficiaries, but do not provide coverage for—

"(I) the deductible under section 1860E(b)(1); or

"(II) more than 90 percent of the coinsurance applicable to an individual under section 1860E(b)(2);

"(iii) uniform language and definitions are used with respect to such revised benefits;

"(iv) uniform format is used in the policy with respect to such revised benefits;

"(v) such revised standards meet any additional requirements imposed by the Medicare Reform Act of 2001; and

"(vi) except as revised under the preceding clauses or as provided under subsection (p)(1)(E), the benefit packages are identical to the benefit packages that were

available on the date of enactment of the Medicare Reform Act of 2001.

''(B) MANNER OF REVISION.—The benefit packages revised under this section shall be revised in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2004.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'G' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) GUARANTEED ISSUANCE AND RENEWAL OF REVISED POLICIES.—The provisions of subsections (q) and (s), including provisions of subsection (s)(3) (relating to special enrollment periods in cases of termination or disenrollment), shall apply to medicare supplemental policies revised under this

subsection in the same manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(4) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE REVISED POLICIES.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer with a benefit package that is revised under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer—

''(i) provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860B(b)(2)(B), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address of that individual) of the offer described in clause (ii) and of the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of outpatient prescription drugs under part D; and

"(ii) offers the policyholder or certificate holder under the terms described in subparagraph (B), during at least the period established under section 1860B(b)(2)(B), a medicare supplemental policy with the benefit package that the Secretary determines is most comparable to the policy in which the individual is enrolled with coverage effective as of the date on which the individual is first entitled to benefits under part D.

"(B) TERMS OF OFFER DESCRIBED.—The terms described in this subparagraph are terms which do not—

"(i) deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (A)(ii) that is offered and is available for issuance to new enrollees by such issuer;

"(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

"(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

"(5) ELIMINATION OF OBSOLETE POLICIES WITH NO GRANDFATHERING.—Except as provided in subparagraph (B), no person may sell, issue, or renew a medicare supplemental policy with a benefit package that is classified as 'H', 'I', or 'J' (or with a benefit package classified as 'J' with a high deductible feature) that has not been revised under this subsection on or after January 1, 2004.

"(6) PENALTIES.—Each penalty under this section shall apply with respect to policies revised under this subsection as if such policies were issued under the standards established under subsection (p), including the penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).".

SEC. 306. STUDIES AND REPORT TO CONGRESS.

(a) STUDIES.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility and advisability of—

(1) establishing a uniform format for pharmacy benefit cards provided to beneficiaries by eligible entities under the outpatient prescription drug benefit

program under part D of title XVIII of the Social Security Act (as added by section 301); and

(2) developing systems to electronically transfer prescriptions under such program from the prescriber to the pharmacist.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the results of the studies conducted under subsection (a), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such studies.

TITLE IV—MEDICARE WELLNESS

SEC. 400. DEFINITIONS.

In this title:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means any individual who is entitled to benefits under part A or enrolled under part B of the medicare program, including any individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

(2) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under

title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle A—Healthy Seniors Promotion Program

SEC. 401. DEFINITIONS.

In this subtitle:

(1) COST-EFFECTIVE BENEFIT.—The term ''cost-effective benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) demonstrated value as measured by unit costs relative to health outcomes achieved.

(2) COST-SAVING BENEFIT.—The term ''cost-saving benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) caused a net reduction in health care costs for medicare beneficiaries.

(3) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity that the Working Group (as defined in paragraph (6)) determines has demonstrated expertise regarding health promotion and disease prevention among medicare beneficiaries.

(4) MEDICALLY EFFECTIVE.—The term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under normal programmatic conditions.

(5) MEDICALLY EFFICACIOUS.—The term ''medically efficacious'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under controlled conditions.

(6) WORKING GROUP.—The term ''Working Group'' means the Working Group on Disease Self-Management and Health Promotion established under section 402.

SEC. 402. WORKING GROUP ON DISEASE SELF-MANAGEMENT AND HEALTH PROMOTION.

(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Working Group on Disease Self-Management and Health Promotion.

(b) COMPOSITION.—

(1) IN GENERAL.—Subject to paragraph (2), the Working Group shall be composed of 5 members as follows:

(A) The Administrator of the Centers for Medicare & Medicaid Services.

(B) The Director of the Centers for Disease Control and Prevention.

(C) The Director of the Agency for Healthcare Research and Quality.

(D) The Assistant Secretary for Aging.

(E) The Director of the National Institutes of Health.

(2) ALTERNATIVE MEMBERSHIP.—Any member of the Working Group described in a subparagraph of paragraph (1) may appoint an individual who is an officer or employee of the Federal Government to serve as a member of the Working Group instead of the member described in such subparagraph.

(c) DUTIES.—The duties of the Working Group are as follows:

(1) HEALTHY SENIORS PROMOTION GRANTS.—The Working Group shall establish general policies and criteria with respect to the functions of the Secretary under section 403, including—

(A) priorities for the approval of applications submitted under subsection (c) of such section;

(B) procedures for monitoring and evaluating research efforts conducted under such section; and

(C) such other matters relating to the grant program established under such section as are recommended by the Working Group and approved by the Secretary.

(2) DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS.—The Working Group shall establish general policies and criteria with respect to the functions of the Secretary under section 404, including—

(A) the identification of medical conditions for which a demonstration project under such section may be implemented;

(B) the prioritization of the conditions identified under subparagraph (A) based on the potential for the self-management of such condition to be medically effective and for such self-management to be a cost-effective benefit or cost-saving benefit;

(C) the identification of target individuals (as defined in section 404(a)(2));

(D) the development of procedures for selecting areas in which such a demonstration project may be implemented; and

(E) such other matters relating to such demonstration projects as are recommended by the Working Group and approved by the Secretary.

(d) CHAIRPERSON.—The Secretary shall designate 1 of the members of the Working Group to be the chairperson of the Group.

(e) QUORUM.—A majority of the members of the Working Group shall constitute a quorum, but, subject to subsection (f), a lesser number of members may hold meetings.

(f) MEETINGS.—The Working Group shall meet at the call of the chairperson, except that—

(1) it shall meet not less than 4 times each year; and

(2) it shall meet upon the written request of a majority of the members.

