

SECURING CARE FOR SENIORS ACT OF 2015

JUNE 16, 2015.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. RYAN of Wisconsin, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 2579]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2579) to amend title XVIII of the Social Security Act to improve the risk adjustment under the Medicare Advantage program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Securing Care for Seniors Act of 2015”.

**SEC. 2. IMPROVEMENTS TO MA RISK ADJUSTMENT SYSTEM.**

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clauses:

“(iv) EVALUATION AND SUBSEQUENT REVISION OF THE RISK ADJUSTMENT SYSTEM TO ACCOUNT FOR CHRONIC CONDITIONS AND OTHER FACTORS FOR THE PURPOSE OF MAKING THE RISK ADJUSTMENT SYSTEM MORE ACCURATE, TRANSPARENT, AND REGULARLY UPDATED.—

“(I) REVISION BASED ON NUMBER OF CHRONIC CONDITIONS.—The Secretary shall revise for 2017 and periodically thereafter, the risk adjustment system under this subparagraph so that a risk score under such system, with respect to an individual, takes into account the number of chronic conditions with which the individual has been diagnosed.

“(II) EVALUATION OF DIFFERENT RISK ADJUSTMENT MODELS.—The Secretary shall evaluate the impact of including two years of data to compare the models used to determine risk scores for 2013 and 2014 under such system.

“(III) EVALUATION AND ANALYSIS ON CHRONIC KIDNEY DISEASE (CKD) CODES.—The Secretary shall evaluate the impact of removing the diagnosis codes related to chronic kidney disease in the 2014 risk adjustment model and conduct an analysis of best practices of MA plans to slow disease progression related to chronic kidney disease.

“(IV) EVALUATION AND RECOMMENDATIONS ON USE OF ENCOUNTER DATA.—The Secretary shall evaluate the impact of including 10 percent of encounter data in computing payment for 2016 and the readiness of the Centers for Medicare & Medicaid Services to incorporate encounter data in risk scores. In conducting such evaluation, the Secretary shall use data collected as encounter data on or after January 1, 2012, shall analyze such data for accuracy and completeness and issue recommendations for improving such accuracy and completeness, and shall not increase the percentage of such encounter data used unless the Secretary releases the data publicly, indicates how such data will be weighted in computing the risk scores, and ensures that the data reflects the degree and cost of care coordination under MA plans.

“(V) CONDUCT OF EVALUATIONS.—Evaluations and analyses under subclause (II) through (IV) shall include an actuarial opinion from the Chief Actuary of the Centers for Medicare & Medicaid Services about the reasonableness of the methods, assumptions, and conclusions of such evaluations and analyses. The Secretary shall consult with the Medicare Payment Advisory Commission and accept and consider comments of stakeholders, such as managed care organizations and beneficiary groups, on such evaluation and analyses. The Secretary shall complete such evaluations and analyses in a manner that permits the results to be applied for plan years beginning with the second plan year that begins after the date of the enactment of this clause.

“(VI) IMPLEMENTATION OF REVISIONS BASED ON EVALUATIONS.—If the Secretary determines, based on such an evaluation or analysis, that revisions to the risk adjustment system to address the matters described in any of subclauses (II) through (IV) would make the risk adjustment system under this subparagraph better reflect and appropriately weight for the population that is served by the plan, the Secretary shall, beginning with 2017, and periodically thereafter, make such revisions.

“(VII) PERIODIC REPORTING TO CONGRESS.—With respect to plan years beginning with 2017 and every third year thereafter, the Sec-

retary shall submit to Congress a report on the most recent revisions (if any) made under this clause, including the evaluations conducted under subclauses (II) through (IV).

“(v) NO CHANGES TO ADJUSTMENT FACTORS THAT PREVENT ACTIVITIES CONSISTENT WITH NATIONAL HEALTH POLICY GOALS.—In making any changes to the adjustment factors, including adjustment for health status under paragraph (3), the Secretary shall ensure that the changes do not prevent Medicare Advantage organizations from performing or undertaking activities that are consistent with national health policy goals, including activities to promote early detection and better care coordination, the use of health risk assessments, care plans, and programs to slow the progression of chronic diseases.

“(vi) OPPORTUNITY FOR REVIEW AND PUBLIC COMMENT REGARDING CHANGES TO ADJUSTMENT FACTORS.—For changes to adjustment factors effective for 2017 and subsequent years, in addition to providing notice of such changes in the announcement under subsection (b)(2), the Secretary shall provide an opportunity for review of proposed changes of not less than 60 days and a public comment period of not less than 30 days before implementing such changes.”.

### SEC. 3. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) the Centers for Medicare & Medicaid Services has inadvertently created a star rating system under section 1853(o)(4) of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) for Medicare Advantage plans that lacks proper accounting for the socioeconomic status of enrollees in such plans and the extent to which such plans serve individuals who are also eligible for medical assistance under title XIX of such Act; and

(2) Congress will work with the Centers for Medicare & Medicaid Services and stakeholders, including beneficiary groups and managed care organizations, to ensure that such rating system properly accounts for the socioeconomic status of enrollees in such plans and the extent to which such plans serve such individuals described in paragraph (1).

## I. SUMMARY AND BACKGROUND

### A. PURPOSE AND SUMMARY

The bill, H.R. 2579, as reported by the Committee on Ways and Means on June 2, 2015, would improve the risk adjustment model under the Medicare Advantage program. The legislation also includes a Sense of Congress that the Centers for Medicare and Medicaid Services’ (CMS) application of the STARS rating system to Medicare Advantage plans lacks necessary accounting with respect to the socioeconomic status and “duals” status of enrollees.

### B. BACKGROUND AND NEED FOR LEGISLATION

On May 29, 2015, Representative Black (R–TN), Representative Blumenauer (D–OR), Representative Guthrie (R–KY), and Representative Loeb sack (D–IA) introduced H.R. 2579, a bill to revise and improve the risk adjustment methods for Medicare Advantage plans. Along with a required revision to the risk adjustment system to account for multiple chronic conditions, due to changes made in recent call letters, there is a need for CMS to reevaluate the use of encounter data and implement revisions based on evaluations as required by this section. This would result in a more accurate risk adjustment system, to be revised in periodic updates. Furthermore, Congress believes that CMS’s application of the STARS rating system for the Medicare Advantage plans does not account properly for low-income and dual beneficiaries, thereby unfairly rating plans that serve certain levels of low-income and frail beneficiaries.

## C. LEGISLATIVE HISTORY

*Background*

H.R. 2579 was introduced on May 29, 2015, and was referred to the Committee on Ways and Means and subsequently to the Committee on Energy and Commerce.

