

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

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.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Reform Act of 2001”.

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

Sec. 1. Short title; table of contents.

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.

Subtitle B—Centers for Medicare & Medicaid Services Leadership

Sec. 111. Salary increase for the CMS Administrator.

Sec. 112. Addition of political appointee positions.

Sec. 113. Hiring flexibility for scientific and clinical experts.

Subtitle C—Increased Funding for Improved Customer Service

Sec. 121. Increased funding for improved customer service.

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

Sec. 131. Care coordination services.

Sec. 132. Disease management services.

Sec. 133. Competitive acquisition of items and services.

Sec. 134. Provider and physician collaborations.

Sec. 135. Preferred participants.

Sec. 136. Simplified center payments.

Sec. 137. Conforming changes to physician group practice demonstration and administrative provisions.

Sec. 138. Increased flexibility in contracting for medicare claims processing.

TITLE II—MEDICARE+CHOICE COMPETITION

Sec. 201. Revision of Medicare+Choice competitive bidding demonstration project.

TITLE III—MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

Sec. 301. Medicare outpatient prescription drug benefit program.

“PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

“Sec. 1860. Definitions.

“Sec. 1860A. Establishment of outpatient prescription drug benefit program.

“Sec. 1860B. Enrollment.

“Sec. 1860C. Providing information to beneficiaries.

“Sec. 1860D. Premiums.

“Sec. 1860E. Outpatient prescription drug benefits.

“Sec. 1860F. Entities eligible to provide outpatient drug benefit.

“Sec. 1860G. Minimum standards for eligible entities.

“Sec. 1860H. Payments.

“Sec. 1860I. Employer incentive program for employment-based retiree drug coverage.

“Sec. 1860J. Prescription drug account in the Federal Supplementary Medical Insurance Trust Fund.

“Sec. 1860K. Medicare Prescription Drug Advisory Committee.”.

- Sec. 302. Part D benefits under Medicare+Choice plans.
- Sec. 303. Reporting requirements for Secretary of the Treasury regarding sliding scale part D premium.
- Sec. 304. Additional assistance for low-income beneficiaries.
- Sec. 305. Medigap revisions.
- Sec. 306. Studies and report to Congress.

TITLE IV—MEDICARE WELLNESS

- Sec. 400. Definitions.

Subtitle A—Healthy Seniors Promotion Program

- Sec. 401. Definitions.
- Sec. 402. Working Group on Disease Self-Management and Health Promotion.
- Sec. 403. Healthy seniors promotion grants.
- Sec. 404. Disease self-management demonstration projects.

Subtitle B—Medicare Coverage of Preventive Health Benefits

- Sec. 411. Therapy and counseling for cessation of tobacco use.
- Sec. 412. Counseling for post-menopausal women.
- Sec. 413. Screening for diminished visual acuity.
- Sec. 414. Screening for hearing impairment.
- Sec. 415. Screening for cholesterol.
- Sec. 416. Screening for hypertension.
- Sec. 417. Expansion of eligibility for bone mass measurement.
- Sec. 418. Coverage of medical nutrition therapy services for beneficiaries with cardiovascular diseases.
- Sec. 419. Elimination of deductibles and coinsurance for existing preventive health benefits.
- Sec. 420. Program integrity.
- Sec. 421. Promotion of preventive health benefits.

Subtitle C—National Falls Prevention Education and Awareness Campaign

- Sec. 431. National falls prevention education and awareness campaign.

Subtitle D—Clinical Depression Screening Demonstration Projects

- Sec. 441. Clinical depression screening demonstration projects.

Subtitle E—Medicare Health Education and Risk Appraisal Program

- Sec. 451. Medicare health education and risk appraisal program.

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.
- Sec. 462. National Institute on Aging study and report on ways to improve the quality of life of elderly.
- Sec. 463. Institute of Medicine medicare prevention benefit study and report.
- Sec. 464. Fast-track consideration of prevention benefit legislation.

Subtitle G—Informatics Systems Grant Program for Hospitals and Skilled Nursing Facilities

Sec. 471. Informatics systems grant program for hospitals and skilled nursing facilities.

TITLE V—MEDICARE SUSTAINABILITY

Sec. 501. Indexing part B deductible to inflation.

Sec. 502. Income-related reduction in medicare subsidy for part B premium.

1 **TITLE I—MEDICARE MANAGE-**
 2 **MENT AND ADMINISTRATION**
 3 **Subtitle A—Transfer of Responsi-**
 4 **bility for National Coverage De-**
 5 **terminations and Establishment**
 6 **of the Medicare Coverage Com-**
 7 **mission**

8 **SEC. 101. TRANSFER OF RESPONSIBILITY FOR NATIONAL**
 9 **COVER AGE DETERMINATIONS AND ESTAB-**
 10 **LISHMENT OF THE MEDICARE COVER AGE**
 11 **COMMISSION.**

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

16 “NATIONAL COVER AGE DETERMINATIONS

17 “SEC. 1869A. (a) RESPONSIBILITY.—

18 “(1) IN GENERAL.—

19 “(A) SOLE RESPONSIBILITY.—Beginning
 20 in 2003, the Medicare Coverage Commission es-
 21 tablished under section 1869B (in this section
 22 referred to as the ‘Commission’) shall have sole

1 responsibility for making national coverage de-
2 terminations under this title.

3 “(B) LOCAL COVERAGE DETERMINA-
4 TIONS.—The Secretary shall continue to have
5 responsibility for local coverage determinations
6 in accordance with section 1869(f).

7 “(2) PROCEDURES.—

8 “(A) IN GENERAL.—The Commission shall
9 establish procedures for making national cov-
10 erage determinations under this title.

11 “(B) REQUIREMENTS.—The procedures es-
12 tablished under subparagraph (A) shall ensure
13 that, in making national coverage
14 determinations—

15 “(i) meetings of advisory committees
16 established under section 1869B(f) with
17 respect to the determination are made on
18 the record;

19 “(ii) the Commission considers appli-
20 cable information (including clinical experi-
21 ence and medical, technical, and scientific
22 evidence) with respect to the subject mat-
23 ter of the determination;

24 “(iii) the Commission provides a clear
25 statement of—

1 “(I) the basis for the determina-
2 tion (including responses to comments
3 received from the public); and

4 “(II) the assumptions underlying
5 that basis; and

6 “(iv) the Commission makes available
7 to the public the data (other than propri-
8 etary data) considered in making the de-
9 termination.

10 “(3) DEFINITION OF NATIONAL COVERAGE DE-
11 TERMINATION.—For purposes of this section, the
12 term ‘national coverage determination’ means a de-
13 termination by the Commission with respect to
14 whether or not a particular item or service is covered
15 nationally under this title, but does not include a de-
16 termination of what code, if any, is assigned to a
17 particular item or service covered under this title or
18 a determination with respect to the amount of pay-
19 ment made for a particular item or service so cov-
20 ered.

21 “(b) REVIEW OF NATIONAL COVERAGE DETERMINA-
22 TIONS.—

23 “(1) IN GENERAL.—Review of any national cov-
24 erage determination shall be subject to the following
25 limitations:

1 “(A) Such a determination shall not be re-
2 viewed by any administrative law judge.

3 “(B) Such a determination shall not be
4 held unlawful or set aside on the ground that
5 a requirement of section 553 of title 5, United
6 States Code, relating to publication in the Fed-
7 eral Register or opportunity for public com-
8 ment, was not satisfied.

9 “(C) Upon the filing of a complaint by an
10 aggrieved person (as described in paragraph
11 (4)), such a determination shall be reviewed by
12 the Appeals Board of the Commission. In con-
13 ducting such a review, the Appeals Board—

14 “(i) shall review the record and shall
15 permit discovery and the taking of evidence
16 to evaluate the reasonableness of the deter-
17 mination, if the Board determines that the
18 record is incomplete or lacks adequate in-
19 formation to support the validity of the de-
20 termination;

21 “(ii) may, as appropriate, consult with
22 appropriate scientific and clinical experts;
23 and

24 “(iii) shall defer only to the reason-
25 able findings of fact, reasonable interpreta-

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

3 “(D) A decision of the Appeals Board con-
4 stitutes a final agency action and is subject to
5 judicial review.

6 “(2) NO MATERIAL ISSUES OF FACT IN DIS-
7 PUTE.—In the case of a determination that may oth-
8 erwise be subject to review under paragraph (1)(C),
9 where the moving party alleges that—

10 “(A) there are no material issues of fact in
11 dispute; and

12 “(B) the only issue of law is the constitu-
13 tionality of a provision of this title, or that a
14 regulation, determination, or ruling by the
15 Commission is invalid,

16 the moving party may seek review by a court of com-
17 petent jurisdiction without filing a complaint under
18 such paragraph and without otherwise exhausting
19 other administrative remedies.

20 “(3) PENDING NATIONAL COVERAGE DETER-
21 MINATIONS.—

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

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

11 “(i) Issue a national coverage deter-
12 mination, with or without limitations.

13 “(ii) Issue a national noncoverage de-
14 termination.

15 “(iii) Issue a determination that no
16 national coverage or noncoverage deter-
17 mination is appropriate as of the end of
18 such 90-day period with respect to national
19 coverage of such items or services.

20 “(iv) Issue a notice that—

21 “(I) states that the Commission
22 has not completed a review of the re-
23 quest for a national coverage deter-
24 mination; and

1 “(II) includes an identification of
2 the remaining steps in the Commis-
3 sion’s review process and a deadline
4 by which the Commission will com-
5 plete the review and take an action
6 described in clause (i), (ii), or (iii).

7 “(B) DEEMED ACTION BY THE COMMIS-
8 SION.—In the case of an action described in
9 subparagraph (A)(iv), if the Commission fails to
10 take an action referred to in such subparagraph
11 by the deadline specified by the Commission
12 under such subparagraph, then the Commission
13 is deemed to have taken an action described in
14 subparagraph (A)(iii) as of the deadline.

15 “(C) EXPLANATION OF DETERMINA-
16 TION.—When issuing a determination under
17 subparagraph (A), the Commission shall include
18 an explanation of the basis for the determina-
19 tion. An action taken under such subparagraph
20 (other than clause (iv) of such subparagraph) is
21 deemed to be a national coverage determination
22 for purposes of review under paragraph (1).

23 “(4) STANDING.—An action under this sub-
24 section seeking review of a national coverage deter-
25 mination may be initiated by—

1 “(A) an individual who is entitled to bene-
2 fits under part A, or enrolled under part B, or
3 both, and who is in need of the items or serv-
4 ices that are the subject of the coverage deter-
5 mination; and

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

8 “(5) PUBLICATION ON THE INTERNET OF DECI-
9 SIONS OF HEARINGS OF THE COMMISSION.—Each
10 decision of a hearing by the Commission with re-
11 spect to a national coverage determination shall be
12 made public, and the Commission shall coordinate
13 with the Secretary for the publication of each deci-
14 sion on the Medicare Internet site of the Depart-
15 ment of Health and Human Services. The Commis-
16 sion shall remove from such decision any informa-
17 tion that would identify any individual, provider of
18 services, or supplier.

19 “(6) ANNUAL REPORT TO CONGRESS ON NA-
20 TIONAL COVERAGE DETERMINATIONS.—

21 “(A) IN GENERAL.—Not later than De-
22 cember 1 of each year, beginning in 2003, the
23 Commission shall submit to Congress a report
24 that sets forth a detailed compilation of—

1 “(i) the actual time periods that were
2 necessary to complete national coverage de-
3 terminations that were made in the pre-
4 vious fiscal year for items or services not
5 previously covered as a benefit under this
6 title; and

7 “(ii) the basis for each such deter-
8 mination.

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

15 “(7) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as permitting administra-
17 tive or judicial review pursuant to this section inso-
18 far as such review is explicitly prohibited or re-
19 stricted under another provision of law.

20 “(c) COMMUNICATION BETWEEN COMMISSION AND
21 SECRETARY.—

22 “(1) NOTIFICATION.—If the Commission or the
23 Appeals Board of the Commission after a review of
24 a determination makes a determination that a par-
25 ticular item or service is covered nationally under

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

3 “(2) IMPLEMENTATION BY SECRETARY.—Upon
4 being notified by the Commission that a determina-
5 tion has been made under this section that a par-
6 ticular item or service is covered nationally under
7 this title, the Secretary shall implement such cov-
8 erage in a timely manner.

9 “MEDICARE COVERAGE COMMISSION

10 “SEC. 1869B. (a) ESTABLISHMENT.—There is estab-
11 lished a Medicare Coverage Commission (in this section
12 referred to as the ‘Commission’). The Commission shall
13 be an independent establishment (as defined in section
14 104 of title 5, United States Code).

15 “(b) STRUCTURE AND MEMBERSHIP.—

16 “(1) STRUCTURE.—

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

21 “(B) RESTRICTION.—No member of the
22 Commission may serve in any other office of the
23 Federal Government while a member of the
24 Commission.

25 “(2) MEMBERSHIP.—

1 “(A) IN GENERAL.—The members of the
2 Commission shall be chosen on the basis of
3 their integrity, impartiality, and good judgment,
4 and shall be individuals who are, by reason of
5 their education, experience, and clinical, med-
6 ical, technical, and scientific expertise, excep-
7 tionally qualified to perform the duties of the
8 members of the Commission.

9 “(B) TERMS OF APPOINTMENT.—The
10 terms of members of the Commission shall be
11 for 3 years.

12 “(C) VACANCIES.—Any member appointed
13 to fill a vacancy occurring before the expiration
14 of the term for which the member’s predecessor
15 was appointed shall be appointed only for the
16 remainder of that term. A member may serve
17 after the expiration of that member’s term until
18 a successor has taken office.

19 “(D) LIMITATION ON NUMBER OF
20 TERMS.—Any person appointed as a member of
21 the Commission shall not be eligible for re-
22 appointment to the Commission after having
23 served 2 terms.

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

1 time of appointment of the member, as chair-
2 person for that term of appointment, except
3 that in the case of any vacancy of the chair-
4 person, the President may designate another
5 member for the remainder of that member’s
6 term.

7 “(c) DUTIES.—

8 “(1) IN GENERAL.—The Commission shall be
9 responsible for making national coverage determina-
10 tions (as defined in section 1869A(a)(3)) under this
11 title, including at the request of medicare bene-
12 ficiaries or their representatives, Federal Govern-
13 ment agencies, including the Centers for Medicare &
14 Medicaid Services, manufacturers and suppliers, and
15 providers for such a determination.

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

20 “(3) OTHER SPECIFIC DUTIES.—In order to
21 carry out the duties described in paragraph (1), the
22 Commission may do the following if determined ap-
23 propriate:

24 “(A) Commission technology assessments
25 and studies.

1 “(B) Request that technology assessments
2 and related studies be conducted by other Fed-
3 eral agencies pursuant to subsection (g).

4 “(C) Establish advisory committees pursu-
5 ant to subsection (f) as appropriate to evaluate
6 new procedures.

7 “(D) Review conflicting local coverage de-
8 terminations (as defined in section
9 1869(f)(1)(B)) and determine whether a na-
10 tional coverage determination is necessary or
11 desirable.

12 “(d) OPERATION OF THE COMMISSION.—

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

16 “(2) QUORUM.—A quorum shall consist of 4
17 members of the Commission, except that the Com-
18 mission may establish a lesser quorum to conduct
19 hearings.

20 “(e) COMMISSION PERSONNEL MATTERS.—

21 “(1) MEMBERS.—

22 “(A) COMPENSATION.—Membership on the
23 Commission is not a full-time position. Each
24 member of the Commission shall be com-
25 pensated at a rate equal to the per diem equiva-

1 lent of the rate provided for level IV of the Ex-
2 ecutive Schedule under section 5315 of title 5,
3 United States Code.

4 “(B) TRAVEL EXPENSES.—The members
5 of the Commission shall be allowed travel ex-
6 penses, including per diem in lieu of subsist-
7 ence, at rates authorized for employees of agen-
8 cies under subchapter I of chapter 57 of title 5,
9 United States Code, while away from their
10 homes or regular places of business in the per-
11 formance of service for the Commission.

12 “(2) STAFF AND SUPPORT SERVICES.—

13 “(A) EXECUTIVE DIRECTOR.—The Chair-
14 person shall appoint an executive director of the
15 Commission who shall be paid at a rate speci-
16 fied by the Commission.

17 “(B) STAFF.—With the approval of the
18 Commission, the executive director may appoint
19 such personnel as the executive director con-
20 siders appropriate.

21 “(C) INAPPLICABILITY OF CIVIL SERVICE
22 LAWS.—The staff of the Commission shall be
23 appointed without regard to the provisions of
24 title 5, United States Code, governing appoint-
25 ments in the competitive service, and shall be

1 paid without regard to the provisions of chapter
2 51 and subchapter III of chapter 53 of such
3 title (relating to classification and General
4 Schedule pay rates).

5 “(D) EXPERTS AND CONSULTANTS.—With
6 the approval of the Commission, the executive
7 director may procure temporary and intermit-
8 tent services under section 3109(b) of title 5,
9 United States Code.

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

18 “(f) APPOINTMENT OF ADVISORY COMMITTEES.—

19 “(1) IN GENERAL.—The Commission may ap-
20 point such advisory committees as the Commission
21 determines appropriate to advise and consult the
22 Commission in carrying out the duties of the Com-
23 mission.

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

1 without regard to the provisions of title 5, United
2 States Code, governing appointments in the competi-
3 tive service.

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

13 “(4) REPORT ON ADVISORY COMMITTEES.—The
14 Commission shall include in the annual report to
15 Congress described in section 1869A(b)(6) the num-
16 ber of committees appointed under subsection (f)
17 during the preceding year and the membership and
18 activities of each such committee.

19 “(g) AUTHORITY TO REQUEST THAT FEDERAL
20 AGENCIES CONDUCT ASSESSMENTS AND STUDIES.—The
21 Commission may request any Federal department or agen-
22 cy to conduct a technology assessment or a related study
23 that the Commission determines is necessary in order to
24 carry out its duties under this section.

1 “(h) FUNDING OF COMMISSION.—There are author-
2 ized to be appropriated such sums as may be necessary
3 to carry out the purposes of this section.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) BIPA PROVISIONS.—

6 (A) Section 1869(c)(3)(B)(ii)(I) of the So-
7 cial Security Act, as added by section 521 of
8 the Medicare, Medicaid, and SCHIP Benefits
9 Improvement and Protection Act of 2000 (114
10 Stat. 2763A–534), as enacted into law by sec-
11 tion 1(a)(6) of Public Law 106–554, is amend-
12 ed by striking “If the Secretary has made a na-
13 tional coverage determination pursuant to the
14 requirements established under the third sen-
15 tence of section 1862(a)” and inserting “If the
16 Medicare Coverage Commission has made a na-
17 tional coverage determination pursuant to the
18 requirements established under section 1869A”.

19 (B) Section 1869(f) of the Social Security
20 Act, as added by section 522(a) of the Medi-
21 care, Medicaid, and SCHIP Benefits Improve-
22 ment and Protection Act of 2000 (114 Stat.
23 2763A–543), as so enacted into law, is amend-
24 ed to read as follows:

1 “(f) REVIEW OF LOCAL COVERAGE DETERMINA-
2 TIONS.—

3 “(1) REVIEW.—

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

7 “(i) Upon the filing of a complaint by
8 an aggrieved party, such a determination
9 shall be reviewed by an administrative law
10 judge of the Social Security Administra-
11 tion. The administrative law judge—

12 “(I) shall review the record and
13 shall permit discovery and the taking
14 of evidence to evaluate the reasonable-
15 ness of the determination, if the ad-
16 ministrative law judge determines that
17 the record is incomplete or lacks ade-
18 quate information to support the va-
19 lidity of the determination;

20 “(II) may, as appropriate, con-
21 sult with appropriate scientific and
22 clinical experts; and

23 “(III) shall defer only to the rea-
24 sonable findings of fact, reasonable in-
25 terpretations of law, and reasonable

1 applications of fact to law by the Sec-
2 retary.

3 “(ii) Upon the filing of a complaint by
4 an aggrieved party, a decision of an admin-
5 istrative law judge under clause (i) shall be
6 reviewed by the Departmental Appeals
7 Board of the Department of Health and
8 Human Services.

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

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

16 “(B) DEFINITION OF LOCAL COVERAGE
17 DETERMINATION.—For purposes of this section,
18 the term ‘local coverage determination’ means a
19 determination by a fiscal intermediary or a car-
20 rier under part A or B, as applicable, respect-
21 ing whether or not a particular item or service
22 is covered on an intermediary- or carrier-wide
23 basis under such parts, in accordance with sec-
24 tion 1862(a)(1)(A).

1 “(2) NO MATERIAL ISSUES OF FACT IN DIS-
2 PUTE.—In the case of a determination that may oth-
3 erwise be subject to review under paragraph
4 (1)(A)(i), where the moving party alleges that—

5 “(A) there are no material issues of fact in
6 dispute, and

7 “(B) the only issue of law is the constitu-
8 tionality of a provision of this title, or that a
9 regulation, determination, or ruling by the Sec-
10 retary is invalid,

11 the moving party may seek review by a court of com-
12 petent jurisdiction without filing a complaint under
13 such paragraph and without otherwise exhausting
14 other administrative remedies.

15 “(3) STANDING.—An action under this sub-
16 section seeking review of a local coverage determina-
17 tion may be initiated only by an individual who is
18 entitled to benefits under part A, or enrolled under
19 part B, or both, and who is in need of the items or
20 services that are the subject of the coverage deter-
21 mination.

22 “(4) CONSTRUCTION.—Nothing in this sub-
23 section shall be construed as permitting administra-
24 tive or judicial review pursuant to this section inso-

1 far as such review is explicitly prohibited or re-
2 stricted under another provision of law.”.

3 (C) Section 1862(a) of the Social Security
4 Act (42 U.S.C. 1395y(a)), as amended by sec-
5 tion 522(b) of the Medicare, Medicaid, and
6 SCHIP Benefits Improvement and Protection
7 Act of 2000 (114 Stat. 2763A–546), as so en-
8 acted into law, is amended by striking the third
9 sentence.

10 (D) Section 1114 of the Social Security
11 Act (42 U.S.C. 1314), as amended by section
12 522(c) of the Medicare, Medicaid, and SCHIP
13 Benefits Improvement and Protection Act of
14 2000 (114 Stat. 2763A–546), as so enacted
15 into law, is amended by striking subsection (i).

16 (2) MEDICARE+CHOICE.—Section 1853(c)(7)
17 of the Social Security Act (42 U.S.C. 1395w–
18 23(c)(7)) is amended by inserting “or the Medicare
19 Coverage Commission” after “If the Secretary”.

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

22 (1) the responsibility for making national cov-
23 erage determinations;

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

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

3 (4) a national coverage determination made,
4 on or after January 1, 2003.

5 **Subtitle B—Centers for Medicare &**
6 **Medicaid Services Leadership**

7 **SEC. 111. SALARY INCREASE FOR THE CMS ADMINIS-**
8 **TRATOR.**

9 (a) IN GENERAL.—Section 5314 of title 5, United
10 States Code, is amended by adding at the end the fol-
11 lowing:

12 “Administrator of the Centers for Medicare &
13 Medicaid Services.”.

14 (b) CONFORMING AMENDMENT.—Section 5315 of
15 title 5, United States Code, is amended by striking “Ad-
16 ministrators of the Health Care Financing Administra-
17 tion.”.

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

20 **SEC. 112. ADDITION OF POLITICAL APPOINTEE POSITIONS.**

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

24 “(c) ADDITIONAL APPOINTEES.—

1 “(1) APPOINTMENT.—In addition to the Ad-
 2 ministrator of the Centers for Medicare & Medicaid
 3 Services, there shall be in such Centers 9 individuals
 4 who shall be appointed by the President.

5 “(2) DUTIES AND POWERS.—The individuals
 6 appointed under paragraph (1) shall perform such
 7 duties and exercise such powers as the Adminis-
 8 trator of the Centers for Medicare & Medicaid Serv-
 9 ices shall from time to time assign or delegate.”.

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

12 (1) in subsection (a), by striking “The Adminis-
 13 trator of the Health Care Financing Administra-
 14 tion” and inserting “ADMINISTRATOR.—The Admin-
 15 istrator of the Centers for Medicare & Medicaid
 16 Services”;

17 (2) in subsection (b)—

18 (A) by striking “(b)(1) There is established
 19 in the Health Care Financing Administration”
 20 and inserting “(b) CHIEF ACTUARY.—

21 “(1) APPOINTMENT.—There is established in
 22 the Centers for Medicare & Medicaid Services”;

23 (B) in the second sentence of paragraph
 24 (1), by striking “of such Administration” and
 25 inserting “of such Centers”; and

1 (C) in paragraph (2), by striking “The
2 Chief Actuary” and inserting “COMPENSA-
3 TION.—The Chief Actuary”; and

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

7 (3) by amending the heading to read as follows:

8 “ORGANIZATION OF THE CENTERS FOR MEDICARE &
9 MEDICAID SERVICES”.

10 **SEC. 113. HIRING FLEXIBILITY FOR SCIENTIFIC AND CLIN-**
11 **ICAL EXPERTS.**

12 Section 1117 of the Social Security Act (42 U.S.C.
13 1317), as amended by section 112(a), is amended by add-
14 ing at the end the following new subsection:

15 “(d) HIRING FLEXIBILITY FOR SCIENTIFIC AND
16 CLINICAL EXPERTS.—

17 “(1) IN GENERAL.—The Administrator of the
18 Centers for Medicare & Medicaid Services may ap-
19 point such individuals with scientific or clinical ex-
20 pertise as the Administrator determines appropriate.

21 “(2) INAPPLICABILITY OF CIVIL SERVICE
22 LAWS.—The Administrator may appoint an indi-
23 vidual described in paragraph (1) without regard to
24 the provisions of title 5, United States Code, gov-
25 erning appointments in the competitive service, and
26 may provide that such an individual is paid without

1 regard to the provisions of chapter 51 and sub-
 2 chapter III of chapter 53 of such title (relating to
 3 classification and General Schedule pay rates).”.

4 **Subtitle C—Increased Funding for**
 5 **Improved Customer Service**

6 **SEC. 121. INCREASED FUNDING FOR IMPROVED CUSTOMER**
 7 **SERVICE.**

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

9 (1) to provide for an annual authorization of
 10 appropriation for the program management budget
 11 of the Centers for Medicare & Medicaid Services
 12 that is based on the growth in expenditures under
 13 the medicare program under title XVIII of the So-
 14 cial Security Act; and

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

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

24 (B) establishing customer services posi-
 25 tions at the regional offices of the Centers for

1 Medicare & Medicaid Services for providers
2 under the medicare program;

3 (C) increasing the amount and availability
4 of grants for health insurance information,
5 counseling, and assistance under section 4360
6 of the Omnibus Budget Reconciliation Act of
7 1990 (42 U.S.C. 1395b-4);

8 (D) updating information technology sys-
9 tems;

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

13 (F) hiring staff to develop—

14 (i) improved mechanisms for risk ad-
15 justing payments under the medicare pro-
16 gram;

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

22 (iii) improved systems for providing
23 information regarding the medicare pro-
24 gram to medicare beneficiaries and poten-
25 tial medicare beneficiaries; and

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

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

8 “AUTHORIZATION OF APPROPRIATIONS FOR CMS
 9 PROGRAM MANAGEMENT

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

12 “(1) For fiscal year 2002, \$2,408,934,900; and

13 “(2) For each subsequent fiscal year, the
 14 amount appropriated under this section for the pre-
 15 vious fiscal year increased by the percentage in-
 16 crease in outlays under this title (determined with-
 17 out regard to amounts appropriated under this sec-
 18 tion) for such subsequent year.

19 **Subtitle D—Private Sector Pur-**
 20 **chasing and Quality Improve-**
 21 **ment Tools for Original Medi-**
 22 **care**

23 **SEC. 131. CARE COORDINATION SERVICES.**

24 (a) PROGRAM AUTHORIZED.—Title XVIII of the So-
 25 cial Security Act (42 U.S.C. 1395 et seq.) is amended—

1 (1) by redesignating section 1866B, as added
2 by section 412 of the Medicare, Medicaid, and
3 SCHIP Benefits Improvement and Protection Act of
4 2000 (114 Stat. 2763A–509), as enacted into law by
5 section 1(a)(6) of Public Law 106–554), as section
6 1866M; and

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

9 “CARE COORDINATION SERVICES

10 “SEC. 1866B. (a) IN GENERAL.—

11 “(1) PROGRAM AUTHORITY.—The Secretary,
12 beginning in 2003, shall implement a care coordina-
13 tion services program in accordance with the provi-
14 sions of this section under which, in appropriate cir-
15 cumstances, eligible individuals may elect to have
16 health care services covered under this title managed
17 and coordinated by a designated care coordinator.

18 “(2) ADMINISTRATION BY CONTRACT.—Except
19 as otherwise specifically provided, the Secretary may
20 administer the program under this section in accord-
21 ance with section 1866M, including subsection (b)(2)
22 of such section (relating to the discretion of the Sec-
23 retary as to the scope of the program).

24 “(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND
25 NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

1 “(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The
2 Secretary shall specify criteria to be used in making
3 a determination as to whether an individual may ap-
4 propriately be enrolled in the care coordination serv-
5 ices program under this section, which shall include
6 at least a finding by the Secretary that for each co-
7 hort of individuals with characteristics identified by
8 the Secretary, professional management and coordi-
9 nation of care can reasonably be expected to improve
10 processes or outcomes of health care.

11 “(2) PROCEDURES TO FACILITATE ENROLL-
12 MENT.—The Secretary shall develop and implement
13 procedures designed to facilitate enrollment of eligi-
14 ble individuals in the program under this section.

15 “(c) ENROLLMENT OF INDIVIDUALS.—

16 “(1) SECRETARY’S DETERMINATION OF ELIGI-
17 BILITY.—The Secretary shall determine the eligi-
18 bility for services under this section of individuals
19 who are enrolled in the program under this section
20 and who make application for such services in such
21 form and manner as the Secretary may prescribe.

22 “(2) ENROLLMENT PERIOD.—

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

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

9 “(B) LIMITATION ON REENROLLMENT.—

10 The Secretary may establish limits on an indi-
11 vidual's eligibility to reenroll in the program
12 under this section if the individual has
13 disenrolled from the program more than once
14 during a specified time period.

15 “(d) PROGRAM.—The care coordination services pro-

16 gram under this section shall include the following ele-
17 ments:

18 “(1) BASIC CARE COORDINATION SERVICES.—

19 “(A) IN GENERAL.—Except as otherwise
20 provided in this section, each enrolled
21 individual—

22 “(i) shall receive the case manage-
23 ment-related services described in section
24 1905(t)(1), assessment services (as defined
25 by the Secretary), and such other care co-

1 ordination services as the Secretary may
2 specify; and

3 “(ii) may receive any additional item
4 or service specified under subparagraph
5 (B).

6 “(B) ADDITIONAL BENEFITS.—The Sec-
7 retary may specify additional benefits for which
8 payment would not otherwise be made under
9 this title that may be available to individuals
10 enrolled in the program under this section (sub-
11 ject to an assessment by the care coordinator of
12 an individual’s circumstance and need for such
13 benefits) in order to encourage enrollment in, or
14 to improve the effectiveness of, such program.

15 “(2) AUTHORITY OF THE SECRETARY TO RE-
16 QUIRE CARE COORDINATION.—Notwithstanding any
17 other provision of this title, the Secretary may pro-
18 vide that an individual enrolled in the program
19 under this section is entitled to payment under this
20 title for any specified health care items or services
21 only if the items or services have been furnished by
22 the care coordinator, or coordinated through the
23 care coordination services program. Under such pro-
24 vision, the Secretary shall prescribe exceptions for
25 emergency medical services as described in section

1 1852(d)(3), and other exceptions determined by the
2 Secretary for the delivery of timely and needed care.

3 “(3) REDUCTION OR ELIMINATION OF COST
4 SHARING.—Notwithstanding any other provision of
5 law, the Secretary may provide for the reduction or
6 elimination of beneficiary cost sharing (such as
7 deductibles, copayments, and coinsurance) with re-
8 spect to any of the items or services furnished under
9 this title (other than the care coordination services
10 and other benefits described in paragraph (1)) and
11 may limit such reduction or elimination to particular
12 service areas.