(g) COMPENSATION OF MEMBERS.—Each member of the Working Group shall serve without compensation in addition to that received for their service as an officer or employee of the Federal Government.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this section.

SEC. 403. HEALTHY SENIORS PROMOTION GRANTS.

(a) PROGRAM AUTHORIZED.—The Secretary, using the general policies and criteria established by the Working Group under section 402(c)(1) and in accordance with the provisions of this section, is authorized to make grants to eligible entities (as defined in section 401(3)) to pay for the costs of the activities described in subsection (b).

(b) USE OF FUNDS.—An eligible entity may use payments received under this section in any fiscal year to conduct a program to—

(1) study whether using different types of providers of care and alternative settings (including community-based senior centers) for the implementation of a successful health promotion and disease

prevention strategy, including the implications regarding the payment of such providers, is medically efficacious or medically effective;

(2) determine the most effective means of educating medicare beneficiaries, either directly or through providers of care, regarding the importance of health promotion and disease prevention among such beneficiaries;

(3) identify incentives that would increase the use of new and existing preventive health benefits and healthy behaviors by medicare beneficiaries;

(4) promote—

(A) the use of preventive health benefits by medicare beneficiaries, including such services that are covered under the medicare program;

(B) the proper use by medicare beneficiaries of prescription and over-the-counter drugs in order to reduce the number of hospital stays and physician visits that are a result of improper use of such drugs; and

(C) the utilization by medicare beneficiaries of the steps (including exercise, maintenance of a proper diet, and the utilization of accident prevention techniques) that research has

shown to promote and safeguard individual health; and

(5) address other topics designated by the Secretary.

(c) APPLICATION.—

(1) IN GENERAL.—Each eligible entity that desires to receive a grant under this section shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may reasonably require.

(2) CONTENTS.—Each application submitted under paragraph (1) shall—

(A) describe the activities for which assistance under this section is sought;

(B) describe how such activities will—

(i) reflect the medical, behavioral, and social aspects of care for medicare beneficiaries;

(ii) lead to the development of cost-effective benefits and cost-saving benefits; and

(iii) impact the quality of life of medicare beneficiaries;

(C) provide assurances that such activities will focus on broad medicare populations rather than unique local medicare populations;

(D) provide evidence that the eligible entity meets the general policies and criteria established by the Working Group under section 402(c)(1);

(E) provide assurances that the eligible entity will take such steps as may be available to the entity in order to continue the activities for which the entity is making application after the period for which assistance is sought; and

(F) provide such additional assurances as the Secretary determines to be essential to ensure compliance with the requirements of this subtitle.

(3) JOINT APPLICATION.—A consortium of eligible entities may file a joint application under the provisions of paragraph (1).

(d) APPROVAL OF APPLICATION.—The Secretary shall approve applications in accordance with the general policies and criteria established by the Working Group under section 402(c)(1).

(e) PAYMENTS.—Subject to amounts appropriated under subsection (g), the Secretary shall pay to each eligi-

ble entity having an application approved under subsection (d) the cost of the activities described in the application.

(f) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an annual evaluation of grants made under this section to determine—

(A) the results of the activities conducted under the programs for which grants were made under this section;

(B) the extent to which research assisted under this section has improved or expanded the general research for health promotion and disease prevention among medicare beneficiaries and identified practical interventions based upon such research;

(C) a list of specific recommendations based upon the activities conducted under the programs for which grants were made under this section which show promise as practical interventions for health promotion and disease prevention among medicare beneficiaries;

(D) whether or not, as a result of the activities conducted under the programs for which grants were made under this section, certain health promotion and disease prevention bene-

fits or education efforts should be added to the medicare program, including discussions of quality of life, translating the applied research results into a benefit under the medicare program, and whether each additional benefit would be a cost-effective benefit or a cost-saving benefit for each proposed addition; and

(E) how best to increase utilization of existing and recommended health promotion and disease prevention services, such as an education and public awareness campaign, providing financial incentives for providers of care and medicare beneficiaries, or utilizing other administrative means.

(2) ANNUAL REPORT.—Not later than December 31, 2003, and annually thereafter through 2005, the Secretary, in consultation with the Working Group, shall submit a report to Congress on the evaluation conducted under paragraph (1), together with such recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purpose of car-

rying out this section $50,000,000 for each of fiscal years 2002, 2003, 2004, and 2005.

SEC. 404. DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary shall conduct demonstration projects for the purpose of promoting disease self-management for conditions identified by the Working Group under section 402(c)(2) for target individuals (as defined in paragraph (2)).

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual who—

(A) is at risk for, or has, 1 or more of the conditions identified by the Working Group under section 402(c)(2); and

(B) is enrolled under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.) or is enrolled under the Medicare+Choice program under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.).

(b) NUMBER; PROJECT AREAS; DURATION.—

(1) NUMBER.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement a series of demonstration projects to carry out the purpose described in subsection (a)(1).

(2) PROJECT AREAS.—The Secretary shall implement the demonstration projects described in paragraph (1) in urban, suburban, and rural areas.

(3) DURATION.—The demonstration projects under this section shall be conducted during the 3-year period beginning on the date on which the initial demonstration project is implemented.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 18 months after the conclusion of the demonstration projects under this section, the Secretary shall submit a report to Congress on such projects.

(2) CONTENTS OF REPORT.—The report required under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

(i) whether each benefit provided under the demonstration projects is a cost-effective benefit or a cost-saving benefit;

(ii) the level of the disease self-management attained by target individuals under the demonstration projects; and

(iii) the satisfaction of target individuals under the demonstration projects.

(C) Recommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis.

(D) Such recommendations for legislation and administrative action as the Secretary determines to be appropriate.

(E) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed $30,000,000 for the costs of carrying out this section.