*Committee hearings*

On July 24, 2014, the Committee on Ways and Means Subcommittee on Health held a hearing on the status of the Medicare Advantage program.

The panel of witnesses included the following:

Chris Wing, Chief Executive Officer, SCAN Health Plans  
 Jeff Burnich, M.D., Senior Vice President & Executive Officer, Sutter Medical Network, (Sacramento, CA) on behalf of CAPG  
 Robert Book, PhD, Senior Research Director, Health Systems Innovation Network, LLC,  
 Outside Healthcare and Economics Expert, American Action Forum  
 Joe Baker, President, Medicare Rights Center

*Committee action*

The Committee on Ways and Means marked up H.R. 2579, Securing Care for Seniors Act of 2015, on May 29, 2015, and ordered the bill favorably reported to the House of Representatives as amended, by a voice vote (with a quorum being present).

**II. EXPLANATION OF THE BILL**

## SECURING CARE FOR SENIORS ACT OF 2015

## PRESENT LAW

This bill creates new legislation to be added to the Social Security Act (42 U.S.C. 1395w-23(a)(1)(C)).

Pledges support to work within Section 1843(o)(4) of the Social Security Act ensuring that CMS and others have proper accountability.

## REASONS FOR CHANGE

The Committee believes that while larger reforms are necessary, bipartisan tweaks and adjustments are necessary to maintain the Medicare Advantage program's successes as well as increase transparency. The Committee believes that the changes made to the risk adjustment system over the last few years are detrimental to the system and Medicare Advantage plans' ability to serve beneficiaries, especially low income and frail seniors. The legislation also requires CMS to release encounter data if the Agency plans to expand its use of the risk adjustment model. The Committee is concerned with the use of this data, as CMS has repeatedly informed Congressional Support agencies, the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC) that they would not release the data due to its lack of readiness.

Lastly, Congress wants to maintain accountability for the STARS rating system with regards to Medicare Advantage plans. Congress

does not want this inadvertent creation to improperly serve individuals who are also eligible for medical assistance under Title XIX.

#### EXPLANATION OF PROVISIONS

H.R. 2579 revises the risk adjustment formula to account for chronic conditions for a more accurate risk score. The bill also recognizes the need for further evaluations and analysis of risk adjustment models to ensure accuracy. The legislation requires that CMS reevaluate changes to the risk adjustment model through the removal of chronic kidney disease codes, and the added use of encounter data. The last section provides a Sense of Congress that CMS created a star rating system for Medicare Advantage plans in a way that potentially disadvantages providers and Medicare Advantage plans that enroll larger portions of low-income or duals beneficiaries.

#### EFFECTIVE DATE

The bill would take effect at the beginning of January 1, 2017.

### III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 2579, Preservation of Access for Seniors in Medicare Advantage Act of 2015, on June 2, 2015.

The bill, H.R. 2579, was ordered favorably reported to the House of Representatives as amended, by voice vote (with a quorum being present).

### IV. BUDGET EFFECTS OF THE BILL

#### A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 2579, as reported. The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO), which is included below.

#### B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new budget authority. The Committee states further that the bill involves no new or increased tax expenditures.

#### C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, June 12, 2015.*

Hon. PAUL RYAN,  
*Chairman, Committee on Ways and Means,  
House of Representatives, Washington.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2579, the Securing Care for Seniors Act of 2015.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Paul Masi.

Sincerely,

KEITH HALL.

Enclosure.

*H.R. 2579—Securing Care for Seniors Act of 2015*

H.R. 2579 would require the Secretary of Health and Human Services to revise the risk adjustment system used in the Medicare Advantage program to account for the number of chronic conditions with which a beneficiary has been diagnosed. The legislation would also require the Secretary to evaluate the effects of other changes to the risk adjustment system including using two years of diagnosis data and removing certain information related to chronic kidney disease, and report on the results of the evaluation.

Under current law, the Secretary has broad flexibility in deciding how to administer the risk adjustment system, and recently has modified the system in ways that have increased and decreased spending under the MA program. Under the legislation, the Secretary would continue to have that flexibility and the bill's requirements would likely not result in any significant additional costs. Pay-as-you-go procedures do not apply because the bill would not affect direct spending or revenues.

H.R. 2579 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would not affect the budgets of state, local, or tribal governments.

The CBO staff contact for this estimate is Paul Masi. The estimate was approved by Holly Harvey, Deputy Assistant Director for Budget Analysis.

**V. OTHER MATTERS TO BE DISCUSSED UNDER THE  
RULES OF THE HOUSE**

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of H.R. 2579 that the Committee concluded that it is appropriate to report the bill, as amended, favorably to the House of Representatives with the recommendation that the bill do pass.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill con-

tains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

#### C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

#### D. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

#### E. DUPLICATION OF FEDERAL PROGRAMS

In compliance with Sec. 3(g)(2) of H. Res. 5 (114th Congress), the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Pub. L. No. 95-220, as amended by Pub. L. No. 98-169).

#### F. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (114th Congress), the following statement is made concerning directed rule makings: The Committee estimates that the bill requires no directed rule makings within the meaning of such section.

### **VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED**

#### A. TEXT OF EXISTING LAW AMENDED OR REPEALED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(A) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the bill, as reported, is shown below:

**SOCIAL SECURITY ACT**

\* \* \* \* \*

**TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND  
DISABLED**

\* \* \* \* \*

**PART C—MEDICARE+CHOICE PROGRAM**

\* \* \* \* \*

**PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS****SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—****(1) MONTHLY PAYMENTS.—**

(A) **IN GENERAL.**—Under a contract under section 1857 and subject to subsections (e), (g), (i), and (l) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) **PAYMENT BEFORE 2006.**—For years before 2006, the payment amount shall be equal to  $\frac{1}{12}$  of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1854(f)(1)(E).

(ii) **PAYMENT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.**—For years beginning with 2006, the amount specified in subparagraph (B).

**(B) PAYMENT AMOUNT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.—**

(i) **PAYMENT OF BID FOR PLANS WITH BIDS BELOW BENCHMARK.**—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) **PAYMENT OF BENCHMARK FOR PLANS WITH BIDS AT OR ABOVE BENCHMARK.**—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) **PAYMENT OF BENCHMARK FOR MSA PLANS.**—Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is



equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—

(i) IN GENERAL.—The Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(ii) APPLICATION OF CODING ADJUSTMENT.—For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.

(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such analysis, the Secretary shall use

data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.5 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.9 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

(D) SEPARATE PAYMENT FOR FEDERAL DRUG SUBSIDIES.—In the case of an enrollee in an MA-PD plan, the MA organization offering such plan also receives—

(i) subsidies under section 1860D–15 (other than under subsection (g)); and

(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–14(c)(1)(C).