13 “(e) CARE COORDINATORS.—

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

17 “(A) be—

18 “(i)(I) a physician; or

19 “(II) a health care professional (other
20 than a physician) who meets such condi-
21 tions as the Secretary may specify; or

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

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

3 “(B) have entered into a care coordination
4 agreement; and

5 “(C) meet such criteria as the Secretary
6 may establish (which may include experience in
7 the provision of care coordination or primary
8 care physician’s services).

9 “(2) AGREEMENT TERM; PAYMENT.—

10 “(A) DURATION AND RENEWAL.—A care
11 coordination agreement under this subsection
12 shall be for 1 year and may be renewed if the
13 Secretary is satisfied that the care coordinator
14 continues to meet the conditions of participa-
15 tion specified in paragraph (1).

16 “(B) PAYMENT FOR SERVICES.—The Sec-
17 retary may negotiate or otherwise establish pay-
18 ment terms and rates for services described in
19 subsection (d)(1).

20 “(C) TERMS.—In addition to such other
21 terms as the Secretary may require, an agree-
22 ment under this section shall include the terms
23 specified in subparagraphs (A) through (C) of
24 section 1905(t)(3).”.

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

3 (1) IN GENERAL.—Section 1861(s) of the So-
4 cial Security Act (42 U.S.C. 1395x(s)) is amended—

5 (A) in the second sentence, by redesi-
6 gnating paragraphs (16) and (17) as clauses (i)
7 and (ii), respectively; and

8 (B) in the first sentence—

9 (i) in paragraph (14), by striking
10 “and” at the end;

11 (ii) in paragraph (15), by striking the
12 period at the end and inserting “; and”;
13 and

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

16 “(16) care coordination services furnished in
17 accordance with section 1866B.”.

18 (2) PART B COINSURANCE AND DEDUCTIBLE
19 NOT APPLICABLE TO CARE COORDINATION SERV-
20 ICES.—

21 (A) COINSURANCE.—Section 1833(a)(1) of
22 the Social Security Act (42 U.S.C.
23 1395l(a)(1)), as amended by section 223(c) of
24 the Medicare, Medicaid, and SCHIP Benefits
25 Improvement and Protection Act of 2000 (114

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

4 (i) by striking “and (U)” and insert-
5 ing “(U)”; and

6 (ii) by inserting before the semicolon
7 at the end the following: “, and (V) with
8 respect to care coordination services de-
9 scribed in section 1861(s)(16), the
10 amounts paid shall be 100 percent of the
11 payment amount established under section
12 1866B”.

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

16 (i) by striking “and (6)” and inserting
17 “(6)”; and

18 (ii) by inserting before the period at
19 the end the following: “, and (7) such de-
20 ductible shall not apply with respect to
21 care coordination services (as described in
22 section 1861(s)(16))”.

23 **SEC. 132. DISEASE MANAGEMENT SERVICES.**

24 (a) PROGRAM AUTHORIZED.—Title XVIII of the So-
25 cial Security Act (42 U.S.C. 1395 et seq.), as amended

1 by section 131(a), is amended by inserting after section
2 1866B the following new section:

3 “DISEASE MANAGEMENT SERVICES

4 “SEC. 1866C. (a) IN GENERAL.—

5 “(1) PROGRAM AUTHORITY.—The Secretary,
6 beginning in 2003, may implement a program in ac-
7 cordance with the provisions of this section under
8 which certain eligible individuals may, in appropriate
9 circumstances, receive disease management services
10 from entities designated by the Secretary with re-
11 spect to diagnoses that the Secretary determines are
12 amenable to such management.

13 “(2) ADMINISTRATION BY CONTRACT.—Except
14 as otherwise specifically provided, the Secretary may
15 administer the program under this section in accord-
16 ance with section 1866M, including subsection (b)(2)
17 of such section (relating to the discretion of the Sec-
18 retary as to the scope of the program).

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

24 “(1) DIAGNOSIS AND RELATED CHARACTERIS-
25 TICS.—

1 “(A) IN GENERAL.—The individual has
2 been diagnosed with congestive heart failure,
3 chronic obstructive pulmonary disease, diabetes,
4 or any other diagnosis, if the Secretary has de-
5 termined with respect to such diagnoses that
6 there is evidence that the provision of disease
7 management services, over clinically relevant
8 time periods, to cohorts of individuals with such
9 diagnoses can reasonably be expected to im-
10 prove processes or outcomes of health care for
11 the medicare population and to reduce aggre-
12 gate costs to the programs under this title.

13 “(B) ADDITIONAL FACTORS.—Where re-
14 quired by the Secretary, the individual also has
15 certain clinical characteristics or conditions, ex-
16 hibits certain patterns of utilization, or mani-
17 fests other factors indicating the need for and
18 potential effectiveness of disease management.

19 “(2) REFERRAL BY QUALIFIED INDIVIDUAL OR
20 ENTITY.—The individual has been referred for con-
21 sideration for such services by an individual or entity
22 furnishing health care items or services, or by an en-
23 tity administering benefits under this title.

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

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

3 “(d) ENROLLMENT OF INDIVIDUALS WITH DISEASE
4 MANAGEMENT ORGANIZATIONS.—

5 “(1) EFFECTIVE DATE AND DURATION.—En-
6 rollment of an individual in the program under this
7 section shall remain in effect for 1 month (or such
8 longer period as the Secretary may specify), and
9 shall be automatically renewed for additional peri-
10 ods, unless terminated in accordance with such pro-
11 cedures as the Secretary shall establish by regula-
12 tion.

13 “(2) LIMITATION ON REENROLLMENT.—The
14 Secretary may establish limits on an individual’s eli-
15 gibility to reenroll in the program under this section
16 if the individual has disenrolled from the program
17 more than once during a specified time period.

18 “(e) DISEASE MANAGEMENT REQUIREMENT.—Not-
19 withstanding any other provision of this title, the Sec-
20 retary may provide that an individual enrolled in the pro-
21 gram under this section may be entitled to payment under
22 this title for any specified health care items or services
23 only if the items or services have been furnished by the
24 disease management organization, or coordinated through
25 the disease management services program. Under such

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

5 “(f) DISEASE MANAGEMENT SERVICES.—

6 “(1) IN GENERAL.—Subject to the cost-effec-
7 tiveness criteria specified in subsection (b)(1), dis-
8 ease management services provided to an individual
9 under this section may include—

10 “(A) initial and periodic health screening
11 and assessment;

12 “(B) management (including coordination
13 with other providers) of, and referral for, med-
14 ical and other health services related to the
15 managed diagnosis (which may include referral
16 for provision of such services by the disease
17 management organization);

18 “(C) monitoring and control of medications
19 (including coordination with the entity man-
20 aging benefits for the individual under part D);

21 “(D) patient education and counseling;

22 “(E) nursing or other health professional
23 home visits, as appropriate;

24 “(F) providing access for consultations by
25 telephone with physicians or other appropriate

1 medical professionals, including 24-hour avail-
2 ability for emergency consultations;

3 “(G) managing and facilitating the transi-
4 tion to other care arrangements in preparation
5 for termination of the disease management en-
6 rollment; and

7 “(H) such other services for which pay-
8 ment would not otherwise be made under this
9 title as the Secretary shall determine to be ap-
10 propriate.

11 “(2) VARIATIONS IN SERVICE PACKAGES.—The
12 types and combinations of disease management serv-
13 ices furnished under agreements under this section
14 may vary (as permitted or required by the Sec-
15 retary) according to the types of diagnoses, condi-
16 tions, patient profiles being managed, expertise of
17 the disease management organization, and other fac-
18 tors the Secretary finds appropriate.

19 “(3) REDUCTION OR ELIMINATION OF COST-
20 SHARING.—Notwithstanding any other provision of
21 law, subject to the cost-effectiveness criteria speci-
22 fied in subsection (b)(1), the Secretary may provide
23 for the reduction or elimination of beneficiary cost-
24 sharing (such as deductibles, copayments, and coin-
25 surance) with respect to any of the items or services

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

5 “(g) AGREEMENTS WITH DISEASE MANAGEMENT
6 ORGANIZATIONS.—

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

14 “(A) the management of each diagnosis
15 and condition with respect to which the entity,
16 if designated, would furnish disease manage-
17 ment services under this section; and

18 “(B) the implementation of each disease
19 management approach that the entity, if des-
20 ignated, would implement under this section.

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

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

1 entity as a disease management organization
2 under this section as the Secretary shall pre-
3 scribe;

4 “(B) meet the standards established by the
5 Secretary under subsection (h); and

6 “(C) meet such other conditions as the
7 Secretary may establish.

8 “(3) SECRETARY’S OPTION FOR NONCOMPETI-
9 TIVE DESIGNATION.—The Secretary may designate
10 an entity to provide disease management services
11 under this section without regard to the require-
12 ments of section 5 of title 41, United States Code.

13 “(h) STANDARDS.—

14 “(1) QUALITY.—The Secretary shall establish
15 standards for, and procedures for assessing, the
16 quality of care provided by disease management or-
17 ganizations under this section, which shall include—

18 “(A) performance standards with respect
19 to the processes or outcomes of health care or
20 the health status of enrolled individuals, includ-
21 ing procedures for establishing a baseline and
22 measuring changes in health care processes or
23 health outcomes with respect to managed dis-
24 eases or health conditions;

1 “(B) a requirement that the organization
2 meet such licensure and other accreditation
3 standards as the Secretary may find appro-
4 priate; and

5 “(C) such other quality standards, includ-
6 ing patient satisfaction, as the Secretary may
7 find appropriate.

8 “(2) COST MANAGEMENT.—The Secretary shall
9 establish a performance standard with respect to
10 management or reduction of the aggregate costs of
11 health care items and services related to managed
12 health conditions furnished to enrolled individuals,
13 including procedures for establishing a baseline and
14 measuring changes in costs for such items and serv-
15 ices.

16 “(i) PAYMENT.—

17 “(1) TERMS OF PAYMENT.—The Secretary may
18 negotiate or otherwise establish payment terms and
19 rates for service packages developed under sub-
20 section (f)(2).

21 “(2) WITHHOLDING OF PAYMENTS.—An agree-
22 ment under subsection (g) may provide that the Sec-
23 retary may withhold up to 10 percent of the amount
24 due a disease management organization under the
25 basis of payment established under paragraph (1)

1 until such time as such organization meets a stand-
2 ard or standards specified in such agreement.”.

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

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

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

10 (B) by striking the period at the end of
11 paragraph (16) and inserting “; and”; and

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

14 “(17) disease management services furnished in
15 accordance with section 1866C.”.

16 (2) PART B COINSURANCE AND DEDUCTIBLE
17 NOT APPLICABLE TO DISEASE MANAGEMENT SERV-
18 ICES.—

19 (A) COINSURANCE.—Section
20 1833(a)(1)(V) of the Social Security Act (42
21 U.S.C. 1395l(a)(1)(V)), as added by section
22 131(b)(2)(A), is amended to read as follows:
23 “(V) with respect to care coordination services
24 described in section 1861(s)(16) and disease
25 management services described in section

1 1861(s)(17), the amounts paid shall be 100
2 percent of the payment amounts established
3 under sections 1866B and 1866C, respec-
4 tively;”.

5 (B) DEDUCTIBLE.—The first sentence of
6 section 1833(b) of the Social Security Act (42
7 U.S.C. 1395l(b)), as amended by section
8 131(b)(2)(B), is amended by inserting before
9 the period at the end the following: “or to dis-
10 ease management services (as described in sec-
11 tion 1861(s)(17))”.

12 **SEC. 133. COMPETITIVE ACQUISITION OF ITEMS AND SERV-**
13 **ICES.**

14 (a) PROGRAM AUTHORIZED.—Title XVIII of the So-
15 cial Security Act (42 U.S.C. 1395 et seq.), as amended
16 by section 132, is amended by inserting after section
17 1866C the following new section:

18 “COMPETITIVE ACQUISITION OF ITEMS AND SERVICES

19 “SEC. 1866D. (a) IN GENERAL.—

20 “(1) PROGRAM AUTHORITY.—The Secretary
21 shall implement a program to purchase, on behalf of
22 individuals enrolled under this part certain competi-
23 tively priced items and services for which payment
24 may be made under part B.

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

1 administer the program under this section in accord-
2 ance with section 1866M, including subsection (b)(2)
3 of such section (relating to the discretion of the Sec-
4 retary as to the scope of the program).

5 “(b) ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—

6
7 “(1) IN GENERAL.—The Secretary shall estab-
8 lish competitive acquisition areas for agreement
9 award purposes for the furnishing under part B of
10 the items and services described in subsection (d)
11 after 2003. The Secretary may establish different
12 competitive acquisition areas under this subsection
13 for different classes of items and services.

14 “(2) CRITERIA FOR ESTABLISHMENT.—The
15 competitive acquisition areas established under para-
16 graph (1) shall be chosen based on the availability
17 and accessibility of individuals and entities able to
18 furnish items and services, and the estimated sav-
19 ings to be realized by the use of competitive acquisi-
20 tion in the furnishing of items and services in the
21 area.

22 “(c) AWARDING OF AGREEMENTS IN COMPETITIVE
23 ACQUISITION AREAS.—

24 “(1) IN GENERAL.—The Secretary shall con-
25 duct a competition among individuals and entities

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

5 “(2) CONDITIONS FOR AWARDING AGREEMENT.—The Secretary may not enter an agreement
6 with any entity under the competition conducted
7 pursuant to paragraph (1) to furnish an item or
8 service unless the Secretary finds that the entity
9 meets quality standards specified by the Secretary,
10 and that the aggregate amounts to be paid under
11 the agreement are expected to be less than the ag-
12 gregate amounts that would otherwise be paid.
13

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

18 “(d) SERVICES DESCRIBED.—The items and services
19 to which this section applies are all items and services de-
20 scribed in paragraphs (3) and (5) through (9) of section
21 1861(s) (other than custom fabricated prostheses, as de-
22 fined by the Secretary), and such other items or services
23 as the Secretary may specify.”.

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

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

3 (1) by striking “or” at the end of paragraph
4 (20);

5 (2) by striking the period at the end of para-
6 graph (21) and inserting “; or”; and

7 (3) by inserting after paragraph (21) the fol-
8 lowing new paragraph:

9 “(22) where the expenses are for an item or
10 service furnished in a competitive acquisition area
11 (as established by the Secretary under section
12 1866D(a)) by an entity other than an entity with
13 which the Secretary has entered into an agreement
14 under section 1866D(c) for the furnishing of such
15 an item or service in that area, except in such cases
16 of emergency or urgent need as the Secretary shall
17 prescribe.”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section apply to items and services furnished after
20 2003.

21 **SEC. 134. PROVIDER AND PHYSICIAN COLLABORATIONS.**

22 Title XVIII of the Social Security Act (42 U.S.C.
23 1395 et seq.), as amended by section 133, is amended by
24 inserting after section 1866D the following new section:

25 “PROVIDER AND PHYSICIAN COLLABORATIONS

26 “SEC. 1866E. (a) IN GENERAL.—

1 “(1) PROGRAM AUTHORITY.—The Secretary
2 may enter into agreements with specific providers,
3 suppliers, or other individuals or entities for the fur-
4 nishing of bundled items and services in selected
5 sites of service or related to specific medical condi-
6 tions or needs for an episode of care. The services
7 may include any items or services covered under this
8 title that the Secretary determines to be appropriate,
9 including post-hospital services.

10 “(2) ADMINISTRATION BY CONTRACT.—Except
11 as otherwise specifically provided, the Secretary may
12 administer the program under this section in accord-
13 ance with section 1866M, including subsection (b)(2)
14 of such section (relating to the discretion of the Sec-
15 retary as to the scope of the program).

16 “(b) BASIS OF SELECTION.—The Secretary shall se-
17 lect entities for agreements under this section on the basis
18 of ability to provide services more efficiently, to provide
19 improved coordination of care, to offer additional benefits,
20 and to meet quality and other standards and beneficiary
21 protections and other requirements set by the Secretary.

22 “(c) PAYMENT.—Payment under this section shall be
23 made on the basis of all-inclusive rates. The all-inclusive
24 rate paid to an entity for bundled items and services fur-
25 nished during an episode of care under this section shall

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

4 “(d) **TERM OF AGREEMENT.**—Agreements under this
5 section shall be for periods that the Secretary may deter-
6 mine.

7 “(e) **INCENTIVES TO BENEFICIARIES FOR USE OF**
8 **CONTRACTING ENTITIES.**—Notwithstanding any other
9 provision of law, entities under a contract under this sec-
10 tion may furnish additional services or waive part or all
11 beneficiary cost-sharing (such as deductibles, copayments,
12 and coinsurance) with respect to any of the items or serv-
13 ices furnished under this section.

14 “(f) **BENEFICIARY ELECTION.**—An individual enti-
15 tled to benefits under this title who elects to obtain serv-
16 ices under an agreement under this section shall agree to
17 receive under such agreement all benefits related to the
18 episode of care covered by the agreement (subject to such
19 exceptions for emergency services and as the Secretary
20 otherwise may specify).”.

21 **SEC. 135. PREFERRED PARTICIPANTS.**

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

1 “PREFERRED PARTICIPANTS

2 “SEC. 1866F. (a) PROGRAM AUTHORITY.—

3 “(1) IN GENERAL.—The Secretary shall imple-
4 ment beginning in 2003, a preferred participant pro-
5 gram, under which the Secretary enters into agree-
6 ments for the furnishing of health care items and
7 services by individuals and entities participating in
8 the program under part A or B of this title that pro-
9 vide high-quality, efficient health care.

10 “(2) LIMITATION.—The Secretary shall not im-
11 plement the program under this section with respect
12 to a service area, or with respect to a category of in-
13 dividuals and entities furnishing items and services
14 in such service area, unless the Secretary estimates
15 that to do so will reduce the cost and improve the
16 quality of the programs under this title.

17 “(3) ADMINISTRATION BY CONTRACT.—Except
18 as otherwise specifically provided, the Secretary shall
19 administer the program under this section in accord-
20 ance with section 1866M, including subsection (b)(2)
21 of such section (relating to the discretion of the Sec-
22 retary as to the scope of the program).

23 “(b) PREFERRED PARTICIPANT AGREEMENT.—

24 “(1) CRITERIA AND TERMS.—In order to be eli-
25 gible to participate in the program under part A or

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

3 “(A) PARTICIPATION CRITERIA.—The indi-
4 vidual or entity shall meet the criteria estab-
5 lished by the Secretary under section
6 1866M(b)(5) (relating to quality, cost-effective-
7 ness, categories of participants in each service
8 area, and such other standards or criteria as
9 the Secretary may establish).

10 “(B) PAYMENT RATE.—The individual or
11 entity shall agree to accept payment, for cov-
12 ered health care items and services furnished
13 during the term of the agreement, at the rates
14 established under this section (which may in-
15 clude rates in effect under part A or B, dis-
16 counted rates, or such other rates as the Sec-
17 retary may find appropriate).

18 “(2) DURATION.—A preferred participant
19 agreement under this section shall be for a calendar
20 year (or, in the case of an agreement commencing
21 after the first day of January (or such later date as
22 the Secretary may specify), for the remainder of
23 such calendar year), and shall be annually renew-
24 able, at the option of the participant, while the par-

1 participant continues to meet all applicable conditions
2 of participation.

3 “(c) OPTION TO REDUCE COST-SHARING.—Notwith-
4 standing any other provision of law, subject to the cost-
5 effectiveness criteria specified in subsection (a)(2), the
6 Secretary may—

7 “(1) provide for the reduction or elimination of
8 beneficiary cost-sharing (such as deductibles, copay-
9 ments, and coinsurance) with respect to any of the
10 items or services furnished under this section, and
11 may limit such reduction or elimination to particular
12 service areas; and

13 “(2) permit individuals or entities under an
14 agreement under this section to waive part or all of
15 such beneficiary cost-sharing.”.

16 (b) DEFINITIONS.—Section 1861 of the Social Secu-
17 rity Act (42 U.S.C. 1395x), as amended by section 105
18 of the Medicare, Medicaid, and SCHIP Benefits Improve-
19 ment and Protection Act of 2000 (114 Stat. 2763A–471),
20 as enacted into law by section 1(a)(6) of Public Law 106–
21 554, is amended by adding at the end the following new
22 subsection:

23 “(ww) PREFERRED PARTICIPANT.—The term ‘pre-
24 ferred participant’ means an individual or entity that fur-
25 nishes health care items or services under part A or B

1 and that has in effect an agreement under section
2 1866F(b).”.

3 **SEC. 136. SIMPLIFIED CENTER PAYMENTS.**

4 Title XVIII of the Social Security Act (42 U.S.C.
5 1395 et seq.), as amended by section 135, is amended by
6 inserting after section 1866F the following new section:

7 ‘SIMPLIFIED CENTER PAYMENTS

8 “SEC. 1866G. (a) IN GENERAL.—

9 “(1) COMPETITION TO FURNISH BUNDLED
10 ITEMS AND SERVICES.—The Secretary, beginning in
11 2003, shall use a competitive process to enter into
12 agreements with specific hospitals or other entities
13 for the furnishing of bundled groups of items and
14 services related to certain surgical procedures, and
15 of other bundled groups of items and services (unre-
16 lated to surgical procedures) specified by the Sec-
17 retary furnished during an episode of care (as de-
18 fined by the Secretary). Such items and services may
19 include any items or services covered under this title
20 that the Secretary determines to be appropriate.

21 “(2) ADMINISTRATION BY CONTRACT.—Except
22 as otherwise specifically provided, the Secretary may
23 administer the program under this section in accord-
24 ance with section 1866M, including subsection (b)(2)
25 of such section (relating to the discretion of the Sec-
26 retary as to the scope of the program).

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

3 “(1) meet quality standards established by the
4 Secretary;

5 “(2) implement an ongoing quality assurance
6 program approved by the Secretary; and

7 “(3) meet such other requirements as the Sec-
8 retary may establish.

9 “(c) PAYMENT.—

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

16 “(2) PAYMENT LIMITATION.—

17 “(A) LIMITATION ON AGGREGATE PAY-
18 MENTS TO ENTITIES.—The estimated amount
19 of aggregate payments to all entities under this
20 section for a year shall be less than the esti-
21 mated amount of aggregate payments that the
22 Secretary would otherwise have made for such
23 year, adjusted for changes in the number of in-
24 dividuals receiving services.

1 “(B) LIMITATION ON PAYMENTS TO PAR-
2 TICULAR ENTITIES.—In no case shall the all-in-
3 clusive rate paid to an entity for items and
4 services furnished during an episode of care
5 under this section exceed the estimated amount
6 of the payments that the Secretary would other-
7 wise have made for such items and services.

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

10 “(e) INCENTIVES FOR USE OF CENTERS.—Notwith-
11 standing any other provision of law, the Secretary may
12 permit entities under an agreement under this section to
13 furnish additional services or to waive part or all bene-
14 ficiary cost-sharing (such as deductibles, copayments, and
15 coinsurance) with respect to any of the items or services
16 furnished under this section.

17 “(f) BENEFICIARY ELECTION.—Notwithstanding any
18 other provision of this title, an individual who voluntarily
19 elects to receive items and services under an arrangement
20 described in subsection (a)(1) with respect to an episode
21 of care shall not be entitled to payment under this title
22 for any such item or service furnished with respect to such
23 episode of care other than through such arrangement, sub-
24 ject to such exceptions as the Secretary may prescribe for

1 emergency medical services as described in section
2 1852(d)(3) and other cases of urgent need.”.

3 **SEC. 137. CONFORMING CHANGES TO PHYSICIAN GROUP**
4 **PRACTICE DEMONSTRATION AND ADMINIS-**
5 **TRATIVE PROVISIONS.**

6 (a) CONFORMING CHANGE TO PHYSICIAN GROUP
7 PRACTICE DEMONSTRATION.—Section 1866A(a)(2), as
8 added by section 412 of the Medicare, Medicaid, and
9 SCHIP Benefits Improvement and Protection Act of 2000
10 (114 Stat. 2763A–509), as enacted into law by section
11 1(a)(6) of Public Law 106–554, is amended by striking
12 “1866B” and inserting “1866M, including subsection
13 (b)(2) of such section (relating to the discretion of the Sec-
14 retary as to the scope of the program)”.

15 (b) CONFORMING CHANGES TO ADMINISTRATIVE
16 PROVISIONS.—Section 1866M (as redesignated by section
17 131(a)(1)) is amended to read as follows:

18 “GENERAL PROVISIONS FOR ADMINISTRATION OF CER-
19 TAIN PRIVATE SECTOR PURCHASING AND QUALITY
20 IMPROVEMENT PROGRAMS

21 “SEC. 1866M. (a) IN GENERAL.—Except as other-
22 wise specifically provided, the provisions of this section
23 apply to the programs under the following provisions of
24 this title:

1 “(1) Section 1866A (demonstration of applica-
2 tion of physician volume increases to group prac-
3 tices).

4 “(2) Section 1866B (care coordination serv-
5 ices).

6 “(3) Section 1866C (disease management serv-
7 ices).

8 “(4) Section 1866D (competitive acquisition of
9 items and services).

10 “(5) Section 1866E (provider and physician col-
11 laborations).

12 “(6) Section 1866F (preferred participants).

13 “(7) Section 1866G (simplified center pay-
14 ments).

15 “(b) PROVISIONS GENERALLY APPLICABLE TO DES-
16 IGNATED PROGRAMS.—The following provisions apply to
17 programs specified in subsection (a), except as otherwise
18 specifically provided:

19 “(1) BENEFICIARY ELIGIBILITY.—Except as
20 otherwise provided by the Secretary, an individual
21 shall only be eligible to receive benefits under a pro-
22 gram specified in subsection (a) if such individual—

23 “(A) is enrolled in under the program
24 under part B;

1 “(B) is not enrolled in a Medicare+Choice
2 plan under part C, an eligible organization
3 under a contract under section 1876 (or a simi-
4 lar organization operating under a demonstra-
5 tion project authority), an organization with an
6 agreement under section 1833(a)(1)(A), or a
7 PACE program under section 1894; and

8 “(C) in the case of the programs specified
9 in paragraphs (1), (2), (3), (5), and (7) of sub-
10 section (a), is entitled to benefits under part A.

11 “(2) SECRETARY’S DISCRETION AS TO SCOPE
12 OF PROGRAM.—The Secretary may limit the imple-
13 mentation of a program specified in subsection (a)
14 to—

15 “(A) a geographic area (or areas) that the
16 Secretary designates for purposes of the pro-
17 gram, based upon such criteria as the Secretary
18 finds appropriate;

19 “(B) a subgroup (or subgroups) of bene-
20 ficiaries or individuals and entities furnishing
21 items or services (otherwise eligible to partici-
22 pate in the program), selected on the basis of
23 the number of such participants that the Sec-
24 retary finds consistent with the effective and ef-
25 ficient implementation of the program;

1 “(C) an element (or elements) of the pro-
2 gram that the Secretary determines to be suit-
3 able for implementation; or

4 “(D) any combination of any of the limits
5 described in subparagraphs (A) through (C).

6 “(3) VOLUNTARY RECEIPT OF ITEMS AND
7 SERVICES.—Except as provided in the authority for
8 the program specified in subsection (a)(4), items and
9 services shall be furnished to an individual under the
10 programs specified in subsection (a) only at the indi-
11 vidual’s election.

12 “(4) AGREEMENTS.—The Secretary is author-
13 ized to enter into agreements with individuals and
14 entities to furnish health care items and services to
15 beneficiaries under the programs specified in sub-
16 section (a).

17 “(5) PROGRAM STANDARDS AND CRITERIA.—
18 The Secretary shall establish performance standards
19 for the programs specified in subsection (a) includ-
20 ing, as applicable, standards for quality of health
21 care items and services, cost-effectiveness, bene-
22 ficiary satisfaction, and such other factors as the
23 Secretary finds appropriate. The eligibility of indi-
24 viduals or entities for the initial award, continuation,
25 and renewal of agreements to provide health care

1 items and services under the program shall be condi-
2 tioned, at a minimum, on performance that meets or
3 exceeds such standards.

4 “(6) ADMINISTRATIVE REVIEW OF ADVERSE
5 DECISION.—

6 “(A) DECISIONS AFFECTING INDIVIDUALS
7 AND ENTITIES FURNISHING SERVICES UNDER
8 PROGRAMS.—An individual or entity furnishing
9 services under a program specified in subsection
10 (a) shall be entitled to a review by the program
11 administrator (or, if the Secretary has not con-
12 tracted with a program administrator, by the
13 Secretary) of a decision not to enter into, or to
14 terminate, or not to renew, an agreement with
15 the individual or entity to provide health care
16 items or services under such program.

17 “(B) DECISIONS AFFECTING BENE-
18 FICIARIES UNDER CARE COORDINATION SERV-
19 ICES OR DISEASE MANAGEMENT SERVICES PRO-
20 GRAMS.—

21 “(i) DETERMINATION OF INELIGI-
22 BILITY.—An individual shall be entitled to
23 a review by the program administrator (or,
24 if the Secretary has not contracted with a
25 program administrator, by the Secretary)

1 of a determination that the individual does
2 not meet the criteria for eligibility to par-
3 ticipate in a program specified in para-
4 graph (2) or (3) of subsection (a).

5 “(ii) DENIAL OF PAYMENT FOR ITEMS
6 OR SERVICES.—A beneficiary shall be enti-
7 tled to a reconsideration or appeal of a de-
8 nial of payment under section 1866B(d)(2)
9 or 1866C(e)(2) in accordance with the pro-
10 visions of section 1852(g), as if such sec-
11 tion applied to this clause. In applying
12 such section 1852(g), any reference to a
13 Medicare+Choice organization is construed
14 to refer to the program administrator or, if
15 the Secretary has not contracted with a
16 program administrator, to the Secretary.

17 “(7) SECRETARY’S REVIEW OF MARKETING MA-
18 TERIALS.—An agreement with an individual or enti-
19 ty furnishing services under a program specified in
20 subsection (a) shall require the individual or entity
21 to guarantee that it will not distribute materials
22 marketing items or services under such program
23 without the Secretary’s prior review and approval;

24 “(8) PAYMENT IN FULL.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), an individual or entity re-
3 ceiving payment from the Secretary under a
4 contract or agreement under a program speci-
5 fied in subsection (a) shall agree to accept such
6 payment as payment in full, and such payment
7 shall be in lieu of any payments to which the
8 individual or entity would otherwise be entitled
9 under this title.

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

14 “(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

15 “(1) IN GENERAL.—The Secretary may admin-
16 ister a program specified in subsection (a) through
17 a contract with a program administrator in accord-
18 ance with the provisions of this subsection.

19 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-
20 TRACTS.—A contract under this subsection may, at
21 the Secretary’s discretion, relate to administration of
22 any or all of the programs specified in subsection
23 (a). The Secretary may enter into such contracts for
24 a limited geographic area, or on a regional or na-
25 tional basis.

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

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

8 “(B) any other entity with substantial ex-
9 perience in managing the type of program con-
10 cerned.

11 “(4) CONTRACT AWARD, DURATION, AND RE-
12 NEWAL.—

13 “(A) IN GENERAL.—A contract under this
14 subsection shall be for an initial term of up to
15 3 years, renewable for additional terms of up to
16 3 years.

17 “(B) NONCOMPETITIVE AWARD AND RE-
18 NEWAL FOR ENTITIES ADMINISTERING PART A
19 OR PART B PAYMENTS.—The Secretary may
20 enter or renew a contract under this subsection
21 with an entity described in paragraph (3)(A)
22 without regard to the requirements of section 5
23 of title 41, United States Code.

24 “(5) APPLICABILITY OF FEDERAL ACQUISITION
25 REGULATION.—The Federal Acquisition Regulation

1 shall apply to program administration contracts
2 under this subsection.

3 “(6) PERFORMANCE STANDARDS.—The Sec-
4 retary shall establish performance standards for the
5 program administrator including, as applicable,
6 standards for the quality and cost-effectiveness of
7 the program administered, and such other factors as
8 the Secretary finds appropriate. The eligibility of en-
9 tities for the initial award, continuation, and renewal
10 of program administration contracts shall be condi-
11 tioned, at a minimum, on performance that meets or
12 exceeds such standards.

13 “(7) FUNCTIONS OF PROGRAM ADMINIS-
14 TRATOR.—A program administrator shall perform
15 any or all of the following functions, as specified by
16 the Secretary:

17 “(A) AGREEMENTS WITH INDIVIDUALS OR
18 ENTITIES FURNISHING HEALTH CARE ITEMS
19 AND SERVICES.—Determine the qualifications
20 of individuals or entities seeking to enter or
21 renew agreements to provide services under a
22 program specified in subsection (a), and as ap-
23 propriate enter or renew (or refuse to enter or
24 renew) such agreements on behalf of the Sec-
25 retary.