Subtitle B—Medicare Coverage of Preventive Health Benefits

SEC. 411. THERAPY AND COUNSELING FOR CESSATION OF TOBACCO USE.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section

105(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–471), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) supplemental preventive health services (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 115(b), is amended by adding at the end the following new subsection:

''Supplemental Preventive Health Services

''(xx) The term 'supplemental preventive health services' means the following:

''(1)(A) Therapy and counseling for cessation of tobacco use for individuals who use tobacco products or who are being treated for tobacco use that is furnished—

''(i) by or under the supervision of a physician; or

''(ii) by any other health care professional who—

''(I) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(II) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(B) Subject to subparagraph (C), such term is limited to—

''(i) therapy and counseling services recommended in 'Treating Tobacco Use and Dependence: A Clinical Practice Guideline', published by the Public Health Service in June 2000, or any subsequent modification of such Guideline; and

''(ii) such other therapy and counseling services that the Secretary recognizes to be effective.

''(C) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING FOR ALL SUPPLEMENTAL PREVENTIVE HEALTH SERVICES.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by sections 111(b)(2)(A) and 112(b)(2)(A), is amended—

(A) in subparagraph (N), by inserting ''other than supplemental preventive health services (as defined in section 1861(xx))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(V)''; and

(C) by inserting before the semicolon at the end the following: '', and (W) with respect to supplemental preventive health services (as defined in section 1861(xx)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848 by the Secretary for the particular supplemental preventive health service involved''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–

4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to supplemental preventive health services (as defined in section 1861(xx)),''.

(4) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 111(b)(2)(B), is amended—

(A) by striking ''and'' before ''(7)''; and

(B) by inserting before the period the following: '', and (8) such deductible shall not apply with respect to supplemental preventive health services (as defined in section 1861(xx))''.

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by section 105(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–472), as enacted into law by section 1(a)(6) of Public Law 106–

554, is amended by adding at the end the following new clause:

''(vii) Any health care professional designated under section 1861(xx)(1)(A)(ii)(II) to perform therapy and counseling for cessation of tobacco use.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 412. COUNSELING FOR POST-MENOPAUSAL WOMEN.

(a) COVERAGE.—Section 1861(xx) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as added by section 411(b), is amended by adding at the end the following new paragraph:

''(2)(A) Counseling for post-menopausal women.

''(B) For purposes of subparagraph (A), the term 'counseling for post-menopausal women' means counseling provided to a post-menopausal woman regarding—

''(i) the symptoms, risk factors, and conditions associated with menopause;

''(ii) appropriate treatment options for post-menopausal women, including hormone replacement therapy; and

''(iii) other interventions that can be implemented to prevent or delay the onset of health risks associated with menopause.

''(C) Such term does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 413. SCREENING FOR DIMINISHED VISUAL ACUITY.

(a) COVERAGE.—Section 1861(xx) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 412(a), is amended by adding at the end the following new paragraph:

''(3)(A) Screening for diminished visual acuity.

''(B) For purposes of subparagraph (A), the term 'screening for diminished visual acuity' means a screening for diminished visual acuity that is furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 414. SCREENING FOR HEARING IMPAIRMENT.

(a) COVERAGE.—Section 1861(xx) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 413(a), is amended by adding at the end the following new paragraph:

''(4)(A) Screening for hearing impairment.

''(B) For purposes of subparagraph (A), the term 'screening for hearing impairment' means the following services:

''(i) A screening for hearing impairment using periodic questions that is furnished by—

''(I) a physician, including an otolaryngologist;

''(II) a qualified audiologist (as defined in subsection (ll)(3)(B)); or

''(III) any other health care professional who is legally authorized to furnish such screening under State law (or the State regulatory mechanism provided by State law) of the State in which the screening is furnished.

''(ii) If the answers to such questions indicate potential hearing impairment, an otoscopic examination and an audiometric screening test that are furnished by an otolaryngologist or a qualified audiologist (as so defined).

''(iii) If the results of such examination or test indicate a need for assistive listening devices (whether or not such examination or test was based on a screening or was diagnostic), counseling about such devices that is furnished by an otolaryngologist or a qualified audiologist (as so defined).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 415. SCREENING FOR CHOLESTEROL.

(a) COVERAGE.—Section 1861(xx) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 414(a), is amended by adding at the end the following new paragraph:

''(5)(A) Screening for cholesterol if the individual involved has not had such a screening during the preceding 5 years.

''(B) Notwithstanding subparagraph (A), payment may be made under this part for a screening for cholesterol with respect to an individual even if the individual has had such a screening during the preceding 5 years if the individual exhibits major risk factors for coronary heart disease or a stroke, including, but not limited to, smoking, hypertension, and diabetes.''.

(b) CONFORMING AMENDMENT.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by section 301(b)(2), is amended—

(1) in subparagraph (I), by striking ''and'' at the end;

(2) in subparagraph (J), by striking the semicolon at the end and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(K) in the case of a screening for cholesterol, which is performed more frequently than is covered under section 1861(xx)(5);''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 416. SCREENING FOR HYPERTENSION.

(a) COVERAGE.—Section 1861(xx) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 415(a), is amended by adding at the end the following new paragraph:

''(6)(A) Screening for hypertension if the individual involved has not had such a screening during the preceding 2 years.

''(B) Notwithstanding subparagraph (A), payment may be made under this part for a screening for hypertension with respect to an individual even if the individual has had such a screening during the preceding 2 years if the individual has a history of, or is at risk for, hypertension.''.

(b) CONFORMING AMENDMENT.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by section 415(b), is amended—

(1) in subparagraph (J), by striking ''and'' at the end;

(2) in subparagraph (K), by striking the semicolon at the end and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(L) in the case of a screening for hypertension, which is performed more frequently than is covered under section 1861(xx)(6);''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 417. EXPANSION OF ELIGIBILITY FOR BONE MASS MEASUREMENT.

(a) EXPANSION.—Section 1861(rr)(2) of the Social Security Act (42 U.S.C. 1395x(rr)(2)) is amended to read as follows:

''(2) For purposes of this subsection, the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

''(A) an estrogen-deficient woman (including those receiving hormone replacement therapy);

''(B) an individual with low trauma or fragility fractures (including vertebral abnormalities and hip, rib, wrist, pelvic, or proximal humeral fractures);

''(C) an individual receiving long-term medications that have associations to bone loss or osteoporosis (including glucocorticoid therapy and androgen deprivation therapy);

''(D) an individual with a long-term medical condition that has association to osteoporosis (including primary hyperparathyroidism);

''(E) a man with risk factors for osteoporosis such as hypogonadism; and

''(F) an individual being monitored to assess the response to, or efficacy of, an approved osteoporosis therapy.''.