(E) PAYMENT OF REBATE FOR PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year (as reduced by the amount of any credit provided under section 1854(b)(1)(C)(iv)).

(F) ADJUSTMENT FOR INTRA-AREA VARIATIONS.—

(i) INTRA-REGIONAL VARIATIONS.—In the case of payment with respect to an MA regional plan for an MA region, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

(ii) INTRA-SERVICE AREA VARIATIONS.—In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

(G) ADJUSTMENT RELATING TO RISK ADJUSTMENT.—The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

(i) the sum of—

(I) the monthly payment made under subparagraph (A)(ii); and

(II) the MA monthly basic beneficiary premium under section 1854(b)(2)(A); equals

(ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).

(H) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section

- covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.
- (2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—
- (A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.
- (B) SPECIAL RULE FOR CERTAIN ENROLLEES.—
- (i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.
- (ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.
- (3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—
- (A) REPORT.—The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.
- (B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare+Choice orga-

nizations (and eligible organizations with risk-sharing contracts under section 1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) INITIAL IMPLEMENTATION.—

(i) IN GENERAL.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) PHASE-IN.—Except as provided in clause (iv), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) 10 percent of  $\frac{1}{12}$  of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006;

and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) DATA FOR RISK ADJUSTMENT METHODOLOGY.—Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.—

(I) EXEMPTION FROM PHASE-IN.—Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) PERIOD OF APPLICATION.—Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the methodology shall be applied uniformly without regard to the type of plan.

(4) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center

that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1857(e)(3))—

(A) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) ANNUAL ANNOUNCEMENTS.—

(A) FOR 2005.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

(i) MA CAPITATION RATES.—The annual MA capitation rate for each MA payment area for 2005.

(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in 2005.

(B) FOR 2006 AND SUBSEQUENT YEARS.—For a year after 2005—

(i) INITIAL ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

(I) MA CAPITATION RATES; MA LOCAL AREA BENCHMARK.—The annual MA capitation rate for each MA payment area for the year.

(II) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in such year.

(ii) REGIONAL BENCHMARK ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1854, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) BENCHMARK ANNOUNCEMENT FOR CCA LOCAL AREAS.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1860C-1(b)(1)(A)), the CCA non-drug monthly benchmark amount under section 1860C-1(e)(1) for that area for the year involved.

(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under para-

graph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in such announcement.

(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A and for part B.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area that is an MA local area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D):

(A) BLENDED CAPITATION RATE.—For a year before 2005, the sum of—

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied (for a year other than 2004) by the budget neutrality adjustment factor determined under paragraph (5).

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) For 1998, \$367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, \$525, and for any other area \$475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) MINIMUM PERCENTAGE INCREASE.—

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2004 and each succeeding year, the greater of—

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D) 100 PERCENT OF FEE-FOR-SERVICE COSTS.—



(i) IN GENERAL.—For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections, 1848(o), and 1886(n) and 1886(h).

(ii) PERIODIC REBASING.—The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

(A) for 1998, the “area-specific percentage” is 90 percent and the “national percentage” is 10 percent,

(B) for 1999, the “area-specific percentage” is 82 percent and the “national percentage” is 18 percent,

(C) for 2000, the “area-specific percentage” is 74 percent and the “national percentage” is 26 percent,

(D) for 2001, the “area-specific percentage” is 66 percent and the “national percentage” is 34 percent,

(E) for 2002, the “area-specific percentage” is 58 percent and the “national percentage” is 42 percent, and

(F) for a year after 2002, the “area-specific percentage” is 50 percent and the “national percentage” is 50 percent.

(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

- (I) 1998 is 20 percent,
- (II) 1999 is 40 percent,
- (III) 2000 is 60 percent,
- (IV) 2001 is 80 percent, and
- (V) a succeeding year is 100 percent.

(C) PAYMENT ADJUSTMENT.—

(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

- (I) for the indirect costs of medical education under section 1886(d)(5)(B), and
- (II) for direct graduate medical education costs under section 1886(h).

(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received serv-

ices from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the “national standardized annual Medicare+Choice capitation rate” for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year (other than 2004), the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv), (a)(4), and (i) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the “national per capita Medicare+Choice growth percentage” for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (o) of section 1848 and subsections (b)(3)(B)(ix) and (n) of section 1886, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

(i) for 1998, 0.8 percentage points,

(ii) for 1999, 0.5 percentage points,

(iii) for 2000, 0.5 percentage points,

(iv) for 2001, 0.5 percentage points,

(v) for 2002, 0.3 percentage points, and

(vi) for a year after 2002, 0 percentage points.

(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1),

the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA PAYMENT AREA; MA LOCAL AREA; MA REGION DEFINED.—

(1) MA PAYMENT AREA.—In this part, except as provided in this subsection, the term “MA payment area” means—

(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an MA regional plan, an MA region (as established under section 1858(a)(2)).

(2) MA LOCAL AREA.—The term “MA local area” means a county or equivalent area specified by the Secretary.

(3) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1) for MA local plans—

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)(A)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the

Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section with respect to MA local plans for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section for such plans in the State shall not exceed the aggregate payments that would have been made under this section for such plans for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) AREAS.—In subparagraph (C), the terms “metropolitan statistical area”, “consolidated metropolitan statistical area”, and “primary metropolitan statistical area” mean any area designated as such by the Secretary of Commerce.

(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

(1) IN GENERAL.—If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1854(b)(2)(C)) for an MSA plan for a year is less than  $\frac{1}{12}$  of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual’s Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the

contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) PAYMENTS FROM TRUST FUNDS.—The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and for payments under subsection (l) and subsection (m) and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Payments to MA organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)), a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv)) as of the effective date of the individual's—

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1886(d) or other payment provision

under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) SPECIAL RULE FOR HOSPICE CARE.—

(1) INFORMATION.—A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

(A) a hospice program participating under this title is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) PAYMENT.—If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).

(i) NEW ENTRY BONUS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered



in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) OFFERED DEFINED.—In this subsection, the term “offered” means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) COMPUTATION OF BENCHMARK AMOUNTS.—For purposes of this part, subject to subsection (o), the term “MA area-specific non-drug monthly benchmark amount” means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1860C–1(d)(2)(A), an amount equal to  $\frac{1}{12}$  of the annual MA capitation rate under section 1853(c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010,  $\frac{1}{12}$  of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011,  $\frac{1}{12}$  of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012,  $\frac{1}{12}$  of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1854(a)(6)(A)(iii)), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment;  
or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1858(f) for the region for the year.