1 “(B) ESTABLISHMENT OF PAYMENT
2 RATES.—Negotiate or otherwise establish, sub-
3 ject to the Secretary’s approval, payment rates
4 for covered health care items and services.

5 “(C) PAYMENT OF CLAIMS OR FEES.—Ad-
6 minister payments for health care items or serv-
7 ices furnished under any such program.

8 “(D) PAYMENT OF BONUSES.—Using such
9 guidelines as the Secretary shall establish, and
10 subject to the approval of the Secretary, make
11 bonus payments as described in subsection
12 (d)(2)(A)(ii) to individuals and entities fur-
13 nishing items or services for which payment
14 may be made under any such program.

15 “(E) LIST OF PROGRAM PARTICIPANTS.—
16 Maintain and regularly update a list of individ-
17 uals or entities with agreements to provide
18 health care items and services under any such
19 program, and ensure that such list, in electronic
20 and hard copy formats, is readily available, as
21 applicable, to—

22 “(i) individuals residing in the service
23 area who are entitled to benefits under
24 part A or enrolled in the program under
25 part B;

1 “(ii) the entities responsible under
2 sections 1816 and 1842 for administering
3 payments for health care items and serv-
4 ices furnished; and

5 “(iii) individuals and entities pro-
6 viding health care items and services in the
7 service area.

8 “(F) BENEFICIARY ENROLLMENT.—Deter-
9 mine eligibility of individuals to enroll under a
10 program specified in subsection (a) and provide
11 enrollment-related services (but only if the Sec-
12 retary finds that the program administrator has
13 no conflict of interest caused by a financial re-
14 lationship with any individual or entity fur-
15 nishing items or services for which payment
16 may be made under any such program, or any
17 other conflict of interest with respect to such
18 function).

19 “(G) OVERSIGHT.—Monitor the compli-
20 ance of individuals and entities with agreements
21 under any such program with the conditions of
22 participation.

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

1 “(I) REVIEW OF MARKETING MATE-
2 RIALS.—Conduct a review of marketing mate-
3 rials proposed by an individual or entity fur-
4 nishing services under any such program.

5 “(J) ADDITIONAL FUNCTIONS.—Perform
6 such other functions as the Secretary may
7 specify.

8 “(8) LIMITATION OF LIABILITY.—The provi-
9 sions of section 1157(b) shall apply with respect to
10 activities of contractors and their officers, employ-
11 ees, and agents under a contract under this sub-
12 section.

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

22 “(d) RULES APPLICABLE TO BOTH PROGRAM
23 AGREEMENTS AND PROGRAM ADMINISTRATION CON-
24 TRACTS.—

1 “(1) RECORDS, REPORTS, AND AUDITS.—The
2 Secretary is authorized to require individuals and
3 entities with agreements to provide health care items
4 or services under programs specified under sub-
5 section (a), and entities with program administration
6 contracts under subsection (c), to maintain adequate
7 records, to afford the Secretary access to such
8 records (including for audit purposes), and to fur-
9 nish such reports and other materials (including au-
10 dited financial statements and performance data) as
11 the Secretary may require for purposes of implemen-
12 tation, oversight, and evaluation of such program
13 and of individuals’ and entities’ effectiveness in per-
14 formance of such agreements or contracts.

15 “(2) BONUSES.—Notwithstanding any other
16 provision of law, but subject to subparagraph
17 (B)(ii), the Secretary may make bonus payments
18 under a program specified in subsection (a) from the
19 Health Insurance and Supplementary Medical Insur-
20 ance Trust Funds in amounts that do not exceed 50
21 percent of the savings to such Trust Funds attrib-
22 utable to such programs (or in the case of the pro-
23 gram specified in subsection (a)(1), in amounts au-
24 thorized under such program), in accordance with
25 the following:

1 “(A) PAYMENTS TO PROGRAM ADMINIS-
2 TRATORS.—The Secretary may make bonus
3 payments under each program specified in sub-
4 section (a) to program administrators.

5 “(B) PAYMENTS TO INDIVIDUALS AND EN-
6 TITIES FURNISHING SERVICES.—

7 “(i) IN GENERAL.—Subject to clause
8 (ii), the Secretary may make bonus pay-
9 ments to individuals or entities furnishing
10 items or services for which payment may
11 be made under the programs specified in
12 paragraphs (1), (2), (3), and (6) of sub-
13 section (a), or may authorize a program
14 administrator to make such bonus pay-
15 ments in accordance with such guidelines
16 as the Secretary shall establish and subject
17 to the Secretary’s approval.

18 “(ii) LIMITATIONS.—The Secretary
19 may limit bonus payments under clause (i)
20 to particular service areas, types of individ-
21 uals or entities furnishing items or services
22 under a program, or kinds of items or
23 services, and may condition such payments
24 on the achievement of such standards re-
25 lated to efficiency, improvement in proc-

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

4 “(3) ANTIDISCRIMINATION LIMITATION.—

5 “(A) IN GENERAL.—The Secretary shall
6 not enter into an agreement with an individual
7 or entity to provide health care items or serv-
8 ices under a program specified under subsection
9 (a), or with an entity to administer such a pro-
10 gram, unless such individual or entity guaran-
11 tees that it will not deny, limit, or condition the
12 coverage or provision of benefits under such
13 program, for individuals eligible to be enrolled
14 under such program, based on any health sta-
15 tus-related factor described in section
16 2702(a)(1) of the Public Health Service Act.

17 “(B) CONSTRUCTION.—Subparagraph (A)
18 shall not be construed to prohibit such indi-
19 vidual or entity from taking any action explic-
20 itly authorized by the provisions of section
21 1866B (care coordination services) or section
22 1866C (disease management services).

23 “(e) LIMITATIONS ON JUDICIAL REVIEW.—The fol-
24 lowing actions and determinations with respect to a pro-

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

3 “(1) Limiting the implementation of a program
4 under subsection (b)(2).

5 “(2) The establishment of program participa-
6 tion standards under subsection (b)(5); or the denial
7 or termination of, or refusal to renew, an agreement
8 with an individual or entity to provide health care
9 items and services under the program.

10 “(3) The determination of a beneficiary’s eligi-
11 bility under subsection (b)(6)(B).

12 “(4) The establishment of program administra-
13 tion contract performance standards under sub-
14 section (c)(6); or the refusal to renew a program ad-
15 ministration contract; or the noncompetitive award
16 or renewal of a program administration contract
17 under subsection (c)(4)(B).

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

21 “(6) A determination with respect to a program
22 (where specifically authorized by the program au-
23 thority or by subsection (d)(2))—

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

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

3 “(C) as to whether to reduce or eliminate
4 beneficiary cost-sharing.

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

9 “(g) REPORTS TO CONGRESS.—Not later than 2
10 years after the date of enactment of this section, and bien-
11 nially thereafter for 6 years, the Secretary shall report to
12 Congress on the use of authorities under each of sections
13 1866A through 1866G. Each report shall address the im-
14 pact of the use of those authorities on expenditures, ac-
15 cess, and quality under the programs under this title.”.

16 (b) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
17 RALS.—Section 1877(b) of the Social Security Act (42
18 U.S.C. 1395m(b)) is amended—

19 (1) by redesignating paragraph (4) as para-
20 graph (5); and

21 (2) by inserting after paragraph (3) the fol-
22 lowing new paragraph:

23 “(4) PRIVATE SECTOR PURCHASING AND QUAL-
24 ITY IMPROVEMENT TOOLS FOR ORIGINAL MEDI-

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

3 “(A) included in the services under section
 4 1866B, 1866C, 1866E, or 1866G; and

5 “(B) provided by an individual or entity
 6 meeting such criteria related to quality assur-
 7 ance, financial disclosure, and other factors as
 8 the Secretary may find appropriate.”.

9 **SEC. 138. INCREASED FLEXIBILITY IN CONTRACTING FOR**
 10 **MEDICARE CLAIMS PROCESSING.**

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

14 (1) in subsection (a), in the matter preceding
 15 paragraph (1), by striking “with carriers” and in-
 16 serting “with agencies and organizations (in this
 17 section referred to as ‘carriers’)”; and

18 (2) by repealing subsection (f).

19 (b) SECRETARIAL FLEXIBILITY IN CONTRACTING
 20 FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CAR-
 21 RIER FUNCTIONS.—

22 (1) AUTHORITY TO ENTER INTO CONTRACTS.—

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

1 “(a)(1) The Secretary may enter into contracts with
2 agencies or organizations to perform any or all of the fol-
3 lowing functions, or parts of those functions (or, to the
4 extent provided in a contract, to secure performance there-
5 of by other organizations) to—

6 “(A) determine (subject to the provisions of sec-
7 tion 1878 and to such review by the Secretary as
8 may be provided for by the contracts) the amount of
9 the payments required pursuant to this part to be
10 made to providers of services;

11 “(B) make payments described in subparagraph
12 (A);

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

17 “(D) serve as a center for, and communicate to
18 individuals entitled to benefits under this part and
19 to providers of services, any information or instruc-
20 tions furnished to the agency or organization by the
21 Secretary, and serve as a channel of communication
22 from individuals entitled to benefits under this part
23 and from providers of services to the Secretary;

1 “(E) make such audits of the records of pro-
 2 viders of services as may be necessary to ensure that
 3 proper payments are made under this part;

4 “(F) perform the functions described by sub-
 5 section (d); and

6 “(G) perform such other functions as are nec-
 7 essary to carry out the purposes of this part.

8 “(2) In this title and title XI, the term ‘fiscal inter-
 9 mediary’ means an agency or organization with a contract
 10 under this section.”.

11 (B) PREREQUISITES FOR CONTRACTS.—
 12 Section 1816(b)(1)(A) of the Social Security
 13 Act (42 U.S.C. 1395h(b)(1)(A)) is amended by
 14 striking “after applying the standards, criteria,
 15 and procedures” and inserting “after evaluating
 16 the ability of the agency or organization to ful-
 17 fill the contract performance requirements”.

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

22 “(d) Each provider of services shall have a fiscal
 23 intermediary that—

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

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

3 “(3) is responsible and accountable for arrang-
4 ing the resolution of issues raised under this part by
5 the provider of services.”.

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

10 “(e) The Secretary, in evaluating the performance of
11 a fiscal intermediary, may solicit comments from providers
12 of services.”.

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

18 “(f)(1) With respect to the establishment of contract
19 performance requirements, the Secretary may consult
20 with—

21 “(A) Medicare+Choice organizations under
22 part C of this title;

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

1 “(C) organizations and agencies performing
2 functions necessary to carry out the purposes of this
3 part.”.

4 (F) CONSULTATION WITH RESPECT TO
5 PERFORMANCE REQUIREMENTS FOR CAR-
6 RIERS.—Section 1842(b)(2) of the Social Secu-
7 rity Act (42 U.S.C. 1395u(b)(2)) is amended—

8 (i) in subparagraph (A)—

9 (I) by inserting “(i)” before “No
10 such contract”;

11 (II) by striking the second sen-
12 tence and inserting the following new
13 clause:

14 “(ii) With respect to the establishment of contract
15 performance requirements, the Secretary may consult
16 with—

17 “(I) Medicare+Choice organizations under part
18 C of this title;

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

22 “(III) organizations and agencies performing
23 functions necessary to carry out the purposes of this
24 part.”;

1 (III) by striking the third sen-
2 tence; and

3 (IV) by striking the fourth sen-
4 tence and inserting the following new
5 clause:

6 “(iii) The Secretary may not require, as a condition
7 of entering into a contract under this section or under sec-
8 tion 1871, that a carrier match data obtained other than
9 in its activities under this part with data used in the ad-
10 ministration of this part for purposes of identifying situa-
11 tions in which section 1862(b) may apply.”;

12 (ii) in subparagraph (B), in the mat-
13 ter preceding clause (i), by striking “estab-
14 lish standards” and inserting “develop con-
15 tract performance requirements”; and

16 (iii) in subparagraph (D), by striking
17 “standards and criteria” each place it ap-
18 pears and inserting “contract performance
19 requirements”.

20 (2) CONFORMING AMENDMENTS.—

21 (A) PREREQUISITES FOR CONTRACTS.—

22 Section 1816(b) of the Social Security Act (42
23 U.S.C. 1395h(b)) is amended—

1 (i) in the matter preceding paragraph
2 (1), by striking “an agreement” and in-
3 sserting “a contract”;

4 (ii) in paragraph (1)(B), by striking
5 “agreement” and inserting “contract”; and

6 (iii) in paragraph (2)(A), by striking
7 “agreement” and inserting “contract”.

8 (B) TERMS AND CONDITIONS OF CON-
9 TRACTS; PROMPT PAYMENT OF CLAIMS.—Sec-
10 tion 1816(c) of the Social Security Act (42
11 U.S.C. 1395h(e)) is amended—

12 (i) in paragraph (1)—

13 (I) in the first sentence, by strik-
14 ing “An agreement” and inserting “A
15 contract”; and

16 (II) in the last sentence, by strik-
17 ing “an agreement” and inserting “a
18 contract”;

19 (ii) in paragraph (2)—

20 (I) in subparagraph (A), in the
21 matter preceding clause (i), by strik-
22 ing “Each agreement under this sec-
23 tion” and inserting “Each contract
24 under this section that provides for

1 making payments under this part”;
2 and

3 (II) in subparagraph (C), by
4 striking “hospital, rural primary care
5 hospital, skilled nursing facility, home
6 health agency, hospice program, com-
7 prehensive outpatient rehabilitation
8 facility, or rehabilitation agency” and
9 inserting “provider of services (as de-
10 fined in section 1861(u))”; and

11 (iii) in paragraph (3)(A), by striking
12 “agreement under this section” and insert-
13 ing “contract under this section that pro-
14 vides for making payments under this
15 part”.

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

19 (i) by striking “An agreement” and
20 inserting “A contract”; and

21 (ii) by striking “the agreement” each
22 place it appears and inserting “the con-
23 tract”.

24 (D) LIMITATION ON LIABILITY FOR CERTI-
25 FYING AND DISBURSING OFFICERS.—Section

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

4 (E) DENIAL OF CLAIM; NOTIFICATION AND
5 RECONSIDERATION.—Section 1816(j) of the So-
6 cial Security Act (42 U.S.C. 1395h(j)) is
7 amended in the matter preceding paragraph
8 (1)—

9 (i) by striking “An agreement” and
10 inserting “A contract”; and

11 (ii) by striking “for home health serv-
12 ices, extended care services, or post-hos-
13 pital extended care services”.

14 (F) ANNUAL REPORTING REQUIREMENT
15 ON ERRONEOUS PAYMENT RECOVERY.—Section
16 1816(k) of the Social Security Act (42 U.S.C.
17 1395h(k)) is amended—

18 (i) by striking “An agreement” and
19 inserting “A contract”; and

20 (ii) by inserting “(as appropriate)”
21 after “submit”.

22 (G) COORDINATION WITH MEDICARE IN-
23 TEGRITY PROGRAM.—Section 1816(l) of the So-
24 cial Security Act (42 U.S.C. 1395h(l)) is

1 amended by striking “an agreement” and in-
2 serting “a contract”.

3 (H) AUTHORITY TO ENTER INTO CON-
4 TRACTS WITH CARRIERS.—Section 1842(a) of
5 the Social Security Act (42 U.S.C. 1395u(a)) is
6 amended—

7 (i) in the matter preceding paragraph
8 (1)—

9 (I) by striking “carriers with
10 which agreements” and inserting “sin-
11 gle contracts under section 1816 and
12 this section together, or separate con-
13 tracts with eligible agencies and orga-
14 nizations with which contracts”; and

15 (II) by striking “some or all of
16 the following functions” and inserting
17 “any or all of the following functions,
18 or parts of those functions”; and

19 (ii) in paragraph (3), by inserting “(to
20 and from individuals enrolled under this
21 part and to and from physicians and other
22 entities that furnish items and services)”
23 after “communication”.

24 (I) APPLICABILITY OF COMPETITIVE BID-
25 DING PROVISIONS; FINDINGS AS TO FINANCIAL

1 RESPONSIBILITIES; CONTRACTUAL DUTIES.—

2 Section 1842(b) of the Social Security Act (42

3 U.S.C. 1395u(b)) is amended—

4 (i) in paragraph (2)(C), in the first
5 sentence, by inserting “(as appropriate)”
6 after “carriers”;

7 (ii) in paragraph (3), in the matter
8 preceding subparagraph (A), by inserting
9 “(as appropriate)” after “contract”;

10 (iii) in paragraph (7)(A), in the mat-
11 ter preceding clause (i), by striking “the
12 carrier” and inserting “a carrier”; and

13 (iv) in paragraph (11)(A), in the mat-
14 ter preceding clause (i), by inserting “(as
15 appropriate)” after “each carrier”.

16 (J) PARTICIPATING PHYSICIAN OR SUP-
17 PLIER; CONTRACTS WITH THE SECRETARY; PAY-
18 MENT OF CLAIMS ON ASSIGNMENT.—Section
19 1842(h) of the Social Security Act (42 U.S.C.
20 1395u(h)) is amended—

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

23 (I) by striking “an agreement”
24 and inserting “a contract”; and

1 (II) by inserting “(as appro-
2 priate)” after “shall”;

3 (ii) in paragraph (3)(A), by striking
4 “an agreement” and inserting “a con-
5 tract”;

6 (iii) in paragraph (3)(B), in the third
7 sentence, by striking “agreements” and in-
8 serting “contracts”;

9 (iv) in paragraph (5)(A), by inserting
10 “(as appropriate)” after “carriers”; and

11 (v) in paragraph (8)—

12 (I) by striking “an agreement”
13 and inserting “a contract”; and

14 (II) by striking “such agree-
15 ment” and inserting “such contract”.

16 (c) ELIMINATION OF SPECIAL PROVISIONS FOR TER-
17 MINATIONS OF CONTRACTS.—

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

21 (A) in subsection (b), in the matter pre-
22 ceding paragraph (1), by striking “or renew”;

23 (B) in subsection (c)(1), in the last sen-
24 tence, by striking “or renewing”; and

25 (C) by repealing subsection (g).

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

4 (d) REPEAL OF FISCAL INTERMEDIARY REQUIRE-
5 MENTS THAT ARE NOT COST-EFFECTIVE.—Section
6 1816(f)(2) of the Social Security Act (42 U.S.C.
7 1395h(f)(2)) is amended—

8 (1) in the matter preceding subparagraph (A),
9 by striking “standards and criteria established
10 under” and inserting “contract performance require-
11 ments described in”; and

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

14 “(A) with respect to claims for services fur-
15 nished under this part by any provider of services
16 (as defined in section 1861(u)) other than a hos-
17 pital, whether such agency or organization is able to
18 process 75 percent of reconsiderations within 60
19 days and 90 percent of reconsiderations within 90
20 days; and”.

21 (e) REPEAL OF COST REIMBURSEMENT REQUIRE-
22 MENTS.—

23 (1) FISCAL INTERMEDIARIES.—Section
24 1816(c)(1) of the Social Security Act (42 U.S.C.
25 1395h(c)(1)) is amended—

1 (A) in the first sentence—

2 (i) by striking the comma after “ap-
3 appropriate” and inserting “and”; and

4 (ii) by striking “, and shall provide
5 for payment” and all that follows before
6 the period; and

7 (B) by striking the second and third sen-
8 tences.

9 (2) CARRIERS.—Section 1842(c)(1) of the So-
10 cial Security Act (42 U.S.C. 1395u(c)(1)) is
11 amended—

12 (A) in the first sentence—

13 (i) by striking “section shall provide”
14 and inserting “section may provide”; and

15 (ii) by striking “, and shall provide”
16 and all that follows before the period; and

17 (B) by striking the second and third sen-
18 tences.

19 (3) CONFORMING AMENDMENT TO DEFICIT RE-
20 DUCION ACT.—Subsection (a) of section 2326 of
21 the Deficit Reduction Act of 1984 (42 U.S.C. 1395h
22 note) is repealed.

23 (f) SECRETARIAL FLEXIBILITY WITH RESPECT TO
24 RENEWING CONTRACTS AND TRANSFER OF FUNC-
25 TIONS.—

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

4 “(4)(A) Except as provided in laws with general ap-
5 plicability to Federal acquisition and procurement or in
6 subparagraph (B), the Secretary shall use competitive pro-
7 cedures when entering into contracts under this section.

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

14 “(ii) Functions may be transferred among fiscal
15 intermediaries without regard to any provision of law re-
16 quiring competition. However, the Secretary shall ensure
17 that performance quality is considered in such transfers.”.

18 (2) CARRIERS.—Section 1842(b)(1) of the So-
19 cial Security Act (42 U.S.C. 1395u(b)(1)) is amend-
20 ed to read as follows:

21 “(b)(1)(A) Except as provided in laws with general
22 applicability to Federal acquisition and procurement or in
23 subparagraph (B), the Secretary shall use competitive pro-
24 cedures when entering into contracts under this section.

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

7 “(ii) Functions may be transferred among carriers
8 without regard to any provision of law requiring competi-
9 tion. However, the Secretary shall ensure that perform-
10 ance quality is considered in such transfers.”.

11 (g) WAIVER OF COMPETITIVE REQUIREMENTS FOR
12 INITIAL CONTRACTS.—Contracts that have periods that
13 begin before or during the 1-year period that begins on
14 the first day of the fourth calendar month that begins
15 after the date of enactment of this Act may be entered
16 into under section 1816(a) or 1842(a) of the Social Secu-
17 rity Act (42 U.S.C. 1395h(a) and 1395u(a)) without re-
18 gard to any provision of law requiring the use of competi-
19 tive procedures.

20 (h) EFFECTIVE DATES.—

21 (1) IN GENERAL.—Except as provided in para-
22 graphs (2) and (3), the amendments made by this
23 section apply to contracts that have periods begin-
24 ning after the third calendar month that begins
25 after the date of enactment of this Act.

1 (2) **ELIMINATION OF SPECIAL PROVISIONS FOR**
 2 **TERMINATIONS OF CONTRACTS.**—The amendments
 3 made by subsection (c) apply to contracts that have
 4 periods ending on or after the end of the third cal-
 5 endar month that begins after the date of enactment
 6 of this Act.

7 (3) **SECRETARIAL FLEXIBILITY WITH RESPECT**
 8 **TO RENEWING CONTRACTS AND TRANSFER OF FUNC-**
 9 **TIONS.**—The amendments made by subsection (f)
 10 apply to contracts that have periods that begin after
 11 the end of the 1-year period specified in subsection
 12 (g).

13 **TITLE II—MEDICARE+CHOICE** 14 **COMPETITION**

15 **SEC. 201. REVISION OF MEDICARE+CHOICE COMPETITIVE** 16 **BIDDING DEMONSTRATION PROJECT.**

17 (a) **AREAS IN FLORIDA.**—Section 4011 of the Bal-
 18 anced Budget Act of 1997 (42 U.S.C. 1395w–23 note)
 19 is amended—

20 (1) by striking subsection (b)(2)(B) and insert-
 21 ing the following:

22 “(B) **LOCATION OF DESIGNATION.**—Of the
 23 4 areas recommended under subparagraph
 24 (A)—

25 “(i) 2 shall be in Florida; and

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

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

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

10 (b) BUDGET NEUTRALITY DURING 5-FISCAL-YEAR
11 PERIOD.—Section 4011(g) of the Balanced Budget Act of
12 1997 (42 U.S.C. 1395w-23 note) is amended—

13 (1) by striking “for a fiscal year” and inserting
14 “for any 5-fiscal-year period”; and

15 (2) by inserting “for such period” after
16 “4001,”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect as if included in the enact-
19 ment of section 533 of the Medicare, Medicaid, and
20 SCHIP Balanced Budget Refinement Act of 1999 (Appen-
21 dix F, 113 Stat. 1501A-389), as enacted into law by sec-
22 tion 1000(a)(6) of Public Law 106-113.

1 **TITLE III—MEDICARE OUT-**
 2 **PATIENT PRESCRIPTION**
 3 **DRUG BENEFIT PROGRAM**

4 **SEC. 301. MEDICARE OUTPATIENT PRESCRIPTION DRUG**
 5 **BENEFIT PROGRAM.**

6 (a) ESTABLISHMENT.—Title XVIII of the Social Se-
 7 curity Act (42 U.S.C. 1395 et seq.) is amended by redesi-
 8 gnating part D as part E and by inserting after part C
 9 the following new part:

10 “PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT
 11 PROGRAM

12 “DEFINITIONS

13 “SEC. 1860. In this part:

14 “(1) COVERED OUTPATIENT DRUG.—

15 “(A) IN GENERAL.—Except as provided in
 16 subparagraph (B), the term ‘covered outpatient
 17 drug’ means any of the following products:

18 “(i) A drug which may be dispensed
 19 only upon prescription, and—

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

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

1 fore the date of enactment of the
2 Drug Amendments of 1962 or which
3 is identical, similar, or related (within
4 the meaning of section 310.6(b)(1) of
5 title 21 of the Code of Federal Regu-
6 lations) to such a drug, and (bb)
7 which has not been the subject of a
8 final determination by the Secretary
9 that it is a ‘new drug’ (within the
10 meaning of section 201(p) of the Fed-
11 eral Food, Drug, and Cosmetic Act)
12 or an action brought by the Secretary
13 under section 301, 302(a), or 304(a)
14 of such Act to enforce section 502(f)
15 or 505(a) of such Act; or

16 “(III)(aa) which is described in
17 section 107(c)(3) of the Drug Amend-
18 ments of 1962 and for which the Sec-
19 retary has determined there is a com-
20 pelling justification for its medical
21 need, or is identical, similar, or re-
22 lated (within the meaning of section
23 310.6(b)(1) of title 21 of the Code of
24 Federal Regulations) to such a drug,
25 and (bb) for which the Secretary has

1 not issued a notice of an opportunity
2 for a hearing under section 505(e) of
3 the Federal Food, Drug, and Cos-
4 metic Act on a proposed order of the
5 Secretary to withdraw approval of an
6 application for such drug under such
7 section because the Secretary has de-
8 termined that the drug is less than ef-
9 fective for all conditions of use pre-
10 scribed, recommended, or suggested in
11 its labeling.

12 “(ii) A biological product which—

13 “(I) may only be dispensed upon
14 prescription;

15 “(II) is licensed under section
16 351 of the Public Health Service Act;
17 and

18 “(III) is produced at an estab-
19 lishment licensed under such section
20 to produce such product.

21 “(iii) Insulin approved under appro-
22 priate Federal law, including needles, sy-
23 ringes, and disposable pumps for the ad-
24 ministration of such insulin.

1 “(iv) A prescribed drug or biological
2 product that would meet the requirements
3 of clause (i) or (ii) except that it is avail-
4 able over-the-counter in addition to being
5 available upon prescription.

6 “(B) EXCLUSION.—The term ‘covered out-
7 patient drug’ does not include any product—

8 “(i) except as provided in subpara-
9 graph (A)(iv), which may be distributed to
10 individuals without a prescription;

11 “(ii) for which payment is available
12 under part A or B or would be available
13 under part B but for the application of a
14 deductible under such part (unless pay-
15 ment for such product is not available be-
16 cause benefits under part A or B have
17 been exhausted), determined without re-
18 gard to whether the beneficiary involved is
19 entitled to benefits under part A or en-
20 rolled under part B; or

21 “(iii) except for agents used to pro-
22 mote smoking cessation, for which cov-
23 erage may be excluded or restricted under
24 section 1927(d)(2).

1 “(2) ELIGIBLE BENEFICIARY.—The term ‘eligi-
2 ble beneficiary’ means an individual that is entitled
3 to benefits under part A or enrolled under part B.

4 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
5 tity’ means any entity that the Secretary determines
6 to be appropriate to provide eligible beneficiaries
7 with covered outpatient drugs under a plan under
8 this part, including—

9 “(A) a pharmacy benefit management com-
10 pany;

11 “(B) a retail pharmacy delivery system;

12 “(C) a health plan or insurer;

13 “(D) a State (through mechanisms estab-
14 lished under a State plan under title XIX);

15 “(E) any other entity approved by the Sec-
16 retary; or

17 “(F) any combination of the entities de-
18 scribed in subparagraphs (A) through (E) if the
19 Secretary determines that such combination—

20 “(i) increases the scope or efficiency
21 of the provision of benefits under this part;

22 and

23 “(ii) is not anticompetitive.

24 “(4) MEDICARE+CHOICE ORGANIZATION;

25 MEDICARE+CHOICE PLAN.—The terms

1 ‘Medicare+Choice organization’ and
 2 ‘Medicare+Choice plan’ have the meanings given
 3 such terms in subsections (a)(1) and (b)(1), respec-
 4 tively, of section 1859 (relating to definitions relat-
 5 ing to Medicare+Choice organizations).

6 “(5) PRESCRIPTION DRUG ACCOUNT.—The
 7 term ‘Prescription Drug Account’ means the Pre-
 8 scription Drug Account (as established under section
 9 1860J) in the Federal Supplementary Medical In-
 10 surance Trust Fund under section 1841.

11 “ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG
 12 BENEFIT PROGRAM

13 “SEC. 1860A. (a) PROVISION OF BENEFIT.—

14 “(1) IN GENERAL.—Beginning in 2004, the
 15 Secretary shall provide for and administer an out-
 16 patient prescription drug benefit program under
 17 which each eligible beneficiary enrolled under this
 18 part shall be provided with coverage of covered out-
 19 patient drugs as follows:

20 “(A) MEDICARE+CHOICE PLAN.—If the el-
 21 igible beneficiary is eligible to enroll in a
 22 Medicare+Choice plan, the beneficiary may en-
 23 roll in such a plan and obtain coverage of cov-
 24 ered outpatient drugs through such plan.

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

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

6 “(2) VOLUNTARY NATURE OF PROGRAM.—
7 Nothing in this part shall be construed as requiring
8 an eligible beneficiary to enroll in the program es-
9 tablished under this part.

10 “(3) SCOPE OF BENEFITS.—The program es-
11 tablished under this part shall provide for coverage
12 of all therapeutic classes of covered outpatient
13 drugs.

14 “(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG
15 COVERAGE.—In the case of an eligible beneficiary who has
16 creditable prescription drug coverage (as defined in section
17 1860B(a)(2)(A)(vi)), such beneficiary—

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

20 “(2) pursuant to section 1860B(a)(2)(A)(iii), is
21 permitted to subsequently enroll under this part
22 without any penalty and obtain coverage of covered
23 outpatient drugs in the manner described in sub-
24 section (a) if the beneficiary involuntarily loses such
25 coverage.

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

4 “ENROLLMENT

5 “SEC. 1860B. (a) ENROLLMENT UNDER THIS
6 PART.—

7 “(1) ESTABLISHMENT OF PROCESS.—

8 “(A) IN GENERAL.—The Secretary shall
9 establish a process through which an eligible
10 beneficiary (including an eligible beneficiary en-
11 rolled in a Medicare+Choice plan offered by a
12 Medicare+Choice organization) may make an
13 election to enroll under this part. Such process
14 shall be similar to the process for enrollment in
15 part B under section 1837, including the deem-
16 ing provisions of such section.

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

21 “(2) ENROLLMENT PROCEDURES.—

22 “(A) LATE ENROLLMENT PENALTY.—

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

1 suant to an enrollment after the bene-
2 ficiary's initial enrollment period under
3 part B (determined pursuant to section
4 1837(d)) and not pursuant to the open en-
5 rollment period described in subparagraph
6 (B), the Secretary shall establish proce-
7 dures for increasing the amount of the
8 monthly part D premium under section
9 1860D applicable to such beneficiary—

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

17 “(II) if determined appropriate
18 by the Secretary, by an amount that
19 the Secretary determines is actuarially
20 sound for each such period.

21 “(ii) PERIODS TAKEN INTO AC-
22 COUNT.—For purposes of calculating any
23 12-month period under clause (i), there
24 shall be taken into account—

1 “(I) the months which elapsed
2 between the close of the eligible bene-
3 ficiary’s initial enrollment period and
4 the close of the enrollment period in
5 which the beneficiary enrolled; and

6 “(II) in the case of an eligible
7 beneficiary who reenrolls under this
8 part, the months which elapsed be-
9 tween the date of termination of a
10 previous coverage period and the close
11 of the enrollment period in which the
12 beneficiary reenrolled.