(b) REFERENCE TO ELIMINATION OF COINSURANCE AND WAIVER OF APPLICATION OF DEDUCTIBLE.—For the elimination of the coinsurance for bone mass measurement and for the waiver of the application of the part B deductible for such measurement, see section 419.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 418. COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH CARDIOVASCULAR DISEASES.

(a) IN GENERAL.—Section 1861(s)(2)(V) of the Social Security Act (42 U.S.C. 1395x(s)(2)(V)), as added by section 105(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–471), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended to read as follows:

''(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary—

''(i) with a cardiovascular disease (including congestive heart failure, arteriosclerosis, hyperlipidemia, hypertension, and hypercholesterolemia), diabetes, or a renal disease (or a combination of such conditions) who—

''(I) has not received diabetes outpatient self-management training services within a time period determined by the Secretary;

''(II) is not receiving maintenance dialysis for which payment is made under section 1881; and

''(III) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations; or

''(ii) with a combination of such conditions who—

''(I) is not described in clause (i) because of the application of subclause (I) or (II) of such clause;

''(II) receives such medical nutrition therapy services in a coordinated manner (as determined appropriate by the Secretary) with any services described in such subclauses that the beneficiary is receiving; and

''(III) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;''.

(b) ELIMINATION OF COINSURANCE.—Section 1833(a)(1)(T) of the Social Security Act (42 U.S.C. 1395l(a)(1)(T)), as added by section 105(c)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–472), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ''80 percent'' and inserting ''100 percent''.

(c) REFERENCE TO WAIVER OF APPLICATION OF DEDUCTIBLE.—For the waiver of the application of the part B deductible for medical nutrition therapy services, see section 419.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 105 of the Medicare, Medicaid, and

SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–471), as enacted into law by section 1(a)(6) of Public Law 106–554.

SEC. 419. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR EXISTING PREVENTIVE HEALTH BENEFITS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

''(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE HEALTH ITEMS AND SERVICES.—The Secretary may not require the payment of any deductible or coinsurance under subsection (a) or (b), respectively, of any individual enrolled for coverage under this part for any of the following preventive health items and services:

''(1) Blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n).

''(2) Diabetes outpatient self-management training services (as defined in section 1861(qq)(1)).

''(3) Pneumococcal, influenza, and hepatitis B vaccines and administration described in section 1861(s)(10).

''(4) Screening mammography (as defined in section 1861(jj)).

''(5) Screening pap smear and screening pelvic exam (as defined in paragraphs (1) and (2) of section 1861(nn), respectively).

''(6) Bone mass measurement (as defined in section 1861(rr)(1)).

''(7) Prostate cancer screening test (as defined in section 1861(oo)(1)).

''(8) Colorectal cancer screening test (as defined in section 1861(pp)(1)).

''(9) Screening for glaucoma (as defined in section 1861(uu)).

''(10) Medical nutrition therapy services (as defined in section 1861(vv)(1)).''.

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1)(B) of the Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is amended to read as follows: ''(B) with respect to preventive health items and services described in subsection (p), the amounts paid shall be 100 percent of the fee schedule or other basis of payment under this title for the particular item or service,''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)), as amended by section

411(c)(3), is amended by inserting after ''section 1861(xx)'' the following: ''and preventive health items and services described in section 1833(p)''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE.—Section 1833(b)(1) of the Social Security Act (42 U.S.C. 1395l(b)(1)) is amended to read as follows: ''(1) such deductible shall not apply with respect to preventive health items and services described in subsection (p),''.

(d) ADDING ''LANCET'' TO DEFINITION OF DME.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by striking ''blood-testing strips and blood glucose monitors'' and inserting ''blood-testing strips, lancets, and blood glucose monitors''.

(e) CONFORMING AMENDMENTS.—

(1) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)), as amended by section 201(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–481), as enacted into law by section 1(a)(6) of Public Law 106–554, are each amended by inserting ''or which are described in subsection (p)'' after ''assignment-related basis''.

(2) ELIMINATION OF COINSURANCE FOR CERTAIN DME.—Section 1834(a)(1)(A) of the Social Security Act (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections'';

(ii) by striking ''(I) in accordance'' and inserting the following:

''(i) in accordance'';

(iii) by striking ''(II) are performed'' and all that follows through ''payment under'' and inserting the following:

"(ii) are performed in an ambulatory surgical center or hospital outpatient department,

payment under"; and

(iv) by striking clause (ii); and

(B) in paragraph (3)(C)—

(i) by striking "(C) FACILITY PAYMENT LIMIT.—" and all that follows through "Notwithstanding subsections" and inserting the following:

"(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections"; and

(ii) by striking clause (ii).

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 420. PROGRAM INTEGRITY.

The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall integrate supplemental preventive health services (as defined in section 1861(xx) of the Social Security Act (as added by the preceding provisions of this subtitle)) with existing program integrity measures.

SEC. 421. PROMOTION OF PREVENTIVE HEALTH BENEFITS.

In order to promote the use by medicare beneficiaries of preventive health benefits, including preventive health services (as defined in section 1861(xx) of the Social Security Act (as added by the preceding provisions of this subtitle)) and preventive health items and services described in section 1833(p) of such Act (as added by section 419), the Secretary shall do the following:

(1) MEDICARE HANDBOOK AND OTHER ANNUAL NOTICES.—Include in any medicare handbook and any other annual notice provided to medicare beneficiaries a detailed description of—

(A) the preventive health benefits that are covered under the medicare program; and

(B) the importance of using such benefits.

(2) FISCAL INTERMEDIARIES AND CARRIERS.—Require that fiscal intermediaries with a contract under section 1816 of the Social Security Act (42 U.S.C. 1395h) and carriers with a contract under section 1842 of such Act (42 U.S.C. 1395u) include preventive health benefits messages on Medicare Summary Notice Statements and Explanations of Medicare Benefits distributed by such entities.

(3) MEDICARE PART B STATEMENT.—Regularly include preventive health benefits messages on the medicare part B statement.