(k) DETERMINATION OF APPLICABLE AMOUNT FOR PURPOSES OF CALCULATING THE BENCHMARK AMOUNTS.—

(1) APPLICABLE AMOUNT DEFINED.—For purposes of subsection (j), subject to paragraphs (2) and (4), the term “applicable amount” means for an area—

(A) for 2007—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

(B) for a subsequent year—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2) and (4)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year.

(2) PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—

(A) IN GENERAL.—Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of—

(i) the percent determined under subparagraph (B) for the year; and

(ii) the applicable phase-out factor for the year under subparagraph (C).

(B) PERCENT DETERMINED.—

(i) IN GENERAL.—For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

(ii) NUMERATOR BASED ON DIFFERENCE BETWEEN DEMOGRAPHIC RATE AND RISK RATE.—

(I) IN GENERAL.—The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

(II) DEMOGRAPHIC RATE.—The demographic rate described in this subclause is the Secretary’s estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to  $\frac{1}{12}$  of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(III) RISK RATE.—The risk rate described in this subclause is the Secretary’s estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(iii) DENOMINATOR BASED ON RISK RATE.—The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) REQUIREMENTS.—In estimating the amounts under the previous clauses, the Secretary shall—

(I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

(II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

(III) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

(V) as necessary, adjust the risk scores for lagged cohorts; and

(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

(v) AUTHORITY.—In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

(C) APPLICABLE PHASE-OUT FACTOR.—For purposes of subparagraph (A)(ii), the term “applicable phase-out factor” means—

- (i) for 2007, 0.55;
- (ii) for 2008, 0.40;
- (iii) for 2009, 0.25; and
- (iv) for 2010, 0.05.

(D) TERMINATION OF APPLICATION.—Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater than the amount estimated under subparagraph (B)(ii)(II) for the year.

(3) NO REVISION IN PERCENT.—

(A) IN GENERAL.—The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority of the Secretary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) PHASE-OUT OF THE INDIRECT COSTS OF MEDICAL EDUCATION FROM CAPITATION RATES.—

(A) IN GENERAL.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1886(d)(5)(B) in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) PERCENTAGES DEFINED.—For purposes of this paragraph:

(i) PHASE-IN PERCENTAGE.—The term “phase-in percentage” means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

(ii) MAXIMUM CUMULATIVE ADJUSTMENT PERCENTAGE.—The term “maximum cumulative adjustment percentage” means, for—

(I) 2010, 0.60 percent; and

(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

(iii) STANDARDIZED IME COST PERCENTAGE.—The term “standardized IME cost percentage” means, for an area for a year, the per capita costs for payments under section 1886(d)(5)(B) (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) FEE-FOR-SERVICE AMOUNT.—The fee-for-service amount specified in this subparagraph for an area for a

year is the amount specified under subsection (c)(1)(D) for the area and the year.

(1) APPLICATION OF ELIGIBLE PROFESSIONAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) IN GENERAL.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1848(o) and 1848(a)(7) shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1848(o)) who—

(A)(i) is employed by the organization; or

(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

(II) furnishes at least 80 percent of the professional services of the eligible professional covered under this title to enrollees of the organization; and

(B) furnishes, on average, at least 20 hours per week of patient care services.

(3) ELIGIBLE PROFESSIONAL INCENTIVE PAYMENTS.—

(A) IN GENERAL.—In applying section 1848(o) under paragraph (1), instead of the additional payment amount under section 1848(o)(1)(A) and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

(B) AVOIDING DUPLICATION OF PAYMENTS.—

(i) IN GENERAL.—In the case of an eligible professional described in paragraph (2)—

(I) that is eligible for the maximum incentive payment under section 1848(o)(1)(A) for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1848(o)(1)(A).

(ii) METHODS.—In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1848(o)(1)(A) but is not de-

scribed in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1848(o)(1)(A); and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(C) FIXED SCHEDULE FOR APPLICATION OF LIMITATION ON INCENTIVE PAYMENTS FOR ALL ELIGIBLE PROFESSIONALS.—In applying section 1848(o)(1)(B)(ii) under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

(4) PAYMENT ADJUSTMENT.—

(A) IN GENERAL.—In applying section 1848(a)(7) under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of percentage points by which the applicable percent (under section 1848(a)(7)(A)(ii)) for the year is less than 100 percent; and

(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE PHYSICIAN EXPENDITURE PROPORTION.—The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

(5) QUALIFYING MA ORGANIZATION DEFINED.—In this subsection and subsection (m), the term “qualifying MA organization” means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act).

(6) MEANINGFUL EHR USER ATTESTATION.—For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner speci-

fied by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1854(a)(1)(A)(iv), identifying—

(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1848(o)(2)) for a year specified by the Secretary; and

(B) whether each eligible hospital described in subsection (m)(1), with respect to such organization, is a meaningful EHR user (as defined in section 1886(n)(3)) for an applicable period specified by the Secretary.

(7) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of—

(A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and

(B) the eligible professionals of such organization for which such incentive payment is based.

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

(B) the methodology and standards for determining eligible professionals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1848(o)(2), including specification of the means of demonstrating meaningful EHR use under section 1848(o)(3)(C) and selection of measures under section 1848(o)(3)(B).

(m) APPLICATION OF ELIGIBLE HOSPITAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) APPLICATION.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1886(n) and 1886(b)(3)(B)(ix) shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1886(n)(6)(A)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

## (3) ELIGIBLE HOSPITAL INCENTIVE PAYMENTS.—

(A) IN GENERAL.—In applying section 1886(n)(2) under paragraph (1), instead of the additional payment amount under section 1886(n)(2), there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

(i) shall, insofar as data to determine the discharge related amount under section 1886(n)(2)(C) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1886(n)(2)(D) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

## (B) AVOIDING DUPLICATION OF PAYMENTS.—

(i) IN GENERAL.—In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1886(n) and not under this subsection.

(ii) METHODS.—In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1886(n) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1886(n); and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

## (4) PAYMENT ADJUSTMENT.—

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in section 1853(l)(5)), if, according to the attestation of the organization submitted under subsection (1)(6) for an applicable period, one or more eligible hospitals (as defined in section 1886(n)(6)(A))



that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1886(n)(3)) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of the percentage point reduction effected under section 1886(b)(3)(B)(ix)(I) for the period; and

(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.

(5) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

(B) a list of the names of the eligible hospitals for which such incentive payment is based.

(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1886(n)(3), including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.

## (n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term “blended benchmark amount” means for an area—

(A) for 2012 the sum of—

(i)  $\frac{1}{2}$  of the applicable amount for the area and year; and

(ii)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

## (2) SPECIFIED AMOUNT.—

(A) IN GENERAL.—The amount specified in this subparagraph for an area and year is the product of—

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4); and

(ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) APPLICABLE PERCENTAGE.—Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked—

(i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;

(ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;

(iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or

(iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) PERIODIC RANKING.—For purposes of this paragraph in the case of an area located—

(i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or

(ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-YEAR TRANSITION FOR CHANGES IN APPLICABLE PERCENTAGE.—If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

(i) the applicable percentage for the area for the previous year; and

(ii) the applicable percentage that would otherwise apply for the area for the year.