13 “(iii) PERIODS NOT TAKEN INTO AC-
14 COUNT.—

15 “(I) IN GENERAL.—For purposes
16 of calculating any 12-month period
17 under clause (i), subject to subclause
18 (II), there shall not be taken into ac-
19 count months for which the eligible
20 beneficiary can demonstrate that the
21 beneficiary had creditable prescription
22 drug coverage (as defined in subpara-
23 graph (vi)).

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

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

5 “(aa) in the case of a bene-
6 ficiary with coverage described in
7 subclause (II) of clause (vi), the
8 date on which the plan termi-
9 nates, ceases to provide, or re-
10 duces the value of the prescrip-
11 tion drug coverage under such
12 plan to below the actuarial value
13 of the coverage provided under
14 the program under this part; or

15 “(bb) in the case of a bene-
16 ficiary with coverage described in
17 subclause (I), (III), or (IV) of
18 clause (vi), the date on which the
19 beneficiary loses eligibility for
20 such coverage.

21 “(iv) PERIODS TREATED SEPA-
22 RATELY.—Any increase in an eligible bene-
23 ficiary’s monthly part D premium under
24 clause (i) with respect to a particular con-
25 tinuous period of eligibility shall not be ap-

1 plicable with respect to any other contin-
2 uous period of eligibility which the bene-
3 ficiary may have.

4 “(v) CONTINUOUS PERIOD OF ELIGI-
5 BILITY.—

6 “(I) IN GENERAL.—Subject to
7 subclause (II), for purposes of this
8 subparagraph, an eligible beneficiary’s
9 ‘continuous period of eligibility’ is the
10 period that begins with the first day
11 on which the beneficiary is eligible to
12 enroll under section 1836 and ends
13 with the beneficiary’s death.

14 “(II) SEPARATE PERIOD.—Any
15 period during all of which an eligible
16 beneficiary satisfied paragraph (1) of
17 section 1836 and which terminated in
18 or before the month preceding the
19 month in which the beneficiary at-
20 tained age 65 shall be a separate ‘con-
21 tinuous period of eligibility’ with re-
22 spect to the beneficiary (and each
23 such period which terminates shall be
24 deemed not to have existed for pur-

1 poses of subsequently applying this
2 subparagraph).

3 “(vi) CREDITABLE PRESCRIPTION
4 DRUG COVERAGE DEFINED.—For purposes
5 of this part, the term ‘creditable prescrip-
6 tion drug coverage’ means any of the fol-
7 lowing:

8 “(I) MEDICAID PRESCRIPTION
9 DRUG COVERAGE.—Prescription drug
10 coverage under a medicaid plan under
11 title XIX, including through the Pro-
12 gram of All-inclusive Care for the El-
13 derly (PACE) under section 1934 and
14 through a social health maintenance
15 organization (referred to in section
16 4104(e) of the Balanced Budget Act
17 of 1997).

18 “(II) PRESCRIPTION DRUG COV-
19 ERAGE UNDER A GROUP HEALTH
20 PLAN.—Prescription drug coverage
21 under a group health plan, including a
22 health benefits plan under the Federal
23 Employees Health Benefit Program
24 under chapter 89 of title 5, United
25 States Code, and a qualified retiree

1 prescription drug plan as defined in
2 section 1860I(e)(3), that provides cov-
3 erage of the cost of prescription drugs
4 the actuarial value of which (as de-
5 fined by the Secretary) to the bene-
6 ficiary equals or exceeds the actuarial
7 value of the benefits provided to an
8 individual enrolled in the outpatient
9 prescription drug benefit program
10 under this part.

11 “(III) STATE PHARMACEUTICAL
12 ASSISTANCE PROGRAM.—Coverage of
13 prescription drugs under a State
14 pharmaceutical assistance program.

15 “(IV) VETERANS’ COVERAGE OF
16 PRESCRIPTION DRUGS.—Coverage of
17 prescription drugs for veterans, and
18 survivors and dependents of veterans,
19 under chapter 17 of title 38, United
20 States Code.

21 “(B) OPEN ENROLLMENT PERIOD FOR
22 CURRENT BENEFICIARIES IN WHICH LATE EN-
23 ROLLMENT PROCEDURES DO NOT APPLY.—The
24 Secretary shall establish an applicable period,
25 which shall begin on the date on which the Sec-

1 retary first begins to accept elections for enroll-
2 ment under this part, during which any eligible
3 beneficiary may enroll under this part without
4 the application of the late enrollment proce-
5 dures established under subparagraph (A)(i).

6 “(3) PERIOD OF COVERAGE.—

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

13 “(B) OPEN ENROLLMENT.—Subject to
14 subparagraph (C), an eligible beneficiary who
15 enrolls under the program under this part pur-
16 suant to paragraph (2)(B) shall be entitled to
17 the benefits under this part beginning on the
18 first day of the month following the month in
19 which such enrollment occurs.

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

22 “(4) TERMINATION.—

23 “(A) IN GENERAL.—The causes of termi-
24 nation specified in section 1838 shall apply to

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

3 “(B) COVERAGE TERMINATED BY TERMI-
4 NATION OF COVERAGE UNDER PARTS A AND
5 B.—

6 “(i) IN GENERAL.—In addition to the
7 causes of termination specified in subpara-
8 graph (A), the Secretary shall terminate
9 an individual’s coverage under this part if
10 the individual is no longer enrolled in ei-
11 ther part A or B.

12 “(ii) EFFECTIVE DATE.—The termi-
13 nation described in clause (i) shall be effec-
14 tive on the effective date of termination of
15 coverage under part A or (if later) under
16 part B.

17 “(C) PROCEDURES REGARDING TERMI-
18 NATION OF A BENEFICIARY UNDER A PLAN.—
19 The Secretary shall establish procedures for de-
20 termining the status of an eligible beneficiary’s
21 enrollment under this part if the beneficiary’s
22 enrollment in a plan offered by an eligible enti-
23 ty under this part is terminated by the entity
24 for cause (pursuant to procedures established
25 by the Secretary under subsection (b)(1)).

1 “(b) ENROLLMENT IN A PLAN.—

2 “(1) PROCESS.—

3 “(A) IN GENERAL.—The Secretary shall
4 establish a process through which an eligible
5 beneficiary who is enrolled under this part but
6 not enrolled in a Medicare+Choice plan offered
7 by a Medicare+Choice organization shall make
8 an annual election to enroll in any plan offered
9 by an eligible entity that has been awarded a
10 contract under this part and serves the geo-
11 graphic area in which the beneficiary resides.

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

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

18 “(I) the establishment of special
19 election periods under subsection
20 (e)(4) of such section; and

21 “(II) the application of the guar-
22 anteed issue and renewal provisions of
23 section 1851(g) (other than para-
24 graph (3)(C)(i), relating to default en-
25 rollment); and

1 “(ii) coordinate enrollments,
2 disenrollments, and terminations of enroll-
3 ment under part C with enrollments,
4 disenrollments, and terminations of enroll-
5 ment under this part.

6 “(2) MEDICARE+CHOICE ENROLLEES.—An eli-
7 gible beneficiary who is enrolled under this part and
8 enrolled in a Medicare+Choice plan offered by a
9 Medicare+Choice organization shall receive coverage
10 of covered outpatient drugs under this part through
11 such plan.

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

18 “(d) ENROLLMENT IN A MEDICARE+CHOICE
19 PLAN.—Enrollment in a Medicare+Choice plan is subject
20 to the rules for enrollment in such plan under section
21 1851.

22 “PROVIDING INFORMATION TO BENEFICIARIES

23 “SEC. 1860C. (a) ACTIVITIES.—

24 “(1) IN GENERAL.—The Secretary shall con-
25 duct activities that are designed to broadly dissemi-
26 nate information to eligible beneficiaries (and pro-

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

3 “(2) SPECIAL RULE FOR FIRST ENROLLMENT
4 UNDER THE PROGRAM.—To the extent practicable,
5 the activities described in paragraph (1) shall ensure
6 that eligible beneficiaries are provided with such in-
7 formation at least 30 days prior to the first enroll-
8 ment period described in section 1860B(c).

9 “(b) REQUIREMENTS.—

10 “(1) IN GENERAL.—The activities described in
11 subsection (a) shall—

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

14 “(B) be coordinated with the activities per-
15 formed by the Secretary under such section and
16 under section 1804; and

17 “(C) provide for the dissemination of infor-
18 mation comparing the plans offered by eligible
19 entities under this part that are available to eli-
20 gible beneficiaries residing in an area.

21 “(2) COMPARATIVE INFORMATION.—The com-
22 parative information described in paragraph (1)(C)
23 shall include a comparison of the following:

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

1 beneficiaries will be charged for covered outpatient
2 drugs, any preferred pharmacy networks used
3 by the eligible entity under the plan, and the
4 formularies and appeals processes under the
5 plan.

6 “(B) QUALITY AND PERFORMANCE.—To
7 the extent available, the quality and perform-
8 ance of the eligible entity offering the plan.

9 “(C) BENEFICIARY COST-SHARING.—The
10 cost-sharing required of eligible beneficiaries
11 under the plan.

12 “(D) CONSUMER SATISFACTION SUR-
13 VEYS.—To the extent available, the results of
14 consumer satisfaction surveys regarding the
15 plan and the eligible entity offering such plan.

16 “(E) ADDITIONAL INFORMATION.—Such
17 additional information as the Secretary may
18 prescribe.

19 “(3) INFORMATION STANDARDS.—The Sec-
20 retary shall develop standards to ensure that the in-
21 formation provided to eligible beneficiaries under
22 this part is complete, accurate, and uniform.

23 “(c) USE OF MEDICARE CONSUMER COALITIONS TO
24 PROVIDE INFORMATION.—

1 “(1) IN GENERAL.—The Secretary may con-
2 tract with Medicare Consumer Coalitions to conduct
3 the informational activities—

4 “(A) under this section;

5 “(B) under section 1851(d); and

6 “(C) under section 1804.

7 “(2) SELECTION OF COALITIONS.—If the Sec-
8 retary determines the use of Medicare Consumer
9 Coalitions to be appropriate, the Secretary shall—

10 “(A) develop and disseminate, in such
11 areas as the Secretary determines appropriate,
12 a request for proposals for Medicare Consumer
13 Coalitions to contract with the Secretary in
14 order to conduct any of the informational ac-
15 tivities described in paragraph (1); and

16 “(B) select a proposal of a Medicare Con-
17 sumer Coalition to conduct the informational
18 activities in each such area, with a preference
19 for broad participation by organizations with
20 experience in providing information to bene-
21 ficiaries under this title.

22 “(3) PAYMENT TO MEDICARE CONSUMER COA-
23 LITIONS.—The Secretary shall make payments to
24 Medicare Consumer Coalitions contracting under

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

3 “(4) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated to the Sec-
5 retary such sums as may be necessary to contract
6 with Medicare Consumer Coalitions under this sec-
7 tion.

8 “(5) MEDICARE CONSUMER COALITION DE-

9 FINED.—In this subsection, the term ‘Medicare Con-
10 sumer Coalition’ means an entity that is a nonprofit
11 organization operated under the direction of a board
12 of directors that is primarily composed of bene-
13 ficiaries under this title.

14 “PREMIUMS

15 “SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF

16 MONTHLY PART D PREMIUM RATES.—

17 “(1) IN GENERAL.—The Secretary shall, during

18 September of each year (beginning in 2003), deter-

19 mine and promulgate a monthly part D premium

20 rate for the succeeding year in accordance with the

21 provisions of this subsection.

22 “(2) ACTUARIAL DETERMINATIONS.—

23 “(A) DETERMINATION OF ANNUAL BEN-

24 EFIT AND ADMINISTRATIVE COSTS.—The Sec-

25 retary shall estimate annually for the suc-

26 ceeding year the amount equal to the total of

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

6 “(B) DETERMINATION OF MONTHLY PART
 7 D PREMIUM RATES.—

8 “(i) IN GENERAL.—The Secretary
 9 shall determine the monthly part D pre-
 10 mium rate for such succeeding year, which
 11 shall be $\frac{1}{12}$ of the applicable share of—

12 “(I) the amount determined
 13 under subparagraph (A); divided by

14 “(II) the total number of enroll-
 15 ees under this part,

16 rounded (if such rate is not a multiple of
 17 10 cents) to the nearest multiple of 10
 18 cents.

19 “(ii) DEFINITION OF APPLICABLE
 20 SHARE.—For purposes of clause (i), the
 21 term ‘applicable share’ means—

22 “(I) one-half, in the case of pre-
 23 miums paid by an eligible beneficiary
 24 enrolled in the program under this
 25 part; and

1 “(II) two-thirds, in the case of
2 premiums paid for such a beneficiary
3 by an employer (as defined in section
4 1860I(e)(2)) with which the bene-
5 ficiary was formerly employed.

6 “(3) PUBLICATION OF ASSUMPTIONS.—The
7 Secretary shall publish, together with the promulga-
8 tion of the monthly part D premium rates for the
9 succeeding year, a statement setting forth the actu-
10 arial assumptions and bases employed in arriving at
11 the amounts and rates determined under paragraphs
12 (1) and (2).

13 “(4) COLLECTION OF PART D PREMIUM.—The
14 monthly part D premium applicable to an eligible
15 beneficiary under this part (after application of any
16 increase under subsection (b) or under section
17 1860B(a)(2)(A)) shall be collected and credited to
18 the Prescription Drug Account in the same manner
19 as the monthly premium determined under section
20 1839 is collected and credited to the Federal Supple-
21 mentary Medical Insurance Trust Fund under sec-
22 tion 1840.

23 “(b) SLIDING SCALE PREMIUM.—

24 “(1) INCREASE.—

25 “(A) AMOUNT.—

1 “(i) IN GENERAL.—Except as pro-
2 vided in paragraph (4), in the case of an
3 eligible beneficiary whose modified ad-
4 justed gross income for a taxable year end-
5 ing with or within a calendar year (as ini-
6 tially determined by the Secretary in ac-
7 cordance with paragraph (2)) exceeds the
8 threshold amount, the Secretary shall in-
9 crease the amount of the monthly part D
10 premium for such individual established
11 under subsection (a) by an amount which
12 bears the same ratio to such premium as
13 such excess bears to an amount equal to
14 $\frac{1}{3}$ of the applicable threshold amount
15 under subparagraph (B).

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

21 “(B) DEFINITION OF THRESHOLD
22 AMOUNT.—For purposes of this subsection, the
23 term ‘threshold amount’ means—

24 “(i) except as otherwise provided in
25 this subparagraph, \$75,000;

1 “(ii) \$150,000 in the case of a joint
2 return; and

3 “(iii) zero in the case of a taxpayer
4 who—

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

8 “(II) does not live apart from his
9 spouse at all times during the taxable
10 year.

11 “(C) INFLATION ADJUSTMENT FOR
12 THRESHOLD AMOUNT.—

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

18 “(I) such dollar amount, multi-
19 plied by

20 “(II) the percentage (if any) by
21 which the average of the Consumer
22 Price Index for all urban consumers
23 (United States city average) for the
24 12-month period ending with June of
25 the preceding calendar year, exceeds

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

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

8 “(D) DEFINITION OF MODIFIED ADJUSTED
9 GROSS INCOME.—For purposes of this sub-
10 section, the term ‘modified adjusted gross in-
11 come’ means adjusted gross income (as defined
12 in section 62 of the Internal Revenue Code of
13 1986)—

14 “(i) determined without regard to sec-
15 tions 135, 911, 931, and 933 of such
16 Code; and

17 “(ii) increased by the amount of inter-
18 est received or accrued by the taxpayer
19 during the taxable year which is exempt
20 from tax under such Code.

21 “(E) DEFINITION OF JOINT RETURN.—
22 For purposes of this subsection, the term ‘joint
23 return’ has the meaning given the term in sec-
24 tion 7701(a)(38) of the Internal Revenue Code
25 of 1986.

1 “(2) DETERMINATION OF MODIFIED ADJUSTED
2 GROSS INCOME.—The Secretary shall make an initial
3 determination of the amount of an eligible bene-
4 ficiary’s modified adjusted gross income for a tax-
5 able year ending with or within a calendar year for
6 purposes of this subsection as follows:

7 “(A) NOTICE.—Not later than September
8 1 of the year preceding the year, the Secretary
9 shall provide notice to each eligible beneficiary
10 whom the Secretary finds (on the basis of the
11 beneficiary’s actual modified adjusted gross in-
12 come for the most recent taxable year for which
13 such information is available or other informa-
14 tion provided to the Secretary by the Secretary
15 of the Treasury) will be subject to an increase
16 under this subsection that the beneficiary will
17 be subject to such an increase, and shall include
18 in such notice the Secretary’s estimate of the
19 beneficiary’s modified adjusted gross income for
20 the year.

21 “(B) CALCULATION BASED ON INFORMA-
22 TION PROVIDED BY BENEFICIARY.—If, during
23 the 60-day period beginning on the date notice
24 is provided to an eligible beneficiary under sub-
25 paragraph (A), the beneficiary provides the Sec-

1 retary with appropriate information (as deter-
2 mined by the Secretary) on the beneficiary’s an-
3 ticipated modified adjusted gross income for the
4 year, the amount initially determined by the
5 Secretary under this paragraph with respect to
6 the beneficiary shall be based on the informa-
7 tion provided by the beneficiary.

8 “(C) CALCULATION BASED ON NOTICE
9 AMOUNT IF NO INFORMATION IS PROVIDED BY
10 THE BENEFICIARY OR IF THE SECRETARY DE-
11 TERMINES THAT THE PROVIDED INFORMATION
12 IS NOT APPROPRIATE.—The amount initially
13 determined by the Secretary under this para-
14 graph with respect to an eligible beneficiary
15 shall be the amount included in the notice pro-
16 vided to the beneficiary under subparagraph
17 (A) if—

18 “(i) the beneficiary does not provide
19 the Secretary with information under sub-
20 paragraph (B); or

21 “(ii) the Secretary determines that
22 the information provided by the beneficiary
23 to the Secretary under such subparagraph
24 is not appropriate.

25 “(3) ADJUSTMENTS.—

1 “(A) IN GENERAL.—If the Secretary deter-
2 mines (on the basis of final information pro-
3 vided by the Secretary of the Treasury) that
4 the amount of an eligible beneficiary’s actual
5 modified adjusted gross income for a taxable
6 year ending with or within a calendar year is
7 less than or greater than the amount initially
8 determined by the Secretary under paragraph
9 (2), the Secretary shall increase or decrease the
10 amount of the beneficiary’s monthly part D pre-
11 mium under this part (as the case may be) for
12 months during the following calendar year by
13 an amount equal to $\frac{1}{12}$ of the difference
14 between—

15 “(i) the total amount of all monthly
16 part D premiums paid by the beneficiary
17 under this part during the previous cal-
18 endar year; and

19 “(ii) the total amount of all such pre-
20 miums which would have been paid by the
21 beneficiary during the previous calendar
22 year if the amount of the beneficiary’s
23 modified adjusted gross income initially de-
24 termined under paragraph (2) were equal
25 to the actual amount of the beneficiary’s

1 modified adjusted gross income determined
2 under this paragraph.

3 “(B) INTEREST.—

4 “(i) INCREASE.—In the case of an eli-
5 gible beneficiary for whom the amount ini-
6 tially determined by the Secretary under
7 paragraph (2) is based on information pro-
8 vided by the beneficiary under subpara-
9 graph (B) of such paragraph, if the Sec-
10 retary determines under subparagraph (A)
11 that the amount of the beneficiary’s actual
12 modified adjusted gross income for a tax-
13 able year is greater than the amount ini-
14 tially determined under paragraph (2), the
15 Secretary shall increase the amount other-
16 wise determined for the year under sub-
17 subparagraph (A) by an amount of interest
18 equal to the sum of the amounts deter-
19 mined under clause (ii) for each of the
20 months described in such clause.

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

1 pounded daily) to any portion of the dif-
2 ference between the amount initially deter-
3 mined under paragraph (2) and the
4 amount determined under subparagraph
5 (A) for the period beginning on the first
6 day of the month beginning after the eligi-
7 ble beneficiary provided information to the
8 Secretary under subparagraph (B) of para-
9 graph (2) and ending 30 days before the
10 first month for which the beneficiary's
11 monthly part D premium is increased
12 under this paragraph.

13 “(iii) EXCEPTION.—Interest shall not
14 be imposed under this subparagraph if the
15 amount of the eligible beneficiary's modi-
16 fied adjusted gross income provided by the
17 beneficiary under subparagraph (B) of
18 paragraph (2) was not less than the bene-
19 ficiary's modified adjusted gross income
20 determined on the basis of information
21 shown on the return of tax imposed by
22 chapter 1 of the Internal Revenue Code of
23 1986 for the taxable year involved.

24 “(C) STEPS TO RECOVER AMOUNTS DUE
25 FROM PREVIOUSLY ENROLLED BENE-

1 FICIARIES.—In the case of an eligible bene-
2 ficiary who is not enrolled under this part for
3 any calendar year for which the beneficiary's
4 monthly part D premium under this part for
5 months during the year would be increased pur-
6 suant to subparagraph (A) if the beneficiary
7 were enrolled under this part for the year, the
8 Secretary may take such steps as the Secretary
9 considers appropriate to recover from the bene-
10 ficiary the total amount by which the bene-
11 ficiary's monthly part D premium under this
12 part for months during the year would have
13 been increased under subparagraph (A) if the
14 beneficiary were enrolled under this part for the
15 year.

16 “(D) DECEASED BENEFICIARY.—In the
17 case of a deceased eligible beneficiary for whom
18 the amount of the monthly part D premium
19 under this part for months in a year would have
20 been decreased pursuant to subparagraph (A) if
21 the beneficiary were not deceased, the Secretary
22 shall make a payment to the beneficiary's sur-
23 viving spouse (or, in the case of an eligible ben-
24 eficiary who does not have a surviving spouse,

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

3 “(i) the total amount by which the
4 beneficiary's premium would have been de-
5 creased for all months during the year pur-
6 suant to subparagraph (A); and

7 “(ii) the amount (if any) by which the
8 beneficiary's premium was decreased for
9 months during the year pursuant to sub-
10 paragraph (A).

11 “(4) WAIVER BY SECRETARY.—The Secretary
12 may waive the imposition of all or part of the in-
13 crease of the premium or all or part of any interest
14 due under this subsection for any period if the Sec-
15 retary determines that a gross injustice would other-
16 wise result without such waiver.

17 “(5) TRANSFER TO PRESCRIPTION DRUG AC-
18 COUNT.—The Secretary shall transfer amounts re-
19 ceived pursuant to this subsection to the Prescrip-
20 tion Drug Account.

21 “OUTPATIENT PRESCRIPTION DRUG BENEFITS

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

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

4 “(2) access to negotiated prices for such drugs
5 under subsection (c).

6 “(b) COST-SHARING.—

7 “(1) DEDUCTIBLE.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), there is an annual deductible that is
10 equal to \$250.

11 “(B) WAIVER OF DEDUCTIBLE FOR GE-
12 NERIC DRUGS.—

13 “(i) IN GENERAL.—An eligible entity
14 offering a plan under this part may pro-
15 vide, with respect to such plan, that ge-
16 neric drugs are not subject to the deduct-
17 ible described in subparagraph (A) if the
18 Secretary determines that the waiver of the
19 deductible—

20 “(I) is tied to the performance
21 goals described in section
22 1860H(b)(1)(C); and

23 “(II) will not result in an in-
24 crease in the expenditures made from
25 the Prescription Drug Account.

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

6 “(2) COINSURANCE.—

7 “(A) ESTABLISHMENT.—

8 “(i) IN GENERAL.—Subject to sub-
9 paragraph (B) and subparagraphs (A)(i)
10 and (B) of section 1860G(b)(4), if any cov-
11 ered outpatient drug is provided to an eli-
12 gible beneficiary in a year after the bene-
13 ficiary has met any deductible requirement
14 under paragraph (1) for the year, the ben-
15 eficiary shall be responsible for making
16 payments for the drug in an amount equal
17 to the applicable percentage of the cost of
18 the drug.

19 “(ii) APPLICABLE PERCENTAGE DE-
20 FINED.—For purposes of clause (i), the
21 ‘applicable percentage’ means, with respect
22 to any covered outpatient drug provided to
23 an eligible beneficiary in a year—

24 “(I) 50 percent to the extent the
25 out-of-pocket expenses of the bene-

1 beneficiary for such drug, when added to
2 the out-of-pocket expenses of the ben-
3 eficiary for covered outpatient drugs
4 previously provided in the year, do not
5 exceed \$3,500;

6 “(II) 25 percent to the extent
7 such expenses, when so added, exceed
8 \$3,500 but do not exceed \$4,000; and

9 “(III) 0 percent to the extent
10 such expenses, when so added, would
11 exceed \$4,000.

12 “(iii) OUT-OF-POCKET EXPENSES DE-
13 FINED.—For purposes of clause (ii), the
14 term ‘out-of-pocket expenses’ means ex-
15 penses incurred as a result of the applica-
16 tion of the deductible under paragraph (1)
17 and the coinsurance required under this
18 subsection.

19 “(B) REDUCTION BY ELIGIBLE ENTITY.—
20 An eligible entity offering a plan under this
21 part may reduce the applicable percentage that
22 an eligible beneficiary enrolled in the plan is
23 subject to under subparagraph (A) if the Sec-
24 retary determines that such reduction—

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

3 “(ii) will not result in an increase in
4 the expenditures made from the Prescrip-
5 tion Drug Account.

6 “(3) INFLATION ADJUSTMENT.—

7 “(A) IN GENERAL.—In the case of any cal-
8 endar year beginning after 2004, each of the
9 dollar amounts in paragraphs (1)(A) and
10 (2)(A)(ii) shall be increased by an amount equal
11 to—

12 “(i) such dollar amount, multiplied by

13 “(ii) the percentage (if any) by which
14 the amount of average per capita expendi-
15 tures under this part in the preceding cal-
16 endar year exceeds the amount of such ex-
17 penditures in 2004.

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

22 “(c) ACCESS TO NEGOTIATED PRICES.—Under a
23 plan offered by an eligible entity with a contract under
24 this part, the eligible entity offering such plan shall pro-
25 vide eligible beneficiaries enrolled in such plan with access

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

7 “ENTITIES ELIGIBLE TO PROVIDE OUTPATIENT DRUG
 8 BENEFIT

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

11 “(1) IN GENERAL.—The Secretary shall estab-
 12 lish procedures under which the Secretary—

13 “(A) accepts bids submitted by eligible en-
 14 tities for the plans which such entities intend to
 15 offer in an area established under subsection
 16 (b); and

17 “(B) awards contracts to such entities to
 18 provide such plans to eligible beneficiaries in
 19 the area.

20 “(2) COMPETITIVE PROCEDURES.—Competitive
 21 procedures (as defined in section 4(5) of the Office
 22 of Federal Procurement Policy Act (41 U.S.C.
 23 403(5))) shall be used to enter into contracts under
 24 this part.

25 “(b) AREA FOR CONTRACTS.—

26 “(1) REGIONAL BASIS.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B) and subject to paragraph (2),
3 the contract entered into between the Secretary
4 and an eligible entity with respect to a plan
5 shall require the eligible entity to provide cov-
6 erage of covered outpatient drugs under the
7 plan in a region determined by the Secretary
8 under paragraph (2).

9 “(B) PARTIAL REGIONAL BASIS.—

10 “(i) IN GENERAL.—If determined ap-
11 propriate by the Secretary, the Secretary
12 may permit the coverage described in sub-
13 paragraph (A) to be provided in a partial
14 region determined appropriate by the Sec-
15 retary.

16 “(ii) REQUIREMENTS.—If the Sec-
17 retary permits coverage pursuant to clause
18 (i), the Secretary shall ensure that the par-
19 tial region in which coverage is provided
20 is—

21 “(I) at least the size of the com-
22 mercial service area of the eligible en-
23 tity for that area; and

24 “(II) not smaller than a State.

25 “(2) DETERMINATION.—

1 “(A) IN GENERAL.—In determining re-
2 gions for contracts under this part, the Sec-
3 retary shall—

4 “(i) take into account the number of
5 eligible beneficiaries in an area in order to
6 encourage participation by eligible entities;
7 and

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

10 “(B) NO ADMINISTRATIVE OR JUDICIAL
11 REVIEW.—The determination of coverage areas
12 under this part shall not be subject to adminis-
13 trative or judicial review.

14 “(c) SUBMISSION OF BIDS.—

15 “(1) SUBMISSION.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (B), each eligible entity desiring to offer
18 a plan under this part in an area shall submit
19 a bid with respect to such plan to the Secretary
20 at such time, in such manner, and accompanied
21 by such information as the Secretary may rea-
22 sonably require.

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

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

3 “(2) REQUIRED INFORMATION.—The bids de-
4 scribed in paragraph (1) shall include—

5 “(A) a proposal for the estimated prices of
6 covered outpatient drugs and the projected an-
7 nual increases in such prices, including differen-
8 tials between formulary and nonformulary
9 prices, if applicable;

10 “(B) a statement regarding the amount
11 that the entity will charge the Secretary for ad-
12 ministering and delivering the benefits under
13 the contract;

14 “(C) a statement regarding whether the
15 entity will waive the deductible for generic
16 drugs pursuant to section 1860E(b)(1)(B), and
17 if so, how such waiver is tied to the perform-
18 ance goals described in section 1860H(b)(1)(C);

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

1 “(E) a detailed description of the perform-
2 ance goals for which the administrative fee of
3 the entity will be subject to risk pursuant to
4 section 1860H(b)(1)(C);

5 “(F) a detailed description of access to
6 pharmacy services provided under the plan, in-
7 cluding information regarding—

8 “(i) whether the entity will use a pre-
9 ferred pharmacy network under the plan;

10 “(ii) if a preferred pharmacy network
11 is used, whether the entity will offer access
12 to pharmacies that are outside such net-
13 work, and if such access is provided, the
14 increased coinsurance that beneficiaries
15 will be subject to if they obtain drugs at
16 such pharmacies;

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

20 “(i) adding new drugs to a thera-
21 peutic class within the formulary; and

22 “(ii) determining when and how often
23 the formulary should be modified;

24 “(H) a detailed description of any owner-
25 ship or shared financial interests with other en-

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

3 “(I) a detailed description of the entity’s
4 estimated marketing and advertising expendi-
5 tures related to enrolling and retaining eligible
6 beneficiaries; and

7 “(J) such other information that the Sec-
8 retary determines is necessary in order to carry
9 out this part, including information relating to
10 the bidding process under this part.

11 “(d) ACCESS TO BENEFITS IN CERTAIN AREAS.—

12 “(1) AREAS NOT COVERED BY CONTRACTS.—

13 The Secretary shall develop procedures for the provi-
14 sion of covered outpatient drugs under this part to
15 each eligible beneficiary enrolled under this part that
16 resides in an area that is not covered by any con-
17 tract under this part.

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

24 “(e) AWARDING OF CONTRACTS.—

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

9 “(2) DETERMINATION.—In determining which
10 of the eligible entities that submitted bids that meet
11 the minimum standards specified under this part
12 and by the Secretary to award a contract, the Sec-
13 retary shall consider the comparative merits of each
14 bid, as determined on the basis of the past perform-
15 ance of the entity and other relevant factors, with
16 respect to—

17 “(A) how well the entity (and the plan of-
18 fered by the entity) meet such minimum stand-
19 ards;

20 “(B) the amount that the entity will
21 charge the Secretary for administering and de-
22 livering the benefits under the contract;

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

1 “(D) the proposed negotiated prices of cov-
2 ered outpatient drugs and annual increases in
3 such prices;

4 “(E) the factors described in section
5 1860C(b)(2);

6 “(F) prior experience of the entity in ad-
7 ministering a prescription drug benefit pro-
8 gram;

9 “(G) effectiveness of the entity and plan in
10 containing costs through pricing incentives and
11 utilization management; and

12 “(H) such other factors as the Secretary
13 deems necessary to evaluate the merits of each
14 bid.

15 “(3) EXCEPTION TO CONFLICT OF INTEREST
16 RULES.—In awarding contracts under this part, the
17 Secretary may waive conflict of interest laws gen-
18 erally applicable to Federal acquisitions (subject to
19 such safeguards as the Secretary may find necessary
20 to impose) in circumstances where the Secretary
21 finds that such waiver—

22 “(A) is not inconsistent with the—

23 “(i) purposes of the programs under
24 this title; or

1 “(ii) best interests of beneficiaries en-
2 rolled under this part; and

3 “(B) permits a sufficient level of competi-
4 tion for such contracts, promotes efficiency of
5 benefits administration, or otherwise serves the
6 objectives of the program under this part.