(4) MEDICARE+CHOICE PLANS.—Require that Medicare+Choice organizations offering a Medicare+Choice plan disclose under section 1852(c)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(c)(1)(B)) information regarding the preventive health benefits that are covered under the plan.

(5) OTHER ACTIVITIES.—Conduct activities in addition to those described in paragraphs (1) through (4) that the Secretary determines to be useful in disseminating information to medicare beneficiaries regarding—

(A) the preventive health benefits that are covered under the medicare program;

(B) the importance of using such benefits; and

(C) general health promotion.

Subtitle C—National Falls Prevention Education and Awareness Campaign

SEC. 431. NATIONAL FALLS PREVENTION EDUCATION AND AWARENESS CAMPAIGN.

(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in consultation with the Administrator of the Centers for Medicare & Medicaid

Services, shall conduct a national falls prevention and awareness campaign to reduce fall-related injuries among medicare beneficiaries.

(b) REPORT TO CONGRESS.—

(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a report on the campaign conducted under this section.

(2) DEADLINE FOR REPORT.—The report required under paragraph (1) shall be submitted not later than the earlier of—

(A) 6 months after the campaign is completed; or

(B) 3 years after the campaign is implemented.

(3) CONTENTS OF REPORT.—The report required under paragraph (1) shall include the following:

(A) A description of the campaign.

(B) An evaluation of—

(i) whether the campaign has effectively reached its target population; and

(ii) the cost-effectiveness of the campaign.

(C) An assessment of whether the campaign has been effective, as measured by whether—

(i) the target population has adopted the interventions suggested in the campaign, and if not, the reasons why such interventions have not been adopted; and

(ii) the fall rates among the target population have decreased since the campaign was implemented, and if not, the reasons why such fall rates have not decreased.

(D) Any other information regarding the campaign that the Director of the Centers for Disease Control and Prevention determines to be appropriate.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this section.

Subtitle D—Clinical Depression Screening Demonstration Projects

SEC. 441. CLINICAL DEPRESSION SCREENING DEMONSTRATION PROJECTS.

(a) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term ''demonstration project'' means a demonstration project established under subsection (b)(1).

(2) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual enrolled for benefits under part B who is not enrolled in any of the following:

(A) A Medicare+Choice plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(B) A plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm).

(C) A program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee).

(D) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

(E) A health care prepayment plan under section 1833(a)(1)(A) of the Social Security Act (42 U.S.C. 1395l(a)(1)(A)).

(3) PART B.—The term ''part B'' means part B of the original medicare fee-for-service program under title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

(4) QUALIFIED HEALTH PROFESSIONAL.—The term ''qualified health professional'' means an individual that—

(A) is—

(i) a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)));

(ii) a nurse practitioner (as defined in section 1861(aa)(5) of such Act (42 U.S.C. 1395x(aa)(5))); or

(iii) a mental health care professional (including a clinical social worker, as defined in section 1861(hh) of such Act (42 U.S.C. 1395x(hh))) that is licensed to perform mental health services by the State in which a screening for clinical depression is furnished under a demonstration project; and

(B) has an agreement in effect with the Secretary under which the professional agrees to accept the amount determined by the Sec-

retary under subsection (b)(4) as full payment for such screening and to accept an assignment described in section 1842(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)(ii)) with respect to payment for each screening furnished by the professional to an eligible beneficiary participating in a demonstration project.

(5) SCREENING FOR CLINICAL DEPRESSION.—

(A) IN GENERAL.—The term ''screening for clinical depression'' means a consultation during which—

(i) a self-administered written screening test (or an alternative format for such test pursuant to subsection (b)(3)(B)) is made available to an eligible beneficiary; and

(ii) a qualified health professional—

(I) interprets the results of such test;

(II) discusses the beneficiary's responses to the questions on the test with the beneficiary;

(III) assesses the beneficiary's risk of clinical depression; and

(IV) if the qualified health professional determines that the beneficiary is at high risk for clinical depression, refers the eligible beneficiary for a full diagnostic evaluation and such additional treatment as may be required.

(B) CONSTRUCTION.—Nothing in subparagraph (A)(ii)(IV) shall be construed as prohibiting a qualified health professional performing the screening for clinical depression with respect to an individual from directly providing the diagnostic evaluation and additional treatment described in such subparagraph to such individual if legally authorized under State law to do so.

(6) SELF-ADMINISTERED WRITTEN SCREENING TEST.—The term ''self-administered written screening test'' means an instrument on which an eligible beneficiary writes answers to questions designed to enable a qualified health professional to establish the level of risk of such eligible beneficiary for clinical depression.

(b) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary shall establish and conduct demonstration projects for the purpose of evaluating the efficacy of providing screenings for clinical depression as a benefit under part B to eligible beneficiaries through qualified health professionals in accordance with the requirements of this section.

(2) NUMBER, PROJECT AREAS, DURATION.—

(A) NUMBER.—The Secretary shall establish no fewer than 6 and no more than 10 demonstration projects.

(B) PROJECT AREAS.—

(i) IN GENERAL.—The Secretary shall conduct demonstration projects in geographic areas that include urban, suburban, and rural areas.

(ii) SELECTION.—The Secretary shall select the geographic areas described in clause (i) in a manner that—

(I) ensures geographic diversity and a mix of screening sites (including physicians' offices, hospital outpatient departments, community mental health centers, and skilled nursing facilities); and

(II) gives preference to areas with a high concentration of eligible beneficiaries.

(C) DURATION.—The demonstration projects under this section shall be conducted during the 3-year period beginning on the date on which the initial demonstration project is implemented.

(3) IDENTIFICATION AND DISTRIBUTION OF SELF-ADMINISTERED TESTS.—

(A) IN GENERAL.—The Secretary, in consultation with professionals experienced in conducting large-scale depression screening projects, shall—

(i) establish or identify a self-administered written screening test to be used in conducting the demonstration projects; and

(ii) not later than the date that is 3 months before the date on which a demonstration project is implemented in a geographic area, distribute such test to each qualified health professional that provides services in such area in which the Secretary conducts a demonstration project,

together with guidelines for making the test available to eligible beneficiaries.