(E) BASE PAYMENT AMOUNT.—Subject to subparagraph (F), the base payment amount specified in this subparagraph—

(i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or

(ii) for a subsequent year that—

(I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.

(F) APPLICATION OF INDIRECT MEDICAL EDUCATION PHASE-OUT.—The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) ALTERNATIVE PHASE-INS.—

(A) 4-YEAR PHASE-IN FOR CERTAIN AREAS.—If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least \$30 but less than \$50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I)  $\frac{3}{4}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{4}$  of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I)  $\frac{1}{2}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I)  $\frac{1}{4}$  of the applicable amount for the area and year; and

(II)  $\frac{3}{4}$  of the amount specified in paragraph (2)(A) for the area and year; and

(iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-YEAR PHASE-IN FOR CERTAIN AREAS.—If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least \$50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I)  $\frac{5}{6}$  of the applicable amount for the area and year; and

- (II)  $\frac{1}{6}$  of the amount specified in paragraph (2)(A) for the area and year;
- (ii) for 2013 the sum of—
  - (I)  $\frac{2}{3}$  of the applicable amount for the area and year; and
  - (II)  $\frac{1}{3}$  of the amount specified in paragraph (2)(A) for the area and year;
- (iii) for 2014 the sum of—
  - (I)  $\frac{1}{2}$  of the applicable amount for the area and year; and
  - (II)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area and year;
- (iv) for 2015 the sum of—
  - (I)  $\frac{1}{3}$  of the applicable amount for the area and year; and
  - (II)  $\frac{2}{3}$  of the amount specified in paragraph (2)(A) for the area and year; and
- (v) for 2016 the sum of—
  - (I)  $\frac{1}{6}$  of the applicable amount for the area and year; and
  - (II)  $\frac{5}{6}$  of the amount specified in paragraph (2)(A) for the area and year; and
- (vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) PROJECTED 2010 BENCHMARK AMOUNT.—The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

- (i)  $\frac{1}{2}$  of the applicable amount (as defined in subsection (k)) for the area for 2010; and
- (ii)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—

- (I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to “the previous year” were deemed a reference to 2010; and

- (II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (o) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) CAP ON BENCHMARK AMOUNT.—In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (o)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) NON-APPLICATION TO PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.

(o) APPLICABLE PERCENTAGE QUALITY INCREASES.—

(1) IN GENERAL.—Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary—

(A) for 2012, by 1.5 percentage points;

(B) for 2013, by 3.0 percentage points; and

(C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) INCREASE FOR QUALIFYING PLANS IN QUALIFYING COUNTIES.—The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) QUALIFYING PLANS AND QUALIFYING COUNTY DEFINED; APPLICATION OF INCREASES TO LOW ENROLLMENT AND NEW PLANS.—For purposes of this subsection:

(A) QUALIFYING PLAN.—

(i) IN GENERAL.—The term “qualifying plan” means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) APPLICATION OF INCREASES TO LOW ENROLLMENT PLANS.—

(I) 2012.—For 2012, the term “qualifying plan” includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) 2013 AND SUBSEQUENT YEARS.—For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) APPLICATION OF INCREASES TO NEW PLANS.—

(I) IN GENERAL.—A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (1), the applicable percentage under subsection (n)(2)(B) shall be increased—

(aa) for 2012, by 1.5 percentage points;

(bb) for 2013, by 2.5 percentage points; and

(cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) NEW MA PLAN DEFINED.—The term “new MA plan” means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) QUALIFYING COUNTY.—The term “qualifying county” means, for a year, a county—

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B)

for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) QUALITY DETERMINATIONS FOR APPLICATION OF INCREASE.—

(A) QUALITY DETERMINATION.—The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1852(e)).

(B) PLANS THAT FAILED TO REPORT.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) SPECIAL RULE FOR FIRST 3 PLAN YEARS FOR PLANS THAT WERE CONVERTED FROM A REASONABLE COST REIMBURSEMENT CONTRACT.—For purposes of applying paragraph (1) and section 1854(b)(1)(C) for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1851(c)(4)—

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(5) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.

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B. CHANGES IN EXISTING LAW PROPOSED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

**SOCIAL SECURITY ACT**

\* \* \* \* \*

**TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED**

\* \* \* \* \*

## PART C—MEDICARE+CHOICE PROGRAM

\* \* \* \* \*

## PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

## SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

## (1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e), (g), (i), and (l) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to  $\frac{1}{12}$  of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1854(f)(1)(E).

(ii) PAYMENT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.—For years beginning with 2006, the amount specified in subparagraph (B).

## (B) PAYMENT AMOUNT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.—

(i) PAYMENT OF BID FOR PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) PAYMENT OF BENCHMARK FOR PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) PAYMENT OF BENCHMARK FOR MSA PLANS.—Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan

described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—

(i) IN GENERAL.—The Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(ii) APPLICATION OF CODING ADJUSTMENT.—For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.

(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.5 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied



for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.9 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

(iv) *EVALUATION AND SUBSEQUENT REVISION OF THE RISK ADJUSTMENT SYSTEM TO ACCOUNT FOR CHRONIC CONDITIONS AND OTHER FACTORS FOR THE PURPOSE OF MAKING THE RISK ADJUSTMENT SYSTEM MORE ACCURATE, TRANSPARENT, AND REGULARLY UPDATED.—*

(I) *REVISION BASED ON NUMBER OF CHRONIC CONDITIONS.—The Secretary shall revise for 2017 and periodically thereafter, the risk adjustment system under this subparagraph so that a risk score under such system, with respect to an individual, takes into account the number of chronic*

conditions with which the individual has been diagnosed.

(II) *EVALUATION OF DIFFERENT RISK ADJUSTMENT MODELS.*—The Secretary shall evaluate the impact of including two years of data to compare the models used to determine risk scores for 2013 and 2014 under such system.

(III) *EVALUATION AND ANALYSIS ON CHRONIC KIDNEY DISEASE (CKD) CODES.*—The Secretary shall evaluate the impact of removing the diagnosis codes related to chronic kidney disease in the 2014 risk adjustment model and conduct an analysis of best practices of MA plans to slow disease progression related to chronic kidney disease.