7 “(4) NO ADMINISTRATIVE OR JUDICIAL RE-
8 VIEW.—The determination of the Secretary to award
9 or not award a contract to an eligible entity with re-
10 spect to a plan under this part shall not be subject
11 to administrative or judicial review.

12 “(f) APPROVAL OF MARKETING MATERIAL AND AP-
13 PLICATION FORMS.—The provisions of section 1851(h)
14 shall apply to marketing material and application forms
15 under this part in the same manner as such provisions
16 apply to marketing material and application forms under
17 part C.

18 “(g) DURATION OF CONTRACTS.—Each contract
19 awarded under this part shall be for a term of at least
20 2 years but not more than 5 years, as determined by the
21 Secretary.

22 “MINIMUM STANDARDS FOR ELIGIBLE ENTITIES

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

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

3 “(1) QUALITY AND FINANCIAL STANDARDS.—

4 The eligible entity meets the quality and financial
5 standards specified by the Secretary.

6 “(2) PROCEDURES TO ENSURE PROPER UTILI-
7 ZATION, COMPLIANCE, AND AVOIDANCE OF ADVERSE
8 DRUG REACTIONS.—The eligible entity has in place
9 drug utilization review procedures to ensure—

10 “(A) the appropriate utilization by eligible
11 beneficiaries enrolled in the plan covered by the
12 contract of the benefits to be provided under
13 the plan; and

14 “(B) the avoidance of adverse drug reac-
15 tions among such beneficiaries, including prob-
16 lems due to therapeutic duplication, drug-dis-
17 ease contraindications, drug-drug interactions
18 (including serious interactions with nonprescrip-
19 tion or over-the-counter drugs), incorrect drug
20 dosage or duration of drug treatment, drug-al-
21 lergy interactions, and clinical abuse and mis-
22 use.

23 “(3) PATIENT PROTECTIONS.—

24 “(A) ACCESS.—

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

8 “(ii) PREFERRED PHARMACY NET-
9 WORKS.—If the eligible entity utilizes a
10 preferred pharmacy network, the network
11 complies with the standards under sub-
12 section (b)(3).

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

16 “(i) the total charge for each covered
17 outpatient drug dispensed to an eligible
18 beneficiary enrolled in the plan covered by
19 the contract does not exceed the negotiated
20 price for the drug (as reported to the Sec-
21 retary pursuant to paragraph (5)(A)); and

22 “(ii) the retail pharmacy dispensing
23 the drug does not charge (or collect from)
24 such beneficiary an amount that exceeds
25 the beneficiary’s obligation (as determined

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

3 “(C) RETAIL PHARMACY MEETS MINIMUM
4 QUALITY AND TECHNOLOGY STANDARDS.—The
5 eligible entity ensures that any retail pharmacy
6 that it contracts with to deliver benefits under
7 this part meets minimum quality and tech-
8 nology standards (as established by the Sec-
9 retary).

10 “(D) CONTINUITY OF CARE.—

11 “(i) IN GENERAL.—The eligible entity
12 ensures that, in the case of an eligible ben-
13 efiary who loses coverage under this part
14 with such entity under circumstances that
15 would permit a special election period (as
16 established by the Secretary under section
17 1860B(b)(1)), the entity will continue to
18 provide coverage under this part to such
19 beneficiary until the beneficiary enrolls and
20 receives such coverage with another eligible
21 entity under this part or, if eligible, with a
22 Medicare+Choice organization.

23 “(ii) LIMITED PERIOD.—In no event
24 shall an eligible entity be required to pro-
25 vide the extended coverage required under

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

4 “(E) PROCEDURES REGARDING THE DE-
5 TERMINATION OF DRUGS THAT ARE MEDICALLY
6 NECESSARY.—The eligible entity has in place
7 procedures to determine if a drug is medically
8 necessary to prevent or slow the deterioration
9 of, or improve or maintain, the health of an eli-
10 gible beneficiary enrolled in the plan that is
11 covered by the contract. Such procedures shall
12 require that such determinations are based on
13 professional medical judgment, the medical con-
14 dition of the beneficiary, and other medical evi-
15 dence.

16 “(F) PROCEDURES REGARDING DENIALS
17 OF CARE.—The eligible entity has in place pro-
18 cedures to ensure—

19 “(i) a timely internal and external re-
20 view and resolution of denials of coverage
21 (in whole or in part) and complaints (in-
22 cluding those regarding the use of
23 formularies under subsection (b)) by eligi-
24 ble beneficiaries enrolled in the plan that is
25 covered by the contract, or by providers,

1 pharmacists, and other individuals acting
2 on behalf of each such beneficiary (with
3 the beneficiary's consent) in accordance
4 with requirements (as established by the
5 Secretary) that are comparable to such re-
6 quirements for Medicare+Choice organiza-
7 tions under part C; and

8 “(ii) that eligible beneficiaries are pro-
9 vided with information regarding the ap-
10 peals procedures under this part at the
11 time of enrollment with the entity.

12 “(G) PROCEDURES REGARDING PATIENT
13 CONFIDENTIALITY.—Insofar as an eligible enti-
14 ty maintains individually identifiable medical
15 records or other health information regarding
16 eligible beneficiaries enrolled in the plan that is
17 covered by the contract, the entity has in place
18 procedures to—

19 “(i) safeguard the privacy of any indi-
20 vidualy identifiable beneficiary informa-
21 tion;

22 “(ii) maintain such records and infor-
23 mation in a manner that is accurate and
24 timely;

1 “(iii) ensure timely access by such
2 beneficiaries to such records and informa-
3 tion; and

4 “(iv) otherwise comply with applicable
5 laws relating to patient confidentiality.

6 “(H) PROCEDURES REGARDING TRANSFER
7 OF MEDICAL RECORDS.—

8 “(i) IN GENERAL.—The eligible entity
9 has in place procedures for the timely
10 transfer of records and information de-
11 scribed in subparagraph (G) (with respect
12 to a beneficiary who loses coverage under
13 this part with the entity and enrolls with
14 another entity (including a
15 Medicare+Choice organization) under this
16 part) to such other entity.

17 “(ii) PATIENT CONFIDENTIALITY.—
18 The procedures described in clause (i) shall
19 comply with the patient confidentiality pro-
20 cedures described in subparagraph (G).

21 “(I) PROCEDURES REGARDING MEDICAL
22 ERRORS.—The eligible entity has in place pro-
23 cedures for working with the Secretary to deter-
24 mine medical errors related to the provision of cov-
25 ered outpatient drugs.

1 “(4) PROCEDURES TO CONTROL FRAUD, ABUSE,
2 AND WASTE.—The eligible entity has in place proce-
3 dures to control fraud, abuse, and waste.

4 “(5) REPORTING REQUIREMENTS.—

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

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

10 “(ii) The prices that eligible bene-
11 ficiaries enrolled in the plan that is covered
12 by the contract will be charged for covered
13 outpatient drugs.

14 “(iii) The administrative costs of pro-
15 viding such benefits.

16 “(iv) Utilization of such benefits.

17 “(v) Marketing and advertising ex-
18 penditures related to enrolling and retain-
19 ing eligible beneficiaries.

20 “(B) TIMEFRAME FOR SUBMITTING RE-
21 PORTS.—

22 “(i) IN GENERAL.—The eligible entity
23 shall submit a report described in subpara-
24 graph (A) to the Secretary within 3
25 months after the end of each 12-month pe-

1 riod in which the eligible entity has a con-
2 tract under this part. Such report shall
3 contain information concerning the benefits
4 provided during such 12-month period.

5 “(ii) LAST YEAR OF CONTRACT.—In
6 the case of the last year of a contract
7 under this part, the Secretary may require
8 that a report described in subparagraph
9 (A) be submitted 3 months prior to the
10 end of the contract. Such report shall con-
11 tain information concerning the benefits
12 provided between the period covered by the
13 most recent report under this subpara-
14 graph and the date that a report is sub-
15 mitted under this clause.

16 “(C) CONFIDENTIALITY OF INFORMA-
17 TION.—

18 “(i) IN GENERAL.—Notwithstanding
19 any other provision of law and subject to
20 clause (ii), information disclosed by an eli-
21 gible entity pursuant to subparagraph (A)
22 (except for information described in clause
23 (ii) of such subparagraph) is confidential
24 and shall only be used by the Secretary for

1 the purposes of, and to the extent nec-
2 essary, to carry out this part.

3 “(ii) UTILIZATION DATA.—Subject to
4 patient confidentiality laws, the Secretary
5 shall make information disclosed by an eli-
6 gible entity pursuant to subparagraph
7 (A)(iv) (regarding utilization data) avail-
8 able for research purposes. The Secretary
9 may charge a reasonable fee for making
10 such information available.

11 “(6) APPROVAL OF MARKETING MATERIAL AND
12 APPLICATION FORMS.—The eligible entity complies
13 with the requirements described in section 1860F(f).

14 “(7) RECORDS AND AUDITS.—The eligible enti-
15 ty maintains adequate records related to the admin-
16 istration of the benefit under this part and affords
17 the Secretary access to such records for auditing
18 purposes.

19 “(b) SPECIAL RULES REGARDING COST-EFFECTIVE
20 PROVISION OF BENEFITS.—

21 “(1) IN GENERAL.—In providing the benefits
22 under a contract under this part, an eligible entity
23 may—

24 “(A) employ mechanisms to provide the
25 benefits economically, including the use of—

1 “(i) formularies (pursuant to para-
2 graph (2));

3 “(ii) alternative methods of distribu-
4 tion;

5 “(iii) preferred pharmacy networks
6 (pursuant to paragraph (3)); and

7 “(iv) generic drug substitution;

8 “(B) use mechanisms to encourage eligible
9 beneficiaries to select cost-effective drugs or less
10 costly means of receiving drugs, including the
11 use of pharmacy incentive programs, thera-
12 peutic interchange programs, and disease man-
13 agement programs; and

14 “(C) encourage pharmacy providers to—

15 “(i) inform beneficiaries of the dif-
16 ferentials in price between generic and
17 nongeneric drug equivalents; and

18 “(ii) provide medication therapy man-
19 agement programs in order to enhance
20 beneficiaries’ understanding of the appro-
21 priate use of medications and to reduce the
22 risk of potential adverse events associated
23 with medications.

24 “(2) FORMULARIES.—If an eligible entity uses
25 a formulary under this part, such formulary shall

1 comply with standards established by the Secretary
2 in consultation with the Medicare Prescription Drug
3 Advisory Committee established under section
4 1860K. Such standards shall require that the eligi-
5 ble entity—

6 “(A) use a pharmacy and therapeutic com-
7 mittee (that meets the standards for a phar-
8 macy and therapeutic committee established by
9 the Secretary in consultation with such Medi-
10 care Prescription Drug Advisory Committee) to
11 develop and implement the formulary;

12 “(B) include in the formulary—

13 “(i) at least 1 drug from each thera-
14 peutic class (as defined by the Secretary in
15 consultation with such Medicare Prescrip-
16 tion Drug Advisory Committee);

17 “(ii) if there is more than 1 drug
18 available in a therapeutic class, at least 2
19 drugs from such class unless determined
20 clinically inappropriate in accordance with
21 standards established by the Secretary;
22 and

23 “(iii) if there are more than 2 drugs
24 available in a therapeutic class, at least 2
25 drugs from such class and a generic drug

1 substitute if available unless determined
2 clinically inappropriate in accordance with
3 standards established by the Secretary;

4 “(C) develop procedures for the modifica-
5 tion of the formulary, including for the addition
6 of new drugs to an existing therapeutic class;

7 “(D) provide for coverage of nonformulary
8 drugs when determined (pursuant to subpara-
9 graph (E) or (F)(i) of subsection (a)(3)) to be
10 medically necessary to prevent or slow the dete-
11 rioration of, or improve or maintain, the health
12 of an eligible beneficiary;

13 “(E) disclose to current and prospective
14 beneficiaries and to providers in the service
15 area the nature of the formulary restrictions,
16 including information regarding the drugs in-
17 cluded in the formulary, coinsurance, and any
18 difference in the cost-sharing for different types
19 of drugs; and

20 “(F) provide a reasonable amount of notice
21 to beneficiaries enrolled in the plan that is cov-
22 ered by the contract under this part of any
23 change in the formulary.

24 “(3) PREFERRED PHARMACY NETWORKS.—

1 “(A) IN GENERAL.—If an eligible entity
2 uses a preferred pharmacy network to deliver
3 benefits under this part, such network shall
4 meet minimum access standards established by
5 the Secretary.

6 “(B) STANDARDS.—In establishing stand-
7 ards under subparagraph (A), the Secretary
8 shall take into account reasonable distances to
9 pharmacy services in both urban and rural
10 areas.

11 “(4) CONSTRUCTION.—

12 “(A) FORMULARIES.—Nothing in this part
13 shall be construed as precluding an eligible enti-
14 ty from—

15 “(i) requiring cost-sharing for nonfor-
16 mulary drugs that is higher than the cost-
17 sharing established in section 1860E(b)(2),
18 except that such entity shall provide for
19 coverage of a nonformulary drug at the
20 same cost-sharing level as a drug within
21 the formulary if such nonformulary drug is
22 determined (pursuant to subparagraph (E)
23 or (F)(i) of subsection (a)(3)) to be medi-
24 cally necessary to prevent or slow the dete-

1 rioration of, or improve or maintain, the
 2 health of an eligible beneficiary;

3 “(ii) educating prescribing providers,
 4 pharmacists, and beneficiaries about the
 5 medical and cost benefits of formulary
 6 drugs (including generic drugs); or

7 “(iii) requesting prescribing providers
 8 to consider a formulary drug prior to dis-
 9 pensing of a nonformulary drug, as long as
 10 such request does not unduly delay the
 11 provision of the drug.

12 “(B) PREFERRED PHARMACY NET-
 13 WORKS.—Nothing in this part shall be con-
 14 strued as precluding the entity from requiring
 15 cost-sharing for a covered outpatient drug that
 16 is higher than the cost-sharing established in
 17 section 1860E(b)(2) if the drug was obtained at
 18 a pharmacy that is not in such network.

19 “PAYMENTS

20 “SEC. 1860H. (a) PROCEDURES FOR PAYMENTS TO
 21 ELIGIBLE ENTITIES.—The Secretary shall establish pro-
 22 cedures for making payments to each eligible entity with
 23 a contract under this part for the administration and de-
 24 livery of the benefits under this part.

25 “(b) REQUIREMENTS FOR PROCEDURES.—

1 “(1) IN GENERAL.—The procedures established
2 under subsection (a) shall provide for the following:

3 “(A) ADMINISTRATIVE PAYMENT.—Pay-
4 ment of administrative fees for such adminis-
5 tration and delivery.

6 “(B) REIMBURSEMENT FOR COSTS OF
7 DRUGS PROVIDED.—Payments for the costs of
8 covered outpatient drugs provided to eligible
9 beneficiaries enrolled under this part and in a
10 plan offered by the eligible entity.

11 “(C) RISK REQUIREMENT.—An adjustment
12 of a percentage (determined under paragraph
13 (2)) of the administrative fee payments made to
14 an eligible entity to ensure that the entity, in
15 administering and delivering the benefits under
16 this part, pursues performance goals established
17 by the Secretary, including the following:

18 “(i) QUALITY SERVICE.—The entity
19 provides eligible beneficiaries enrolled in
20 the plan that is covered by the contract
21 under this part with quality services, as
22 measured by such factors as sustained
23 pharmacy network access, timeliness and
24 accuracy of service delivery in claims proc-
25 essing and card production, pharmacy and

1 member service support access, response
2 time in mail delivery service, and timely
3 action with regard to appeals and current
4 beneficiary service surveys.

5 “(ii) QUALITY CLINICAL CARE.—The
6 entity provides such beneficiaries with
7 quality clinical care, as measured by such
8 factors as providing—

9 “(I) notification to such bene-
10 ficiaries and to providers in order to
11 prevent adverse drug reactions; and

12 “(II) specific clinical suggestions
13 to improve health and patient and
14 prescriber education as appropriate.

15 “(iii) CONTROL OF MEDICARE
16 COSTS.—The entity contains costs to the
17 Prescription Drug Account, as measured
18 by generic substitution rates, price dis-
19 counts, and other factors determined ap-
20 propriate by the Secretary that do not re-
21 duce the access of beneficiaries to medi-
22 cally necessary covered outpatient drugs.

23 “(2) PERCENTAGE OF PAYMENT TIED TO
24 RISK.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the Secretary shall determine the
3 percentage of the administrative payments to
4 an eligible entity that will be tied to the per-
5 formance goals described in paragraph (1)(C).

6 “(B) LIMITATION ON RISK TO ENSURE
7 PROGRAM STABILITY.—In order to provide for
8 program stability, the Secretary may not estab-
9 lish a percentage to be adjusted under this sub-
10 section at a level that jeopardizes the ability of
11 an eligible entity to administer and deliver the
12 benefits under this part or administer and de-
13 liver such benefits in a quality manner.

14 “(3) RISK ADJUSTMENT OF PAYMENTS BASED
15 ON ENROLLEES IN PLAN.—To the extent that an eli-
16 gible entity is at risk under this subsection, the pro-
17 cedures established under subsection (a) may include
18 a methodology for risk adjusting the payments made
19 to such entity based on the differences in actuarial
20 risk of different enrollees being served if the Sec-
21 retary determines such adjustments to be necessary
22 and appropriate.

23 “(c) PAYMENTS TO MEDICARE+CHOICE ORGANIZA-
24 TIONS.—For provisions related to payments to
25 Medicare+Choice organizations for the administration

1 and delivery of benefits under this part to eligible bene-
 2 ficiaries enrolled in a Medicare+Choice plan offered by the
 3 organization, see section 1853(c)(8).

4 “(d) SECONDARY PAYER PROVISIONS.—The provi-
 5 sions of section 1862(b) shall apply to the benefits pro-
 6 vided under this part.

7 “EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-
 8 BASED RETIREE DRUG COVERAGE

9 “SEC. 1860I. (a) PROGRAM AUTHORITY.—The Sec-
 10 retary is authorized to develop and implement a program
 11 under this section to be known as the ‘Employer Incentive
 12 Program’ that encourages employers and other sponsors
 13 of employment-based health care coverage to provide ade-
 14 quate prescription drug benefits to retired individuals by
 15 subsidizing, in part, the sponsor’s cost of providing cov-
 16 erage under qualifying plans.

17 “(b) SPONSOR REQUIREMENTS.—In order to be eligi-
 18 ble to receive an incentive payment under this section with
 19 respect to coverage of an individual under a qualified re-
 20 tiree prescription drug plan (as defined in subsection
 21 (e)(3)), a sponsor shall meet the following requirements:

22 “(1) ASSURANCES.—The sponsor shall—

23 “(A) annually attest, and provide such as-
 24 surances as the Secretary may require, that the
 25 coverage offered by the sponsor is a qualified
 26 retiree prescription drug plan, and will remain

1 such a plan for the duration of the sponsor's
2 participation in the program under this section;
3 and

4 “(B) guarantee that it will give notice to
5 the Secretary and covered retirees—

6 “(i) at least 120 days before termi-
7 nating its plan; and

8 “(ii) immediately upon determining
9 that the actuarial value of the prescription
10 drug benefit under the plan falls below the
11 actuarial value of the outpatient prescrip-
12 tion drug benefit under this part.

13 “(2) BENEFICIARY INFORMATION.—The spon-
14 sor shall report to the Secretary, for each calendar
15 quarter for which it seeks an incentive payment
16 under this section, the names and social security
17 numbers of all retirees (and their spouses and de-
18 pendents) covered under such plan during such
19 quarter and the dates (if less than the full quarter)
20 during which each such individual was covered.

21 “(3) AUDITS.—The sponsor and the employ-
22 ment-based retiree health coverage plan seeking in-
23 centive payments under this section shall agree to
24 maintain, and to afford the Secretary access to, such
25 records as the Secretary may require for purposes of

1 audits and other oversight activities necessary to en-
2 sure the adequacy of prescription drug coverage, the
3 accuracy of incentive payments made, and such
4 other matters as may be appropriate.

5 “(4) OTHER REQUIREMENTS.—The sponsor
6 shall provide such other information, and comply
7 with such other requirements, as the Secretary may
8 find necessary to administer the program under this
9 section.

10 “(c) INCENTIVE PAYMENTS.—

11 “(1) IN GENERAL.—A sponsor that meets the
12 requirements of subsection (b) with respect to a
13 quarter in a calendar year shall be entitled to have
14 payment made by the Secretary on a quarterly basis
15 (to the sponsor or, at the sponsor’s direction, to the
16 appropriate employment-based health plan) of an in-
17 centive payment, in the amount determined in para-
18 graph (2), for each retired individual (or spouse)
19 who—

20 “(A) was covered under the sponsor’s
21 qualified retiree prescription drug plan during
22 such quarter; and

23 “(B) was eligible for but was not enrolled
24 in the outpatient prescription drug benefit pro-
25 gram under this part.

1 “(2) AMOUNT OF INCENTIVE.—The payment
2 under this section with respect to each individual de-
3 scribed in paragraph (1) for a month shall be equal
4 to $\frac{2}{3}$ of the monthly part D premium amount pay-
5 able by an eligible beneficiary enrolled under this
6 part, as set for the calendar year pursuant to section
7 1860D(a)(2).

8 “(3) PAYMENT DATE.—The incentive under
9 this section with respect to a calendar quarter shall
10 be payable as of the end of the next succeeding cal-
11 endar quarter.

12 “(d) CIVIL MONEY PENALTIES.—A sponsor, health
13 plan, or other entity that the Secretary determines has,
14 directly or through its agent, provided information in con-
15 nection with a request for an incentive payment under this
16 section that the entity knew or should have known to be
17 false shall be subject to a civil monetary penalty in an
18 amount up to 3 times the total incentive amounts under
19 subsection (c) that were paid (or would have been payable)
20 on the basis of such information.

21 “(e) DEFINITIONS.—In this section:

22 “(1) EMPLOYMENT-BASED RETIREE HEALTH
23 COVERAGE.—The term ‘employment-based retiree
24 health coverage’ means health insurance or other
25 coverage of health care costs for retired individuals

1 (or for such individuals and their spouses and de-
2 pendents) based on their status as former employees
3 or labor union members.

4 “(2) EMPLOYER.—The term ‘employer’ has the
5 meaning given the term in section 3(5) of the Em-
6 ployee Retirement Income Security Act of 1974 (ex-
7 cept that such term shall include only employers of
8 2 or more employees).

9 “(3) QUALIFIED RETIREE PRESCRIPTION DRUG
10 PLAN.—The term ‘qualified retiree prescription drug
11 plan’ means health insurance coverage included in
12 employment-based retiree health coverage that—

13 “(A) provides coverage of the cost of pre-
14 scription drugs whose actuarial value (as de-
15 fined by the Secretary) to each retired bene-
16 ficiary equals or exceeds the actuarial value of
17 the benefits provided to an individual enrolled
18 in the outpatient prescription drug benefit pro-
19 gram under this part; and

20 “(B) does not deny, limit, or condition the
21 coverage or provision of prescription drug bene-
22 fits for retired individuals based on age or any
23 health status-related factor described in section
24 2702(a)(1) of the Public Health Service Act.

1 “(4) SPONSOR.—The term ‘sponsor’ has the
2 meaning given the term ‘plan sponsor’ in section
3 3(16)(B) of the Employer Retirement Income Secu-
4 rity Act of 1974.

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated from time to time, out
7 of any moneys in the Treasury not otherwise appropriated,
8 such sums as may be necessary to carry out the program
9 under this section.

10 “PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL
11 SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

12 “SEC. 1860J. (a) ESTABLISHMENT.—

13 “(1) IN GENERAL.—There is created within the
14 Federal Supplementary Medical Insurance Trust
15 Fund established by section 1841 an account to be
16 known as the ‘Prescription Drug Account’ (in this
17 section referred to as the ‘Account’).

18 “(2) FUNDS.—The Account shall consist of
19 such gifts and bequests as may be made as provided
20 in section 201(i)(1), and such amounts as may be
21 deposited in, or appropriated to, the account as pro-
22 vided in this part.

23 “(3) SEPARATE FROM REST OF TRUST FUND.—
24 Funds provided under this part to the Account shall
25 be kept separate from all other funds within the

1 Federal Supplementary Medical Insurance Trust
2 Fund.

3 “(b) PAYMENTS FROM ACCOUNT.—

4 “(1) IN GENERAL.—The Managing Trustee
5 shall pay from time to time from the Account such
6 amounts as the Secretary certifies are necessary to
7 make payments to operate the program under this
8 part, including payments to eligible entities under
9 section 1860H and payments with respect to admin-
10 istrative expenses under this part in accordance with
11 section 201(g).

12 “(2) TRANSFER TO PART A AND B TRUST
13 FUNDS FOR MEDICARE+CHOICE PAYMENTS.—The
14 Managing Trustee shall establish procedures for the
15 transfer of funds from the Account, in an amount
16 determined appropriate by the Secretary, to the Fed-
17 eral Hospital Insurance Trust Fund and the Federal
18 Supplementary Medical Insurance Trust Fund in
19 order to reimburse such trust funds for payments to
20 Medicare+Choice organizations for the provision of
21 covered outpatient drugs pursuant to section
22 1853(e)(8).

23 “(3) TREATMENT IN RELATION TO PART B PRE-
24 MIUM.—Amounts payable from the Account shall not

1 be taken into account in computing actuarial rates
2 or premium amounts under section 1839.

3 “(c) APPROPRIATIONS TO COVER BENEFITS AND
4 ADMINISTRATIVE COSTS.—There are appropriated to the
5 Account in a fiscal year, out of any moneys in the Treas-
6 ury not otherwise appropriated, an amount equal to the
7 amount by which the benefits and administrative costs of
8 providing the benefits under this part in the year exceed
9 the premiums collected under section 1860D(a)(4) for the
10 year.

11 “MEDICARE PRESCRIPTION DRUG ADVISORY COMMITTEE
12 “SEC. 1860K. (a) ESTABLISHMENT OF COM-
13 MITTEE.—There is established a Medicare Prescription
14 Drug Advisory Committee (in this section referred to as
15 the ‘Committee’).

16 “(b) FUNCTIONS OF COMMITTEE.—On and after
17 March 1, 2002, the Committee shall advise the Secretary
18 on policies related to—

19 “(1) the development of guidelines for the im-
20 plementation and administration of the outpatient
21 prescription drug benefit program under this part;
22 and

23 “(2) the development of—

24 “(A) standards for a pharmacy and thera-
25 peutics committee required of eligible entities
26 under section 1860G(b)(2)(A);

1 “(B) standards required of eligible entities
2 under subparagraphs (E) and (F) of section
3 1860G(a)(3) for determining if a drug is medi-
4 cally necessary to prevent or slow the deteriora-
5 tion of, or improve or maintain, the health of
6 an eligible beneficiary;

7 “(C) standards for—

8 “(i) defining therapeutic classes; and

9 “(ii) adding new therapeutic classes to
10 a formulary;

11 “(D) procedures to evaluate the bids sub-
12 mitted by eligible entities under this part; and

13 “(E) procedures to ensure that eligible en-
14 tities with a contract under this part are in
15 compliance with the requirements under this
16 part.

17 “(c) STRUCTURE AND MEMBERSHIP OF THE COM-
18 MITTEE.—

19 “(1) STRUCTURE.—The Committee shall be
20 composed of 19 members who shall be appointed by
21 the Secretary.

22 “(2) MEMBERSHIP.—

23 “(A) IN GENERAL.—The members of the
24 Committee shall be chosen on the basis of their
25 integrity, impartiality, and good judgment, and

1 shall be individuals who are, by reason of their
2 education, experience, and attainments, excep-
3 tionally qualified to perform the duties of mem-
4 bers of the Committee.

5 “(B) SPECIFIC MEMBERS.—Of the mem-
6 bers appointed under paragraph (1)—

7 “(i) nine shall be chosen to represent
8 physicians;

9 “(ii) four shall be chosen to represent
10 pharmacists;

11 “(iii) one shall be chosen to represent
12 the Centers for Medicare & Medicaid Serv-
13 ices;

14 “(iv) four shall be chosen to represent
15 actuaries, pharmacoeconomists, research-
16 ers, and other appropriate experts; and

17 “(v) one shall be chosen to represent
18 emerging drug technologies.

19 “(d) TERMS OF APPOINTMENT.—Each member of
20 the Committee shall serve for a term determined appro-
21 priate by the Secretary. The terms of service of the mem-
22 bers initially appointed shall begin on January 1, 2002.

23 “(e) CHAIRPERSON.—The Secretary shall designate
24 a member of the Committee as Chairperson. The term as
25 Chairperson shall be for a 1-year period.

1 “(f) COMMITTEE PERSONNEL MATTERS.—

2 “(1) MEMBERS.—

3 “(A) COMPENSATION.—Each member of
4 the Committee who is not an officer or em-
5 ployee of the Federal Government shall be com-
6 pensated at a rate equal to the daily equivalent
7 of the annual rate of basic pay prescribed for
8 level IV of the Executive Schedule under section
9 5315 of title 5, United States Code, for each
10 day (including travel time) during which such
11 member is engaged in the performance of the
12 duties of the Committee. All members of the
13 Committee who are officers or employees of the
14 United States shall serve without compensation
15 in addition to that received for their services as
16 officers or employees of the United States.

17 “(B) TRAVEL EXPENSES.—The members
18 of the Committee shall be allowed travel ex-
19 penses, including per diem in lieu of subsist-
20 ence, at rates authorized for employees of agen-
21 cies under subchapter I of chapter 57 of title 5,
22 United States Code, while away from their
23 homes or regular places of business in the per-
24 formance of services for the Committee.

1 “(2) STAFF.—The Committee may appoint
2 such personnel as the Committee considers appro-
3 priate.

4 “(g) OPERATION OF THE COMMITTEE.—

5 “(1) MEETINGS.—The Committee shall meet at
6 the call of the Chairperson (after consultation with
7 the other members of the Committee) not less often
8 than quarterly to consider a specific agenda of
9 issues, as determined by the Chairperson after such
10 consultation.

11 “(2) QUORUM.—Ten members of the Com-
12 mittee shall constitute a quorum for purposes of
13 conducting business.

14 “(h) FEDERAL ADVISORY COMMITTEE ACT.—Section
15 14 of the Federal Advisory Committee Act (5 U.S.C.
16 App.) shall not apply to the Committee.

17 “(i) TRANSFER OF PERSONNEL, RESOURCES, AND
18 ASSETS.—For purposes of carrying out its duties, the Sec-
19 retary and the Committee may provide for the transfer
20 to the Committee of such civil service personnel in the em-
21 ploy of the Department of Health and Human Services
22 (including the Centers for Medicare & Medicaid Services),
23 and such resources and assets of the Department used in
24 carrying out this title, as the Committee requires.

1 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out the purposes of this section.”.

4 (b) EXCLUSIONS FROM COVERAGE.—

5 (1) APPLICATION TO PART D.—Section 1862(a)
6 of the Social Security Act (42 U.S.C. 1395y(a)) is
7 amended in the matter preceding paragraph (1) by
8 striking “part A or part B” and inserting “part A,
9 B, or D”.

10 (2) PRESCRIPTION DRUGS NOT EXCLUDED
11 FROM COVERAGE IF REASONABLE AND NEC-
12 ESSARY.—Section 1862(a)(1) of the Social Security
13 Act (42 U.S.C. 1395y(a)(1)) is amended—

14 (A) in subparagraph (H), by striking
15 “and” at the end;

16 (B) in subparagraph (I), by striking the
17 semicolon at the end and inserting “, and”; and

18 (C) by adding at the end the following new
19 subparagraph:

20 “(J) in the case of prescription drugs cov-
21 ered under part D, which are not reasonable
22 and necessary to prevent or slow the deteriora-
23 tion of, or improve or maintain, the health of
24 eligible beneficiaries;”.