(B) ALTERNATIVE FORMATS FOR TEST.—The Secretary shall also establish and distribute alternative formats for the self-administered written screening test under subparagraph (A) which shall be available for use when circumstances do not permit an individual to complete the self-administered written screening test.

(4) PAYMENT FOR SCREENINGS FOR CLINICAL DEPRESSION.—

(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall provide for payment of the reasonable charges for each screening for clinical depression furnished to an eligible beneficiary by a qualified health professional from the amounts transferred under subsection (d).

(B) WAIVER OF COINSURANCE AND DEDUCTIBLES.—The Secretary may not require the payment of any deductible or coinsurance by any eligible beneficiary for a screening for clinical depression furnished under a demonstration project.

(C) FREQUENCY LIMITATION.—No payment may be made under this section for a screening for clinical depression if such a screening is performed with respect to an eligible beneficiary within the year after a previous screening of such beneficiary.

(5) WAIVER AUTHORITY.—The Secretary may waive such requirements under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as the Secretary determines necessary to carry out the demonstration projects under this section.

(c) REPORTS TO CONGRESS.—

(1) INTERIM REPORT.—

(A) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration project, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(B) CONTENTS OF REPORT.—The report submitted under subparagraph (A) shall contain—

(i) a description of the demonstration projects conducted under this section;

(ii) an evaluation of—

(I) whether screening for clinical depression is a cost-effective benefit or a cost-saving benefit; and

(II) the level of satisfaction of eligible beneficiaries to whom such a screening is furnished under the demonstration project; and

(iii) any other information regarding the demonstration projects that the Secretary determines to be appropriate.

(2) FINAL REPORT.—Not later than 1 year after the conclusion of the demonstration projects, the Secretary shall submit a final report to Congress on the demonstration projects containing the recommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis, together with such recommendations for legislation and administrative action as the Secretary considers appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed $30,000,000 for the costs of carrying out the demonstration projects under this section.

Subtitle E—Medicare Health Education and Risk Appraisal Program

SEC. 451. MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

''SEC. 1897. (a) ESTABLISHMENT.—Not later than 18 months after the date of the conclusion of the demonstration projects conducted under subsection (b)(1), the Secretary shall implement the demonstration project that the Secretary identifies as being the most effective project under subsection (c)(2)(C) on a nationwide and permanent basis.

''(b) DEMONSTRATION PROJECTS.—

''(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, in consultation with the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality, shall conduct a demonstration project for the purpose of developing a comprehen-

sive and systematic model for delivering health promotion and disease prevention services that—

"(A) through self-assessment identifies—

"(i) behavioral risk factors, such as tobacco use, physical inactivity, alcohol use, and depression, among target individuals;

"(ii) needed medicare clinical preventive and screening health benefits among target individuals; and

"(iii) functional and self-management information the Secretary determines to be appropriate;

"(B) provides ongoing followup to reduce risk factors and promote the appropriate use of preventive and screening health benefits;

"(C) improves clinical outcomes, satisfaction, quality of life, and appropriate use by target individuals of items and services covered under the medicare program; and

"(D) provides target individuals with information regarding the adoption of healthy behaviors.

"(2) SELF-ASSESSMENT AND PROVISION OF INFORMATION.—The Secretary shall conduct the dem-

onstration projects established under paragraph (1) in the following manner:

"(A) SELF-ASSESSMENT.—

"(i) IN GENERAL.—The Secretary shall test different—

"(I) methods of making self-assessments available to each target individual;

"(II) methods of encouraging each target individual to participate in the self-assessment; and

"(III) methods for processing responses to the self-assessment.

"(ii) CONTENTS.—A self-assessment made available under clause (i) shall include—

"(I) questions regarding behavioral risk factors;

"(II) questions regarding needed preventive screening health services;

"(III) questions regarding the target individual's preferences for receiving follow-up information; and

"(IV) other information that the Secretary determines appropriate.

''(B) PROVISION OF INFORMATION.—After each target individual completes the self-assessment, the Secretary shall ensure that the target individual is provided with such information as the Secretary determines appropriate, which may include—

''(i) information regarding the results of the self-assessment;

''(ii) recommendations regarding any appropriate behavior modification based on the self-assessment;

''(iii) information regarding how to access behavior modification assistance that promotes healthy behavior, including information on nurse hotlines, counseling services, provider services, and case-management services;

''(iv) information, feedback, support, and recommendations regarding any need for clinical preventive and screening health services or treatment; and

''(v) referrals to available community resources in order to assist the target individual in reducing health risks.

''(3) PROJECT AREAS AND DURATION.—

''(A) PROJECT AREAS.—The Secretary shall implement the demonstration projects in geographic areas that include urban, suburban, and rural areas.

''(B) DURATION.—The Secretary shall conduct the demonstration projects during the 3-year period beginning on the date on which the first demonstration project is implemented.

''(c) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on such projects.

''(2) CONTENTS OF REPORT.—The report submitted under paragraph (1) shall—

''(A) describe the demonstration projects conducted under this section;

''(B) identify the demonstration project that is the most effective; and

''(C) contain such other information regarding the demonstration projects as the Secretary determines appropriate.

''(3) MEASUREMENT OF EFFECTIVENESS.—For purposes of paragraph (2)(B), in identifying the

demonstration project that is the most effective, the Secretary shall consider—

''(A) how successful the project was at—

''(i) reaching target individuals and engaging them in an assessment of the risk factors of such individuals;

''(ii) educating target individuals on healthy behaviors and getting such individuals to modify their behaviors in order to diminish the risk of chronic disease; and

''(iii) ensuring that target individuals were provided with necessary information;

''(B) the cost-effectiveness of the demonstration project; and

''(C) the degree of beneficiary satisfaction under the demonstration projects.

''(d) WAIVER AUTHORITY.—The Secretary may waive such requirements under this title as the Secretary determines necessary to carry out the demonstration projects under this section.

''(e) FUNDING.—There are authorized to be appropriated $25,000,000 for carrying out the demonstration project under this section.

''(f) DEFINITIONS.—In this section:

''(1) TARGET INDIVIDUAL.—The term 'target individual' means each individual that is—

''(A) entitled to benefits under part A or enrolled under part B, including an individual enrolled under the Medicare+Choice program under part C; or

''(B) between the ages of 50 and 64 who is not a beneficiary under this title.