(IV) *EVALUATION AND RECOMMENDATIONS ON USE OF ENCOUNTER DATA.*—The Secretary shall evaluate the impact of including 10 percent of encounter data in computing payment for 2016 and the readiness of the Centers for Medicare & Medicaid Services to incorporate encounter data in risk scores. In conducting such evaluation, the Secretary shall use data collected as encounter data on or after January 1, 2012, shall analyze such data for accuracy and completeness and issue recommendations for improving such accuracy and completeness, and shall not increase the percentage of such encounter data used unless the Secretary releases the data publicly, indicates how such data will be weighted in computing the risk scores, and ensures that the data reflects the degree and cost of care coordination under MA plans.

(V) *CONDUCT OF EVALUATIONS.*—Evaluations and analyses under subclause (II) through (IV) shall include an actuarial opinion from the Chief Actuary of the Centers for Medicare & Medicaid Services about the reasonableness of the methods, assumptions, and conclusions of such evaluations and analyses. The Secretary shall consult with the Medicare Payment Advisory Commission and accept and consider comments of stakeholders, such as managed care organizations and beneficiary groups, on such evaluation and analyses. The Secretary shall complete such evaluations and analyses in a manner that permits the results to be applied for plan years beginning with the second plan year that begins after the date of the enactment of this clause.

(VI) *IMPLEMENTATION OF REVISIONS BASED ON EVALUATIONS.*—If the Secretary determines, based on such an evaluation or analysis, that revisions to the risk adjustment system to address the matters described in any of subclauses (II) through (IV) would make the risk adjustment system under this subparagraph better reflect and appropriately weight for the population that is served by the

*plan, the Secretary shall, beginning with 2017, and periodically thereafter, make such revisions.*

*(VII) PERIODIC REPORTING TO CONGRESS.—With respect to plan years beginning with 2017 and every third year thereafter, the Secretary shall submit to Congress a report on the most recent revisions (if any) made under this clause, including the evaluations conducted under subclauses (II) through (IV).*

*(v) NO CHANGES TO ADJUSTMENT FACTORS THAT PREVENT ACTIVITIES CONSISTENT WITH NATIONAL HEALTH POLICY GOALS.—In making any changes to the adjustment factors, including adjustment for health status under paragraph (3), the Secretary shall ensure that the changes do not prevent Medicare Advantage organizations from performing or undertaking activities that are consistent with national health policy goals, including activities to promote early detection and better care coordination, the use of health risk assessments, care plans, and programs to slow the progression of chronic diseases.*

*(vi) OPPORTUNITY FOR REVIEW AND PUBLIC COMMENT REGARDING CHANGES TO ADJUSTMENT FACTORS.—For changes to adjustment factors effective for 2017 and subsequent years, in addition to providing notice of such changes in the announcement under subsection (b)(2), the Secretary shall provide an opportunity for review of proposed changes of not less than 60 days and a public comment period of not less than 30 days before implementing such changes.*

**(D) SEPARATE PAYMENT FOR FEDERAL DRUG SUBSIDIES.—**In the case of an enrollee in an MA–PD plan, the MA organization offering such plan also receives—

(i) subsidies under section 1860D–15 (other than under subsection (g)); and

(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–14(c)(1)(C).

**(E) PAYMENT OF REBATE FOR PLANS WITH BIDS BELOW BENCHMARK.—**In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year (as reduced by the amount of any credit provided under section 1854(b)(1)(C)(iv)).

**(F) ADJUSTMENT FOR INTRA-AREA VARIATIONS.—**

(i) **INTRA-REGIONAL VARIATIONS.—**In the case of payment with respect to an MA regional plan for an MA region, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

(ii) INTRA-SERVICE AREA VARIATIONS.—In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

(G) ADJUSTMENT RELATING TO RISK ADJUSTMENT.—The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

(i) the sum of—

(I) the monthly payment made under subparagraph (A)(ii); and

(II) the MA monthly basic beneficiary premium under section 1854(b)(2)(A); equals

(ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).

(H) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individ-

uals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) INITIAL IMPLEMENTATION.—

(i) IN GENERAL.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) PHASE-IN.—Except as provided in clause (iv), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) 10 percent of  $\frac{1}{12}$  of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006;

and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) DATA FOR RISK ADJUSTMENT METHODOLOGY.—Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.—

(I) EXEMPTION FROM PHASE-IN.—Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) PERIOD OF APPLICATION.—Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the methodology shall be applied uniformly without regard to the type of plan.

(4) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1857(e)(3))—

(A) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) ANNUAL ANNOUNCEMENTS.—

(A) FOR 2005.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

(i) MA CAPITATION RATES.—The annual MA capitation rate for each MA payment area for 2005.

(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in 2005.

(B) FOR 2006 AND SUBSEQUENT YEARS.—For a year after 2005—

(i) INITIAL ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

(I) MA CAPITATION RATES; MA LOCAL AREA BENCHMARK.—The annual MA capitation rate for each MA payment area for the year.

(II) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in such year.

(ii) REGIONAL BENCHMARK ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1854, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) BENCHMARK ANNOUNCEMENT FOR CCA LOCAL AREAS.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1860C–1(b)(1)(A)), the CCA non-drug monthly benchmark amount under section 1860C–1(e)(1) for that area for the year involved.

(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in such announcement.

(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service

program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A and for part B.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area that is an MA local area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D):

(A) BLENDED CAPITATION RATE.—For a year before 2005, the sum of—

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied (for a year other than 2004) by the budget neutrality adjustment factor determined under paragraph (5).

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) For 1998, \$367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a popu-



lation of more than 250,000, \$525, and for any other area \$475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) MINIMUM PERCENTAGE INCREASE.—

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2004 and each succeeding year, the greater of—

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D) 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

(i) IN GENERAL.—For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections, 1848(o), and 1886(n) and 1886(h).

(ii) PERIODIC REBASING.—The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a

per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

(A) for 1998, the “area-specific percentage” is 90 percent and the “national percentage” is 10 percent,

(B) for 1999, the “area-specific percentage” is 82 percent and the “national percentage” is 18 percent,

(C) for 2000, the “area-specific percentage” is 74 percent and the “national percentage” is 26 percent,

(D) for 2001, the “area-specific percentage” is 66 percent and the “national percentage” is 34 percent,

(E) for 2002, the “area-specific percentage” is 58 percent and the “national percentage” is 42 percent, and

(F) for a year after 2002, the “area-specific percentage” is 50 percent and the “national percentage” is 50 percent.

(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) PAYMENT ADJUSTMENT.—

(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

(I) for the indirect costs of medical education under section 1886(d)(5)(B), and

(II) for direct graduate medical education costs under section 1886(h).