1 (c) CONFORMING AMENDMENTS TO FEDERAL SUP-
2 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—Sec-
3 tion 1841 of the Social Security Act (42 U.S.C. 1395t)
4 is amended—

5 (1) in the last sentence of subsection (a)—

6 (A) by striking “and” before “such
7 amounts”; and

8 (B) by inserting before the period the fol-
9 lowing: “, and such amounts as may be depos-
10 ited in, or appropriated to, the Prescription
11 Drug Account established by section 1860J”;

12 (2) in subsection (g), by inserting after “by this
13 part,” the following: “the payments provided for
14 under part D (in which case the payments shall be
15 made from the Prescription Drug Account in the
16 Trust Fund),”;

17 (3) in subsection (h), by inserting after
18 “1840(d)” the following: “and section 1860D(a)(4)
19 (in which case the payments shall be made from the
20 Prescription Drug Account in the Trust Fund)”;
21 and

22 (4) in subsection (i), by inserting after “section
23 1840(b)(1)” the following: “, section 1860D(a)(4)
24 (in which case the payments shall be made from the
25 Prescription Drug Account in the Trust Fund),”.

1 (d) CONFORMING REFERENCES TO PREVIOUS PART
2 D.—

3 (1) IN GENERAL.—Any reference in law (in ef-
4 fect before the date of enactment of this Act) to part
5 D of title XVIII of the Social Security Act is deemed
6 a reference to part E of such title (as in effect after
7 such date).

8 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE
9 PROPOSAL.—Not later than 6 months after the date
10 of enactment of this Act, the Secretary of Health
11 and Human Services shall submit to the appropriate
12 committees of Congress a legislative proposal pro-
13 viding for such technical and conforming amend-
14 ments in the law as are required by the provisions
15 of this title.

16 **SEC. 302. PART D BENEFITS UNDER MEDICARE+CHOICE**
17 **PLANS.**

18 (a) ELIGIBILITY, ELECTION, AND ENROLLMENT.—
19 Section 1851 of the Social Security Act (42 U.S.C.
20 1395w-21) is amended—

21 (1) in subsection (a)(1)(A), by striking “parts
22 A and B” and inserting “parts A, B, and D”; and

23 (2) in subsection (i)(1), by striking “parts A
24 and B” and inserting “parts A, B, and D”.

1 (b) VOLUNTARY BENEFICIARY ENROLLMENT FOR
2 DRUG COVERAGE.—Section 1852(a)(1)(A) of the Social
3 Security Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended
4 by inserting “(and under part D to individuals also en-
5 rolled under that part)” after “parts A and B”.

6 (c) ACCESS TO SERVICES.—Section 1852(d)(1) of the
7 Social Security Act (42 U.S.C. 1395w–22(d)(1)) is
8 amended—

9 (1) in subparagraph (D), by striking “and” at
10 the end;

11 (2) in subparagraph (E), by striking the period
12 at the end and inserting “; and”; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(F) in the case of covered outpatient
16 drugs (as defined in section 1860(1)) provided
17 to individuals enrolled under part D, the orga-
18 nization complies with the access requirements
19 applicable under part D.”.

20 (d) PAYMENTS TO ORGANIZATIONS.—Section
21 1853(a)(1)(A) of the Social Security Act (42 U.S.C.
22 1395w–23(a)(1)(A)) is amended—

23 (1) by inserting “determined separately for the
24 benefits under parts A and B and under part D (for

1 individuals enrolled under that part)” after “as cal-
2 culated under subsection (c)”;

3 (2) by striking “that area, adjusted for such
4 risk factors” and inserting “that area. In the case
5 of payment for the benefits under parts A and B,
6 such payment shall be adjusted for such risk factors
7 as”; and

8 (3) by inserting before the last sentence the fol-
9 lowing: “In the case of the payments for the benefits
10 under part D, such payment shall be adjusted for
11 the risk factors of each enrollee as the Secretary de-
12 termines to be feasible and appropriate to ensure ac-
13 tuarial equivalence.”.

14 (e) CALCULATION OF ANNUAL MEDICARE+CHOICE
15 CAPITATION RATES.—Section 1853(c) of the Social Secu-
16 rity Act (42 U.S.C. 1395w–23(c)) is amended—

17 (1) in paragraph (1), in the matter preceding
18 subparagraph (A), by inserting “for benefits under
19 parts A and B” after “capitation rate”; and

20 (2) by adding at the end the following new
21 paragraph:

22 “(8) PAYMENT FOR PART D BENEFITS.—The
23 Secretary shall determine a capitation rate for part
24 D benefits (for individuals enrolled under such part)
25 as follows:

1 “(A) DRUGS DISPENSED IN 2004.—In the
 2 case of prescription drugs dispensed in 2004,
 3 the capitation rate shall be based on the pro-
 4 jected national per capita costs for prescription
 5 drug benefits under part D and associated
 6 claims processing costs for beneficiaries enrolled
 7 under part D and not enrolled with a
 8 Medicare+Choice organization under this part.

9 “(B) DRUGS DISPENSED IN SUBSEQUENT
 10 YEARS.—In the case of prescription drugs dis-
 11 pensed in a subsequent year, the capitation rate
 12 shall be equal to the capitation rate for the pre-
 13 ceding year increased by the Secretary’s esti-
 14 mate of the projected per capita rate of annual
 15 growth in expenditures under this title for an
 16 individual enrolled under part D for such subse-
 17 quent year.”.

18 (f) LIMITATION ON ENROLLEE LIABILITY.—Section
 19 1854(e) of the Social Security Act (42 U.S.C. 1395w-
 20 24(e)) is amended by adding at the end the following new
 21 paragraph:

22 “(5) SPECIAL RULE FOR PART D BENEFITS.—
 23 With respect to outpatient prescription drug benefits
 24 under part D, a Medicare+Choice organization may
 25 not require that an enrollee pay a deductible or a co-

1 insurance percentage that exceeds the deductible or
2 coinsurance percentage applicable for such benefits
3 for an eligible beneficiary under part D.”.

4 (g) REQUIREMENT FOR ADDITIONAL BENEFITS.—
5 Section 1854(f)(1) of the Social Security Act (42 U.S.C.
6 1395w–24(f)(1)) is amended by adding at the end the fol-
7 lowing new sentence: “Such determination shall be made
8 separately for the benefits under parts A and B and for
9 prescription drug benefits under part D.”.

10 (h) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to items and services provided
12 under a Medicare+Choice plan on or after January 1,
13 2004.

14 **SEC. 303. REPORTING REQUIREMENTS FOR SECRETARY OF**
15 **THE TREASURY REGARDING SLIDING SCALE**
16 **PART D PREMIUM.**

17 (a) IN GENERAL.—Subsection (l) of section 6103 of
18 the Internal Revenue Code of 1986 (relating to disclosure
19 of returns and return information for purposes other than
20 tax administration) is amended by adding at the end the
21 following new paragraph:

22 “(18) DISCLOSURE OF RETURN INFORMATION
23 TO CARRY OUT SLIDING SCALE MEDICARE PART D
24 PREMIUM.—

1 “(A) IN GENERAL.—The Secretary may,
2 upon written request from the Secretary of
3 Health and Human Services, disclose to officers
4 and employees of the Department of Health
5 and Human Services return information with
6 respect to a taxpayer who is required to pay a
7 monthly part D premium under part D of the
8 medicare program. Such return information
9 shall be limited to—

10 “(i) taxpayer identity information
11 with respect to such taxpayer,

12 “(ii) the filing status of such tax-
13 payer,

14 “(iii) the adjusted gross income of
15 such taxpayer,

16 “(iv) the amounts excluded from such
17 taxpayer’s gross income under sections 135
18 and 911,

19 “(v) the interest received or accrued
20 during the taxable year which is exempt
21 from the tax imposed by chapter 1 to the
22 extent such information is available, and

23 “(vi) the amounts excluded from such
24 taxpayer’s gross income under sections 931

1 and 933 to the extent such information is
2 available.

3 “(B) RESTRICTION ON USE OF DISCLOSED
4 INFORMATION.—Return information disclosed
5 under subparagraph (A) may be used by offi-
6 cers and employees of the Department of
7 Health and Human Services only for the pur-
8 poses of, and to the extent necessary in, estab-
9 lishing the appropriate monthly part D pre-
10 mium under part D of the medicare program.”.

11 (b) CONFORMING AMENDMENT.—Paragraphs (3)(A)
12 and (4) of section 6103(p) of such Code are each amended
13 by striking “or (17)” each place it appears and inserting
14 “(17), or (18)”.

15 **SEC. 304. ADDITIONAL ASSISTANCE FOR LOW-INCOME**
16 **BENEFICIARIES.**

17 (a) INCLUSION IN MEDICARE COST-SHARING.—Sec-
18 tion 1905(p)(3) of the Social Security Act (42 U.S.C.
19 1396d(p)(3)) is amended—

20 (1) in subparagraph (A)—

21 (A) in clause (i), by striking “and” at the
22 end;

23 (B) in clause (ii), by inserting “and” at
24 the end; and

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

3 “(iii) premiums under section 1860D(a).”;

4 (2) in subparagraph (B), by striking “section
5 1813” and inserting “sections 1813 and
6 1860E(b)(2)”; and

7 (3) in subparagraph (C), by striking “section
8 1813 and section 1833(b)” and inserting “sections
9 1813, 1833(b), and 1860E(b)(1)”.

10 (b) EXPANSION OF MEDICAL ASSISTANCE.—Section
11 1902(a)(10)(E) of the Social Security Act (42 U.S.C.
12 1396a(a)(10)(E)) is amended—

13 (1) in clause (iii)—

14 (A) by striking “section 1905(p)(3)(A)(ii)”
15 and inserting “clauses (ii) and (iii) of section
16 1905(p)(3)(A), for the coinsurance described in
17 section 1860E(b)(2), and for the deductible de-
18 scribed in section 1860E(b)(1)”; and

19 (B) by striking “and” at the end;

20 (2) by redesignating clause (iv) as clause (vi);
21 and

22 (3) by inserting after clause (iii) the following
23 new clauses:

24 “(iv) for making medical assistance avail-
25 able for medicare cost-sharing described in sec-

1 tion 1905(p)(3)(A)(iii), for the coinsurance de-
2 scribed in section 1860E(b)(2), and for the de-
3 ductible described in section 1860E(b)(1) for
4 individuals who would be qualified medicare
5 beneficiaries described in section 1905(p)(1)
6 but for the fact that their income exceeds 120
7 percent but does not exceed 135 percent of such
8 official poverty line for a family of the size in-
9 volved;

10 “(v) for making medical assistance avail-
11 able for medicare cost-sharing described in sec-
12 tion 1905(p)(3)(A)(iii) on a linear sliding scale
13 based on the income of such individuals for in-
14 dividuals who would be qualified medicare bene-
15 ficiaries described in section 1905(p)(1) but for
16 the fact that their income exceeds 135 percent
17 but does not exceed 150 percent of such official
18 poverty line for a family of the size involved;
19 and”.

20 (c) NONAPPLICABILITY OF PAYMENT DIFFERENTIAL
21 REQUIREMENTS TO MEDICARE PART D COST-SHAR-
22 ING.—Section 1902(n)(2) of the Social Security Act (42
23 U.S.C. 1396a(n)(2)) is amended by adding at the end the
24 following new sentence: “The preceding sentence shall not

1 apply to coinsurance described in section 1860E(b)(2) or
2 deductibles described in section 1860E(b)(1).”.

3 (d) 100 PERCENT FEDERAL MEDICAL ASSISTANCE
4 PERCENTAGE.—The first sentence of section 1905(b) of
5 the Social Security Act (42 U.S.C. 1396d(b)) is
6 amended—

7 (1) by striking “and” before “(4)”; and

8 (2) by inserting before the period at the end the
9 following: “, and (5) the Federal medical assistance
10 percentage shall be 100 percent with respect to med-
11 ical assistance provided under clauses (iv) and (v) of
12 section 1902(a)(10)(E)”.

13 (e) TREATMENT OF TERRITORIES.—Section 1108(g)
14 of such Act (42 U.S.C. 1308(g)) is amended by adding
15 at the end the following new paragraph:

16 “(3) Notwithstanding the preceding provisions of this
17 subsection, with respect to fiscal year 2004 and any fiscal
18 year thereafter, the amount otherwise determined under
19 this subsection (and subsection (f)) for the fiscal year for
20 a Commonwealth or territory shall be increased by the
21 ratio (as estimated by the Secretary) of—

22 “(A) the aggregate amount of payments made
23 to the 50 States and the District of Columbia for
24 the fiscal year under title XIX that are attributable
25 to making medical assistance available for individ-

1 uals described in clauses (i), (iii), (iv), and (v) of
2 section 1902(a)(10)(E) for payment of medicare
3 cost-sharing that consists of premiums under section
4 1860D(a), coinsurance described in section
5 1860E(b)(2), or deductibles described in section
6 1860E(b)(1); to

7 “(B) the aggregate amount of total payments
8 made to such States and District for the fiscal year
9 under such title.”.

10 (f) CONFORMING AMENDMENTS.—Section 1933 of
11 the Social Security Act (42 U.S.C. 1396u–3) is
12 amended—

13 (1) in subsection (a), by striking “section
14 1902(a)(10)(E)(iv)” and inserting “section
15 1902(a)(10)(E)(vi)”;

16 (2) in subsection (c)(2)(A)—

17 (A) in clause (i), by striking “section
18 1902(a)(10)(E)(iv)(I)” and inserting “section
19 1902(a)(10)(E)(vi)(I)”;

20 (B) in clause (ii), by striking “section
21 1902(a)(10)(E)(iv)(II)” and inserting “section
22 1902(a)(10)(E)(vi)(II)”;

23 (3) in subsection (d), by striking “section
24 1902(a)(10)(E)(iv)” and inserting “section
25 1902(a)(10)(E)(vi)”;

1 (4) in subsection (e), by striking “section
2 1902(a)(10)(E)(iv)” and inserting “section
3 1902(a)(10)(E)(vi)”.

4 (g) EFFECTIVE DATE.—The amendments made by
5 this section shall apply for medical assistance provided
6 under section 1902(a)(10)(E) of the Social Security Act
7 (42 U.S.C. 1396a(a)(10)(E)) on and after January 1,
8 2004.

9 **SEC. 305. MEDIGAP REVISIONS.**

10 Section 1882 of the Social Security Act (42 U.S.C.
11 1395ss) is amended by adding at the end the following
12 new subsection:

13 “(v) MODERNIZED BENEFIT PACKAGES FOR MEDI-
14 CARE SUPPLEMENTAL POLICIES.—

15 “(1) REVISION OF BENEFIT PACKAGES.—

16 “(A) IN GENERAL.—Notwithstanding sub-
17 section (p), the benefit packages classified as
18 ‘H’, ‘I’, and ‘J’ under the standards established
19 by subsection (p)(2) (including the benefit
20 package classified as ‘J’ with a high deductible
21 feature, as described in subsection (p)(11))
22 shall be revised so that—

23 “(i) the coverage of outpatient pre-
24 scription drugs available under such ben-
25 efit packages is replaced with coverage of

1 outpatient prescription drugs that com-
2 plements but does not duplicate the cov-
3 erage of outpatient prescription drugs that
4 is otherwise available under this title;

5 “(ii) the revised benefit packages pro-
6 vide a range of coverage options for out-
7 patient prescription drugs for beneficiaries,
8 but do not provide coverage for—

9 “(I) the deductible under section
10 1860E(b)(1); or

11 “(II) more than 90 percent of
12 the coinsurance applicable to an indi-
13 vidual under section 1860E(b)(2);

14 “(iii) uniform language and defini-
15 tions are used with respect to such revised
16 benefits;

17 “(iv) uniform format is used in the
18 policy with respect to such revised benefits;

19 “(v) such revised standards meet any
20 additional requirements imposed by the
21 Medicare Reform Act of 2001; and

22 “(vi) except as revised under the pre-
23 ceding clauses or as provided under sub-
24 section (p)(1)(E), the benefit packages are
25 identical to the benefit packages that were

1 available on the date of enactment of the
2 Medicare Reform Act of 2001.

3 “(B) MANNER OF REVISION.—The benefit
4 packages revised under this section shall be re-
5 vised in the manner described in subparagraph
6 (E) of subsection (p)(1), except that for pur-
7 poses of subparagraph (C) of such subsection,
8 the standards established under this subsection
9 shall take effect not later than January 1,
10 2004.

11 “(2) CONSTRUCTION OF BENEFITS IN OTHER
12 MEDICARE SUPPLEMENTAL POLICIES.—Nothing in
13 the benefit packages classified as ‘A’ through ‘G’
14 under the standards established by subsection (p)(2)
15 (including the benefit package classified as ‘F’ with
16 a high deductible feature, as described in subsection
17 (p)(11)) shall be construed as providing coverage for
18 benefits for which payment may be made under part
19 D.

20 “(3) GUARANTEED ISSUANCE AND RENEWAL
21 OF REVISED POLICIES.—The provisions of sub-
22 sections (q) and (s), including provisions of sub-
23 section (s)(3) (relating to special enrollment periods
24 in cases of termination or disenrollment), shall apply
25 to medicare supplemental policies revised under this

1 subsection in the same manner as such provisions
2 apply to medicare supplemental policies issued under
3 the standards established under subsection (p).

4 “(4) OPPORTUNITY OF CURRENT POLICY-
5 HOLDERS TO PURCHASE REVISED POLICIES.—

6 “(A) IN GENERAL.—No medicare supple-
7 mental policy of an issuer with a benefit pack-
8 age that is revised under paragraph (1) shall be
9 deemed to meet the standards in subsection (c)
10 unless the issuer—

11 “(i) provides written notice during the
12 60-day period immediately preceding the
13 period established for the open enrollment
14 period established under section
15 1860B(b)(2)(B), to each individual who is
16 a policyholder or certificate holder of a
17 medicare supplemental policy issued by
18 that issuer (at the most recent available
19 address of that individual) of the offer de-
20 scribed in clause (ii) and of the fact that,
21 so long as such individual retains coverage
22 under such policy, the individual shall be
23 ineligible for coverage of outpatient pre-
24 scription drugs under part D; and

1 “(ii) offers the policyholder or certifi-
2 cate holder under the terms described in
3 subparagraph (B), during at least the pe-
4 riod established under section
5 1860B(b)(2)(B), a medicare supplemental
6 policy with the benefit package that the
7 Secretary determines is most comparable
8 to the policy in which the individual is en-
9 rolled with coverage effective as of the date
10 on which the individual is first entitled to
11 benefits under part D.

12 “(B) TERMS OF OFFER DESCRIBED.—The
13 terms described in this subparagraph are terms
14 which do not—

15 “(i) deny or condition the issuance or
16 effectiveness of a medicare supplemental
17 policy described in subparagraph (A)(ii)
18 that is offered and is available for issuance
19 to new enrollees by such issuer;

20 “(ii) discriminate in the pricing of
21 such policy because of health status, claims
22 experience, receipt of health care, or med-
23 ical condition; or

1 “(iii) impose an exclusion of benefits
2 based on a preexisting condition under
3 such policy.

4 “(5) ELIMINATION OF OBSOLETE POLICIES
5 WITH NO GRANDFATHERING.—Except as provided in
6 subparagraph (B), no person may sell, issue, or
7 renew a medicare supplemental policy with a benefit
8 package that is classified as ‘H’, ‘I’, or ‘J’ (or with
9 a benefit package classified as ‘J’ with a high de-
10 ductible feature) that has not been revised under
11 this subsection on or after January 1, 2004.

12 “(6) PENALTIES.—Each penalty under this sec-
13 tion shall apply with respect to policies revised under
14 this subsection as if such policies were issued under
15 the standards established under subsection (p), in-
16 cluding the penalties under subsections (a), (d),
17 (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and
18 (t)(2)(D).”.

19 **SEC. 306. STUDIES AND REPORT TO CONGRESS.**

20 (a) STUDIES.—The Secretary of Health and Human
21 Services shall conduct a study to determine the feasibility
22 and advisability of—

23 (1) establishing a uniform format for pharmacy
24 benefit cards provided to beneficiaries by eligible en-
25 tities under the outpatient prescription drug benefit

1 program under part D of title XVIII of the Social
2 Security Act (as added by section 301); and

3 (2) developing systems to electronically transfer
4 prescriptions under such program from the pre-
5 scriber to the pharmacist.

6 (b) REPORT.—Not later than 2 years after the date
7 of enactment of this Act, the Secretary of Health and
8 Human Services shall submit to Congress a report on the
9 results of the studies conducted under subsection (a), to-
10 gether with any recommendations for legislation that the
11 Secretary determines to be appropriate as a result of such
12 studies.

13 **TITLE IV—MEDICARE WELLNESS**

14 **SEC. 400. DEFINITIONS.**

15 In this title:

16 (1) **MEDICARE BENEFICIARY.**—The term
17 “medicare beneficiary” means any individual who is
18 entitled to benefits under part A or enrolled under
19 part B of the medicare program, including any indi-
20 vidual enrolled in a Medicare+Choice plan offered
21 by a Medicare+Choice organization under part C of
22 such program.

23 (2) **MEDICARE PROGRAM.**—The term “medicare
24 program” means the health benefits program under

1 title XVIII of the Social Security Act (42 U.S.C.
2 1395 et seq.).

3 (3) SECRETARY.—The term “Secretary” means
4 the Secretary of Health and Human Services.

5 **Subtitle A—Healthy Seniors**
6 **Promotion Program**

7 **SEC. 401. DEFINITIONS.**

8 In this subtitle:

9 (1) COST-EFFECTIVE BENEFIT.—The term
10 “cost-effective benefit” means a benefit or technique
11 that has—

12 (A) been subject to peer review;

13 (B) been described in scientific journals;

14 and

15 (C) demonstrated value as measured by
16 unit costs relative to health outcomes achieved.

17 (2) COST-SAVING BENEFIT.—The term “cost-
18 saving benefit” means a benefit or technique that
19 has—

20 (A) been subject to peer review;

21 (B) been described in scientific journals;

22 and

23 (C) caused a net reduction in health care
24 costs for medicare beneficiaries.

1 (3) ELIGIBLE ENTITY.—The term “eligible enti-
2 ty” means an entity that the Working Group (as de-
3 fined in paragraph (6)) determines has dem-
4 onstrated expertise regarding health promotion and
5 disease prevention among medicare beneficiaries.

6 (4) MEDICALLY EFFECTIVE.—The term “medi-
7 cally effective” means, with respect to a benefit or
8 technique, that the benefit or technique has been—

9 (A) subject to peer review;

10 (B) described in scientific journals; and

11 (C) determined to achieve an intended goal

12 under normal programmatic conditions.

13 (5) MEDICALLY EFFICACIOUS.—The term
14 “medically efficacious” means, with respect to a ben-
15 efit or technique, that the benefit or technique has
16 been—

17 (A) subject to peer review;

18 (B) described in scientific journals; and

19 (C) determined to achieve an intended goal

20 under controlled conditions.

21 (6) WORKING GROUP.—The term “Working
22 Group” means the Working Group on Disease Self-
23 Management and Health Promotion established
24 under section 402.

1 **SEC. 402. WORKING GROUP ON DISEASE SELF-MANAGE-**
2 **MENT AND HEALTH PROMOTION.**

3 (a) ESTABLISHMENT.—There is established within
4 the Department of Health and Human Services a Working
5 Group on Disease Self-Management and Health Pro-
6 motion.

7 (b) COMPOSITION.—

8 (1) IN GENERAL.—Subject to paragraph (2),
9 the Working Group shall be composed of 5 members
10 as follows:

11 (A) The Administrator of the Centers for
12 Medicare & Medicaid Services.

13 (B) The Director of the Centers for Dis-
14 ease Control and Prevention.

15 (C) The Director of the Agency for
16 Healthcare Research and Quality.

17 (D) The Assistant Secretary for Aging.

18 (E) The Director of the National Institutes
19 of Health.

20 (2) ALTERNATIVE MEMBERSHIP.—Any member
21 of the Working Group described in a subparagraph
22 of paragraph (1) may appoint an individual who is
23 an officer or employee of the Federal Government to
24 serve as a member of the Working Group instead of
25 the member described in such subparagraph.

1 (c) DUTIES.—The duties of the Working Group are
2 as follows:

3 (1) HEALTHY SENIORS PROMOTION GRANTS.—
4 The Working Group shall establish general policies
5 and criteria with respect to the functions of the Sec-
6 retary under section 403, including—

7 (A) priorities for the approval of applica-
8 tions submitted under subsection (c) of such
9 section;

10 (B) procedures for monitoring and evalu-
11 ating research efforts conducted under such
12 section; and

13 (C) such other matters relating to the
14 grant program established under such section
15 as are recommended by the Working Group and
16 approved by the Secretary.

17 (2) DISEASE SELF-MANAGEMENT DEMONSTRA-
18 TION PROJECTS.—The Working Group shall estab-
19 lish general policies and criteria with respect to the
20 functions of the Secretary under section 404,
21 including—

22 (A) the identification of medical conditions
23 for which a demonstration project under such
24 section may be implemented;

1 (B) the prioritization of the conditions
2 identified under subparagraph (A) based on the
3 potential for the self-management of such con-
4 dition to be medically effective and for such
5 self-management to be a cost-effective benefit
6 or cost-saving benefit;

7 (C) the identification of target individuals
8 (as defined in section 404(a)(2));

9 (D) the development of procedures for se-
10 lecting areas in which such a demonstration
11 project may be implemented; and

12 (E) such other matters relating to such
13 demonstration projects as are recommended by
14 the Working Group and approved by the Sec-
15 retary.

16 (d) CHAIRPERSON.—The Secretary shall designate 1
17 of the members of the Working Group to be the chair-
18 person of the Group.

19 (e) QUORUM.—A majority of the members of the
20 Working Group shall constitute a quorum, but, subject to
21 subsection (f), a lesser number of members may hold
22 meetings.

23 (f) MEETINGS.—The Working Group shall meet at
24 the call of the chairperson, except that—

1 (1) it shall meet not less than 4 times each
2 year; and

3 (2) it shall meet upon the written request of a
4 majority of the members.

5 (g) COMPENSATION OF MEMBERS.—Each member of
6 the Working Group shall serve without compensation in
7 addition to that received for their service as an officer or
8 employee of the Federal Government.

9 (h) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary for the purpose of carrying out this section.

12 **SEC. 403. HEALTHY SENIORS PROMOTION GRANTS.**

13 (a) PROGRAM AUTHORIZED.—The Secretary, using
14 the general policies and criteria established by the Work-
15 ing Group under section 402(c)(1) and in accordance with
16 the provisions of this section, is authorized to make grants
17 to eligible entities (as defined in section 401(3)) to pay
18 for the costs of the activities described in subsection (b).

19 (b) USE OF FUNDS.—An eligible entity may use pay-
20 ments received under this section in any fiscal year to con-
21 duct a program to—

22 (1) study whether using different types of pro-
23 viders of care and alternative settings (including
24 community-based senior centers) for the implemen-
25 tation of a successful health promotion and disease

1 prevention strategy, including the implications re-
2 garding the payment of such providers, is medically
3 efficacious or medically effective;

4 (2) determine the most effective means of edu-
5 cating medicare beneficiaries, either directly or
6 through providers of care, regarding the importance
7 of health promotion and disease prevention among
8 such beneficiaries;

9 (3) identify incentives that would increase the
10 use of new and existing preventive health benefits
11 and healthy behaviors by medicare beneficiaries;

12 (4) promote—

13 (A) the use of preventive health benefits by
14 medicare beneficiaries, including such services
15 that are covered under the medicare program;

16 (B) the proper use by medicare bene-
17 ficiaries of prescription and over-the-counter
18 drugs in order to reduce the number of hospital
19 stays and physician visits that are a result of
20 improper use of such drugs; and

21 (C) the utilization by medicare bene-
22 ficiaries of the steps (including exercise, mainte-
23 nance of a proper diet, and the utilization of ac-
24 cident prevention techniques) that research has

1 shown to promote and safeguard individual
2 health; and

3 (5) address other topics designated by the Sec-
4 retary.

5 (c) APPLICATION.—

6 (1) IN GENERAL.—Each eligible entity that de-
7 sires to receive a grant under this section shall sub-
8 mit an application to the Secretary, at such time, in
9 such manner, and accompanied by such additional
10 information as the Secretary may reasonably re-
11 quire.

12 (2) CONTENTS.—Each application submitted
13 under paragraph (1) shall—

14 (A) describe the activities for which assist-
15 ance under this section is sought;

16 (B) describe how such activities will—

17 (i) reflect the medical, behavioral, and
18 social aspects of care for medicare bene-
19 ficiaries;

20 (ii) lead to the development of cost-ef-
21 fective benefits and cost-saving benefits;

22 and

23 (iii) impact the quality of life of medi-
24 care beneficiaries;

1 (C) provide assurances that such activities
2 will focus on broad medicare populations rather
3 than unique local medicare populations;

4 (D) provide evidence that the eligible entity
5 meets the general policies and criteria estab-
6 lished by the Working Group under section
7 402(c)(1);

8 (E) provide assurances that the eligible en-
9 tity will take such steps as may be available to
10 the entity in order to continue the activities for
11 which the entity is making application after the
12 period for which assistance is sought; and

13 (F) provide such additional assurances as
14 the Secretary determines to be essential to en-
15 sure compliance with the requirements of this
16 subtitle.

17 (3) JOINT APPLICATION.—A consortium of eli-
18 gible entities may file a joint application under the
19 provisions of paragraph (1).

20 (d) APPROVAL OF APPLICATION.—The Secretary
21 shall approve applications in accordance with the general
22 policies and criteria established by the Working Group
23 under section 402(c)(1).

24 (e) PAYMENTS.—Subject to amounts appropriated
25 under subsection (g), the Secretary shall pay to each eligi-

1 ble entity having an application approved under subsection
2 (d) the cost of the activities described in the application.

3 (f) EVALUATION AND REPORT.—

4 (1) EVALUATION.—The Secretary shall conduct
5 an annual evaluation of grants made under this sec-
6 tion to determine—

7 (A) the results of the activities conducted
8 under the programs for which grants were
9 made under this section;

10 (B) the extent to which research assisted
11 under this section has improved or expanded
12 the general research for health promotion and
13 disease prevention among medicare beneficiaries
14 and identified practical interventions based
15 upon such research;

16 (C) a list of specific recommendations
17 based upon the activities conducted under the
18 programs for which grants were made under
19 this section which show promise as practical
20 interventions for health promotion and disease
21 prevention among medicare beneficiaries;

22 (D) whether or not, as a result of the ac-
23 tivities conducted under the programs for which
24 grants were made under this section, certain
25 health promotion and disease prevention bene-

1 fits or education efforts should be added to the
2 medicare program, including discussions of
3 quality of life, translating the applied research
4 results into a benefit under the medicare pro-
5 gram, and whether each additional benefit
6 would be a cost-effective benefit or a cost-saving
7 benefit for each proposed addition; and

8 (E) how best to increase utilization of ex-
9 isting and recommended health promotion and
10 disease prevention services, such as an edu-
11 cation and public awareness campaign, pro-
12 viding financial incentives for providers of care
13 and medicare beneficiaries, or utilizing other
14 administrative means.

15 (2) ANNUAL REPORT.—Not later than Decem-
16 ber 31, 2003, and annually thereafter through 2005,
17 the Secretary, in consultation with the Working
18 Group, shall submit a report to Congress on the
19 evaluation conducted under paragraph (1), together
20 with such recommendations for such legislation and
21 administrative actions as the Secretary considers ap-
22 propriate.

23 (g) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated for the purpose of car-

1 rying out this section \$50,000,000 for each of fiscal years
2 2002, 2003, 2004, and 2005.

3 **SEC. 404. DISEASE SELF-MANAGEMENT DEMONSTRATION**
4 **PROJECTS.**

5 (a) DEMONSTRATION PROJECTS.—

6 (1) IN GENERAL.—The Secretary shall conduct
7 demonstration projects for the purpose of promoting
8 disease self-management for conditions identified by
9 the Working Group under section 402(c)(2) for tar-
10 get individuals (as defined in paragraph (2)).

11 (2) TARGET INDIVIDUAL DEFINED.—In this
12 section, the term “target individual” means an indi-
13 vidual who—

14 (A) is at risk for, or has, 1 or more of the
15 conditions identified by the Working Group
16 under section 402(c)(2); and

17 (B) is enrolled under the original medicare
18 fee-for-service program under parts A and B of
19 title XVIII of the Social Security Act (42
20 U.S.C. 1395c et seq.; 1395j et seq.) or is en-
21 rolled under the Medicare+Choice program
22 under part C of title XVIII of such Act (42
23 U.S.C. 1395w–21 et seq.).

24 (b) NUMBER; PROJECT AREAS; DURATION.—

1 (1) NUMBER.—Not later than 2 years after the
2 date of enactment of this Act, the Secretary shall
3 implement a series of demonstration projects to
4 carry out the purpose described in subsection (a)(1).