''(2) MAJOR BEHAVIORAL RISK FACTOR.—The term 'major behavioral risk factor' includes—

''(A) the lack of proper nutrition;

''(B) the use of alcohol;

''(C) the lack of regular exercise;

''(D) the use of tobacco;

''(E) depression; and

''(F) any other risk factor identified by the Secretary.''.

Subtitle F—Studies, Evaluations, and Reports In the Field of Disease Prevention and the Elderly

SEC. 461. MEDPAC EVALUATION AND REPORT ON MEDICARE BENEFIT PACKAGE IN RELATION TO PRIVATE SECTOR BENEFIT PACKAGES.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)), as amended by section

544(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–551), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period and inserting ''; and''; and

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

''(E) on the date that is 3 years after the date of enactment of the Medicare Reform Act of 2001, and each successive 3-year anniversary thereafter, submit the report described in paragraph (8)(C) to Congress.''; and

(2) by adding at the end the following new paragraph:

''(8) EVALUATION OF MEDICARE BENEFIT PACKAGE IN RELATION TO PRIVATE SECTOR BENEFIT PACKAGES.—

''(A) EVALUATION.—The Commission shall evaluate—

''(i) the benefit package offered under the medicare program under this title; and

"(ii) the degree to which such benefit package compares to the benefit packages offered by health benefit programs available in the private sector to individuals over age 55.

"(B) ISSUES.—In conducting the evaluation under subparagraph (A)(ii), the Commission shall address the following issues:

"(i) Whether the benefit packages available under the programs are—

"(I) similar;

"(II) appropriate for the enrollees of the programs (based on what experts recommend for such enrollees);

"(III) actuarially equivalent; and

"(IV) comprehensive.

"(ii) The financial liabilities of enrollees of the programs and whether such liabilities are appropriate.

"(iii) The ability of enrollees of the programs to take advantage of benefits under the programs.

"(C) REPORT.—The Commission shall submit a report to Congress that shall contain—

"(i) a detailed statement of the findings and conclusions of the Commission regarding the evaluation conducted under subparagraph (A);

"(ii) the recommendations of the Commission regarding changes in the benefit package offered under the medicare program under this title that would keep the program modern and competitive in relation to health benefit packages offered by health benefit programs available in the private sector to individuals over age 55; and

"(iii) the recommendations of the Commission for such legislation and administrative actions as it considers appropriate.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 462. NATIONAL INSTITUTE ON AGING STUDY AND REPORT ON WAYS TO IMPROVE THE QUALITY OF LIFE OF ELDERLY.

(a) STUDIES.—The Director of the National Institute on Aging, in consultation with the Working Group on Disease Self-Management and Health Promotion (established in section 402) and the United States Preventive Services Task Force, shall conduct 1 or more studies focusing on ways to—

(1) improve quality of life for the elderly; and

(2) develop better ways to prevent or delay the onset of age-related functional decline and disease and disability among the elderly.

(b) REPORTS.—

(1) REPORT FOR EACH STUDY.—The Director of the National Institute on Aging, in consultation with the Working Group on Disease Self-Management and Health Promotion and the United States Preventive Services Task Force, shall submit a report to the Secretary regarding each study conducted under subsection (a), together with a detailed statement of research findings and conclusions that are scientifically valid and are demonstrated to prevent or delay the onset of chronic illness or disability among the elderly.

(2) TIMING FOR SUBMITTING REPORTS.—Each report regarding a study that is required to be submitted pursuant to paragraph (1) shall be submitted by not later than the earlier of—

(A) the date that is 18 months after the completion of the study involved; or

(B) January 1, 2008.

(c) TRANSMISSION TO INSTITUTE OF MEDICINE.—Upon receipt of each report described in subsection (b), the Secretary shall transmit such report to the Institute of Medicine of the National Academy of Sciences for consideration in its effort to conduct the comprehensive study of current literature and best practices in the field of health promotion and disease prevention among the medicare beneficiaries described in section 463.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated for the purpose of carrying out this section such sums as may be necessary for the period of fiscal years 2002 through 2008.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until September 30, 2008.

SEC. 463. INSTITUTE OF MEDICINE MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to—

(A) conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries, including the issues described in paragraph (2); and

(B) submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each health promotion and disease prevention benefit covered under the medicare program is—

(i) medically effective (as defined in section 401(4)); and

(ii) a cost-effective benefit (as defined in section 401(2)) or a cost-saving benefit (as defined in section 401(3));

(B) utilization by medicare beneficiaries of such benefits (including any barriers to or incentives to increase utilization);

(C) quality of life issues associated with such benefits; and

(D) health promotion and disease prevention benefits that are not covered under the medicare program that would affect all medicare beneficiaries.

(b) REPORTS.—

(1) THREE-YEAR REPORT.—On the date that is 3 years after the date of enactment of this Act, and each successive 3-year anniversary thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains—

(A) a detailed statement of the findings and conclusions of the study conducted under subsection (a); and

(B) the recommendations for legislation described in paragraph (3).

(2) INTERIM REPORT BASED ON NEW GUIDELINES.—If the United States Preventive Services Task Force or the Task Force on Community Preventive Services establishes new guidelines regarding

preventive health benefits for medicare beneficiaries more than 1 year prior to the date that a report described in paragraph (1) is due to be submitted to the President, then not later than 6 months after the date such new guidelines are established, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed description of such new guidelines. Such report may also contain recommendations for legislation described in paragraph (3).

(3) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the United States Preventive Services Task Force and the Task Force on Community Preventive Services, shall develop recommendations in legislative form that—

(A) prioritize the preventive health benefits under the medicare program; and

(B) modify such benefits, including adding new benefits under such program, based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in paragraph (1) of subsection (b) (or paragraph (2) of such subsection if the report con-

tains recommendations in legislative form described in subsection (b)(3)) is submitted to the President, the President shall transmit the report and recommendations to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

SEC. 464. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Con-

gress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 463(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of

Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be con-

sidered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191). The implementing bill shall be subject to all congressional budget points of order, including points of order under the Congressional Budget Act of 1974.