(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the “national standardized annual Medicare+Choice capitation rate” for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians’ services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year (other than 2004), the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv), (a)(4), and (i) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the “national per capita Medicare+Choice growth percentage” for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (o) of section 1848 and subsections (b)(3)(B)(ix) and (n) of section 1886, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

- (i) for 1998, 0.8 percentage points,
- (ii) for 1999, 0.5 percentage points,
- (iii) for 2000, 0.5 percentage points,
- (iv) for 2001, 0.5 percentage points,
- (v) for 2002, 0.3 percentage points, and
- (vi) for a year after 2002, 0 percentage points.

(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare &

Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA PAYMENT AREA; MA LOCAL AREA; MA REGION DEFINED.—

(1) MA PAYMENT AREA.—In this part, except as provided in this subsection, the term “MA payment area” means—

(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an MA regional plan, an MA region (as established under section 1858(a)(2)).

(2) MA LOCAL AREA.—The term “MA local area” means a county or equivalent area specified by the Secretary.

(3) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1) for MA local plans—

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)(A)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section with respect to MA local plans for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section for such plans in the State shall not exceed the aggregate payments that would have been made under this section for such plans for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) AREAS.—In subparagraph (C), the terms “metropolitan statistical area”, “consolidated metropolitan statistical area”, and “primary metropolitan statistical area” mean any area designated as such by the Secretary of Commerce.

(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

(1) IN GENERAL.—If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1854(b)(2)(C)) for an MSA plan for a year is less than  $\frac{1}{12}$  of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual’s Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) PAYMENTS FROM TRUST FUNDS.—The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and for payments under subsection (l) and subsection (m) and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Payments to MA organizations for statutory drug benefits provided under this title are made from

the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)), a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv)) as of the effective date of the individual's—

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1886(d) or other payment provision under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) SPECIAL RULE FOR HOSPICE CARE.—

(1) INFORMATION.—A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

(A) a hospice program participating under this title is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) PAYMENT.—If an individual who is enrolled with a Medicare+Choice organization under this part makes an elec-



tion under section 1812(d)(1) to receive hospice care from a particular hospice program—

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).

(i) NEW ENTRY BONUS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) OFFERED DEFINED.—In this subsection, the term “offered” means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) COMPUTATION OF BENCHMARK AMOUNTS.—For purposes of this part, subject to subsection (o), the term “MA area-specific non-drug monthly benchmark amount” means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1860C–1(d)(2)(A), an amount equal to  $\frac{1}{12}$  of the annual MA capitation rate under section 1853(c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010,  $\frac{1}{12}$  of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011,  $\frac{1}{12}$  of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012,  $\frac{1}{12}$  of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1854(a)(6)(A)(iii)), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment;  
or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1858(f) for the region for the year.

(k) DETERMINATION OF APPLICABLE AMOUNT FOR PURPOSES OF CALCULATING THE BENCHMARK AMOUNTS.—

(1) APPLICABLE AMOUNT DEFINED.—For purposes of subsection (j), subject to paragraphs (2) and (4), the term “applicable amount” means for an area—

(A) for 2007—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

(B) for a subsequent year—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2) and (4)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year.

(2) PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—

(A) IN GENERAL.—Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of—

(i) the percent determined under subparagraph (B) for the year; and

(ii) the applicable phase-out factor for the year under subparagraph (C).

(B) PERCENT DETERMINED.—

(i) IN GENERAL.—For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

(ii) NUMERATOR BASED ON DIFFERENCE BETWEEN DEMOGRAPHIC RATE AND RISK RATE.—

(I) IN GENERAL.—The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

(II) DEMOGRAPHIC RATE.—The demographic rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to  $\frac{1}{12}$  of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(III) RISK RATE.—The risk rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under

subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(iii) DENOMINATOR BASED ON RISK RATE.—The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) REQUIREMENTS.—In estimating the amounts under the previous clauses, the Secretary shall—

(I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

(II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

(III) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

(V) as necessary, adjust the risk scores for lagged cohorts; and

(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

(v) AUTHORITY.—In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

(C) APPLICABLE PHASE-OUT FACTOR.—For purposes of subparagraph (A)(ii), the term “applicable phase-out factor” means—

- (i) for 2007, 0.55;
- (ii) for 2008, 0.40;
- (iii) for 2009, 0.25; and
- (iv) for 2010, 0.05.

(D) TERMINATION OF APPLICATION.—Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater than the amount estimated under subparagraph (B)(ii)(II) for the year.

(3) NO REVISION IN PERCENT.—

(A) IN GENERAL.—The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority of the Secretary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) PHASE-OUT OF THE INDIRECT COSTS OF MEDICAL EDUCATION FROM CAPITATION RATES.—

(A) IN GENERAL.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary’s estimate of the standardized costs for payments under section 1886(d)(5)(B) in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) PERCENTAGES DEFINED.—For purposes of this paragraph:

(i) PHASE-IN PERCENTAGE.—The term “phase-in percentage” means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

(ii) MAXIMUM CUMULATIVE ADJUSTMENT PERCENTAGE.—The term “maximum cumulative adjustment percentage” means, for—

(I) 2010, 0.60 percent; and

(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

(iii) STANDARDIZED IME COST PERCENTAGE.—The term “standardized IME cost percentage” means, for an area for a year, the per capita costs for payments under section 1886(d)(5)(B) (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) FEE-FOR-SERVICE AMOUNT.—The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.

(1) APPLICATION OF ELIGIBLE PROFESSIONAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) IN GENERAL.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1848(o) and 1848(a)(7) shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1848(o)) who—

(A)(i) is employed by the organization; or

- (ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and
  - (II) furnishes at least 80 percent of the professional services of the eligible professional covered under this title to enrollees of the organization; and
  - (B) furnishes, on average, at least 20 hours per week of patient care services.
- (3) ELIGIBLE PROFESSIONAL INCENTIVE PAYMENTS.—
- (A) IN GENERAL.—In applying section 1848(o) under paragraph (1), instead of the additional payment amount under section 1848(o)(1)(A) and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.
  - (B) AVOIDING DUPLICATION OF PAYMENTS.—
    - (i) IN GENERAL.—In the case of an eligible professional described in paragraph (2)—
      - (I) that is eligible for the maximum incentive payment under section 1848(o)(1)(A) for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and
      - (II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1848(o)(1)(A).
    - (ii) METHODS.—In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1848(o)(1)(A) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—
      - (I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1848(o)(1)(A); and
      - (II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.
  - (C) FIXED SCHEDULE FOR APPLICATION OF LIMITATION ON INCENTIVE PAYMENTS FOR ALL ELIGIBLE PROFESSIONALS.—In applying section 1848(o)(1)(B)(ii) under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.
- (4) PAYMENT ADJUSTMENT.—
- (A) IN GENERAL.—In applying section 1848(a)(7) under paragraph (1), instead of the payment adjustment being an

applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of percentage points by which the applicable percent (under section 1848(a)(7)(A)(ii)) for the year is less than 100 percent; and

(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE PHYSICIAN EXPENDITURE PROPORTION.—The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

(5) QUALIFYING MA ORGANIZATION DEFINED.—In this subsection and subsection (m), the term “qualifying MA organization” means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act).