5 (2) PROJECT AREAS.—The Secretary shall im-
6 plement the demonstration projects described in
7 paragraph (1) in urban, suburban, and rural areas.

8 (3) DURATION.—The demonstration projects
9 under this section shall be conducted during the 3-
10 year period beginning on the date on which the ini-
11 tial demonstration project is implemented.

12 (c) REPORT TO CONGRESS.—

13 (1) IN GENERAL.—Not later than 18 months
14 after the conclusion of the demonstration projects
15 under this section, the Secretary shall submit a re-
16 port to Congress on such projects.

17 (2) CONTENTS OF REPORT.—The report re-
18 quired under paragraph (1) shall include the fol-
19 lowing:

20 (A) A description of the demonstration
21 projects.

22 (B) An evaluation of—

23 (i) whether each benefit provided
24 under the demonstration projects is a cost-
25 effective benefit or a cost-saving benefit;

1 (ii) the level of the disease self-man-
2 agement attained by target individuals
3 under the demonstration projects; and

4 (iii) the satisfaction of target individ-
5 uals under the demonstration projects.

6 (C) Recommendations of the Secretary re-
7 garding whether to conduct the demonstration
8 projects on a permanent basis.

9 (D) Such recommendations for legislation
10 and administrative action as the Secretary de-
11 termines to be appropriate.

12 (E) Any other information regarding the
13 demonstration projects that the Secretary de-
14 termines to be appropriate.

15 (d) FUNDING.—The Secretary shall provide for the
16 transfer from the Federal Hospital Insurance Trust Fund
17 under section 1817 of the Social Security Act (42 U.S.C.
18 1395i) an amount not to exceed \$30,000,000 for the costs
19 of carrying out this section.

20 **Subtitle B—Medicare Coverage of** 21 **Preventive Health Benefits**

22 **SEC. 411. THERAPY AND COUNSELING FOR CESSATION OF** 23 **TOBACCO USE.**

24 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
25 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section

1 105(a) of the Medicare, Medicaid, and SCHIP Benefits
2 Improvement and Protection Act of 2000 (114 Stat.
3 2763A–471), as enacted into law by section 1(a)(6) of
4 Public Law 106–554, is amended—

5 (1) in subparagraph (U), by striking “and” at
6 the end;

7 (2) in subparagraph (V), by inserting “and” at
8 the end; and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(W) supplemental preventive health services
12 (as defined in subsection (ww));”.

13 (b) SERVICES DESCRIBED.—Section 1861 of the So-
14 cial Security Act (42 U.S.C. 1395x), as amended by sec-
15 tion 115(b), is amended by adding at the end the following
16 new subsection:

17 “Supplemental Preventive Health Services

18 “(xx) The term ‘supplemental preventive health serv-
19 ices’ means the following:

20 “(1)(A) Therapy and counseling for cessation of
21 tobacco use for individuals who use tobacco products
22 or who are being treated for tobacco use that is
23 furnished—

24 “(i) by or under the supervision of a physi-
25 cian; or

1 “(ii) by any other health care professional
2 who—

3 “(I) is legally authorized to furnish
4 such services under State law (or the State
5 regulatory mechanism provided by State
6 law) of the State in which the services are
7 furnished; and

8 “(II) is authorized to receive payment
9 for other services under this title or is des-
10 ignated by the Secretary for this purpose.

11 “(B) Subject to subparagraph (C), such term is
12 limited to—

13 “(i) therapy and counseling services rec-
14 ommended in ‘Treating Tobacco Use and De-
15 pendence: A Clinical Practice Guideline’, pub-
16 lished by the Public Health Service in June
17 2000, or any subsequent modification of such
18 Guideline; and

19 “(ii) such other therapy and counseling
20 services that the Secretary recognizes to be ef-
21 fective.

22 “(C) Such term shall not include coverage for
23 drugs or biologicals that are not otherwise covered
24 under this title.”.

1 (c) PAYMENT AND ELIMINATION OF COST-SHARING
2 FOR ALL SUPPLEMENTAL PREVENTIVE HEALTH SERV-
3 ICES.—

4 (1) PAYMENT AND ELIMINATION OF COINSUR-
5 ANCE.—Section 1833(a)(1) of the Social Security
6 Act (42 U.S.C. 1395l(a)(1)), as amended by sections
7 111(b)(2)(A) and 112(b)(2)(A), is amended—

8 (A) in subparagraph (N), by inserting
9 “other than supplemental preventive health
10 services (as defined in section 1861(xx))” after
11 “(as defined in section 1848(j)(3))”;

12 (B) by striking “and” before “(V)”; and

13 (C) by inserting before the semicolon at
14 the end the following: “, and (W) with respect
15 to supplemental preventive health services (as
16 defined in section 1861(xx)), the amount paid
17 shall be 100 percent of the lesser of the actual
18 charge for the services or the amount deter-
19 mined under the payment basis determined
20 under section 1848 by the Secretary for the
21 particular supplemental preventive health serv-
22 ice involved”.

23 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-
24 ULE.—Section 1848(j)(3) (42 U.S.C. 1395w-

1 4(j)(3)) is amended by inserting “(2)(W),” after
2 “(2)(S),”.

3 (3) ELIMINATION OF COINSURANCE IN OUT-
4 PATIENT HOSPITAL SETTINGS.—The third sentence
5 of section 1866(a)(2)(A) of the Social Security Act
6 (42 U.S.C. 1395cc(a)(2)(A)) is amended by insert-
7 ing after “1861(s)(10)(A)” the following: “, with re-
8 spect to supplemental preventive health services (as
9 defined in section 1861(xx)),”.

10 (4) ELIMINATION OF DEDUCTIBLE.—The first
11 sentence of section 1833(b) of the Social Security
12 Act (42 U.S.C. 1395l(b)), as amended by section
13 111(b)(2)(B), is amended—

14 (A) by striking “and” before “(7)”; and

15 (B) by inserting before the period the fol-
16 lowing: “, and (8) such deductible shall not
17 apply with respect to supplemental preventive
18 health services (as defined in section
19 1861(xx))”.

20 (d) APPLICATION OF LIMITS ON BILLING.—Section
21 1842(b)(18)(C) of the Social Security Act (42 U.S.C.
22 1395u(b)(18)(C)), as amended by section 105(d) of the
23 Medicare, Medicaid, and SCHIP Benefits Improvement
24 and Protection Act of 2000 (114 Stat. 2763A–472), as
25 enacted into law by section 1(a)(6) of Public Law 106–

1 554, is amended by adding at the end the following new
2 clause:

3 “(vii) Any health care professional designated
4 under section 1861(xx)(1)(A)(ii)(II) to perform ther-
5 apy and counseling for cessation of tobacco use.”.

6 (e) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to services furnished on or after
8 the day that is 1 year after the date of enactment of this
9 Act.

10 **SEC. 412. COUNSELING FOR POST-MENOPAUSAL WOMEN.**

11 (a) COVERAGE.—Section 1861(xx) of the Social Se-
12 curity Act (42 U.S.C. 1395x(s)(2)), as added by section
13 411(b), is amended by adding at the end the following new
14 paragraph:

15 “(2)(A) Counseling for post-menopausal
16 women.

17 “(B) For purposes of subparagraph (A), the
18 term ‘counseling for post-menopausal women’ means
19 counseling provided to a post-menopausal woman
20 regarding—

21 “(i) the symptoms, risk factors, and condi-
22 tions associated with menopause;

23 “(ii) appropriate treatment options for
24 post-menopausal women, including hormone re-
25 placement therapy; and

1 “(iii) other interventions that can be imple-
2 mented to prevent or delay the onset of health
3 risks associated with menopause.

4 “(C) Such term does not include coverage for
5 drugs or biologicals that are not otherwise covered
6 under this title.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall apply to services furnished on or after
9 the day that is 1 year after the date of enactment of this
10 Act.

11 **SEC. 413. SCREENING FOR DIMINISHED VISUAL ACUITY.**

12 (a) COVERAGE.—Section 1861(xx) of the Social Se-
13 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
14 412(a), is amended by adding at the end the following new
15 paragraph:

16 “(3)(A) Screening for diminished visual acuity.

17 “(B) For purposes of subparagraph (A), the
18 term ‘screening for diminished visual acuity’ means
19 a screening for diminished visual acuity that is fur-
20 nished by or under the supervision of an optometrist
21 or ophthalmologist who is legally authorized to fur-
22 nish such services under State law (or the State reg-
23 ulatory mechanism provided by State law) of the
24 State in which the services are furnished.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to services furnished on or after
3 the day that is 1 year after the date of enactment of this
4 Act.

5 **SEC. 414. SCREENING FOR HEARING IMPAIRMENT.**

6 (a) COVERAGE.—Section 1861(xx) of the Social Se-
7 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
8 413(a), is amended by adding at the end the following new
9 paragraph:

10 “(4)(A) Screening for hearing impairment.

11 “(B) For purposes of subparagraph (A), the
12 term ‘screening for hearing impairment’ means the
13 following services:

14 “(i) A screening for hearing impairment
15 using periodic questions that is furnished by—

16 “(I) a physician, including an
17 otolaryngologist;

18 “(II) a qualified audiologist (as de-
19 fined in subsection (l)(3)(B)); or

20 “(III) any other health care profes-
21 sional who is legally authorized to furnish
22 such screening under State law (or the
23 State regulatory mechanism provided by
24 State law) of the State in which the
25 screening is furnished.

1 “(ii) If the answers to such questions indi-
2 cate potential hearing impairment, an otoscopic
3 examination and an audiometric screening test
4 that are furnished by an otolaryngologist or a
5 qualified audiologist (as so defined).

6 “(iii) If the results of such examination or
7 test indicate a need for assistive listening de-
8 vices (whether or not such examination or test
9 was based on a screening or was diagnostic),
10 counseling about such devices that is furnished
11 by an otolaryngologist or a qualified audiologist
12 (as so defined).”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply to services furnished on or after
15 the day that is 1 year after the date of enactment of this
16 Act.

17 **SEC. 415. SCREENING FOR CHOLESTEROL.**

18 (a) COVERAGE.—Section 1861(xx) of the Social Se-
19 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
20 414(a), is amended by adding at the end the following new
21 paragraph:

22 “(5)(A) Screening for cholesterol if the indi-
23 vidual involved has not had such a screening during
24 the preceding 5 years.

1 “(B) Notwithstanding subparagraph (A), pay-
2 ment may be made under this part for a screening
3 for cholesterol with respect to an individual even if
4 the individual has had such a screening during the
5 preceding 5 years if the individual exhibits major
6 risk factors for coronary heart disease or a stroke,
7 including, but not limited to, smoking, hypertension,
8 and diabetes.”.

9 (b) CONFORMING AMENDMENT.—Section 1862(a)(1)
10 of the Social Security Act (42 U.S.C. 1395y(a)(1)), as
11 amended by section 301(b)(2), is amended—

12 (1) in subparagraph (I), by striking “and” at
13 the end;

14 (2) in subparagraph (J), by striking the semi-
15 colon at the end and inserting “, and”; and

16 (3) by adding at the end the following new sub-
17 paragraph:

18 “(K) in the case of a screening for choles-
19 terol, which is performed more frequently than
20 is covered under section 1861(xx)(5);”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to services furnished on or after
23 the day that is 1 year after the date of enactment of this
24 Act.

1 **SEC. 416. SCREENING FOR HYPERTENSION.**

2 (a) **COVERAGE.**—Section 1861(xx) of the Social Se-
3 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
4 415(a), is amended by adding at the end the following new
5 paragraph:

6 “(6)(A) Screening for hypertension if the indi-
7 vidual involved has not had such a screening during
8 the preceding 2 years.

9 “(B) Notwithstanding subparagraph (A), pay-
10 ment may be made under this part for a screening
11 for hypertension with respect to an individual even
12 if the individual has had such a screening during the
13 preceding 2 years if the individual has a history of,
14 or is at risk for, hypertension.”.

15 (b) **CONFORMING AMENDMENT.**—Section 1862(a)(1)
16 of the Social Security Act (42 U.S.C. 1395y(a)(1)), as
17 amended by section 415(b), is amended—

18 (1) in subparagraph (J), by striking “and” at
19 the end;

20 (2) in subparagraph (K), by striking the semi-
21 colon at the end and inserting “, and”; and

22 (3) by adding at the end the following new sub-
23 paragraph:

24 “(L) in the case of a screening for hyper-
25 tension, which is performed more frequently
26 than is covered under section 1861(xx)(6);”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 the day that is 1 year after the date of enactment of this
4 Act.

5 **SEC. 417. EXPANSION OF ELIGIBILITY FOR BONE MASS**
6 **MEASUREMENT.**

7 (a) EXPANSION.—Section 1861(rr)(2) of the Social
8 Security Act (42 U.S.C. 1395x(rr)(2)) is amended to read
9 as follows:

10 “(2) For purposes of this subsection, the term ‘quali-
11 fied individual’ means an individual who is (in accordance
12 with regulations prescribed by the Secretary)—

13 “(A) an estrogen-deficient woman (including
14 those receiving hormone replacement therapy);

15 “(B) an individual with low trauma or fragility
16 fractures (including vertebral abnormalities and hip,
17 rib, wrist, pelvic, or proximal humeral fractures);

18 “(C) an individual receiving long-term medica-
19 tions that have associations to bone loss or
20 osteoporosis (including glucocorticoid therapy and
21 androgen deprivation therapy);

22 “(D) an individual with a long-term medical
23 condition that has association to osteoporosis (in-
24 cluding primary hyperparathyroidism);

1 “(E) a man with risk factors for osteoporosis
2 such as hypogonadism; and

3 “(F) an individual being monitored to assess
4 the response to, or efficacy of, an approved
5 osteoporosis therapy.”.

6 (b) REFERENCE TO ELIMINATION OF COINSURANCE
7 AND WAIVER OF APPLICATION OF DEDUCTIBLE.—For
8 the elimination of the coinsurance for bone mass measure-
9 ment and for the waiver of the application of the part B
10 deductible for such measurement, see section 419.

11 (c) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall apply to services furnished on or after
13 the day that is 1 year after the date of enactment of this
14 Act.

15 **SEC. 418. COVERAGE OF MEDICAL NUTRITION THERAPY**
16 **SERVICES FOR BENEFICIARIES WITH CAR-**
17 **DIOVASCULAR DISEASES.**

18 (a) IN GENERAL.—Section 1861(s)(2)(V) of the So-
19 cial Security Act (42 U.S.C. 1395x(s)(2)(V)), as added by
20 section 105(a) of the Medicare, Medicaid, and SCHIP
21 Benefits Improvement and Protection Act of 2000 (114
22 Stat. 2763A–471), as enacted into law by section 1(a)(6)
23 of Public Law 106–554, is amended to read as follows:

1 “(V) medical nutrition therapy services (as de-
2 fined in subsection (vv)(1)) in the case of a
3 beneficiary—

4 “(i) with a cardiovascular disease (includ-
5 ing congestive heart failure, arteriosclerosis,
6 hyperlipidemia, hypertension, and
7 hypercholesterolemia), diabetes, or a renal dis-
8 ease (or a combination of such conditions)
9 who—

10 “(I) has not received diabetes out-
11 patient self-management training services
12 within a time period determined by the
13 Secretary;

14 “(II) is not receiving maintenance di-
15 alysis for which payment is made under
16 section 1881; and

17 “(III) meets such other criteria deter-
18 mined by the Secretary after consideration
19 of protocols established by dietitian or nu-
20 trition professional organizations; or

21 “(ii) with a combination of such conditions
22 who—

23 “(I) is not described in clause (i) be-
24 cause of the application of subclause (I) or
25 (II) of such clause;

1 “(II) receives such medical nutrition
2 therapy services in a coordinated manner
3 (as determined appropriate by the Sec-
4 retary) with any services described in such
5 subclauses that the beneficiary is receiving;
6 and

7 “(III) meets such other criteria deter-
8 mined by the Secretary after consideration
9 of protocols established by dietitian or nu-
10 trition professional organizations;”.

11 (b) ELIMINATION OF COINSURANCE.—Section
12 1833(a)(1)(T) of the Social Security Act (42 U.S.C.
13 1395l(a)(1)(T)), as added by section 105(c)(2) of the
14 Medicare, Medicaid, and SCHIP Benefits Improvement
15 and Protection Act of 2000 (114 Stat. 2763A–472), as
16 enacted into law by section 1(a)(6) of Public Law 106–
17 554, is amended by striking “80 percent” and inserting
18 “100 percent”.

19 (c) REFERENCE TO WAIVER OF APPLICATION OF
20 DEDUCTIBLE.—For the waiver of the application of the
21 part B deductible for medical nutrition therapy services,
22 see section 419.

23 (d) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect as if included in the enact-
25 ment of section 105 of the Medicare, Medicaid, and

1 SCHIP Benefits Improvement and Protection Act of 2000
2 (114 Stat. 2763A–471), as enacted into law by section
3 1(a)(6) of Public Law 106–554.

4 **SEC. 419. ELIMINATION OF DEDUCTIBLES AND COINSUR-**
5 **ANCE FOR EXISTING PREVENTIVE HEALTH**
6 **BENEFITS.**

7 (a) IN GENERAL.—Section 1833 of the Social Secu-
8 rity Act (42 U.S.C. 1395l) is amended by inserting after
9 subsection (o) the following new subsection:

10 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR
11 PREVENTIVE HEALTH ITEMS AND SERVICES.—The Sec-
12 retary may not require the payment of any deductible or
13 coinsurance under subsection (a) or (b), respectively, of
14 any individual enrolled for coverage under this part for
15 any of the following preventive health items and services:

16 “(1) Blood-testing strips, lancets, and blood
17 glucose monitors for individuals with diabetes de-
18 scribed in section 1861(n).

19 “(2) Diabetes outpatient self-management
20 training services (as defined in section 1861(qq)(1)).

21 “(3) Pneumococcal, influenza, and hepatitis B
22 vaccines and administration described in section
23 1861(s)(10).

24 “(4) Screening mammography (as defined in
25 section 1861(jj)).

1 “(5) Screening pap smear and screening pelvic
2 exam (as defined in paragraphs (1) and (2) of sec-
3 tion 1861(nn), respectively).

4 “(6) Bone mass measurement (as defined in
5 section 1861(rr)(1)).

6 “(7) Prostate cancer screening test (as defined
7 in section 1861(oo)(1)).

8 “(8) Colorectal cancer screening test (as de-
9 fined in section 1861(pp)(1)).

10 “(9) Screening for glaucoma (as defined in sec-
11 tion 1861(uu)).

12 “(10) Medical nutrition therapy services (as de-
13 fined in section 1861(vv)(1)).”.

14 (b) WAIVER OF COINSURANCE.—

15 (1) IN GENERAL.—Section 1833(a)(1)(B) of the
16 Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is
17 amended to read as follows: “(B) with respect to
18 preventive health items and services described in
19 subsection (p), the amounts paid shall be 100 per-
20 cent of the fee schedule or other basis of payment
21 under this title for the particular item or service,”.

22 (2) ELIMINATION OF COINSURANCE IN OUT-
23 PATIENT HOSPITAL SETTINGS.—The third sentence
24 of section 1866(a)(2)(A) of the Social Security Act
25 (42 U.S.C. 1395cc(a)(2)(A)), as amended by section

1 411(c)(3), is amended by inserting after “section
2 1861(xx)” the following: “and preventive health
3 items and services described in section 1833(p)”.

4 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—
5 Section 1833(b)(1) of the Social Security Act (42 U.S.C.
6 1395l(b)(1)) is amended to read as follows: “(1) such de-
7 ductible shall not apply with respect to preventive health
8 items and services described in subsection (p),”.

9 (d) ADDING “LANCET” TO DEFINITION OF DME.—
10 Section 1861(n) of the Social Security Act (42 U.S.C.
11 1395x(n)) is amended by striking “blood-testing strips
12 and blood glucose monitors” and inserting “blood-testing
13 strips, lancets, and blood glucose monitors”.

14 (e) CONFORMING AMENDMENTS.—

15 (1) ELIMINATION OF COINSURANCE FOR CLIN-
16 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs
17 (1)(D)(i) and (2)(D)(i) of section 1833(a) of the So-
18 cial Security Act (42 U.S.C. 1395l(a)), as amended
19 by section 201(b)(1) of the Medicare, Medicaid, and
20 SCHIP Benefits Improvement and Protection Act of
21 2000 (114 Stat. 2763A–481), as enacted into law by
22 section 1(a)(6) of Public Law 106–554, are each
23 amended by inserting “or which are described in
24 subsection (p)” after “assignment-related basis”.

1 (2) ELIMINATION OF COINSURANCE FOR CER-
2 TAIN DME.—Section 1834(a)(1)(A) of the Social Se-
3 curity Act (42 U.S.C. 1395m(a)(1)(A)) is amended
4 by inserting “(or 100 percent, in the case of such an
5 item described in section 1833(p))” after “80 per-
6 cent”.

7 (3) ELIMINATION OF DEDUCTIBLES AND COIN-
8 SURANCE FOR COLORECTAL CANCER SCREENING
9 TESTS.—Section 1834(d) of the Social Security Act
10 (42 U.S.C. 1395m(d)) is amended—

11 (A) in paragraph (2)(C)—

12 (i) by striking “(C) FACILITY PAY-
13 MENT LIMIT.—” and all that follows
14 through “Notwithstanding subsections”
15 and inserting the following:

16 “(C) FACILITY PAYMENT LIMIT.—Notwith-
17 standing subsections”;

18 (ii) by striking “(I) in accordance”
19 and inserting the following:

20 “(i) in accordance”;

21 (iii) by striking “(II) are performed”
22 and all that follows through “payment
23 under” and inserting the following:

1 “(ii) are performed in an ambulatory
2 surgical center or hospital outpatient de-
3 partment,

4 payment under”; and

5 (iv) by striking clause (ii); and

6 (B) in paragraph (3)(C)—

7 (i) by striking “(C) FACILITY PAY-
8 MENT LIMIT.—” and all that follows
9 through “Notwithstanding subsections”
10 and inserting the following:

11 “(C) FACILITY PAYMENT LIMIT.—Notwith-
12 standing subsections”; and

13 (ii) by striking clause (ii).

14 (f) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished on or after
16 the day that is 1 year after the date of enactment of this
17 Act.

18 **SEC. 420. PROGRAM INTEGRITY.**

19 The Secretary, in consultation with the Inspector
20 General of the Department of Health and Human Serv-
21 ices, shall integrate supplemental preventive health serv-
22 ices (as defined in section 1861(xx) of the Social Security
23 Act (as added by the preceding provisions of this subtitle))
24 with existing program integrity measures.

1 **SEC. 421. PROMOTION OF PREVENTIVE HEALTH BENEFITS.**

2 In order to promote the use by medicare beneficiaries
3 of preventive health benefits, including preventive health
4 services (as defined in section 1861(xx) of the Social Secu-
5 rity Act (as added by the preceding provisions of this sub-
6 title)) and preventive health items and services described
7 in section 1833(p) of such Act (as added by section 419),
8 the Secretary shall do the following:

9 (1) **MEDICARE HANDBOOK AND OTHER ANNUAL**
10 **NOTICES.**—Include in any medicare handbook and
11 any other annual notice provided to medicare bene-
12 ficiaries a detailed description of—

13 (A) the preventive health benefits that are
14 covered under the medicare program; and

15 (B) the importance of using such benefits.

16 (2) **FISCAL INTERMEDIARIES AND CARRIERS.**—
17 Require that fiscal intermediaries with a contract
18 under section 1816 of the Social Security Act (42
19 U.S.C. 1395h) and carriers with a contract under
20 section 1842 of such Act (42 U.S.C. 1395u) include
21 preventive health benefits messages on Medicare
22 Summary Notice Statements and Explanations of
23 Medicare Benefits distributed by such entities.

24 (3) **MEDICARE PART B STATEMENT.**—Regularly
25 include preventive health benefits messages on the
26 medicare part B statement.

1 (4) MEDICARE+CHOICE PLANS.—Require that
2 Medicare+Choice organizations offering a
3 Medicare+Choice plan disclose under section
4 1852(e)(1)(B) of the Social Security Act (42 U.S.C.
5 1395w–22(e)(1)(B)) information regarding the pre-
6 ventive health benefits that are covered under the
7 plan.

8 (5) OTHER ACTIVITIES.—Conduct activities in
9 addition to those described in paragraphs (1)
10 through (4) that the Secretary determines to be use-
11 ful in disseminating information to medicare bene-
12 ficiaries regarding—

13 (A) the preventive health benefits that are
14 covered under the medicare program;

15 (B) the importance of using such benefits;

16 and

17 (C) general health promotion.

18 **Subtitle C—National Falls Preven-**
19 **tion Education and Awareness**
20 **Campaign**

21 **SEC. 431. NATIONAL FALLS PREVENTION EDUCATION AND**
22 **AWARENESS CAMPAIGN.**

23 (a) IN GENERAL.—The Director of the Centers for
24 Disease Control and Prevention, in consultation with the
25 Administrator of the Centers for Medicare & Medicaid

1 Services, shall conduct a national falls prevention and
2 awareness campaign to reduce fall-related injuries among
3 medicare beneficiaries.

4 (b) REPORT TO CONGRESS.—

5 (1) IN GENERAL.—The Director of the Centers
6 for Disease Control and Prevention, in consultation
7 with the Administrator of the Centers for Medicare
8 & Medicaid Services, shall submit to Congress a re-
9 port on the campaign conducted under this section.

10 (2) DEADLINE FOR REPORT.—The report re-
11 quired under paragraph (1) shall be submitted not
12 later than the earlier of—

13 (A) 6 months after the campaign is com-
14 pleted; or

15 (B) 3 years after the campaign is imple-
16 mented.

17 (3) CONTENTS OF REPORT.—The report re-
18 quired under paragraph (1) shall include the fol-
19 lowing:

20 (A) A description of the campaign.

21 (B) An evaluation of—

22 (i) whether the campaign has effec-
23 tively reached its target population; and

24 (ii) the cost-effectiveness of the cam-
25 paign.

1 (C) An assessment of whether the cam-
2 paign has been effective, as measured by
3 whether—

4 (i) the target population has adopted
5 the interventions suggested in the cam-
6 paign, and if not, the reasons why such
7 interventions have not been adopted; and

8 (ii) the fall rates among the target
9 population have decreased since the cam-
10 paign was implemented, and if not, the
11 reasons why such fall rates have not de-
12 creased.

13 (D) Any other information regarding the
14 campaign that the Director of the Centers for
15 Disease Control and Prevention determines to
16 be appropriate.

17 (e) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated such sums as may be
19 necessary for the purpose of carrying out this section.

20 **Subtitle D—Clinical Depression**
21 **Screening Demonstration Projects**

22 **SEC. 441. CLINICAL DEPRESSION SCREENING DEMONSTRA-**
23 **TION PROJECTS.**

24 (a) DEFINITIONS.—In this section:

1 (1) DEMONSTRATION PROJECT.—The term
2 “demonstration project” means a demonstration
3 project established under subsection (b)(1).

4 (2) ELIGIBLE BENEFICIARY.—The term “eligi-
5 ble beneficiary” means an individual enrolled for
6 benefits under part B who is not enrolled in any of
7 the following:

8 (A) A Medicare+Choice plan under part C
9 of title XVIII of the Social Security Act (42
10 U.S.C. 1395w–21 et seq.).

11 (B) A plan offered by an eligible organiza-
12 tion under section 1876 of such Act (42 U.S.C.
13 1395mm).

14 (C) A program of all-inclusive care for the
15 elderly (PACE) under section 1894 of such Act
16 (42 U.S.C. 1395eee).

17 (D) A social health maintenance organiza-
18 tion (SHMO) demonstration project established
19 under section 4018(b) of the Omnibus Budget
20 Reconciliation Act of 1987 (Public Law 100–
21 203).

22 (E) A health care prepayment plan under
23 section 1833(a)(1)(A) of the Social Security Act
24 (42 U.S.C. 1395l(a)(1)(A)).

1 (3) PART B.—The term “part B” means part
2 B of the original medicare fee-for-service program
3 under title XVIII of the Social Security Act (42
4 U.S.C. 1395j et seq.).

5 (4) QUALIFIED HEALTH PROFESSIONAL.—The
6 term “qualified health professional” means an indi-
7 vidual that—

8 (A) is—

9 (i) a physician (as defined in section
10 1861(r)(1) of the Social Security Act (42
11 U.S.C. 1395x(r)(1)));

12 (ii) a nurse practitioner (as defined in
13 section 1861(aa)(5) of such Act (42 U.S.C.
14 1395x(aa)(5))); or

15 (iii) a mental health care professional
16 (including a clinical social worker, as de-
17 fined in section 1861(hh) of such Act (42
18 U.S.C. 1395x(hh))) that is licensed to per-
19 form mental health services by the State in
20 which a screening for clinical depression is
21 furnished under a demonstration project;
22 and

23 (B) has an agreement in effect with the
24 Secretary under which the professional agrees
25 to accept the amount determined by the Sec-

1 retary under subsection (b)(4) as full payment
2 for such screening and to accept an assignment
3 described in section 1842(b)(3)(B)(ii) of the So-
4 cial Security Act (42 U.S.C.
5 1395u(b)(3)(B)(ii)) with respect to payment for
6 each screening furnished by the professional to
7 an eligible beneficiary participating in a dem-
8 onstration project.

9 (5) SCREENING FOR CLINICAL DEPRESSION.—

10 (A) IN GENERAL.—The term “screening
11 for clinical depression” means a consultation
12 during which—

13 (i) a self-administered written screen-
14 ing test (or an alternative format for such
15 test pursuant to subsection (b)(3)(B)) is
16 made available to an eligible beneficiary;
17 and

18 (ii) a qualified health professional—

19 (I) interprets the results of such
20 test;

21 (II) discusses the beneficiary’s
22 responses to the questions on the test
23 with the beneficiary;

24 (III) assesses the beneficiary’s
25 risk of clinical depression; and

1 (IV) if the qualified health pro-
2 fessional determines that the bene-
3 ficiary is at high risk for clinical de-
4 pression, refers the eligible beneficiary
5 for a full diagnostic evaluation and
6 such additional treatment as may be
7 required.

8 (B) CONSTRUCTION.—Nothing in subpara-
9 graph (A)(ii)(IV) shall be construed as prohib-
10 iting a qualified health professional performing
11 the screening for clinical depression with re-
12 spect to an individual from directly providing
13 the diagnostic evaluation and additional treat-
14 ment described in such subparagraph to such
15 individual if legally authorized under State law
16 to do so.

17 (6) SELF-ADMINISTERED WRITTEN SCREENING
18 TEST.—The term “self-administered written screen-
19 ing test” means an instrument on which an eligible
20 beneficiary writes answers to questions designed to
21 enable a qualified health professional to establish the
22 level of risk of such eligible beneficiary for clinical
23 depression.

24 (b) DEMONSTRATION PROJECTS.—

1 (1) IN GENERAL.—The Secretary shall establish
2 and conduct demonstration projects for the purpose
3 of evaluating the efficacy of providing screenings for
4 clinical depression as a benefit under part B to eligi-
5 ble beneficiaries through qualified health profes-
6 sionals in accordance with the requirements of this
7 section.

8 (2) NUMBER, PROJECT AREAS, DURATION.—

9 (A) NUMBER.—The Secretary shall estab-
10 lish no fewer than 6 and no more than 10 dem-
11 onstration projects.

12 (B) PROJECT AREAS.—

13 (i) IN GENERAL.—The Secretary shall
14 conduct demonstration projects in geo-
15 graphic areas that include urban, subur-
16 ban, and rural areas.

17 (ii) SELECTION.—The Secretary shall
18 select the geographic areas described in
19 clause (i) in a manner that—

20 (I) ensures geographic diversity
21 and a mix of screening sites (includ-
22 ing physicians' offices, hospital out-
23 patient departments, community men-
24 tal health centers, and skilled nursing
25 facilities); and

1 (II) gives preference to areas
2 with a high concentration of eligible
3 beneficiaries.

4 (C) DURATION.—The demonstration
5 projects under this section shall be conducted
6 during the 3-year period beginning on the date
7 on which the initial demonstration project is
8 implemented.

9 (3) IDENTIFICATION AND DISTRIBUTION OF
10 SELF-ADMINISTERED TESTS.—

11 (A) IN GENERAL.—The Secretary, in con-
12 sultation with professionals experienced in con-
13 ducting large-scale depression screening
14 projects, shall—

15 (i) establish or identify a self-adminis-
16 tered written screening test to be used in
17 conducting the demonstration projects; and

18 (ii) not later than the date that is 3
19 months before the date on which a dem-
20 onstration project is implemented in a geo-
21 graphic area, distribute such test to each
22 qualified health professional that provides
23 services in such area in which the Sec-
24 retary conducts a demonstration project,

1 together with guidelines for making the
2 test available to eligible beneficiaries.