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section 463(b)(3), transmitted by the President to the House of Representatives and the Senate under section 463(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

Subtitle G—Informatics Systems Grant Program for Hospitals and Skilled Nursing Facilities

SEC. 471. INFORMATICS SYSTEMS GRANT PROGRAM FOR HOSPITALS AND SKILLED NURSING FACILITIES.

(a) GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program to make grants to eligible entities that have submitted applications in accordance with subsection (b) for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing standardized clinical health care informatics systems designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(2) DURATION.—The authority of the Secretary to make grants under this section shall terminate on September 30, 2011.

(3) COSTS DEFINED.—For purposes of this section, the term ''costs'' shall include total expenditures incurred for—

(A) purchasing, leasing, and installing computer software and hardware, including handheld computer technologies;

(B) making improvements to existing computer software and hardware;

(C) purchasing or leasing communications capabilities necessary for clinical data access, storage, and exchange; and

(D) providing education and training to eligible entity staff on computer patient safety information systems.

(4) ELIGIBLE ENTITY DEFINED.—For purposes of this section, the term ''eligible entity'' means the following entities:

(A) HOSPITAL.—A hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))).

(B) SKILLED NURSING FACILITY.—A skilled nursing facility (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(e))).

(b) APPLICATION.—An eligible entity seeking a grant under this section shall submit an application to the Secretary at such time, in such form and manner, and containing such information as the Secretary specifies.

(c) SPECIAL CONSIDERATION FOR ELIGIBLE ENTITIES THAT SERVE A LARGE NUMBER OF MEDICARE AND MEDICAID ELIGIBLE INDIVIDUALS.—In awarding grants under this section, the Secretary shall give special consideration to eligible entities in which individuals that are eligible for benefits under the medicare program under title XVIII of the Social Security Act or the medicaid program under title XIX of such Act make up a high percentage of the total patient population of the entity.

(d) LIMITATION ON AMOUNT OF GRANT.—

(1) IN GENERAL.—A grant awarded under this section may not exceed the lesser of—

(A) an amount equal to the applicable percentage of the costs incurred by the eligible entity for the project for which the entity is seeking funding under this section; or

(B) in the case of a grant made to—

(i) a hospital, $750,000; or

(ii) a skilled nursing facility, $200,000.

(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)(A), the term ''applicable percentage'' means, with respect to an eligible entity, the percentage of total net revenues for such period as determined appropriate by the Secretary for the en-

tity that consists of net revenues from the medicare program under title XVIII of the Social Security Act.

(e) ELIGIBLE ENTITY REQUIRED TO FURNISH SECRETARY WITH INFORMATION.—An eligible entity receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to—

(1) evaluate the project for which the grant is made; and

(2) ensure that funding provided under the grant is expended for the purposes for which it is made.

(f) REPORTS.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—The Secretary shall submit, at least annually, a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the grant program established under this section.

(B) CONTENTS.—A report submitted pursuant to subparagraph (A) shall include information on—

(i) the number of grants made;

(ii) the nature of the projects for which funding is provided under the grant program;

(iii) the geographic distribution of grant recipients; and

(iv) such other matters as the Secretary determines appropriate.

(2) FINAL REPORT.—Not later than 180 days after the completion of all of the projects for which a grant is made under this section, the Secretary shall submit a final report to the committees referred to in paragraph (1)(A) on the grant program established under this section, together with such recommendations for legislation and administrative action as the Secretary determines appropriate.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) AUTHORIZATION.—

(A) HOSPITALS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $93,000,000, for each of the fiscal years 2002 through 2011, for the purpose of making grants under this section to eligible entities that are hospitals.

(B) SKILLED NURSING FACILITIES.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) $4,500,000, for each of the fiscal years 2002 through 2011, for the purpose of making grants under this section to eligible entities that are skilled nursing facilities.

(2) AVAILABILITY.—Any amounts appropriated pursuant to the authority contained in subparagraph (A) or (B) of paragraph (1) shall remain available, without fiscal year limitation, through September 30, 2011.

TITLE V—MEDICARE SUSTAINABILITY

SEC. 501. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended by inserting after ''1991 and subsequent years'' the following: '', adjusted annually, effective January 1 of each year (beginning in 2004), by a percentage increase or decrease equal to the percentage increase or decrease in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar''.

SEC. 502. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY FOR PART B PREMIUM.

(a) IN GENERAL.—Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

''(h)(1)(A) Notwithstanding the previous subsections of this section, and subject to paragraph (2), in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year exceeds the threshold amount, the Secretary shall increase the amount of the monthly premium for such individual for months in the calendar year by the amount which bears the same ratio to the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1)) for that year as such excess bears to an amount equal to ⅓ of the applicable threshold amount).

''(B) In no event shall the increase described in subparagraph (A) exceed an amount equal to the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1)) for the year.

''(2) For purposes of this subsection—

''(A) the threshold amount, the modified adjusted gross income, and joint return shall be determined under section 1860D(b)(1); and

''(B) rules similar to the rules of paragraphs (2) through (5) of section 1860D(b) shall apply to this subsection.''.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), as amended by section 606(a)(2)(B)(i) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–557), as enacted into law by section 1(a)(6) of Public Law 106–554), by striking ''and (f)'' and inserting ''(f), and (h)'';

(B) in subsection (b), by inserting ''(and as increased under subsection (h))'' after ''subsection (a)''; and

(C) in subsection (f), by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(2) PAYMENT TO SECRETARY.—Section 1840(c) of the Social Security Act (42 U.S.C. 1395s(c)) is amended by inserting ''or an individual determines that the estimate of modified adjusted gross income

used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,'' before ''he may''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—Paragraph (18) of section 6103(l) of the Internal Revenue Code of 1986, as added by section 304(a), is amended—

(1) in the heading, by inserting ''AND INCOME-RELATED REDUCTION IN SUBSIDY FOR MEDICARE PART B PREMIUM after ''PART D PREMIUM'';

(2) in subparagraph (A), in the matter preceding clause (i), by striking ''part D'' and inserting ''part B or D''; and

(3) in subparagraph (B), by striking ''part D'' and inserting ''part B or D''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act (42 U.S.C. 1395r) for months beginning with January 2004.

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