(6) MEANINGFUL EHR USER ATTESTATION.—For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1854(a)(1)(A)(iv), identifying—

(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1848(o)(2)) for a year specified by the Secretary; and

(B) whether each eligible hospital described in subsection (m)(1), with respect to such organization, is a meaningful EHR user (as defined in section 1886(n)(3)) for an applicable period specified by the Secretary.

(7) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of—

(A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and

(B) the eligible professionals of such organization for which such incentive payment is based.

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

(B) the methodology and standards for determining eligible professionals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1848(o)(2), including specification of the means of demonstrating meaningful EHR use under section 1848(o)(3)(C) and selection of measures under section 1848(o)(3)(B).

(m) APPLICATION OF ELIGIBLE HOSPITAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) APPLICATION.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1886(n) and 1886(b)(3)(B)(ix) shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1886(n)(6)(A)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

(3) ELIGIBLE HOSPITAL INCENTIVE PAYMENTS.—

(A) IN GENERAL.—In applying section 1886(n)(2) under paragraph (1), instead of the additional payment amount under section 1886(n)(2), there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

(i) shall, insofar as data to determine the discharge related amount under section 1886(n)(2)(C) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1886(n)(2)(D) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of



the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

(B) AVOIDING DUPLICATION OF PAYMENTS.—

(i) IN GENERAL.—In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1886(n) and not under this subsection.

(ii) METHODS.—In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1886(n) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1886(n); and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(4) PAYMENT ADJUSTMENT.—

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in section 1853(l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1886(n)(6)(A)) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1886(n)(3)) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of the percentage point reduction effected under section 1886(b)(3)(B)(ix)(I) for the period; and

(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the pro-

portion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.

(5) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

(B) a list of the names of the eligible hospitals for which such incentive payment is based.

(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1886(n)(3), including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.

(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term “blended benchmark amount” means for an area—

(A) for 2012 the sum of—

(i)  $\frac{1}{2}$  of the applicable amount for the area and year; and

(ii)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(2) SPECIFIED AMOUNT.—

(A) IN GENERAL.—The amount specified in this subparagraph for an area and year is the product of—

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4); and

(ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) APPLICABLE PERCENTAGE.—Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked—

(i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;

(ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;

(iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or

(iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) PERIODIC RANKING.—For purposes of this paragraph in the case of an area located—

(i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or

(ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-YEAR TRANSITION FOR CHANGES IN APPLICABLE PERCENTAGE.—If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

(i) the applicable percentage for the area for the previous year; and

(ii) the applicable percentage that would otherwise apply for the area for the year.

(E) BASE PAYMENT AMOUNT.—Subject to subparagraph (F), the base payment amount specified in this subparagraph—

(i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or

(ii) for a subsequent year that—

(I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.

(F) APPLICATION OF INDIRECT MEDICAL EDUCATION PHASE-OUT.—The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same

manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) ALTERNATIVE PHASE-INS.—

(A) 4-YEAR PHASE-IN FOR CERTAIN AREAS.—If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least \$30 but less than \$50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I)  $\frac{3}{4}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{4}$  of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I)  $\frac{1}{2}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I)  $\frac{1}{4}$  of the applicable amount for the area and year; and

(II)  $\frac{3}{4}$  of the amount specified in paragraph (2)(A) for the area and year; and

(iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-YEAR PHASE-IN FOR CERTAIN AREAS.—If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least \$50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I)  $\frac{5}{6}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{6}$  of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I)  $\frac{2}{3}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{3}$  of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I)  $\frac{1}{2}$  of the applicable amount for the area and year; and

(II)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area and year;

(iv) for 2015 the sum of—

(I)  $\frac{1}{3}$  of the applicable amount for the area and year; and

(II)  $\frac{2}{3}$  of the amount specified in paragraph (2)(A) for the area and year; and

(v) for 2016 the sum of—

(I)  $\frac{1}{6}$  of the applicable amount for the area and year; and

(II)  $\frac{5}{6}$  of the amount specified in paragraph (2)(A) for the area and year; and

(vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) PROJECTED 2010 BENCHMARK AMOUNT.—The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

(i)  $\frac{1}{2}$  of the applicable amount (as defined in subsection (k)) for the area for 2010; and

(ii)  $\frac{1}{2}$  of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—

(I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to “the previous year” were deemed a reference to 2010; and

(II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (o) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) CAP ON BENCHMARK AMOUNT.—In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (o)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) NON-APPLICATION TO PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.

(o) APPLICABLE PERCENTAGE QUALITY INCREASES.—

(1) IN GENERAL.—Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary—

(A) for 2012, by 1.5 percentage points;

(B) for 2013, by 3.0 percentage points; and

(C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) INCREASE FOR QUALIFYING PLANS IN QUALIFYING COUNTIES.—The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) QUALIFYING PLANS AND QUALIFYING COUNTY DEFINED; APPLICATION OF INCREASES TO LOW ENROLLMENT AND NEW PLANS.—For purposes of this subsection:

(A) QUALIFYING PLAN.—

(i) IN GENERAL.—The term “qualifying plan” means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or

higher based on the most recent data available for such year.

(ii) APPLICATION OF INCREASES TO LOW ENROLLMENT PLANS.—

(I) 2012.—For 2012, the term “qualifying plan” includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) 2013 AND SUBSEQUENT YEARS.—For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) APPLICATION OF INCREASES TO NEW PLANS.—

(I) IN GENERAL.—A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (1), the applicable percentage under subsection (n)(2)(B) shall be increased—

(aa) for 2012, by 1.5 percentage points;

(bb) for 2013, by 2.5 percentage points; and

(cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) NEW MA PLAN DEFINED.—The term “new MA plan” means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) QUALIFYING COUNTY.—The term “qualifying county” means, for a year, a county—

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) QUALITY DETERMINATIONS FOR APPLICATION OF INCREASE.—

(A) QUALITY DETERMINATION.—The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1852(e)).

(B) PLANS THAT FAILED TO REPORT.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) SPECIAL RULE FOR FIRST 3 PLAN YEARS FOR PLANS THAT WERE CONVERTED FROM A REASONABLE COST REIMBURSEMENT CONTRACT.—For purposes of applying paragraph (1) and section 1854(b)(1)(C) for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1851(c)(4)—

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(5) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.

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