3 (B) ALTERNATIVE FORMATS FOR TEST.—

4 The Secretary shall also establish and distribute
5 alternative formats for the self-administered
6 written screening test under subparagraph (A)
7 which shall be available for use when cir-
8 cumstances do not permit an individual to com-
9 plete the self-administered written screening
10 test.

11 (4) PAYMENT FOR SCREENINGS FOR CLINICAL
12 DEPRESSION.—

13 (A) IN GENERAL.—Subject to subpara-
14 graph (C), the Secretary shall provide for pay-
15 ment of the reasonable charges for each screen-
16 ing for clinical depression furnished to an eligi-
17 ble beneficiary by a qualified health professional
18 from the amounts transferred under subsection
19 (d).

20 (B) WAIVER OF COINSURANCE AND
21 DEDUCTIBLES.—The Secretary may not require
22 the payment of any deductible or coinsurance
23 by any eligible beneficiary for a screening for
24 clinical depression furnished under a dem-
25 onstration project.

1 (C) FREQUENCY LIMITATION.—No pay-
2 ment may be made under this section for a
3 screening for clinical depression if such a
4 screening is performed with respect to an eligi-
5 ble beneficiary within the year after a previous
6 screening of such beneficiary.

7 (5) WAIVER AUTHORITY.—The Secretary may
8 waive such requirements under title XVIII of the So-
9 cial Security Act (42 U.S.C. 1395 et seq.) as the
10 Secretary determines necessary to carry out the
11 demonstration projects under this section.

12 (c) REPORTS TO CONGRESS.—

13 (1) INTERIM REPORT.—

14 (A) IN GENERAL.—Not later than 2 years
15 after the Secretary implements the initial dem-
16 onstration project, the Secretary shall submit to
17 Congress a report regarding the demonstration
18 projects conducted under this section.

19 (B) CONTENTS OF REPORT.—The report
20 submitted under subparagraph (A) shall
21 contain—

22 (i) a description of the demonstration
23 projects conducted under this section;

24 (ii) an evaluation of—

1 (I) whether screening for clinical
2 depression is a cost-effective benefit or
3 a cost-saving benefit; and

4 (II) the level of satisfaction of el-
5 igible beneficiaries to whom such a
6 screening is furnished under the dem-
7 onstration project; and

8 (iii) any other information regarding
9 the demonstration projects that the Sec-
10 retary determines to be appropriate.

11 (2) FINAL REPORT.—Not later than 1 year
12 after the conclusion of the demonstration projects,
13 the Secretary shall submit a final report to Congress
14 on the demonstration projects containing the rec-
15 ommendations of the Secretary regarding whether to
16 conduct the demonstration projects on a permanent
17 basis, together with such recommendations for legis-
18 lation and administrative action as the Secretary
19 considers appropriate.

20 (d) FUNDING.—The Secretary shall provide for the
21 transfer from the Federal Hospital Insurance Trust Fund
22 under section 1817 of the Social Security Act (42 U.S.C.
23 1395i) an amount not to exceed \$30,000,000 for the costs
24 of carrying out the demonstration projects under this sec-
25 tion.

1 **Subtitle E—Medicare Health Edu-**
2 **cation and Risk Appraisal Pro-**
3 **gram**

4 **SEC. 451. MEDICARE HEALTH EDUCATION AND RISK AP-**
5 **PRAISAL PROGRAM.**

6 Title XVIII of the Social Security Act (42 U.S.C.
7 1395 et seq.) is amended by adding at the end the fol-
8 lowing new section:

9 “MEDICARE HEALTH EDUCATION AND RISK APPRAISAL
10 PROGRAM

11 “SEC. 1897. (a) ESTABLISHMENT.—Not later than
12 18 months after the date of the conclusion of the dem-
13 onstration projects conducted under subsection (b)(1), the
14 Secretary shall implement the demonstration project that
15 the Secretary identifies as being the most effective project
16 under subsection (c)(2)(C) on a nationwide and perma-
17 nent basis.

18 “(b) DEMONSTRATION PROJECTS.—

19 “(1) ESTABLISHMENT.—Not later than 1 year
20 after the date of enactment of this Act, the Sec-
21 retary, in consultation with the Centers for Medicare
22 & Medicaid Services, the Centers for Disease Control
23 and Prevention, and the Agency for Healthcare Re-
24 search and Quality, shall conduct a demonstration
25 project for the purpose of developing a comprehen-

1 sive and systematic model for delivering health pro-
2 motion and disease prevention services that—

3 “(A) through self-assessment identifies—

4 “(i) behavioral risk factors, such as
5 tobacco use, physical inactivity, alcohol
6 use, and depression, among target individ-
7 uals;

8 “(ii) needed medicare clinical preven-
9 tive and screening health benefits among
10 target individuals; and

11 “(iii) functional and self-management
12 information the Secretary determines to be
13 appropriate;

14 “(B) provides ongoing followup to reduce
15 risk factors and promote the appropriate use of
16 preventive and screening health benefits;

17 “(C) improves clinical outcomes, satisfac-
18 tion, quality of life, and appropriate use by tar-
19 get individuals of items and services covered
20 under the medicare program; and

21 “(D) provides target individuals with infor-
22 mation regarding the adoption of healthy behav-
23 iors.

24 “(2) SELF-ASSESSMENT AND PROVISION OF IN-
25 FORMATION.—The Secretary shall conduct the dem-

1 demonstration projects established under paragraph (1)
2 in the following manner:

3 “(A) SELF-ASSESSMENT.—

4 “(i) IN GENERAL.—The Secretary
5 shall test different—

6 “(I) methods of making self-as-
7 sessments available to each target in-
8 dividual;

9 “(II) methods of encouraging
10 each target individual to participate in
11 the self-assessment; and

12 “(III) methods for processing re-
13 sponses to the self-assessment.

14 “(ii) CONTENTS.—A self-assessment
15 made available under clause (i) shall
16 include—

17 “(I) questions regarding behav-
18 ioral risk factors;

19 “(II) questions regarding needed
20 preventive screening health services;

21 “(III) questions regarding the
22 target individual’s preferences for re-
23 ceiving follow-up information; and

24 “(IV) other information that the
25 Secretary determines appropriate.

1 “(B) PROVISION OF INFORMATION.—After
2 each target individual completes the self-assess-
3 ment, the Secretary shall ensure that the target
4 individual is provided with such information as
5 the Secretary determines appropriate, which
6 may include—

7 “(i) information regarding the results
8 of the self-assessment;

9 “(ii) recommendations regarding any
10 appropriate behavior modification based on
11 the self-assessment;

12 “(iii) information regarding how to
13 access behavior modification assistance
14 that promotes healthy behavior, including
15 information on nurse hotlines, counseling
16 services, provider services, and case-man-
17 agement services;

18 “(iv) information, feedback, support,
19 and recommendations regarding any need
20 for clinical preventive and screening health
21 services or treatment; and

22 “(v) referrals to available community
23 resources in order to assist the target indi-
24 vidual in reducing health risks.

25 “(3) PROJECT AREAS AND DURATION.—

1 “(A) PROJECT AREAS.—The Secretary
2 shall implement the demonstration projects in
3 geographic areas that include urban, suburban,
4 and rural areas.

5 “(B) DURATION.—The Secretary shall
6 conduct the demonstration projects during the
7 3-year period beginning on the date on which
8 the first demonstration project is implemented.

9 “(c) REPORT TO CONGRESS.—

10 “(1) IN GENERAL.—Not later than 1 year after
11 the date on which the demonstration projects con-
12 clude, the Secretary shall submit to Congress a re-
13 port on such projects.

14 “(2) CONTENTS OF REPORT.—The report sub-
15 mitted under paragraph (1) shall—

16 “(A) describe the demonstration projects
17 conducted under this section;

18 “(B) identify the demonstration project
19 that is the most effective; and

20 “(C) contain such other information re-
21 garding the demonstration projects as the Sec-
22 retary determines appropriate.

23 “(3) MEASUREMENT OF EFFECTIVENESS.—For
24 purposes of paragraph (2)(B), in identifying the

1 demonstration project that is the most effective, the
2 Secretary shall consider—

3 “(A) how successful the project was at—

4 “(i) reaching target individuals and
5 engaging them in an assessment of the risk
6 factors of such individuals;

7 “(ii) educating target individuals on
8 healthy behaviors and getting such individ-
9 uals to modify their behaviors in order to
10 diminish the risk of chronic disease; and

11 “(iii) ensuring that target individuals
12 were provided with necessary information;

13 “(B) the cost-effectiveness of the dem-
14 onstration project; and

15 “(C) the degree of beneficiary satisfaction
16 under the demonstration projects.

17 “(d) WAIVER AUTHORITY.—The Secretary may
18 waive such requirements under this title as the Secretary
19 determines necessary to carry out the demonstration
20 projects under this section.

21 “(e) FUNDING.—There are authorized to be appro-
22 priated \$25,000,000 for carrying out the demonstration
23 project under this section.

24 “(f) DEFINITIONS.—In this section:

1 “(1) TARGET INDIVIDUAL.—The term ‘target
2 individual’ means each individual that is—

3 “(A) entitled to benefits under part A or
4 enrolled under part B, including an individual
5 enrolled under the Medicare+Choice program
6 under part C; or

7 “(B) between the ages of 50 and 64 who
8 is not a beneficiary under this title.

9 “(2) MAJOR BEHAVIORAL RISK FACTOR.—The
10 term ‘major behavioral risk factor’ includes—

11 “(A) the lack of proper nutrition;

12 “(B) the use of alcohol;

13 “(C) the lack of regular exercise;

14 “(D) the use of tobacco;

15 “(E) depression; and

16 “(F) any other risk factor identified by the
17 Secretary.”.

18 **Subtitle F—Studies, Evaluations,**
19 **and Reports In the Field of Dis-**
20 **ease Prevention and the Elderly**

21 **SEC. 461. MEDPAC EVALUATION AND REPORT ON MEDI-**
22 **CARE BENEFIT PACKAGE IN RELATION TO**
23 **PRIVATE SECTOR BENEFIT PACKAGES.**

24 (a) IN GENERAL.—Section 1805(b) of the Social Se-
25 curity Act (42 U.S.C. 1395b–6(b)), as amended by section

1 544(b) of the Medicare, Medicaid, and SCHIP Benefits
2 Improvement and Protection Act of 2000 (114 Stat.
3 2763A–551), as enacted into law by section 1(a)(6) of
4 Public Law 106–554, is amended—

5 (1) in paragraph (1)—

6 (A) in subparagraph (C), by striking
7 “and” at the end;

8 (B) in subparagraph (D), by striking the
9 period and inserting “; and”; and

10 (C) by adding at the end the following new
11 subparagraph:

12 “(E) on the date that is 3 years after the
13 date of enactment of the Medicare Reform Act
14 of 2001, and each successive 3-year anniversary
15 thereafter, submit the report described in para-
16 graph (8)(C) to Congress.”; and

17 (2) by adding at the end the following new
18 paragraph:

19 “(8) EVALUATION OF MEDICARE BENEFIT
20 PACKAGE IN RELATION TO PRIVATE SECTOR BEN-
21 EFIT PACKAGES.—

22 “(A) EVALUATION.—The Commission shall
23 evaluate—

24 “(i) the benefit package offered under
25 the medicare program under this title; and

1 “(ii) the degree to which such benefit
2 package compares to the benefit packages
3 offered by health benefit programs avail-
4 able in the private sector to individuals
5 over age 55.

6 “(B) ISSUES.—In conducting the evalua-
7 tion under subparagraph (A)(ii), the Commis-
8 sion shall address the following issues:

9 “(i) Whether the benefit packages
10 available under the programs are—

11 “(I) similar;

12 “(II) appropriate for the enroll-
13 ees of the programs (based on what
14 experts recommend for such enroll-
15 ees);

16 “(III) actuarially equivalent; and

17 “(IV) comprehensive.

18 “(ii) The financial liabilities of enroll-
19 ees of the programs and whether such li-
20 abilities are appropriate.

21 “(iii) The ability of enrollees of the
22 programs to take advantage of benefits
23 under the programs.

1 “(C) REPORT.—The Commission shall
2 submit a report to Congress that shall
3 contain—

4 “(i) a detailed statement of the find-
5 ings and conclusions of the Commission re-
6 garding the evaluation conducted under
7 subparagraph (A);

8 “(ii) the recommendations of the
9 Commission regarding changes in the ben-
10 efit package offered under the medicare
11 program under this title that would keep
12 the program modern and competitive in re-
13 lation to health benefit packages offered by
14 health benefit programs available in the
15 private sector to individuals over age 55;
16 and

17 “(iii) the recommendations of the
18 Commission for such legislation and ad-
19 ministrative actions as it considers appro-
20 priate.”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect on the date of enactment of
23 this Act.

1 **SEC. 462. NATIONAL INSTITUTE ON AGING STUDY AND RE-**
2 **PORT ON WAYS TO IMPROVE THE QUALITY**
3 **OF LIFE OF ELDERLY.**

4 (a) STUDIES.—The Director of the National Institute
5 on Aging, in consultation with the Working Group on Dis-
6 ease Self-Management and Health Promotion (established
7 in section 402) and the United States Preventive Services
8 Task Force, shall conduct 1 or more studies focusing on
9 ways to—

10 (1) improve quality of life for the elderly; and

11 (2) develop better ways to prevent or delay the
12 onset of age-related functional decline and disease
13 and disability among the elderly.

14 (b) REPORTS.—

15 (1) REPORT FOR EACH STUDY.—The Director
16 of the National Institute on Aging, in consultation
17 with the Working Group on Disease Self-Manage-
18 ment and Health Promotion and the United States
19 Preventive Services Task Force, shall submit a re-
20 port to the Secretary regarding each study con-
21 ducted under subsection (a), together with a detailed
22 statement of research findings and conclusions that
23 are scientifically valid and are demonstrated to pre-
24 vent or delay the onset of chronic illness or disability
25 among the elderly.

1 (2) TIMING FOR SUBMITTING REPORTS.—Each
2 report regarding a study that is required to be sub-
3 mitted pursuant to paragraph (1) shall be submitted
4 by not later than the earlier of—

5 (A) the date that is 18 months after the
6 completion of the study involved; or

7 (B) January 1, 2008.

8 (c) TRANSMISSION TO INSTITUTE OF MEDICINE.—
9 Upon receipt of each report described in subsection (b),
10 the Secretary shall transmit such report to the Institute
11 of Medicine of the National Academy of Sciences for con-
12 sideration in its effort to conduct the comprehensive study
13 of current literature and best practices in the field of
14 health promotion and disease prevention among the medi-
15 care beneficiaries described in section 463.

16 (d) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) IN GENERAL.—There are authorized to be
18 appropriated for the purpose of carrying out this
19 section such sums as may be necessary for the pe-
20 riod of fiscal years 2002 through 2008.

21 (2) AVAILABILITY.—Any sums appropriated
22 under the authorization contained in this subsection
23 shall remain available, without fiscal year limitation,
24 until September 30, 2008.

1 **SEC. 463. INSTITUTE OF MEDICINE MEDICARE PREVEN-**
2 **TION BENEFIT STUDY AND REPORT.**

3 (a) STUDY.—

4 (1) IN GENERAL.—The Secretary shall contract
5 with the Institute of Medicine of the National Acad-
6 emy of Sciences to—

7 (A) conduct a comprehensive study of cur-
8 rent literature and best practices in the field of
9 health promotion and disease prevention among
10 medicare beneficiaries, including the issues de-
11 scribed in paragraph (2); and

12 (B) submit the report described in sub-
13 section (b).

14 (2) ISSUES STUDIED.—The study required
15 under paragraph (1) shall include an assessment
16 of—

17 (A) whether each health promotion and
18 disease prevention benefit covered under the
19 medicare program is—

20 (i) medically effective (as defined in
21 section 401(4)); and

22 (ii) a cost-effective benefit (as defined
23 in section 401(2)) or a cost-saving benefit
24 (as defined in section 401(3));

1 (B) utilization by medicare beneficiaries of
2 such benefits (including any barriers to or in-
3 centives to increase utilization);

4 (C) quality of life issues associated with
5 such benefits; and

6 (D) health promotion and disease preven-
7 tion benefits that are not covered under the
8 medicare program that would affect all medi-
9 care beneficiaries.

10 (b) REPORTS.—

11 (1) THREE-YEAR REPORT.—On the date that is
12 3 years after the date of enactment of this Act, and
13 each successive 3-year anniversary thereafter, the
14 Institute of Medicine of the National Academy of
15 Sciences shall submit to the President a report that
16 contains—

17 (A) a detailed statement of the findings
18 and conclusions of the study conducted under
19 subsection (a); and

20 (B) the recommendations for legislation
21 described in paragraph (3).

22 (2) INTERIM REPORT BASED ON NEW GUIDE-
23 LINES.—If the United States Preventive Services
24 Task Force or the Task Force on Community Pre-
25 ventive Services establishes new guidelines regarding

1 preventive health benefits for medicare beneficiaries
2 more than 1 year prior to the date that a report
3 described in paragraph (1) is due to be submitted
4 to the President, then not later than 6 months after
5 the date such new guidelines are established, the In-
6 stitute of Medicine of the National Academy of
7 Sciences shall submit to the President a report that
8 contains a detailed description of such new guide-
9 lines. Such report may also contain recommenda-
10 tions for legislation described in paragraph (3).

11 (3) RECOMMENDATIONS FOR LEGISLATION.—

12 The Institute of Medicine of the National Academy
13 of Sciences, in consultation with the United States
14 Preventive Services Task Force and the Task Force
15 on Community Preventive Services, shall develop
16 recommendations in legislative form that—

17 (A) prioritize the preventive health benefits
18 under the medicare program; and

19 (B) modify such benefits, including adding
20 new benefits under such program, based on the
21 study conducted under subsection (a).

22 (c) TRANSMISSION TO CONGRESS.—

23 (1) IN GENERAL.—On the day on which the re-
24 port described in paragraph (1) of subsection (b) (or
25 paragraph (2) of such subsection if the report con-

1 tains recommendations in legislative form described
2 in subsection (b)(3)) is submitted to the President,
3 the President shall transmit the report and rec-
4 ommendations to Congress.

5 (2) DELIVERY.—Copies of the report and rec-
6 ommendations in legislative form required to be
7 transmitted to Congress under paragraph (1) shall
8 be delivered—

9 (A) to both Houses of Congress on the
10 same day;

11 (B) to the Clerk of the House of Rep-
12 resentatives if the House is not in session; and

13 (C) to the Secretary of the Senate if the
14 Senate is not in session.

15 **SEC. 464. FAST-TRACK CONSIDERATION OF PREVENTION**
16 **BENEFIT LEGISLATION.**

17 (a) RULES OF HOUSE OF REPRESENTATIVES AND
18 SENATE.—This section is enacted by Congress—

19 (1) as an exercise of the rulemaking power of
20 the House of Representatives and the Senate, re-
21 spectively, and is deemed a part of the rules of each
22 House of Congress, but—

23 (A) is applicable only with respect to the
24 procedure to be followed in that House of Con-

1 gress in the case of an implementing bill (as de-
2 fined in subsection (d)); and

3 (B) supersedes other rules only to the ex-
4 tent that such rules are inconsistent with this
5 section; and

6 (2) with full recognition of the constitutional
7 right of either House of Congress to change the
8 rules (so far as relating to the procedure of that
9 House of Congress) at any time, in the same man-
10 ner and to the same extent as in the case of any
11 other rule of that House of Congress.

12 (b) INTRODUCTION AND REFERRAL.—

13 (1) INTRODUCTION.—

14 (A) IN GENERAL.—Subject to paragraph
15 (2), on the day on which the President trans-
16 mits the report pursuant to section 463(c) to
17 the House of Representatives and the Senate,
18 the recommendations in legislative form trans-
19 mitted by the President with respect to such re-
20 port shall be introduced as a bill (by request)
21 in the following manner:

22 (i) HOUSE OF REPRESENTATIVES.—In
23 the House of Representatives, by the Ma-
24 jority Leader, for himself and the Minority
25 Leader, or by Members of the House of

1 Representatives designated by the Majority
2 Leader and Minority Leader.

3 (ii) SENATE.—In the Senate, by the
4 Majority Leader, for himself and the Mi-
5 nority Leader, or by Members of the Sen-
6 ate designated by the Majority Leader and
7 Minority Leader.

8 (B) SPECIAL RULE.—If either House of
9 Congress is not in session on the day on which
10 such recommendations in legislative form are
11 transmitted, the recommendations in legislative
12 form shall be introduced as a bill in that House
13 of Congress, as provided in subparagraph (A),
14 on the first day thereafter on which that House
15 of Congress is in session.

16 (2) REFERRAL.—Such bills shall be referred by
17 the presiding officers of the respective Houses to the
18 appropriate committee, or, in the case of a bill con-
19 taining provisions within the jurisdiction of 2 or
20 more committees, jointly to such committees for con-
21 sideration of those provisions within their respective
22 jurisdictions.

23 (c) CONSIDERATION.—After the recommendations in
24 legislative form have been introduced as a bill and referred
25 under subsection (b), such implementing bill shall be con-

1 sidered in the same manner as an implementing bill is con-
2 sidered under subsections (d), (e), (f), and (g) of section
3 151 of the Trade Act of 1974 (19 U.S.C. 2191). The im-
4 plementing bill shall be subject to all congressional budget
5 points of order, including points of order under the Con-
6 gressional Budget Act of 1974.

7 (d) IMPLEMENTING BILL DEFINED.—In this section,
8 the term “implementing bill” means only the recommenda-
9 tions in legislative form of the Institute of Medicine of the
10 National Academy of Sciences described in section
11 463(b)(3), transmitted by the President to the House of
12 Representatives and the Senate under section 463(c), and
13 introduced and referred as provided in subsection (b) as
14 a bill of either House of Congress.

15 (e) COUNTING OF DAYS.—For purposes of this sec-
16 tion, any period of days referred to in section 151 of the
17 Trade Act of 1974 shall be computed by excluding—

18 (1) the days on which either House of Congress
19 is not in session because of an adjournment of more
20 than 3 days to a day certain or an adjournment of
21 Congress sine die; and

22 (2) any Saturday and Sunday, not excluded
23 under paragraph (1), when either House is not in
24 session.

1 **Subtitle G—Informatics Systems**
2 **Grant Program for Hospitals**
3 **and Skilled Nursing Facilities**

4 **SEC. 471. INFORMATICS SYSTEMS GRANT PROGRAM FOR**
5 **HOSPITALS AND SKILLED NURSING FACILI-**
6 **TIES.**

7 (a) GRANTS.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services (in this section referred to as the
10 “Secretary”) shall establish a program to make
11 grants to eligible entities that have submitted appli-
12 cations in accordance with subsection (b) for the
13 purpose of assisting such entities in offsetting the
14 costs related to purchasing, leasing, developing, and
15 implementing standardized clinical health care
16 informatics systems designed to improve patient
17 safety and reduce adverse events and health care
18 complications resulting from medication errors.

19 (2) DURATION.—The authority of the Secretary
20 to make grants under this section shall terminate on
21 September 30, 2011.

22 (3) COSTS DEFINED.—For purposes of this sec-
23 tion, the term “costs” shall include total expendi-
24 tures incurred for—

1 (A) purchasing, leasing, and installing
2 computer software and hardware, including
3 handheld computer technologies;

4 (B) making improvements to existing com-
5 puter software and hardware;

6 (C) purchasing or leasing communications
7 capabilities necessary for clinical data access,
8 storage, and exchange; and

9 (D) providing education and training to el-
10 igible entity staff on computer patient safety in-
11 formation systems.

12 (4) ELIGIBLE ENTITY DEFINED.—For purposes
13 of this section, the term “eligible entity” means the
14 following entities:

15 (A) HOSPITAL.—A hospital (as defined in
16 section 1861(e) of the Social Security Act (42
17 U.S.C. 1395x(e))).

18 (B) SKILLED NURSING FACILITY.—A
19 skilled nursing facility (as defined in section
20 1819(a) of such Act (42 U.S.C. 1395i–3(e))).

21 (b) APPLICATION.—An eligible entity seeking a grant
22 under this section shall submit an application to the Sec-
23 retary at such time, in such form and manner, and con-
24 taining such information as the Secretary specifies.

1 (c) SPECIAL CONSIDERATION FOR ELIGIBLE ENTI-
2 TIES THAT SERVE A LARGE NUMBER OF MEDICARE AND
3 MEDICAID ELIGIBLE INDIVIDUALS.—In awarding grants
4 under this section, the Secretary shall give special consid-
5 eration to eligible entities in which individuals that are eli-
6 gible for benefits under the medicare program under title
7 XVIII of the Social Security Act or the medicaid program
8 under title XIX of such Act make up a high percentage
9 of the total patient population of the entity.

10 (d) LIMITATION ON AMOUNT OF GRANT.—

11 (1) IN GENERAL.—A grant awarded under this
12 section may not exceed the lesser of—

13 (A) an amount equal to the applicable per-
14 centage of the costs incurred by the eligible en-
15 tity for the project for which the entity is seek-
16 ing funding under this section; or

17 (B) in the case of a grant made to—

18 (i) a hospital, \$750,000; or

19 (ii) a skilled nursing facility,
20 \$200,000.

21 (2) APPLICABLE PERCENTAGE.—For purposes
22 of paragraph (1)(A), the term “applicable percent-
23 age” means, with respect to an eligible entity, the
24 percentage of total net revenues for such period as
25 determined appropriate by the Secretary for the en-

1 tity that consists of net revenues from the medicare
2 program under title XVIII of the Social Security
3 Act.

4 (e) ELIGIBLE ENTITY REQUIRED TO FURNISH SEC-
5 RETARY WITH INFORMATION.—An eligible entity receiv-
6 ing a grant under this section shall furnish the Secretary
7 with such information as the Secretary may require to—

8 (1) evaluate the project for which the grant is
9 made; and

10 (2) ensure that funding provided under the
11 grant is expended for the purposes for which it is
12 made.

13 (f) REPORTS.—

14 (1) INTERIM REPORTS.—

15 (A) IN GENERAL.—The Secretary shall
16 submit, at least annually, a report to the Com-
17 mittee on Ways and Means of the House of
18 Representatives and the Committee on Finance
19 of the Senate on the grant program established
20 under this section.

21 (B) CONTENTS.—A report submitted pur-
22 suant to subparagraph (A) shall include infor-
23 mation on—

24 (i) the number of grants made;

1 (ii) the nature of the projects for
2 which funding is provided under the grant
3 program;

4 (iii) the geographic distribution of
5 grant recipients; and

6 (iv) such other matters as the Sec-
7 retary determines appropriate.

8 (2) FINAL REPORT.—Not later than 180 days
9 after the completion of all of the projects for which
10 a grant is made under this section, the Secretary
11 shall submit a final report to the committees re-
12 ferred to in paragraph (1)(A) on the grant program
13 established under this section, together with such
14 recommendations for legislation and administrative
15 action as the Secretary determines appropriate.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) AUTHORIZATION.—

18 (A) HOSPITALS.—There are authorized to
19 be appropriated from the Federal Hospital In-
20 surance Trust Fund under section 1817 of the
21 Social Security Act (42 U.S.C. 1395i)
22 \$93,000,000, for each of the fiscal years 2002
23 through 2011, for the purpose of making grants
24 under this section to eligible entities that are
25 hospitals.

1 (B) SKILLED NURSING FACILITIES.—

2 There are authorized to be appropriated from
3 the Federal Hospital Insurance Trust Fund
4 under section 1817 of the Social Security Act
5 (42 U.S.C. 1395i) \$4,500,000, for each of the
6 fiscal years 2002 through 2011, for the purpose
7 of making grants under this section to eligible
8 entities that are skilled nursing facilities.

9 (2) AVAILABILITY.—Any amounts appropriated
10 pursuant to the authority contained in subparagraph
11 (A) or (B) of paragraph (1) shall remain available,
12 without fiscal year limitation, through September
13 30, 2011.

14 **TITLE V—MEDICARE**
15 **SUSTAINABILITY**

16 **SEC. 501. INDEXING PART B DEDUCTIBLE TO INFLATION.**

17 The first sentence of section 1833(b) of the Social
18 Security Act (42 U.S.C. 1395l(b)) is amended by inserting
19 after “1991 and subsequent years” the following: “, ad-
20 justed annually, effective January 1 of each year (begin-
21 ning in 2004), by a percentage increase or decrease equal
22 to the percentage increase or decrease in the consumer
23 price index for all urban consumers (U.S. city average)
24 for the 12-month period ending with June of the previous
25 year, rounded to the nearest dollar”.

1 **SEC. 502. INCOME-RELATED REDUCTION IN MEDICARE**
2 **SUBSIDY FOR PART B PREMIUM.**

3 (a) IN GENERAL.—Section 1839 of the Social Secu-
4 rity Act (42 U.S.C. 1395r) is amended by adding at the
5 end the following new subsection:

6 “(h)(1)(A) Notwithstanding the previous subsections
7 of this section, and subject to paragraph (2), in the case
8 of an individual whose modified adjusted gross income for
9 a taxable year ending with or within a calendar year ex-
10 ceeds the threshold amount, the Secretary shall increase
11 the amount of the monthly premium for such individual
12 for months in the calendar year by the amount which
13 bears the same ratio to the monthly actuarial rate for en-
14 rollees age 65 and over (as determined under subsection
15 (a)(1)) for that year as such excess bears to an amount
16 equal to $\frac{1}{3}$ of the applicable threshold amount).

17 “(B) In no event shall the increase described in sub-
18 paragraph (A) exceed an amount equal to the monthly ac-
19 tuarial rate for enrollees age 65 and over (as determined
20 under subsection (a)(1)) for the year.

21 “(2) For purposes of this subsection—

22 “(A) the threshold amount, the modified ad-
23 justed gross income, and joint return shall be deter-
24 mined under section 1860D(b)(1); and

1 “(B) rules similar to the rules of paragraphs
2 (2) through (5) of section 1860D(b) shall apply to
3 this subsection.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) IN GENERAL.—Section 1839 of the Social
6 Security Act (42 U.S.C. 1395r) is amended—

7 (A) in subsection (a)(2), as amended by
8 section 606(a)(2)(B)(i) of the Medicare, Med-
9 icaid, and SCHIP Benefits Improvement and
10 Protection Act of 2000 (114 Stat. 2763A–557),
11 as enacted into law by section 1(a)(6) of Public
12 Law 106–554), by striking “and (f)” and in-
13 serting “(f), and (h)”;

14 (B) in subsection (b), by inserting “(and
15 as increased under subsection (h))” after “sub-
16 section (a)”;

17 (C) in subsection (f), by striking “if an in-
18 dividual” and inserting the following: “if an in-
19 dividual (other than an individual subject to an
20 increase in the monthly premium under this
21 section pursuant to subsection (h))”.

22 (2) PAYMENT TO SECRETARY.—Section 1840(c)
23 of the Social Security Act (42 U.S.C. 1395s(c)) is
24 amended by inserting “or an individual determines
25 that the estimate of modified adjusted gross income

1 used in determining whether the individual is subject
2 to an increase in the monthly premium under section
3 1839 pursuant to subsection (h) of such section (or
4 in determining the amount of such increase) is too
5 low and results in a portion of the premium not
6 being deducted,” before “he may”.

7 (c) REPORTING REQUIREMENTS FOR SECRETARY OF
8 THE TREASURY.—Paragraph (18) of section 6103(l) of
9 the Internal Revenue Code of 1986, as added by section
10 304(a), is amended—

11 (1) in the heading, by inserting “AND INCOME-
12 RELATED REDUCTION IN SUBSIDY FOR MEDICARE
13 PART B PREMIUM after “PART D PREMIUM”;

14 (2) in subparagraph (A), in the matter pre-
15 ceding clause (i), by striking “part D” and inserting
16 “part B or D”; and

17 (3) in subparagraph (B), by striking “part D”
18 and inserting “part B or D”.

19 (d) EFFECTIVE DATE.—The amendments made by
20 subsections (a) and (b) shall apply to the monthly pre-
21 mium under section 1839 of the Social Security Act (42
22 U.S.C. 1395r) for months beginning with January 2004.

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